17.0709.03000

FISCAL NOTE

Requested by Legislative Council
01/23/2017

Amendment to: HB 1256

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures				$31,775		$12,429
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1256 authorizes regulation and license of dental therapist; provides two new board members; requires rules amendments; requires periodic reports to legislative management.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

It is anticipated that costs for the addition of dental therapists would not be offset by dental therapist license fees because minimal number of dental therapist licenses are expected due to a limited number of educated therapists. Annual costs associated with meetings of the Board for two new members include honorariums, meals, mileage, and lodging expenses; $5500 for 2017-2019 and $5500 plus a five percent increase per year for the years 2019-2021.

Based on the previous administrative rulemaking process, including reproduction of law books, newspaper publication for hearings, additional Board meeting costs: $6000. Revision of Board website pages, programming and content of website, updating the "forms tool," estimated expenses: $12,000. Web page content revisions administrative time, estimated expenses: $2500.

The North Dakota Board of Dental Examiners operates under ND 54-44-12, deposit and disbarment of funds of occupational and professional boards, and does not receive monies from the State's general fund. The NDBDE would offset increased costs by increasing renewal and licensing fees.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

A fiscal impact to allow dental therapists would not be offset by dental therapist license fees. Small numbers of dental therapists are anticipated due to a limited number of available therapists. Due to anticipating a limited number of dental therapists seeking license in ND, additional revenue from dental therapists' licenses for 2017-2021 would be negligible.

The North Dakota Board of Dental Examiners does not obtain general funds and is not included in the executive budget.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Approximately $20,000 of the $31,775 would be required as a one-time expenditure for implementation of HB1256 with the remainder incurred biennially.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Name: Rita Sommers
Agency: ND Board of Dental Examiners
Telephone: 701-833-9551
Date Prepared: 01/24/2017

17.0709.02000

FISCAL NOTE

Requested by Legislative Council
01/23/2017

Bill/Resolution No.: HB 1256

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures				$31,775		$12,429
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1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1256 authorizes regulation and license of dental therapist; provides two new board members; requires rules amendments; requires periodic reports to legislative management.

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Name: Rita Sommers
Agency: ND Board of Dental Examiners
Telephone: 701-833-9551
Date Prepared: 01/24/2017

2017 HOUSE HUMAN SERVICES

HB 1256

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1256
1/18/2017
27055

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Judy Kepple

Explanation or reason for introduction of bill/resolution:

Relating to the regulation of dental therapists; to provide for reports; and to provide application

Minutes:

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

Chairman Weisz: called the committee to order.

Attendance taken.

Chairman Weisz: Opened the hearing on HB 1256
Is there testimony in support of HB 1256?

Representative Devlin: Introduced HB 1256
(Attachment 1)

Chairman Weisz: Questions for Representative Devlin from the committee? Seeing none.

Is there more testimony in support of HB 1256?

Josh Ashvig, AARP
(Attachments 2, 3, 4,)
These are from people that could not be present, J. Ashvig brought it.
(Attachment 5)

Chairman Weisz: Are there any questions from the committee? Seeing none.

Chairman Weisz: Further testimony in support of HB 1256.

Dr. Karl Self, Dir. Of the Division of Dental Therapy at the U. of Minnesota
(Attachment 6)

Chairman Weisz: Are the questions from the committee?

Representative McWilliams: Will the students that graduate from Minnesota have reciprocity to ND?

Dr. Self: That depends on how your state would set it up.

Chairman Weisz: If you expand your program to include ND how many people will be allocated for ND?

Dr. Self: That is yet to be determined.

Representative Westlind:What is the education process?

Dr. Self: We educate dental hygienists and dental therapists. Our program lasts 32 months. They have 10 classes that are required.

Representative Kiefert: Do they have to be in the same office as the dentist?

Dr. Self: A licensed therapist is in the office with the dentist. Once they are certified as advanced dental therapists they don't have to be in the office.

Representative Schneider: How do you get people to go to areas where there are gaps in care?
Dr. Self: Most of our students want to go where they can make a difference. Also the state of Minnesota has a loan forgiveness program that encourages them to go to some of those areas.

Representative Schneider: Have you done research in ND to see where it is needed?

Dr. Self: I only deal with Minnesota.

Representative Skroch: How close is the Certified Advance Dental Therapist to being a dentist?

Dr. Self: They are not any closer as a Certified Advanced Therapist or a regular dental therapist

Representative McWilliams: Do you carve out a place, so that you can now not train as many dentist?

Dr. Self: No, there are actually more people in the dental program now. That program is always growing.

Representative P. Anderson: Where else are they training dental therapists.

Dr. Self: The states of Washington and Oregon are in the beginning stages, but have nnot graduated a class.

Representative P. Anderson: Does Alaska have a program?

Dr. Self: Alaska has a program, but are making changes. Vermont is working on a program, as well

Representative Seibel: How much practical, clinical training do they get?

Dr. Self: Therapists have one year and dentists have two years.

Chairman Weisz: Further testimony in support 1256.

Christy Jo Fogarty, the first certified advanced dental therapist in the state of Minnesota (Attachment 7)
I have had a very rewarding occupation and I urge a do pas on HB 1256.

Chairman Weisz: Are there questions from the committee for Ms. Fogarty?

Representative D. Anderson: Can you walk me through the supervision of the dentist in the extraction of the tooth. How you worked with the dentist?

Ms. Fogarty: At that time I was still a dental therapist so I was working in the building. The dentist and I looked at the x-rays together and determined that the tooth needed to come out. It was abscessed. Then I was allowed to take the tooth out. My dentist allows me to do everything that is within my scope of practice. You are working with a dentist that you both decide what you are comfortable with. In the beginning my dentist did not want me to do stainless steel crowns. It wasn't that she didn't think I was competent, she just wanted to do them herself. So she was able to restrict me from doing stainless steel crowns. This was a determination that we made together. If I was working in the building the doctor and I decided together that the tooth should come out and I did the extraction. If I were working offsite, then we work off of standing orders.

Representative D. Anderson: How often do you use tele medicine in your practice.

Ms. Fogarty: Daily. We have a brick and mortar building in Minneapolis that I can go 3 months without setting foot in. I mainly work in Head Start and I am commuting to all kinds of schools, so I am almost always in our schools working off site.

Representative McWilliams: Do you ever find yourself in the position where you are doing a procedure and felt like you had a lack of education and wish you knew more about that procedure or about the background in case something went wrong.

Ms. Fogarty: I never found myself in the position where I felt like I did not have enough education. There were some times when I felt I wanted to refer to an oral surgeon or someone that had more skills. It wasn't from lack of education or experience, but because it was just the kind of procedure that needed to be referred to someone with greater expertise and we have the authority to do that and have done that before.

Chairman Weisz: Further questions from the committee? Seeing none. Thank you.

Chairman Weisz: Further testimony in support of HB 1256?
8:18
Michael T. Hamilton, Researcher
(Attachments 8, 9)

Chairman Weisz: Questions from the committee for Mr. Hamilton?
18:22

Chairman Weisz: Are there any questions from the committee? Seeing none.
Chairman Weisz: Further testimony in support of HB 1256?

Jenna Herman, Family Nurse Practioner
(Attachment 10)

Chairman Weisz: Questions from the committee? Seeing none, thank you.
Is there further testimony in support of HB 1256?

Donene Feist, Exe. Dir. Of Family Voices of ND
(Attachment 11)
20:17
Chairman Weisz: Questions from the committee?

Representative Kiefert: I am not sure if this is the correct witness to ask this question, but perhaps one of those still coming will be able to answer it. We have heard there are two different classifications for therapists. One can travel and one cannot. In ND line 5 beginning on page 5 leads to my question can dentist therapists set up shop in a different place than the dentist and if so, can they write prescriptions?

Chairman Weisz: Someone else may be able to answer that question.

Chairman Weisz: Further testimony in support of HB 1256?

Renee Stromme, Exe. Dir. Of ND Women's Network
Attachment 12
29:15

Chairman Weisz: Are there questions from the committee?

Representative P. Anderson: You said that dental hygienists make $35-$40 an hour. How much do therapists make?

R. Stromme: No, that is what the dental therapists make.

Representative P. Anderson: Ok, then what do the hygienists make?

R. Stromme: Hygienists make less, but I am not sure. They are about $10 less per hour.

Chairman Weisz: Further questions from the committee? Seeing none. Is there further testimony in support of HB 1256?

Connie Kalanek, NDDHA 32:30 gave testimony for Dana Schmidt
(Attachment 13, 14)
If you have questions for Dana I can email them to her. I spoke to here recently and asked her what it would take for her to become a dental therapist in her rural community. She has an associate degree and she would need to obtain a bachelor's degree and then continue the course work for dental therapist as she understood it.

Chairman Weisz: Are there questions from the committee?

Chairman Weisz: Further support for HB 1256?

Dr. Self: I believe the question was would ND law allow a provider, dental therapist, to work in other areas outside of dental office and whether they have prescription authority. I am not an expert in ND law, but my understanding is that given the fact that they are eligible to work under general supervision, it would be up to the dentist to allow them to do that, but the law would give them that flexibility. As far as prescription authority it is my understanding that they cannot write prescriptions.

Chairman Weisz: Further questions from the committee?
Chairman Weisz: is there any further testimony in support of HB 1256?
I am sure there will be some to testify on the other side of this, so we will take a 7 minute break. We will start the opposition when we get back.

Chairman Weisz: We will call the committee back to order, please.

Chairman Weisz: Is there any testimony in opposition to HB 1256?

Senator Brad Bekkedahl, Dentist
(Attachment 15) 39:25
A couple of other comments I make. I would be remiss if I didn't welcome my colleague, Dr. Karl Self. We were classmates at the U of M many years ago. I am happy to see that he is engaged. I wish it was under different circumstances, but we are both here and we know each other. It is good to see you, Karl. I don't think I have seen you for over 30 years. There was some testimony earlier about demographics from institutes. I am not sure how many of dentists, but they are experts in their field to give you a lot of numbers. I would like to address some of their facts. While 65% of people can't see dentists in ND I am not sure that they can't see dentist, because if you look at national statistics 50% of the population doesn't want to see a dentist. We do have those issues. There are other issues in access to care as well, transportation, pay ability, and fear is a huge issue. I have seen it many times in my practice. I can't say the 65% of the people can't see a dentist in ND. It isn't because we don't have enough dentists or that people like me are refusing to see those people. I don't think that is the issue before you. The percentage of children missing school for oral pain is very high. In my 30+ years as a dentist, some of those were actually at a tribal agency clinic for 10 years to help keep that clinic operating when they couldn't find a dentist. Sometimes we have children that have pain in the night and the parents

would call us in the morning and we would get them in that day. I can never think of a situation where I denied access to a child in pain. Many times it was nights, weekends or whenever they could get there, but they missed a day of school. They say the dentist, got their treatment, and it was taken care of, but they still missed a day of school. So when this says that 31% of children had to miss a day of school because of a dental pain issue is not clear. They still miss school when they see us. In terms of elderly population seeing a dentist. I have just gone through a period where I lost my father after 7 years in a nursing home in Williston and I can tell you that our community dentists have stepped up and put a dental clinic into that facility and we go there to see patients. That is not something that we had to do. It is something that we wanted to do. We also for a period of 15 years carried a pager with us as a service to our hospital to come in on call 24 hours a day whenever they needed us to come in. We all did that and we helped out. That is not something we were paid to do. It frequently took a lot of our weekends and evenings when we should have had time to ourselves, but we did it. Plus we also saw our own patients after hours and weekends when they would call us. So again access to care issues. I can't remember ever denying anyone access to care in my clinic when I got a call that I was needed any hour of the day or night. Lastly I would tell you that there is a serious issue out there in promoting this campaign nationally. I would like to think we would look at this as a local issue and we will deal with it in the ND way and not have a national campaign tell us what to do. There is a lot of glossy print and demographic information. There are lot of dinners for stake holders and decision makers. There are a lot of travel opportunities for people to go places and see things. That's all paid for by somebody. This is a national campaign for smaller states to institute this program so it can be made to match the national model in other places. We want to do what is best for ND.

Chairman Weisz: Questions for Senator Bekkedahl?

Representative McWilliams: If you have a therapist that has to work under a dentist what is the worst scenario of moving forward with this program if the dental therapist has to be employed by a dentist anyway?

Senator Bekkedahl: I will tell you that these are going to be personal opinions based on my experience and what I have seen. I have issues with the quality of care. We do really difficult work, technically challenging work and I will tell you that a lot of the Medicaid patients that I saw are even more technically challenging because typically their issues have been delayed. They are very severe when they come in. I takes someone with a great deal of experience to treat that to the quality of standards that I would have, what I would want for myself or my family. The second issue that I see is opening up a scenario where we have small towns that have dentists in right now. I see this as a challenge for small town dentists to remain in small communities. It opens up the opportunity for more corporate dentistry coming to the state. If I were smart and wanted to make a lot of money, I would probably do this. Open up a large clinic somewhere in Bismarck, Grand Forks, Fargo, Williston, or Minot and employ a lot of dental therapists and actually shut down small town dentist's clinics, because they can't compete with me. I would have a corporate model that works at a higher financial level than they can attain. Those are the two things that I see as a challenge.

Representative Porter: I have a couple of questions. Regarding the inability of a dental therapist to write a prescription. So if you are employing a dental therapist and they are working 70 miles away from you and the patient need a prescription what problems would it pose for you as the doctor and prescription writer of prescribing medication to someone that you haven't physically seen?

Senator Bekkedahl : That would be a challenge for me for a couple of reasons. One, I would want to make the assessment and the FDA would want me to do that as well. We also have written script laws in ND that require me to deliver that script to that patient and not call in as we used to be able to do for pain medication. How that happens is that someone gets in a car and drives to Williston to get the script. It certainly is not very convenient for the patient.

Representative Porter: Recently we have kind of had an expansion in the Bismarck and Mandan area. As that happens, people come back and they want to throw their shingle out and own and operate their own business and in some cases this might be a dental practice. We have had two now in Bismarck that have gone out of business, so to me access inside of the business model of dentistry the way you pay your bills is you have your chair full. If you hire a therapist in rural ND in your practice for $72,800/year and they go out to rural ND and no one shows up that day. Now you are out that day's work and then the next day you have a full schedule and only half of the patients show up. We hear from the dental community all the time that it is not a matter of access to the chair and to the business, it's that this population isn't the greatest at full filling their appointments. You can't run your business when the chair is empty.

Senator Bekkedahl: You are exactly right. That is one of the challenges of a private dental practice in any case. It is a big issue, but it is not because they don't want to. Sometimes they can't get there or they can't get transportation. Transportation is a huge issue. That is not the way you run a business. It is still a business and if the model doesn't work, you will see dentists close up shop and do what has happened in Bismarck. That is unfortunate. I hope they went somewhere else in the state and helped us out. That is different than the Medicaid payment system to hospitals and other clinics on the medical side, because when you look at the medical side from when I was growing up. All of the doctors had their own clinic and their own place of practice. Now they are all working. They work for the hospitals. They are paid a salary and if someone doesn't show up they still get paid. They have ways to absorb that and we don't.

Representative Porter: That kind of comes full circle to my questions about rural areas and rural access. The number of patients needed to operate in the rural areas if there were enough patients to do that wouldn't the business owner see that and throw up his shingle? I see this as using the excuse of rural access to bring in dental therapy in to our state so they can all practice in urban areas. That is what they will do anyway.

Senator Bekkedahl: If I thought this would fix the system, I would be the first one up there to say let's do this. Let's fix the system, but I don't think this fixes the system as it is being described here today. First of all, I don't think the system is as broken as it is being painted to be. You hear lots of information that can be used whatever way you want it to be. Let's take Slope County for example. It is a county in our state with about 700 residents not very

far from me. We are criticized because they don't have a dentist. Statically you need about 1800 patients in your system to support a dental clinic in a solo practice. That is just what it takes to be able to pay the bills. They will probably never have a dentist with only 700 people in the county, but they have access to dentists nearby. That is what we do. We provide as close as we can to the people that need it.

Chairman Weisz: What about the liability issue? The bill doesn't seem to address anything. If you hire a dental therapist will that effect your malpractice insurance or do you have liability insurance. You would be the supervising dentist the way the bill is written.

Senator Bekkdahl: I don't know how that model works. I would assume that it would be under my liability and as the supervising dentist I would be liable for anything that goes wrong. That is what goes back to my concerns about the quality of care. If the quality of care is not at the standard that I think it should be then I would be liable ethically and I am probably also liable legally. I don't want to put my license in that kind of jeopardy. If they are 70 miles away and they are doing something. Trust me I have seen a lot of things go wrong in my 33 years of practice. There are a lot of things that can happen with the human anatomy that you don't understand until they actually happen. When they do happen, you don' have a lot of time to react to that. If it is 70 miles away from me and I have a person in that clinic providing that service and something goes bad, I am really nervous. I am more nervous about the health and welfare of that patient than I am about my liability.

Representative Skroch: If this would go corporate how many therapists could one dentist manage? How would that play out?

Senator Bekkdahl: I don't have an answer to that, but it is one of my fears. I don't know if there is a limit to how many therapists you could have under one license or not. It would be a nightmare to keep track of the quality of care with that many practitioners out there, but I suppose that could be the case. It is not the fear of the challenge that somebody is going to have a big office and run me out of business. I guess the fear is the management of the quality of care issues and making sure that the small towns that do have a dentist right now could lose that opportunity.

Representative Skroch: I am suspecting that one of your highest costs in your practice is you malpractice insurance or liability insurance, so in the corporate setting you could spread that cost out over a much broader income and be much more successful financially than independent dentists trying to maintain a solo practice?

Senator Bekkdahl: That is an issue that I don't know anything about, because I am not an insurance person, but I suspect there would be riders and such which would be extra cost to the corporate entity of the dentist, so I am not sure that would be an advantage. The other advantage would is that the more people you have working for you the less administrative costs you have. That is a plus.

Representative McWilliams: If you were uncomfortable with any part of the scope of care that the therapist can do you can limit that scope of care if you want to within this bill. Is that correct? You can limit it until you feel comfortable with that therapist.

Senator Bekkdahl: You will see testimony behind me where people will bring up that exact circumstance. In my case, I would probably be most comfortable with my hygienist doing as much as they are able to do. I could probably use a dental therapist and have them do one or two procedures that I could be comfortable with, but I am not sure that solves the issue that people are saying they can solve with this.

Chairman Weisz: Further questions from the committee? Seeing none, thank you.

Chairman Weisz: Further testimony in opposition to HB 1256
1:03
Dr. Katie Stewart, President of the ND Dental Association
(Attachment 16)

Does not save money. Procedures are paid at a rate regardless of who performs it.
(Attachment 17)

Chairman Weisz: questions from the committee?
1:13:19

Representative Schneider: When you said that the dental therapists are congregating in the cities, could they be underserved area as well?

Dr. Stewart: Absolutely they could be. I went to school at the U of M and I practiced in some of those outreach clinics in the inner part of Minneapolis and there are definitely underserved areas there, but most of the underserved areas in Minnesota are north of the interstate. If you look at the numbers of the therapists that are centered around the twin cities area and not in northern rural Minnesota. They are helping in some of those underserved areas in the metro, but that doesn't address the access to care issues in northern Minnesota.

Representative Schneider: Are you aware of the real issues in rural areas? We have heard testimony about a lot of different things, so can you give us facts so we know what we are dealing with?

Dr. Stewart: Yes, having been in a dental practice in Bismarck for the last 9 ½ years, I know there are problems. I have been more involved in the ND Dental Assoc. in the past 5 years and I have seen the things they are trying to help with these solutions. We are all trying to rally all the 300 dentists in ND. One dentist can't solve the problem, but 300 can make a difference. Together we can deal with this with what we already have in ND. We are listening and coming up with ND solutions to our problems. The ND Dental Assoc. has been trying to do the Take 5 program where they encourage each dentist to take 5 more on Medicaid. Take 5 more patients, or 5 more families or whatever works in your practice, but take 5 more. As far as emergency room stuff that was brought up earlier, in Sanford in Fargo that has been set up for close to a year now where a dental clinic has agreed with Sanford that they will take all next day referrals from Sanford for dental emergencies. I think that is really helping in Fargo and the clinic is not flooded, so they are still able to see their regular patients. We are working to get that set up in Bismarck too. We are trying to get a direct referral program set up between Sanford and our Bridging the Gap Dental

Clinic which is our nonprofit clinic here. We are trying to get an electronic program set up between Sanford and the clinic so that right away in the morning they will have that information in front of them and be able to get them in. WE also have dentists that have agreed to see whoever Bridging the Gap can't get in that day. One thing that was brought up was about emergencies. Most dental issues that come in to the ER are not things that just came up. Most have had that problem for a while and for whatever reason just didn't get it taken care of in a timely manner. They need education on why they need to have regular checkups and regular maintenance to prevent some of these emergencies.

Representative Devlin: I want some clarification. What is irreversible surgery and where can they do that? We were told they couldn't do surgery because it is not within their scope of practice.

Dr. Stewart: Irreversible surgery is removing a tooth. You can't put that tooth back in. There are so many time that something that looks so simple turns out to be much more complicated. Sometimes you can't get someone numb no matter what you do and they are in pain. Sometimes they might have a heart issue and their blood pressure might sky rocket. Removing a tooth is a surgical procedure.

Representative Devlin: If the dentist was not comfortable with that he wouldn't let them do it. He can choose what he wants to allow them to do.

Dr. Stewart: Sometimes you don't know what will happen until you actually get in there.

Representative Devlin: They said that 48% of the therapists practice outside of the cities and 52% are practicing in the cities.

Dr. Stewart: I look at the map and see the area above the interstate and that is where the majority of the rural, underserved people are and I don't see many therapists there. I look at North Dakota as not being the same as Minnesota. Our rural and urban communities are different. We are a unique space and I don't think that comparison can be made.

Representative Seibel: You and Senator Bekkdahl keep talking about the quality care of care issues, but the testimony we heard in the interim committee was that there were no more complaints for therapists than there are for dentists. I am not quite sure where this quality issue is coming from.

Dr. Stewart: I am not sure there is really enough information out there about how they are doing. There is only one state doing it, so how do they even have enough information on it since there is just one state employing them and one state training them.

Representative McWilliams: How much time do you think we need to monitor the program in Minnesota before we would know if this program really works? So we could know what kind of pitfalls there might be or whatever. That program has been going on for about 7 years. Do we give it another 7 or 3 or just 1? In your professional opinion how much of a sample group do we need and how much time before we move forward?

Dr. Stewart: I don't know if there is a time, but why should we be jumping into something new before we look at our ND unique solutions. North Dakota dentists have been working on solutions that are already started and they we are seeing some good results in solving some of the access to care issues.

Representative McWilliams: Would you see a therapist and a dentist working together to continue to work on the solutions that you are working on or are they mutually exclusive that you cannot pursue these other solutions as the 300 dentists in our state along with the dental therapists?

Dr. Stewart: We already have programs in place. We would be able to save money.

Chairman Weisz: Are there further questions from the committee? How many dentists are currently licensed in ND? Do you have that number?

Dr. Stewart: Close to 400.

Chairman Weisz: Further testimony in opposition of HB 1256?
1:28
Anthony Hilleren,
(Attachment 18)

Chairman: Weisz: Questions from the committee? Where do you practice?

Dr. Hilleren: Benson, Minnesota

Chairman Weisz: Are there any questions from the committee? Seeing none.

Chairman Weisz: Further testimony in opposition to HB 1256?
1:40
Dr. Peder Arneson, a dentist in Fargo-Moorhead.
(Attachment 19)

Chairman Weisz: Are there questions from the committee?

Representative D. Anderson: How many patients do you see a day and how many days a year do you work? If you don't mind my asking.

Dr. Arneson: In the morning I can see between 7-10 patients and afternoon can be about the same. I would say about 14 - 15 patients a day that would be a relatively average day. We also have exams that are needed. It also depends on whether our patients show up which was expressed earlier that is a continuing issue at some of these clinics where people have transportation issues or even just weather can limit their ability to get to the clinic. As for how many days I work a year I get to work at 7. I usually take a ½ hour lunch and I work until 5. I work Monday – Thursday. On Fridays I still work with Apple Tree Dental and do nursing home work at some of the nursing homes around the Fargo-Moorhead area. If there is funding available, I have been working with community health

on Fridays as well. It is not necessarily every week, but it does make for some very long days if you have to travel to Grafton or Wilmar.

Representative Schneider: How do you feel about being cloned?

Dr. Arneson: I am not too fond of those kinds of experiences.

Representative Schneider: Thank you for all you do. We were pretty concerned with a statistic we got earlier and I don't know if you got it, so I want to read you and if you have ideas about how we can fix this with dentists, great. After you hear I would like to know if you think the dental therapy program might be one way to address this as well. "Nearly half of ND counties have no dentists or just one and 2/3 of kids on Medicaid aren't getting the care they need ranking us 3rd worst in the nation. With only 56% of the dentists in the state accepting Medicaid, it is a clear there is a lack of access to care." What can we do about that? I know you are doing everything you can do and maybe even more, but do you have any ideas about how we can meet this massive need and could the dental therapy program be part of that?

Dr. Arneson: The number of payment options that do exist whether it is through the state or through the National Health Service Corp. are phenomenal options. I do think that expansion of something like that would be one of the options in recruiting dentists to come to these underserved areas whether it be in the far west of ND or up near Grafton in the north east corners of the state. That would be one way of improving access. I do echo Dr. Hilleren's testimony in that I am a very open minded person to many things and working with a diverse group of people to help accomplish a common goal. You have that hear wirth the individuals in this room and talking is going to be the best way to move forward.

Representative Schneider: We did look at a dental loan repayment program and we had trouble keeping dentists for the length of time they were supposed to be here to repay the loan. Do you see a place for a dental therapy program as part of the way to address these overall needs even if you would prefer to have more dentists doing the work?

Dr. Arneson; It certainly is my opinion, but I believe that ND does face different issues than Minnesota might. To equate those two without knowing what results we have is not tested as a solution. I can't agree with moving forward with something in ND right now, because of the issues I see in the majority of patients that walk in to my clinic on a walk in basis and we see 7 – 10 of those a day. I need to treat that, because it is usually a surgical extraction or something beyond what a dental therapist can treat.

Rep. Skroch: Do you have access to the same Medicaid programs for reimbursement to cover the costs of services provided that a dental therapist would also be able to access to provide care to the most needy patients and is there a reason why some dentists do not accept Medicaid patients?

Dr. Arneson: I am sorry I don't understand your question.

Representative Skroch: In order for you to receive reimbursement for services you have provided to the most needy who don't have the ability to pay, you are able to access Medicaid to cover those costs? Is that correct?

Dr. Arneson: I am not comfortable answering that question, because I am not involved in that end of the work. I focus on patient care and delivery of treatment.

Representative Skroch: Maybe there is someone else in the room that could answer that, but the other question is that you mentioned that some dentists don't accept Medicaid patients?

Dr. Arneson: I don't know if I was the one that mentioned that, but I do know that there are dentists that don't accept Medicaid patients. Reimbursement is part of that issue as well. Minnesota is different than North Dakota as well. There are different levels of reimbursement based on what state funds are available.

Chairman Weisz: Further questions from the committee?

Chairman Weisz: Further testimony in opposition to HB 1256

Dr. April Robinson, Dentist
(Attachment 20)
2:00
We now work to take care of the whole person and help find all kinds of illnesses.
Dentists need to wear many hats.
Cost is very prohibitive, because you would have to buy the same equipment twice while the other one could only do part of the scope of care.
2:05:20

Chairman Weisz: Questions from the committee?

Representative Schneider: The higher amount of care that you see that Medicaid patients need. Could it be helped to keep the costs down by seeing them earlier and having routine intervention? Could therapists help that?

Dr. Robinson: Yes, that is why I work with Head Start. We start with pregnancy and go all the way up to 5. That is why we are educating parents and starting kids that young, so that as they grow up that is what our hope is.

Representative Schneider: Could you have done that as a hygienist or do you see some roll for a dental therapist? Not necessarily a satellite one, but a dental therapist in working with the prevention?

Dr. Robinson: We can use all the help that we can get, but as you see the treatment needed is not just preventative or basic. You have to look at the whole person. The dentists are trained to look at all of those scopes. There are multiple reasons why people don't get care. There is not just one reason, but we need to be able to address all areas.

Chairman Weisz: Further questions?

How many more of you are planning to testify?

Chairman Weisz: Is there further opposition?

Chairman Weisz: Someone wants to provide so information in a neutral capacity.

Shawnda Schrader
I am here just to provide information. I have been working with those in opposition and support of this bill. I do not have a position, but I just wanted to answer some of the questions, because both sides have used data from our reports. I just wanted to be here to answer questions that you might have and to share information on a survey that we have been working with many partners in the state to complete. This is a survey that is still out. It is a survey of all of our licensed dentists in the state. It is still active. We have had about 28% of our dentists respond already and the questions that we have been asked multiple times are in regard to how busy our dentists are and another is whether or not they would participate in dental therapy if it were to pass. I just want to update you on those two points and then I will answer any questions you may have. Again these are preliminary results, but so far with 114 dentists responding the majority of dentists have reported not being overworked, 61%. Some are not busy enough, 21%. However in contradiction to other data we are also finding questions about support and participation of dental therapy. So far we are showing that in regard to participation whether or not they would participate in dental therapy if it were passed 60% said they would participate. If we look at rural versus urban providers, we have 24% of our rural dentists have responded saying they would participate depending on the details in dental therapy. I just wanted to provide you with that information and as the final surveys come in we will review that publically, but for now I just wanted to give you that data.

Representative Devlin: How long has the survey been out?

Shawnda Schrader: It has been out for2 1/2 weeks. We sent it out at the beginning of the year.

Chairman Weisz: When do you expect to be completing it?

S. Schrader: We are sending out one more round to those who did not respond. That will be out for 2 weeks and then there will be a final data result. We already have all of the codes built in so it should be final in 2 or 3 weeks.

Chairman Weisz: Further questions from the committee.

Vice Chairman Rohr: I have a question for K. Fogerty please. We had someone provide a scenario of a child with Autism. Could you explain to us what within your scope of practice would have helped you handle that situation? That is question 1 and the 2nd one is could you address the liability issue.

K. Fogerty: We deal with situations like this far too often. We work with special needs kids with all kinds of issues. We have several things within our system to help with these children. Contrary to what someone else said, we would see them more often, not less often. That would help desensitize them. We also have the advantage that we work in the schools with the aides that make them more comfortable. Also because I am doing all of the things within my scope of practice it opens up my dentist's time to get into surgery more often. In answer to your second question about insurance. Our clinic goes with an overall policy and it covers all of our providers. We did not see an increase at all when we added dental therapists. Some of the therapists have taken our individual policies and they have actually been given very low premiums. Part of that is because there is a long history of dental hygiene and the safety of working in that environment of being under a dentist supervision and they saw that as one more step in the ladder and it is a safe profession. If they are under an umbrella policy there is not an increase in rates at all.

Close hearing on HB 1256

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1256
1/31/2017
27687

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Judy Pepple

Explanation or reason for introduction of bill/resolution:

Relating to the regulation of dental therapists; to provide for reports; and to provide for application

Minutes: 1

Chairman Weisz: called the committee to order and opened the discussion on HB 1256
Representative Devlin: Do you have amendments on this bill

Representative Devlin:
(Attachment 1)

Explained his amendments to this bill.

Representative Devlin: I move that we accept the amendments.

Representative Porter: I second it.

Chairman Weisz: Representative Devlin, I am having a little struggle with the language there. The regulatory board would have to decide to let them go out of the facility.

Representative Devlin: I would be surprised if that is so, because legislative council worked on this three different times and say it is correct, but I will be happy to take it back and the we can deal with it next week.

Chairman Weisz: I am not saying it isn't right, I am just having some trouble understanding it. It says that they cannot perform the services provided in subsection 1 under the general supervision of a supervising dentist unless the regulatory board says they can.

Representative Devlin: Unless the regulatory board says they can. That would allow them to go off site, but the regulatory board would have to decide that.

Representative Schneider: I am concerned about the access of help to those on the Reservation and if Indian Health could use these people if we approved these therapists,

but if they have to be under direct supervision of the dentist in the office, does this help at all? I really don't know what is available on the reservation, but I would think it maybe there are not dental offices.

Representative Devlin: There is certainly a lack of dental providers on the reservation. I started this journey after being in Alaska and seeing how they worked up there to meet the needs of the Native American that were not being met. I have a reservation in my district and when I meet with those folks and ask them about dental practice they say the dentist they go to is the emergency room. They don't have one. There is federal funding in place for our region to use dental therapists on the reservation, but only if we pass this law. Those funds will not be available to ND unless we pass this bill. I believe that if you are going to reach the reservation, rural ND and reach the underserved needs of our state, we need fully trained dental therapists.

Representative Schneider: Will they be able to practice on the reservation if we adopt the amendment that says they have to be in a dental office. Is there a way to accommodate? both of those things?

Representative Devlin: I think there is a way. I think you will find the dentists willing to do that with five dental therapists or two dentists or whatever to make that work. It has certainly worked for the dentists there.

Chairman Weisz: They are limiting that the dentists have to be on site and that could prove difficult.

Devlin: In Oregon the tribes just got tired of fighting it and went directly to the federal government sovereign nation to sovereign nation. I would much rather be regulated by the ND board.

Representative Schneider: Do you think there would be a carve out or something that would work for the reservations something. You know either associate with a dentist in another area or do telemedicine connections or something that would not require them to recruit and establish a dental practice in order to be able to access. I wouldn't mind a carve out that would allow them to associate with another dentist and get supervision just on the reservation in a way that is needed to provide access.

Representative Devlin: I was told that the Indian Health Service would work with the dentists to be sure that they are there along with dental therapists if this bill is passed. We are talking a lot of money to be available to our region, $17,000,864. That could be utilized to help meet the needs of the tribes in those states.

Representative Skroch: This is a question for Rep. Devlin. It is not only an issue of lack of people to provide the service, but also the lack of motivation of these people wanting to seek out the services that are available. They don't keep their appointments or show up for them . I am not sure if that will be alleviated by this or not.

Representative Devlin: I think it will go a long ways to alleviating the problem. I can point to the reservations where this is a problem. I can point to rural ND where it is a problem. I can

point to Fargo and Bismarck where it is a problem, because you saw that we don't have enough help. We need people trained in the state of ND to meet the needs so that they don't just go to the emergency room for their dental needs. These people are not just on the reservation. We have an opportunity to move ahead and we need to do it. If the dentists don't agree with this there will not be one dental therapist in the state of ND. I know that we are getting more dentists in the state of ND all the time and we have done some things to make that happen, but I do not believe that we are even going to have enough new dentists to fill the holes made by those dentists that want to retire. We have to d something more to expand the services to the people of ND. If the dentists don't agree with this, there won't be one dental therapist in the state of ND.

Representative Westlind: I look at the training that goes into these people and they were equated with nurse practitioners. The level of training is not even close to that of a nurse practitioner. I look down here and I talked to a dentist in my area, one of which practices at reservation south of Devils Lake one day a month. I also know that all of these dentists are taking Medicaid patients at this time. One of the simple surgical extraction of permanent teeth in many cases can turn bad where they require surgery where they have to pull the gums down and try to remove these teeth that are basically in chunks. I just don't feel that without a dentist being on sight they aren't going to have the ability to finish that when they run into problems. Maybe if they had more information and training it would work, but I don' think these people have enough training. If they would provide the training level of a nurse practitioner where they are in clinic more often or longer and also have a degree. These people go to school for 32 months. They do not have degrees. They are basically a technician and I feel that more education is necessary to implement a program like this. I know there a lots of young people on the reservation and in Cando where I am from that are not getting treatment, but I have to believe that a lot of that comes from parenting. The parents don't provide the care that these kids need and we can have dental therapists in every town, but it still is not going to alleviate the problem.

Representative Devlin: I didn't compare them to nurse practitioners. Their training that they get for what is in their scope of practice is the same as that of a dentist. I understand that the therapists have the year of prerequisites and the 32 months. I understand what the dentists do as well.But we are not asking these people to do what the dentists have trained to do past that stage. All we are asking them to do is what they were trained to do under the direct supervision of the dentist. I will say that I was involved when we increase what nurse practitioners can do and the same arguments came up only then they were from the doctors.

Representative McWilliams: I am not concerned with the training they have, but the training they don't have is what scares me. I had a grand mal seizure the last two times I went to the dentist and I am sure that a therapist would not necessarily know what to do then. It wasn't the person that gave me the shot, because I think they could both have done it equally as well, but it was that they didn't know what to do after that when I had the seizure I know that things can go wrong in a hurry.

Representative Devlin: The dentist will be there. That is the way the law is written. We changed it so that they will be there. Dental hygienists do a lot of work in the dentist's office that is within their scope of practice and the dentist is there. This would be the same

The dental therapist will do the work within their scope of practice and the dentist will be there. That is why we changed it, so that the dentist will be there.

Representative McWilliams: As rules provided by the board would then give them permission to practice outside of the office. Is that the dental board then that would give the permission of the dental therapist to practice outside of the dental office? Is that correct?

Representative Devlin: Yes, that is correct. The way the dental board in the current time, it is more likely that you and I will be splitting the lottery tomorrow night than that they will give permission to do that.

Representative B. Anderson: I was concerned that the dentist could be 60 miles away. Now you have made that fear go away with your amendments.

Chairman Weisz: Representative Devlin, under your amendment though what if the board doesn't adopt any rules?

Representative Devlin: Under the amendment they wouldn't adopt any rules except if you wanted to move in to the general one.

Chairman Weisz: But this says "if authorized by the rules a dental therapist may not perform these services except section 1 which is what the therapist can do under this supervision, so they wouldn't be able to do anything.

Representative Devlin: My understanding only on the general. We can certainly run that back by legislative council.

Chairman Weisz: Maybe I am just hung up on the definition of general supervision. Do we have a definition of general supervision. You are saying that that section only applies to off campus so to speak.

Representative Devlin: Yes, that is the way this was drafted and that was the intent. That that would only apply to off site.

Representative Skroch: Again I am drawn to page 6 line 12. That is giving our authority away to a board. So what is to say that next session they change this and say that they now can go anywhere to practice without being in the same building?

Representative Devlin: The dental board now writes the rules for dentists in the state and then those rules come before the legislative rules committee to be sure they follow legislative intent. They have always had the authority to write the rules, so nothing will change.

Chairman Weisz: The next session could do whatever.

Representative Skroch: The rules could enable them to

Representative Devlin: Yes, they have that authority.

Representative Damschen: the next legislature could do whatever they want whether or not we pass this legislation.

Representative P. Anderson: I am bothered that not one dentist in ND said they would hire a dental therapist. I received emails and phone calls.

Representative Devlin: According the dental in UND about 20% of them would.

Chairman Weisz: Remember committee, we have an amendment before us. We can continue the discussion, but don't forget about that. I have the intern looking it up, but I think there is a difference between supervision and general supervision.

Representative Schneider: Can we just clarify that you want direct supervision, right? Is it your intent that dental therapists could not perform that list of duties except under the general supervision of a dentist?
things unless they were under the direct supervision of the dentist.

Chairman Weisz: No. If the board would approve it they would be able to do it off site. If the board would approve it then they would be allowed to do it offsite.

Representative Skroch: That is the only way that you could service those people that need the most help.

Representative Devlin: Yes, that would be the only way that you could send someone offsite by themselves. If the board approved it.

Chairman Weisz: changing it to a maximum of 5 therapists under a dentist and the only time that they can practice out of the office the dental board has ruled on that.

Representative McWilliams Why is it limited to 5?

Representative Devlin: That seemed be the comfort level of practices in Minnesota that were using that. That is where it came from. It could have been 3 or whatever.

Voice vote to adopt the amendments taken.
Motions carried.

Chairman Weisz: Now we have an amended bill before us. Are there any further amendments? Seeing none.

Representative Devlin: I move a do pass as amended to HB 1256
Discussion

Representative Seibel: Seconded it.

Chairman Weisz: Ok now committee, we have an amended bill before us. Now we can discuss it.

Representative Damschen: I will probably support it in the committee here, but I do want to talk to my dentist and share the amendments with them. I can then reserve my options for on the floor. I feel that they were not real understanding of what the original bill did when visited with them.

Representative Seibel: The only thing that I heard was that they were concerned about their level of training. We went back to Dr. Self in Minnesota. Remember a dental therapist is trained in 94 codes and a dentist is trained to do 498 codes. So the dental therapist spends one year learning 94 codes and the dentist spends 2 years learning 498 code, so the dentist learns 404 more codes in one year. So I think they are as well trained as the dentists are. The other thing is according to Dr. Schrader from UND Center for Rural Health, in her survey she has had 28% of the dentists respond in 2 ½ weeks and 16% said they would participate 24% of rural dentists said they will participate.

Representative McWilliams: I understand the training, but what I have heard from my dentist and other dentists is that they may know those 94 procedures very well, but what about the 2 years of medical school training prior to back up what they have learned like a.regular dentist has.

Representative Skroch: This is one where I am really caught on the fence. I have had many people contacting me to vote against this, but not one that asked me to vote for it. I would feel much more comfortable voting for this if I had people that support it. My community has many low income families and I haven't heard from them. That concerns me.

Representative Devlin: The only ones I have heard against this are the dentists. I have heard from many others that are really in favor of it. Only the dentists are against this.

Representative McWilliams: I think if we voted on this today my vote would be no. I would like to go talk to my dentist and wait to vote on this tomorrow.

Chairman Weisz: I don't think we will be able to do this tomorrow. If you wish to vote and then change it when you get to the floor that is fine, but just let me know. I guess we have had this bill here for quite a while and I would like to take it up. Just for the committee, I wil read you the definition of general supervision. "If the dentist has authorized the procedure and they are carried out in accordance with the dentist's diagnosis is necessary and treatment plan. The dentist is not required to be in the treatment facility."

Chairman Weisz: Further discussion

Representative Kiefert: I wasn't going to speak on this. Most of the people that talked to me were opposed to this. In the other fields, if we are short on something we deal with that not putting in a "kind of dentist".

Representative D. Anderson: We need more help in some way. We need to do something.

Representative Schneider: I like my dentist and I am concerned that we still have between 50 -60% of kids that don't get these services. Those are the ones that need this the most I

appreciate all the dentists try to do and yet we are still facing a terrible problem.

Representative Devlin: the whole $17,000,000 doesn't come into ND. It is for the region, but we are certainly working with Indian Health Services and we would be eligible to receive some of that funding if this is passed.

Chairman Weisz: Further questions or further discussion? If not, the clerk will call the roll for a do pass as amended on HB 1256.

Roll call vote taken. Yes 8 No 6 Absent 0
Motion carried for a do pass as amended on HB 1256.

Carrier will be Representative Devlin

Chairman Weisz: we will change the carrier to Representative D. Anderson.

17.0709.02002
Title.03000

Prepared by the Legislative Council staff for
Representative Devlin
January 31, 2017

1/31/17

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1256

Page 5, line 6, replace the first underscored comma with "or"

Page 5, line 6, remove ", or general"

Page 6, line 12, after "2." insert "Unless authorized by rules adopted by the board, a dental therapist may not perform the services provided in subsection 1 under the general supervision of a supervising dentist.

3."

Page 6, line 14, replace "3." with "4."

Page 9, line 16, after the underscored period insert "Except as otherwise authorized by rule, a supervising dentist may enter a written collaborative management agreement with no more than five dental therapists at any one time."

Renumber accordingly

Date: 1-31-17
Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1256

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 17.0709.02002

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. Devlin Seconded By Rep. Porter

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. P. Anderson		
Vice Chairman Rohr			Rep. Schneider		
Rep. B. Anderson					
Rep. D. Anderson					
Rep. Damschen					
Rep. Devlin					
Rep. Kiefert					
Rep. McWilliams					
Rep. Porter					
Rep. Seibel					
Rep. Skroch					
Rep. Westlind					

Voice vote to accept amendment - carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Date: 1/31/17
Roll Call Vote #: 2

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1256

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. Devlin Seconded By Rep. Seibel

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. P. Anderson		✓
Vice Chairman Rohr	✓		Rep. Schneider	✓	
Rep. B. Anderson	✓				
Rep. D. Anderson	✓				
Rep. Damschen	✓				
Rep. Devlin	✓				
Rep. Kiefert		✓			
Rep. McWilliams		✓			
Rep. Porter		✓			
Rep. Seibel	✓				
Rep. Skroch		✓			
Rep. Westlind		✓			

Total (Yes) 8 No 6

Absent

Floor Assignment Rep. D. Anderson

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

REPORT OF STANDING COMMITTEE

HB 1256: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (8 YEAS, 6 NAYS, 0 ABSENT AND NOT VOTING). HB 1256 was placed on the Sixth order on the calendar.

Page 5, line 6, replace the first underscored comma with "or"

Page 5, line 6, remove ", or general"

Page 6, line 12, after "2." insert "Unless authorized by rules adopted by the board, a dental therapist may not perform the services provided in subsection 1 under the general supervision of a supervising dentist.

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Renumber accordingly

2017 TESTIMONY

HB 1256

Att. 1
HB 1256
1-18-17

Rep. Bill Devlin Testimony
HB 1256

- Chairman Weisz and fellow members of the House Human Services Committee, for the record I am Rep. Bill Devlin of District 23. I am proud to introduce HB 1256 for your consideration. The subject of Dental Therapists is nothing new. Over 50 countries use them very effectively since they started in New Zealand in 1921.

- I learned about the use of Dental Therapists while on a CSG trip to Alaska. They have proved to be very effective in reaching Native Americans in that state. If we pass this bill the same would be true in North Dakota.

- By allowing for the licensing of dental therapists in North Dakota, it would give tribes the ability to use funding from the Indian Health Service to support dental therapy programs of their own. At the current time, federal law prohibits Indian Health Service funds from being used for tribal dental therapy programs *unless* the state has also authorized a similar provider.

- North Dakota currently suffers from a significant shortage of dentists. Even though the number of dentists practicing in North Dakota has gradually increased during recent years, thousands of North Dakotans are unable to receive affordable, routine dental care every year.[i] We simply do not have enough dentists to serve our state's growing population.

- During the past two interims, the Center for Rural Health at UND has studied North Dakota's oral health needs. They reported a number of startling statistics that illustrate the lack of access to dental care for many North Dakotans:

    - Nearly half of North Dakota counties have no dentists or just one.[ii]
    - North Dakota is 3rd worst in the nation at providing dental care to Medicaid-enrolled kids, with 65% not seeing a dentist in 2015 – despite one of the most generous reimbursement rates in the nation.[iii]
    - 1 in 4 third graders have untreated tooth decay, including half of American Indian children.[iv]
    - One-third of all seniors have dental problems, far more than any other age group.[v]
    - Among nursing home residents with teeth, 1/3 need urgent care – but facilities report a major barrier to providing oral health care is finding dentists who accept Medicaid.[vi]

        - The report also included ways to improve access across our state. One of their top recommendations was to train hygienists to do more.[vii] HB 1256 would give hygienists and other dental professionals the opportunity to do just that, which would also create a career advancement opportunity.

        - HB 1256 would do this by authorizing the licensing of dental therapists in North Dakota, giving dentists, if they desire, an opportunity to extend routine care to more patients, including the underserved I mentioned earlier. After becoming licensed, dental therapists would be able to provide preventive and routine care, like filling cavities, under the supervision of a dentist.

- And that's one of the key safeguards in place to guarantee patients still receive quality care: Like in other states where they practice, dental therapists are required to work under the supervision of a dentist. That dentist and the dental therapist must develop a written collaborative management agreement, which specifically details the scope of practice the dental therapist is allowed to perform, and what needs to be referred to the dentist.

- In addition to giving dental practices and nonprofit programs the opportunity to extend care to more patients, dentists could send dental therapists out of the office to provide care in places like nursing homes, assisted living centers, and schools. This flexible supervision could also help them extend their care more easily to other underserved areas such as rural communities and reservations, providing oral health care closer to where people are, rather than making them travel long distances to receive much-needed dental care. Currently, many North Dakotans have to drive to the next county or farther because there aren't dentists nearby. Finally, dental therapists could also give entrepreneurial dentists more flexibility to extend their office hours into the evening and weekends for routine care.

- Having access to affordable, routine dental care is not only an oral health issue, it's also a quality of life and economic issue. A 2015 national survey conducted by Delta Dental found that 31% of parents said their children between the ages of 6 and 12 had to miss school due to an oral health problem.[viii] And employed adults lose more than 164 million hours of work a year related to oral health problems or dental visits.[ix] Adults who work in lower-paying industries, such as customer service, lose two to four times more work hours due to oral health-related issues than adults who have professional positions.[x] So dental problems impact our small business owners, too.

- Utilizing the highly trained dental therapists is a common sense solution to increasing access to affordable, routine dental care for all North Dakotans, which is why I'm proud to sponsor HB 1256.

- One important factor to remember is that this bill doesn't force a dentist to do anything different than they are doing now. If they don't want to utilize the services of a Dental Therapist, they don't have to bring one or more into their practice. Dental Therapists can't practice on their own and must be under the supervision of a dentist.

Thank you, Chairman Weisz, and members of the committee. I am happy to answer any questions you may have but also know there are a lot of experts who will follow me, who can provide you answers to every question.

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Opening Testimony of Josh Askvig
North Dakotans for Dental Access Coalition
ND House Human Services Committee
January 18, 2017

Chairman Weisz and members of the committee, thank you for the opportunity to testify today in support of House Bill 1256 on behalf of the North Dakotans for Dental Access Coalition. This coalition includes 15 diverse organizations representing a broad spectrum of focus and ideology:

- AARP North Dakota
- Alliance for Health Care Access (Grand Forks)
- Community Action Partnership of ND
- Family Voices of ND
- North Dakota Chapter of the American Academy of Pediatrics
- North Dakota Dental Hygienists Association
- North Dakota Nurses Association
- North Dakota Nurse Practitioners Association
- North Dakota Protection and Advocacy Project
- North Dakota Public Health Association
- North Dakota Women's Network
- Northland Health Centers
- Third Street Clinic
- Americans for Prosperity
- Americans for Tax Reform

This broad coalition of organizations supports the bill before you as a great opportunity to increase access to dental care. You'll find a **fact sheet** from the North Dakotans for Dental Access coalition before you, which provides cited information about the quality of care dental therapists provide, how they are helping increase access to care, and some startling statistics about the need for dental care in our state.

House Bill 1256 will help provide that access by giving dentists the freedom to hire Dental Therapists who can enable them to serve more patients within their practices. They can even be sent by their supervising dentist to schools, nursing homes, reservations and other rural areas to provide routine care to the most underserved populations in our state.

Let me take a moment to walk through the key sections of the bill:

- Sections 1 and 2: Establishes definitions and outlines the educational, clinical practice training, and testing requirements a dental therapist must successfully complete in order to be licensed by the Board of Dental Examiners.
- Section 6: Prohibits independent practice by dental therapists.
- Section 7: Outlines the full list of duties that a dental therapist will be allowed to perform under direct, indirect, or general supervision of a dentist, subject to restrictions by the supervising dentist in the written collaborative practice agreement.
- Section 14: Reaffirms that dental therapists can only practice under the supervision of a dentist, and states that their relationship must be managed by a written collaborative management agreement that addresses the scope of practice the dental therapist is allowed to perform. The agreement must be submitted to the Board of Dental Examiners upon request.
- Section 15: Makes it very clear that a dental therapist may not prescribe any drug. With authorization from the supervising dentist they may provide, dispense, and administer

/

analgesics, anti-inflammatories, and antibiotics. However, they cannot provide, dispense, or administer any narcotic drug.

- Sections 16 and 17: Adds a dental therapist and a registered dental assistant to the Board of Dental Examiners. Currently it includes five dentists, one hygienist, and one consumer member.

There are a few coalition members and supporters who weren't able to make it to the hearing today. We have passed out their written testimony and we'd encourage you to review them. They include:

- Dr. Louis Sullivan, former Secretary of Health and Human under President George W. Bush
- Dr. John Powers, DDS, a private practice dentist from Montevideo, MN, who has hired dental therpaists
- Renae Moch of the ND Public Health Association
- Jason Flohrs from Americans for Prosperity
- Debbie Swanson, a member of the Northern Valley Dental Health Coalition (Grand Forks)
- Pam Mack, Director of Advocacy for Protection and Advocacy Project

And now I would like to turn the podium over to two speakers from Minnesota who will discuss how this policy is working there, a speaker from the Heartland Institute who will point out the "free market" arguments for licensing dental therapists, and several organizations representing a variety of North Dakotans.

Thank you for your time and attention to this important issue.

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Dental Therapists

Good for North Dakotans' Health and Good for North Dakota

FACT:

Dental therapists are highly educated, trained and tested professionals—and like dental hygienists and assistants, dentists must hire and supervise them and can restrict their scope of practice.

Dentists will supervise licensed dental therapists, and set their scope of practice

EVIDENCE:

- A dentist will supervise each licensed dental therapist, affirm their abilities and set their scope of practice through a written management agreement.
- Like many dentists in ND (42%), dental therapists can be trained by well-established and highly respected programs in MN.[i]
- Both MN programs are eager to receive applications from North Dakotans (and one program had a ND student graduate in May 2016).[ii]
- To become licensed, dental therapists will need to go through the ND Board of Dental Examiners process similar to dentists and other dental providers.
- The national accrediting commission for schools educating dentists and other dental providers has approved standards for dental therapy.[iii]
- Support among MN dentists for dental therapists is growing, as "most or all have jobs lined up prior to graduation." 95% are employed (about half in private practice) and the number graduating is increasing.[iv]

FACT:

Dental therapists will work within a narrow scope of practice to allow dentists to extend needed routine and preventive care to underserved North Dakotans, as well as focus on more complicated needs and higher-revenue work.

76%

of appointments were for preventive check-ups or routine treatments

EVIDENCE:

- There will be 94 procedures in a dental therapist's scope of practice compared to nearly 400 for a general dentist.[v]
- Dental therapists allow dentists to see more patients, decrease travel and appointment wait times, increase productivity, increase patient satisfaction and lower "no-shows."[vi]
- Patients in MN said 76% of appointments were for preventive check-ups or routine treatment like fillings.[vi]
- A rural private practice employing a dental therapist in MN increased Medicaid patients and profits despite a far lower reimbursement rate there.[vii]
- Experience in 50+ countries, AK and MN shows allowing dentists to hire them can extend care to more rural, low-income, and uninsured patients—including in schools and nursing homes.[i]

FACT:

Dental therapists provide quality care under the supervision of a dentist.

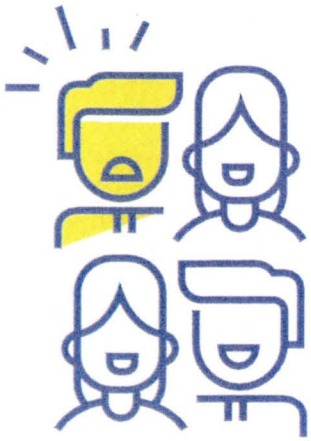
More than 1,100 studies show dental therapists provide high quality care

EVIDENCE:

- More than 1,100 studies show dental therapists provide high quality care.[viii]
- Actuaries set malpractice insurance rates for dental therapists in MN at $93/year because their number crunching demonstrates dental therapists are safe.[ix]
- The Journal of the American Dental Association published a study in 2011 stating that dental therapists provided high quality care comparable to dentists for procedures both can do.[x]
- Dental teams employing dental therapists reduce untreated tooth decay more than dentist-only teams.[xi]

FACT:

Thousands of North Dakotans do not receive regular, routine dental care because there is not enough access to providers in rural areas or for many people with low-incomes in urban centers.[xii]



1 in 4

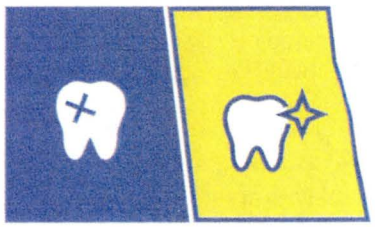
North Dakota 3rd graders have untreated tooth decay

EVIDENCE:

- More than 1 in 4 ND 3rd graders have untreated tooth decay.[xiii]
- Only 56% of practicing dentists reported accepting Medicaid patients in 2015, despite one of the most generous Medicaid reimbursement rates in the U.S.[xiv]
- ND is 3rd worst in the nation at providing dental care to Medicaid-enrolled kids, with 65% not seeing a dentist in 2015.[xiv]
- Half of American Indian 3rd graders have had untreated tooth decay.[xiii]
- Among nursing home residents with teeth, 1/3 need urgent care—but facilities report a major barrier to providing oral health care is finding dentists who accept Medicaid.[xv]
- 1 in 3 seniors report having dental problems. They are "far more likely than any other age group" to do so.[xv]

FACT:

Despite a gradual increase in the number of dentists over the past few years, ND still does not have enough to provide routine care for the state's growing population.



Nearly half of North Dakota counties have only one dentist or none at all

EVIDENCE:

- Nearly half of ND counties have no dentists or just one (17 have none, 8 have one).[i]
- According to the American Dental Association, ND dentists are the busiest in the nation.[xvi]
- Over 60% of all practicing dentists are located in the four largest counties (Burleigh, Cass, Grand Forks, and Ward).[i]
- Allowing dentists to hire dental therapists would increase access to care for North Dakotans in rural and urban communities.[xii]

North Dakotans for Dental Access Coalition Members

AARP North Dakota
Alliance for Health Care Access (Grand Forks)
Community Action Partnership of ND
Family Voices of ND
North Dakota Chapter of the American Academy of Pediatrics
North Dakota Dental Hygienists' Association
North Dakota Nurses Association
North Dakota Nurse Practitioners Association
North Dakota Protection and Advocacy Project
North Dakota Public Health Association
North Dakota Women's Network
Northland Health Centers
Third Street Clinic (Grand Forks)
Americans for Prosperity
Americans for Tax Reform

[i] UND Center for Rural Health, "Dental Workforce in Rural and Urban ND," June 2016. [ii] Testimony by Colleen Brickle, Dean, Health Science, Normandale Community College and testimony by Leon Assael, Dean, University of MN School of Dentistry, to the ND Senate Human Services Committee, Hearing on SB 2354, February 10, 2015. [iii] American Dental Association, Commission on Dental Accreditation. Accreditation Standards for Dental Therapy Education Programs. August 2015. [iv] Presentation by Dr. Karl Self, Director, Division of Dental Therapy, University of MN, at the National Oral Health Conference, April 20, 2016; Email communication from Dr. Jayne Cernohous, Director of Dental Therapy, Metropolitan State University, to The Pew Charitable Trusts, December 7, 2016. [v] The Pew Charitable Trusts. Analysis using 2013 American Dental Association Codes on Dental Procedures and Nomenclature, ADA Commission on Dental Accreditation 2015 Accreditation Standards for Dental Therapy Programs, and ND Admin. Code 20-01 through 20-05 (via the ND Board of Dental Examiners) current as of April 1, 2015. [vi] MN Department of Health and MN Board of Dentistry, "Early Impacts of Dental Therapists in MN" (February 2014). [vii] Expanding the Dental Team: Studies of Two Private Practices, Pew Charitable Trusts, 2014. [viii] Nash D et al., "A Review of the Global Literature on Dental Therapists," Community Dentistry and Oral Epidemiology (2013). [ix] Wovcha, S., Pietig, E. (2015). Dental Therapy in MN: A Study of Quality and Efficiency Outcomes. [PowerPoint slides]. [x] Bader JD et al. Clinical technical performance of dental therapists in AK. JADA 2011;142(3):322-326. [xi] Wright JT et al. A systematic review of oral health outcomes produced by dental teams incorporating midlevel providers. JADA. 2013;144(1):75-91. [xii] UND Center for Rural Health. ND Oral Health Report: Needs and Proposed Models, December 2014. [xiii] Njau G and Yineman K, "Findings and Lessons from the 2014-2015 ND Oral Health Third Grade Basic Screening Survey," ND Department of Health, (Presented at the Dakota Conference on Rural and Public Health, May 16, 2016). [xiv] UND Center for Rural Health. Oral Health among ND Medicaid Recipients. December 2016. [xv] UND Center for Rural Health, "Oral Health among the North Dakota Elderly," October 2016, Schroeder S, UND Center for Rural Health, "Oral Health Services Provided and the Perceived Barriers to Providing Services in LTC Facilities," (Presented at AcademyHealth Annual Research Meeting, Boston, MA), June 27, 2016. [xvi] Vujicic M. Solving dentistry's "busyness" problem. JADA 146(8), August 2015.

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AARP Real Possibilities in

North Dakota

SUPPORT HB 1256

Josh Askvig, State Director
jaskvig@aarp.org – 701-989-0129

Chair Weisz, and members of the House Human Services Committee, I am Josh Askvig, State Director for AARP North Dakota. We stand in support of HB 1256.

AARP is a nonprofit, nonpartisan membership organization with 87,000 members in North that leads positive social change and delivers value to all people 50+ and to society through advocacy, service and information. We understand the priorities and dreams of people 50+ and are committed to helping them live life to the fullest, including here in North Dakota.

In late 2014 and early 2015, AARP North Dakota testified in front of the Interim Health Services and Senate Human Services Committees. We highlighted how the oral health of older citizens in North Dakota was in a state of decay. Two years later that statement is still true and little action has been taken to help our state's seniors. In North Dakota, 1 in 3 seniors report having dental problems and are "far more likely than any other age group" to do so.[i] Access to dental care remains one of the greatest challenges facing older adults and many of those near retirement are not even aware that Medicare does not cover dental care.

Poor oral health is related to other problems including diabetes, cardiac disease, stroke and respiratory diseases, specifically pneumonia.[ii] Nationally, 23% of seniors have severe gum disease, one in three seniors have untreated cavities and 30,000 people (mostly elderly) are diagnosed with oral and pharyngeal cancers yearly. [iii]

The elderly, particularly those living in nursing homes in North Dakota, are at risk for not receiving oral healthcare for many reasons: decreased mobility or declining mental status, a lack of financial resources to pay for care, and the lack of portable dental service programs in the state. For the elderly in rural areas of the state, geography complicates access.[iv]

According to the UND Center for Rural Health, in 2016 one in three seniors in a nursing home who still have teeth need urgent care and 32 percent have experienced total tooth loss.[v] Among those who experienced total tooth loss, 62% were Medicaid enrollees.[vi] Seniors who have substantial tooth loss, untreated tooth or gum disease, or even ill-fitting dentures find their diets are negatively impacted because they cannot chew properly and their ability to speak and interact socially is impaired.

Seniors on Medicaid struggle with finding care, even though North Dakota has one of the highest Medicaid reimbursement rates (63%) in the U.S.[vii] Despite the higher reimbursement rate, in 2015 only 56% of practicing dentists reported accepting Medicaid patients.[viii]

According to the UND Center for Rural Health, roughly 48% of North Dakota nursing home residents surveyed in 2015 were Medicaid enrollees and when compared to nursing home residents with private insurance, residents with Medicaid were actually more likely to: have substantial tooth loss (less than 20 teeth), have untreated decay; experience gingivitis; and, have less teeth.[ix]

The lack of access to affordable, routine dental care for those on Medicare is especially true for low-income and elderly individuals. While about half of seniors purchase Medigap supplemental insurance, it does not cover dental.[x] In 2010, nearly half (44%) of all Medicare beneficiaries reported no dentist visit in the previous year, and 22% reported they had not seen a dental provider in the previous five years.[xi]

There is a solution that will help older Americans access care: allowing dentists to hire dental therapists.

North Dakota already has dental assistants, dental hygienists and dentists in the state, but not a mid-level dental provider like a dental therapist. Dental therapists—similar to nurse practitioners or physician assistants on a medical team—can be educated to perform preventive and routine restorative dental care, like filling cavities. They already practice in Minnesota and Alaska and more recently have been authorized in Maine and Vermont. Because these providers are trained to specialize in a much smaller number of routine procedures, dental practices can add them to the team and a practice can increase efficiency and serve larger numbers of Medicaid patients in a financially viable way. Even for the uninsured, dental practices can use these highly trained but lower cost providers to provide care to more patients. Dental therapists give dentists the flexibility to triage patients conveniently in the patient's community and provide routine care on site, while integrating these patients into the dentist's practice.

Dental therapists in North Dakota would expand quality care to more patients and would help dentists serve more low-income people. In Minnesota and Alaska they are already allowing dental practices to see more patients on Medicaid, and extend care to people in rural areas where distance and mobility issues can make it even more difficult for many seniors to see a dentist.[xii] They are also working in programs that treat kids in community settings. In fact, one nonprofit program in Minnesota even serves a state operated veterans nursing home.

At AARP North Dakota, we know access to dental care for the elderly is a growing problem for members in our state. That is why we urge this committee to give HB 1256, a DO PASS RECOMMENDATION.

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[i] UND Center for Rural Health, "Oral Health among the North Dakota Elderly,"
October 2016; Schroeder S, UND Center for Rural Health, "Oral Health Services Provided and the Perceived Barriers to Providing Services in LTC Facilities," (Presented at
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[iv] UND Center for Rural Health, "Oral Health among North Dakota Elderly," October 2016.

[v] UND Center for Rural Health, "Oral Health among North Dakota Elderly," October 2016.

[vi] UND Center for Rural Health, "Oral Health among North Dakota Medicaid Recipients," December 2016.

[vii] UND Center for Rural Health, "Oral Health among North Dakota Medicaid Recipients," December 2016.

[viii] UND Center for Rural Health, "Oral Health among North Dakota Medicaid Recipients," December 2016.

[ix] UND Center for Rural Health, "Oral Health among North Dakota Medicaid Recipients," December 2016.

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THE SULLIVAN ALLIANCE

NORTH DAKOTA LEGISLATIVE ASSEMBLY
HUMAN SERVICES COMMITTEE
WEDNESDAY, JANUARY 18, 2017
Written Testimony Submitted by
Louis W. Sullivan, M.D.

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

Oral health is an integral part of overall health. Dental caries is the most common chronic disease in children and adults in the U.S. Dental caries is largely, if not entirely, preventable. Yet in 2011, there were over 850,000 visits to emergency rooms for preventable dental conditions.[i] Poor oral health increases risk for diabetes, heart disease and poor birth outcomes. It can affect a child's ability to eat, sleep and learn. A recent study by the University of Southern California showed that teens with poor oral health were four times more likely to have a low grade point average.[ii]

Other studies show bad teeth prevent otherwise qualified candidates from getting jobs or promotions.

In 2000, the U.S. Surgeon General's report, *Oral Health in America*, called attention to oral health in relation to overall health and well-being.[iii] Current oral health disparities data indicates millions of Americans – adults and children – lack access to routine dental care and preventive services. This lack of access is widening. Over the past 20 years, the number of dental Health Professional Shortage Areas has grown six-fold – from nearly 800 in 1993 to more than 4,900 in 2014.[iv,v]

As you might expect, dental caries disproportionately impacts low income and rural populations in the U.S. The statistics are startling.

- More than 47 million people in the U.S. live in places where it is difficult to access dental care.[vi]
- More than 14.5 million low-income children received no dental care in 2011.[vii] Low income adults are almost twice as likely as higher–income adults to have gone without a dental check up in the prior year.[viii]
- More than 70 million Americans receiving water from community water systems have no access to fluoridation which is known to significantly reduce tooth decay.[ix]
- More than one fourth of adults in the U.S. aged 65 and over have lost all their teeth.[x]
- About 130 million Americans (43 percent of the population) have no dental coverage whatsoever.[xi]

In North Dakota, the numbers closely reflect national trends. Only 66 percent of North Dakotan adults, 18 and older, reported having been to the dentist in the past year.[xii] According to a 2014 report by the University of North Dakota Center for Rural Health, data pointed to three primary oral health needs for the state:

1) enhanced oral health literacy and prevention programs across the state,
2) improved dental coverage, and
3) increased access to dental care through adequate dental workforce distribution.

North Dakota has one of the highest Medicaid reimbursement rates nationwide (63 percent).[xiii]

In 2014, the American Dental Association (ADA) reported that 83% of North Dakota dentists were participating in Medicaid for child dental services compared to 42% of dentists nationally. However, in 2015, North Dakota dentists self-reported that only 56% were accepting at least a limited Medicaid patient base. Only 17% reported accepting any and all Medicaid patients requesting dental care. Improving Medicaid reimbursement rates is one avenue to increasing access to care, but other options are critically important to pursue.[xiv]

Certainly the country needs more dentists. North Dakota ranks 23rd among states when considering the gap between available oral health professions and community need.[xv] The dentist to population ratio is approximately 55 per 100,000 in North Dakota.[xvi] Over 60 percent of all the licensed North Dakota dentists worked in the four largest counties: Burleigh, Cass, Grand Forks, and Ward. Furthermore, 17 counties have no dentist and 8 had 1 dentist.[xvii]

Of course training new dental providers takes time – and money. We hope new dentists will want to practice in areas of need. However, dentists joining the National Health Service Corps have, on average, $142,000 in student loan debt – this is more than 10 percent greater debt than the average for physicians.[xviii]

While we can hope and expect these new dentists to bring passion for their profession and a responsibility to care for their fellow citizens, what is their financial incentive to locate traditional practices in dental professional shortage areas? The reality is if we are to meet the oral health needs of our citizens, we must consider new models of care.

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

Last April, a senior representative of the Commission on Dental Accreditation (CODA) testified before the Interim Health Services Committee about CODA's adoption and implementation of standards for dental therapy education. By creating and confirming these standards, CODA has ensured the quality and scope of educational training for Dental Therapists will be consistent from one state to another.

This significant decision by the CODA guarantees patients – and dentists – the same level of confidence in the qualifications and standards of training for a dental therapist as they have for a dentist.

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

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

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

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

In this country, Alaska Native Tribes have led the way in establishing the dental therapist model.[xix] 2014 marked the 10th year of practice for the Alaska Dental Health Aide Therapists (DHATs).

Today more than 40,000 Alaska Native people living in 81 rural, mostly remote communities across the state, have access to dental care and prevention services as a result of this community-driven solution.

Alaska Dental Health Aide Therapists (DHATs) are trained in Alaska according to a proven worldwide model: a two-year (full-time), post-high school competency-based primary care curriculum, incorporating innovative preventive and clinical strategies.

In the lower 48 states where in many areas of the country. the need is just as great as that of Alaska's remote villages. Change is coming. Your neighboring state, Minnesota, was the first state beyond Alaska, to establish licensure of dental therapists. Their legislation created two types of dental therapists: Dental Therapist (DT) and Advanced Dental Therapist (ADT).

The scopes of practice of these two provider types are very similar; the major difference lies in the level of supervision.

I know you are considering legislation introduced during this session (HB 1256) which would establish a mid-level dental therapy model to address North Dakota's need for oral health access.

Kansas, New Mexico, Washington state and others are considering legislative options that create real solutions for their states' lack of oral health access by establishing Dental Therapists within their states' oral health delivery teams. In Maine and Vermont, their legislatures have already passed laws to implement the Dental Therapist model to improve oral health access in their rural communities.

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

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

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

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

I commend the North Dakota Legislative Assembly for exploring opportunities to reduce dental service provider shortages statewide. Increasing access to care in communities currently without regular dental care is so important. It changes lives.

Chairman Weisz, I realize you have a very heavy legislative schedule ahead. Therefore, if you or the members of the Human Services Committee have questions related to my prepared statement, I will be pleased to address those questions by phone.

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[vi] Ibid.

[vii] W.K. Kellogg Foundation. *Oral Health*. Accessed on 9/24/14. http://www.wkkf.org/what-we-do/healthy-kids/oral-health

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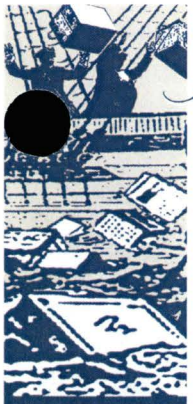

AMERICANS for TAX REFORM

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January 18, 2017

Dear Members of the Human Services Committee,

I write today in support of House Bill 1256. If approved, HB 1256 would tear down an unnecessary government barrier to the dental services that North Dakota small businesses can provide to consumers in the state. Often, proposals that increase health care options for underserved populations do so at a significant cost to taxpayers. HB 1256, however, utilizes the free market at no cost to the state.

Dentists who want to expand their practices to include educated and qualified mid-level practitioners should be free to do so. Dental therapists are highly educated, thoroughly trained and tested professionals who operate as part of a larger dental team, and focus on preventative and restorative treatments under the supervision of a dentist. Innovative ideas like this have faced intense opposition but are very similar to the fights that took place decades ago with the emergence of nurse practitioners. Physicians began working and collaborating with nurses who had clinical experience to fill a void left by specialization in the medical field. Today, nurse practitioners provide equivalent or superior care to that provided by physicians. HB 1256 responsibly follows the nurse practitioner model for dental practices.

Americans for Tax Reform supports a wide range of free market solutions to today's health care issues. It is undeniable that there is a dentist shortage, particularly in underserved and rural areas of the state. HB 1256 would alleviate this issue by permitting, but not requiring, small businesses to hire Dental Therapists and the state should not stand in the way.

I encourage the legislature to pass HB 1256 because this legislation doesn't only benefit small businesses and consumers; it also benefits taxpayers who bear the burden of rising health care costs, including Medicaid. At no cost to taxpayers, HB 1256 is common sense legislation and is a model for free market health care reform in the states.

If you have any questions, or if ATR can be of assistance, please contact me or Margaret Mire, ATR's state affairs coordinator, at mmire@atr.org or 202-785-0266.

Onward,

Grover Norquist
President
Americans for Tax Reform

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Main Street Dental Care

January 16, 2017

Representative Robin Weisz
Chairman, House Human Services Committee
State of North Dakota
C/O Legislative Council
State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Dear Chairman Weisz and Members of the Committee:

I write to offer testimony on the impact of allowing dentists like myself to hire dental therapists.

My private dental practice was the first in the nation to hire a dental therapist and is located in Montevideo, Minnesota, a town of roughly 5,000 people in the rural western part of the state. Montevideo is about two and a half hours away from Minneapolis and fairly similar distances to Fargo, North Dakota and Sioux Falls, South Dakota. The first dental therapist started in my office in early 2012; she was previously a dental assistant in my practice and went through one of the two dental therapy training programs in Minnesota. In preparation for bringing her into my practice as a dental therapist, I sent out information to citizens in our community about what she could do and how she'd be integrated into the dental team in my practice. We also began to increase the number of patients with Medicaid as their insurance.

My practice's schedule and patient base grew so much over the first three years of having a dental therapist that patients had to be scheduled out six months for restorative appointments. That is why in in the fall of 2014, I made the decision to expand. By April 2015, we moved from a five operatory practice to a nine operatory practice and hired a second dental therapist. However, our schedule again began to be overbooked and patients were scheduling three to four months out. This led me to hire a third dental therapist on a part-time basis in August 2015 who splits time with another office. Finally, last summer I hired a fourth dental therapist. In total, my practice now has three full-time therapists and one part-time. We are now able to see many more patients, with some traveling as far as three hours away.

While I know your committee focuses on health issues, it may also be interested to know that just a few years ago, in 2012, my practice had eight employees. Now it has 21. This has happened because with more dental therapists on staff and more patients to treat, we have also needed to expand the number of support staff. That's an additional 13 jobs created in my community. Comparing the first year with a dental therapist (2012) to last year (2016) we have increased production by $2,025,441, and collections by $1,161,113. The difference between production and collections is due to the

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John T. Powers D.D.S.

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Main Street Dental Care

fact that we are treating more patients on Medicaid, which reimburses at a lower amount.

Dental therapy is a great option for dentists who are trying to meet the oral health challenges in their communities, especially for the underserved, and helping to keep people out of expensive emergency rooms for preventable dental problems. However, it also helps create jobs in rural areas like mine that are often in need of economic development. I strongly recommend allowing dentists in North Dakota to have this same great option.

Thank you for your attention to this issue and please feel free to let me know if you have questions. You may contact my Melissa Jerve in my office at melissa@mainstreetdental.org or 320-269-6406.

Sincerely,

Dr. John Powers
Owner, Main Street Dental Care

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John T. Powers D.D.S.

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TESTIMONY ON HOUSE BILL 1256
House Human Services Committee

Deborah J. Swanson
January 18, 2017

Chairman Weisz and Members of the House Human Services Committee:

Thank you for the opportunity to provide written testimony in support of HB 1256 – a bill relating to the practice of dental therapy in North Dakota. I have served in a leadership role for the **Northern Valley Dental Health Coalition** since 2002. Our coalition was formed with the goal of improving access to dental care for residents of the Northern Red River Valley. We were responsible for establishing Valley Community Health Centers' Dental Clinic in 2007 – a clinic that has brought dental care to thousands of residents in our region in the past 10 years. Our coalition also sponsored the American Dental Association's signature event "Give Kids a Smile" in February, and have worked with the Third Street Clinic to refer patients to donated dental care in Grand Forks.

While these activities have greatly improved access to care, there are still individuals in our community and across North Dakota not receiving the dental care that they need and deserve. Our coalition conducted a survey of our members in 2016 and the **top priorities for our members include: oral health policy and advocacy activities, expanding the dental workforce, and establishing oral health programs in long term care**. HB 1256 provides the opportunity to impact all three of these focus areas.

Dental therapists work under the supervision of a licensed dentist and perform procedures that focus on prevention and restoration – all within a limited and defined scope of practice. I had the opportunity to see dental therapists performing as members of the dental team at a community clinic and a school in Minnesota, and also hear testimony from dentists who employ them. Dentists in private practice have chosen to employ dental therapists as a means to expand their capacity to serve more patients and ensuring that the dentist can focus on patients needing more complex care. In Minnesota, this has increased the number of patients with public insurance who can get care in both urban and rural areas, while also increasing the profitability of the dental practice.

HB 1256 provides an opportunity to expand the dental team through **dental therapists who provide high quality, preventive care to a full range of patients**. The practice settings can include schools, public health dental clinics, community settings and long term care. The effectiveness and quality of care provided by dental therapists has been demonstrated through careful study at the University of Minnesota. Ample evidence exists that there continues to be a need for dental care in North Dakota.

My 15 year history of working to improve access to dental care, and studying the role of dental therapists has led me to believe that this legislation is a much needed tool to expand the dental workforce in North Dakota, thus improving access to care. Dental therapy is a sustainable model, saves money, and will improve the lives of North Dakota residents. **I urge you to vote yes on HB 1256.**

AMERICANS FOR PROSPERITY

Testimony to the North Dakota House Human Services Committee

January 18, 2017

Chairman and Members of Committee, thank you for holding this hearing and for the opportunity to provide testimony.

On behalf of the more than 6,000 Americans for Prosperity activists in North Dakota, I urge you to support proposed legislation (House Bill 1256) that permits dentists to hire licensed dental therapists, and allows said therapists to perform expanded services under the supervision of a dentist.

Americans for Prosperity is committed to eliminating unnecessary government restrictions to market entry and promoting free market solutions to the problems that face our country. One such problem is the access to proper health and dental care. The federal government has clearly failed to properly address this issue – and in many cases has exacerbated the problem. We believe states are the "laboratories of democracy" and should be free to innovate and solve problems as they see best. House Bill 1256 seeks to do just that by addressing the issue of access to dental care in North Dakota.

While this common-sense, free market solution will make it easier for all North Dakota residents to obtain affordable dental care, it will especially benefit underserved, poorer, and more rural communities. In the process, dentists who are interested in expanding their small practices will have another option through which to do so. With dental therapists, dental offices can decrease wait times, increase productivity, and see more patients, all of which are conducive to better outcomes for both patients and dentists.

House Bill 1256 represents a strong first step in state-based free market health care reform. Americans for Prosperity strongly supports its passage, and we look forward to working with you in the future.

Jason Flohrs
North Dakota State Director
Americans for Prosperity

Americans for Prosperity (AFP) exists to recruit, educate, and mobilize citizens in support of the policies and goals of a free society at the local, state, and federal level, helping every American live their dream – especially the least fortunate. AFP has more than 3.2 million activists across the nation, a local infrastructure that includes 36 state chapters, and has received financial support from more than 100,000 Americans in all 50 states. For more information, visit www.AmericansForProsperity.org.

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NORTH DAKOTA
Public Health Association

Renae Moch, MBA, FACMPE, Vice President
North Dakota Public Health Association
Testimony, House Human Services Committee
January 18, 2017

Good morning, Mr. Chairman and members of the committee. My name is Renae Moch. I am Vice President for the North Dakota Public Health Association. We are a multidisciplinary organization made up of individuals and representatives of public, private, non-profit organizations and institutions who are interested in the health of North Dakotans, with the mission of improving, promoting, and protecting health for residents of North Dakota through leadership in policy, partnerships, and best practices.

I am including in my testimony a copy of a 2015 resolution passed by NDPHA on increasing access to oral health in North Dakota. As the resolution states and as you've heard from other witnesses, access to oral health care is a serious problem in our state.

One of the issues our resolution discusses which directly impacts many of the other reasons it is difficult to access dental care is, "A state dental practice act that restricts scope and practice for allied dental health professionals." While we are in need of more affordable care, more high priced providers for routine care will not help. That is why the ND Public Health Association supports policies like HB 1256, which will do two things mentioned in our resolution:

- Expand the scope of practice to allow dental professionals to practice to the full extent of their education and training.
- Develop and implement new innovative workforce models and effective programs to expand access to oral health services that can reduce disparities.

Of course, dental therapists aren't new in many other parts of the world, and they're becoming more and more common in both Minnesota and Alaska as well. They and the dentists who have hired them have proven that access to care can be improved. HB 1256 will allow for them to be hired by dentists here in North Dakota, and will also allow existing dental professionals like hygienists and assistants to have another way to expand what they do.

North Dakota's current dental delivery system has proven inadequate to meet the modern demands our state is facing. But this innovative bill with a proven solution will help modernize our system by welcoming a highly-trained professional class that has been successful around the world.[i] By embracing dental therapists, we can be national leaders in protecting the health and wellbeing of our citizens.

Thank you for your consideration.

Renae Moch, MBA, FACMPE, Vice President
ND Public Health Association

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[i] David A. Nash et al., "A review of the global literature on dental therapists," *Community Dentistry and Oral Epidemiology* 42 (2014): 1–10, doi: 10.1111/cdoe.12052; MN Department of Health and MN Board of Dentistry, "Early Impacts of Dental Therapists in MN," February 2014.

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Karl Self, DDS, MBA
Testimony for the North Dakota House Committee (Bill 1256)
January 18, 2017

Thank you, Mr. Chairman and members of the committee. My name is Dr. Karl Self. I have been a dentist for more than 30 years, and I have worked in a variety of practice settings, but I spent most of my career in a community clinic setting. I have been on faculty at the University of Minnesota School of Dentistry since 2006, and I was appointed the Director of the Division of Dental Therapy at the School in 2010.

I appreciate the opportunity to speak with you about the University of Minnesota's experience educating dental therapists as well as the State of Minnesota's experience utilizing dental therapists. I am here because seven years ago, Minnesota acknowledged the same basic challenge that you are dealing with today: that despite all of the exceptional dental providers and policies in place to increase access to dental care for underserved and rural communities, gaps in dental care remain.

The University of Minnesota has educated dental therapists since our state authorized these providers in 2009. Dental therapists in Minnesota are trained in a defined scope of practice that includes both preventive and routine restorative procedures. At the University of Minnesota, our dental therapy students are educated alongside our dental and our dental hygiene students. As an example, where the scope of practice of a dental therapy student overlaps with that of a dental student, like drilling and filling a cavity, both student groups take the same courses, have the same clinical requirements, and must pass the same examinations. Upon graduation from our educational program, dental therapy graduates are required to pass a patient-based clinical examination that is the same as a portion of the examination that dental graduates have to pass. Both groups take the exam at the same time and exam evaluators are unaware as to which individuals are testing to become a licensed dentist and which will become a licensed dental therapist. This blind evaluation ensures that dental therapists have the same skills and abilities as dentists for the procedures both providers are licensed to perform. Thus, from a quality of care standpoint, our dental therapy graduates are educated to the same standards as dentists for the limited scope of practice they are licensed to perform.

Since our first dental therapy class graduated in 2011, the U of M has graduated 50 individuals, and another school in Minnesota has graduated 28 individuals for a total of 78 dental therapists in our state. While 78 graduates in six years may sound like a small number of providers, we have intentionally limited our class sizes to balance the supply of dental therapists with the demand of the dental market as it exists today. We continue to monitor these market forces and will consider expanding our class size as more dentists learn of the effectiveness and benefits of dental therapists, and as they bring DTs on their dental team.

Data from this past fall showed 95 percent of licensed dental therapists who were seeking work were employed, and they work in a variety of settings, including private practices, nonprofit clinics, FQHCs, and large group practices. About half worked in underserved areas in and around the Twin Cities, and the other half worked in rural and remote corners of our state. Over 75% of clinics located outside the Twin Cities metropolitan area which employ a dental therapist are located in a Dental Health Professional Shortage Area. Additionally, given the requirement that dental therapists in Minnesota are "limited to primarily practicing in settings that serve low-income, uninsured, and underserved patients or in a dental health professional shortage area", all dental therapists are having an impact in improving access to care.

One positive development, for those exploring the concept of authorizing dental therapy, is that in August of 2015 the Commission on Dental Accreditation agreed to begin the implementation of dental therapy educational standards. The Commission on Dental Accreditation, or CODA, is recognized by the U.S. Department of Education as the sole accrediting body for dental schools and dental hygiene educational programs. They work as an independent and autonomous entity when developing and approving accreditation standards. The CODA dental therapy standards state a minimum length for education programs, an appropriate scope of practice and many other specifics that are necessary for creating a dental therapy education program. Additionally, CODA standards provide national recognition of dental therapy as a legitimate profession that will continue to spread throughout the United States.

I continue to be excited that I have the opportunity to lead the dental therapy education program at the University of Minnesota, and I am proud of our dental therapists that care for underserved people in Minnesota every day. They are amazing individuals and they are truly pioneers of this new profession. For nearly 25 years I have advocated for healthcare for underserved populations and I am personally thrilled that Minnesota as a state chose not to stay with the status quo but to try something different to improve access to dental care and to help reduce oral health care disparities. So too are the underserved patients of Minnesota who have been very happy to be able to receive care from a dental therapist these past 5 years.

Finally, dental therapy is not a miracle cure that will eliminate all of our barriers to care. But it is a tool, a tool that is showing positive results with the practices that have chosen to adopt it. Additionally, as would be expected with the initiation of any new profession, there are folks who went into the dental therapy profession and have found that it was not what they were looking for. Yet a 2015, Minnesota Department of Health survey found 89% of dental therapists were either satisfied or very satisfied with their career. Similarly, there are dentists who have explored adding a dental therapist to their dental team and determined it did not fit into their

practice. Yet roughly 43% of dentists and clinics which currently employ a dental therapist have more than 1 dental therapist in their practice or clinic.

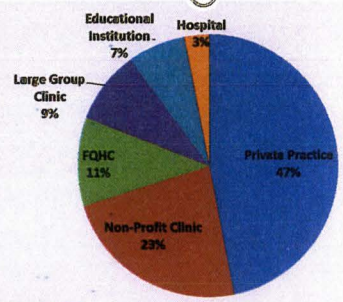
While no dentist in my state will ever be forced to hire a dental therapist, those who do will continue to see firsthand their skills and abilities, their dedication to serving those individuals and communities who otherwise would not have access to dental care, and the value they bring to the dental team working under the supervision of a dentist. This is why I strongly believe the profession of dental therapy will continue to grow and dental therapists will be well accepted, valued members of the dental team both in Minnesota and around the country.

I support dental therapy as an effective tool for closing gaps in access to care and the University of Minnesota dental therapy program stands ready to work with North Dakota stakeholders to educate dental therapists to help address North Dakota's access to care concerns. Thank you for the opportunity to speak here today. I am happy to answer any questions you may have.

DT Employment Stats

- 63 Licensed Dental Therapists (Nov. 2016)
  - 30 of those have achieved ADT certification
  - 22 of the 63 are dual licensed in dental hygiene and dental therapy (DH/DT)
- 95% of all licensed DTs are currently employed
- Settings that serve low-income, uninsured and underserved; or dental professional shortage area

DT Employment Stats



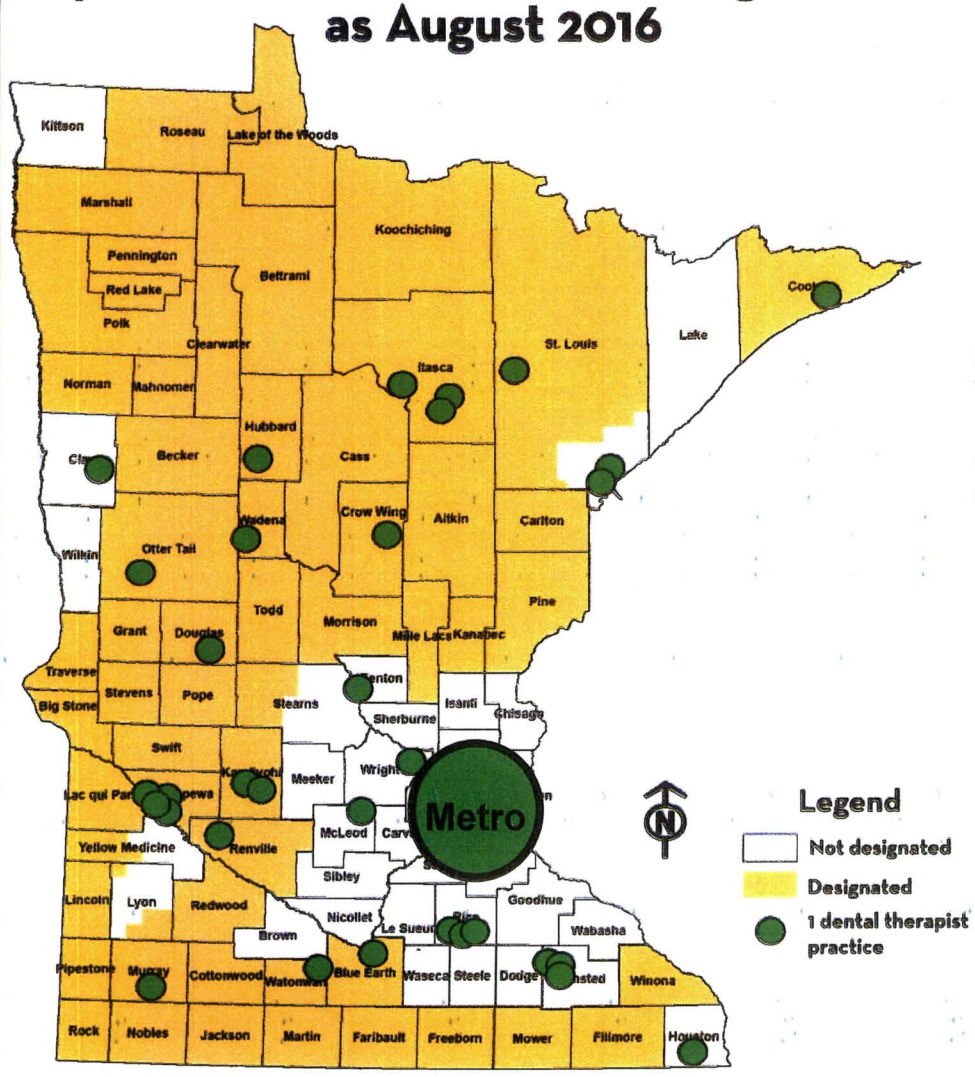
* As of August 2016

Minnesota DT Education:
Graduates by Year

YEAR	UMN	MNSCU	CUM TOTAL
2011	9	7	16
2012	9	-	25
2013	9	4	38
2014	9	5	52
2015	6	-	58
2016	8	11	77
2017*	7	6	90

* Anticipated

MN Dental Therapists in Practice by Health Professional Shortage Areas as August 2016



This map provided by the University of MN
School of Dentistry
Data Source:
Minnesota Department of Health
Office of Rural Health and Primary Care
State DD HPSA Nov 2014

Dental Therapy Employment Sites by County

Metro Area – 52%

Greater MN – 48%

*** As of August 2016**

UNIVERSITY OF MINNESOTA
School of Dentistry
Driven to Discover℠

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Christy Jo Fogarty

Testimony for House Human Services Committee

January 18, 2017

Chairman Weisz and members of the committee, I appreciate the opportunity to testify before you today. My name is Christy Jo Fogarty and I am the first certified advanced dental therapist from MN, a provider very similar to the one you are hearing about today. I am here today in support of House Bill 1256.

I have been in dentistry for over 20 years. I started as a dental assist in 1995. As I trained I fell in love with dentistry and before I even finished school I was applying for dental hygiene school. Three years later, I became a dental hygienist. In my first job as a dental hygienist, I worked for a dentist in the inner city that took about 20% medical assistance patients—as a result I saw the significant need for dental care, and the difficulty accessing it. I was able to give care to people who had never had dental care before. A few years later, as my family grew, I needed more flexibility in my job. I left that practice and spent the next seven years doing independent contracting (temping myself out) where I worked for dozens of dental offices across the state. I had the opportunity to work in rural parts of the state, the inner city and the suburbs. One thing was consistent; lack of access to dental care was everywhere!

When I heard about the opportunity to become a dental therapist, a practitioner who I knew would help increase access to dental care for more people; I knew I wanted to be one. In 2009, three weeks before the legislation passed in Minnesota I became a member of the first class of dental therapists.

Currently I work for an organization called Children's Dental Services (CDS) where we serve children from birth to age 26 and pregnant woman, regardless of family income. We accept all forms of public and commercial insurance, and have a sliding scale for income eligible families. Families who are below 100% of the federal poverty level often receive free care. No one is denied care based on inability to pay.

We have quadrupled in size since 2000 due to lack of access to affordable dental care for low-income children and families. Today we are the single largest provider of on-site dental care in Minnesota schools and Head Start centers. In 2016 CDS treated nearly 35,000 patients. Of those patients, 99 percent had incomes below the Federal Poverty Guideline. 85 percent received Medical Assistance, 14 percent were uninsured and enrolled in sliding scale program—less than one percent had private insurance.

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Dental therapists are community-based practitioners that integrate preventive care and routine restorative care such as fillings into patient visits—freeing dentists to practice at the "top of their license" and focus on complex cases. Many of our dentists, including my supervising dentist, do hospital based care. We have been able to expand that care because of dental therapy. According to a joint study released two years ago by the Minnesota Board of Dentistry and Department of Health, The addition of dental therapists to a dental team:

- Significantly decreased wait times in Federally Qualified Health Centers and community health centers;
- Significantly lowered no-show rates in dental offices;
- Increased efficiency of the team met with positive acceptance by both the patients they served and the team members they worked with; and
- Have the potential to decrease ER visits for preventable dental related conditions.

One of the reasons dental therapists are so effective is because they are able to work remotely. I frequently work in remote settings in rural Minnesota while my supervising dentist is in Twin Cities metro area. Through use of digital x-rays and electronic charts—otherwise known as tele-dentistry—I am able to connect with my supervising dentist, regardless of location. We are able to collaborate without stopping care at the sites where we are seeing patients. It's a highly efficient model—which should not be a surprise because medicine has been using similar providers in the same capacity for over 30 years.

The economic impact to CDS as a result of integrating dental therapists into their dental team is worth noting. Since employing dental therapists, CDS has experienced continuous increase in productivity and profit from year to year.

Production stats/Economic savings:

- 2011: Average production of team is $280.72/hr
- 2012: Average production of team is $298.09/hr; Average production of ADT is $340.35/hr
- 2013: Average production of team is $336.87 per hour; Average production of ADT is $365.04/hr

In addition to increasing production numbers, I cost our non-profit considerably less than a dentist. As a result I have provided CDS an annual costs savings of over $62,000 annually. Equally as important, the patient acceptance has been outstanding.

While dental therapy in Minnesota continues to be a tremendous success, the concept of this type of dental provider when introduced in 2007 in MN, was met great opposition from organized dentistry—similar to the arguments you will likely hear today. Since that time, opposition has waned. Even one of the most vocal opponents at the time, a past president of the Minnesota Dental Association, has worked with, and been a collaborating dentist for advanced dental therapists. In addition the incoming MDA president has been working in cooperation with the Minnesota Dental Therapy Association (MDTA) on many issues, including the incorporation of DTs in their annual dental convention.

In my view, the best part of being an advanced dental therapist is the ability to treat kids who might not otherwise receive care. As a parent myself, I know you never want to see your child in pain. When a kid has a toothache they may miss school, find it hard to concentrate and can cause serious side effects if the tooth is not treated. I have the ability to treat those kids and keep them healthy so they can focus on school and just be a kid. It is an extremely rewarding profession and I urge the committee to give HB 1256 a "do pass" recommendation so that dentists, hygienists and kids in North Dakota have the same opportunity.

I appreciate the opportunity to testify and am happy to answer any question you may have.

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The Heartland INSTITUTE

Testimony: The Case for Licensing Dental Therapists in North Dakota
By Michael T. Hamilton

January 18, 2017

Presented to the House Human Services Committee
North Dakota 65th Legislative Assembly

Distinguished Members of the Committee:

Thank you for the honor of your attention. I am Michael Hamilton, a research fellow for health care policy at The Heartland Institute, managing editor of the print newspaper for lawmakers *Health Care News*, and coauthor of "The Case for Licensing Dental Therapists in North Dakota," the 20-page *Policy Brief* in front of you, published on January 13.[1]

The *Policy Brief* and the one-page *Policy Tips* sheet accompanying it ("Licensing Dental Therapists in North Dakota") make a straightforward argument for licensing dental therapists. First they describe North Dakota's oral care shortage. Then they explain what dental therapy is and how it works, how dental therapy expands patient access in shortage areas, how dental therapy increases provider efficiency, and why continuing to blockade dental therapy would diminish provider liberty, patient access, and stewardship of North Dakota tax dollars.[2]

Instead of merely regurgitating the bulletproof argument of these documents, I will use my few minutes to present crucial facts about dental therapy alongside objections to dental therapy these facts refute.

Objections to dental therapy range from the clumsy to the creative and are riddled with cavities.

Quality. Some opponents imagine licensing dental therapists would jeopardize quality of patient care. But as one Michigan lawmaker told The Heartland Institute in 2016, "I put the concern over quality right back in dentists' laps."[3] He is right to do so. Dental therapists function exclusively under the supervision of licensed dentists. If therapists obtain licensure in North Dakota, dentists would remain responsible for the quality of treatment patients receive in their offices from any and all employees, whether dental hygienists, dental assistants, associate licensed dentists, or dental therapists. Therefore, to block dental therapy based on concern for quality of treatment is to doubt the quality, competence, and judgment of licensed dentists themselves. Lawmakers should resist fantasizing with opponents' about the imaginary threat dental therapy poses to patients. Instead, this committee should consider in addition to being supervised by dentists, dental therapists exit their training programs with more experience than dentists have performing the services and procedures within therapists' scope of practice. This is because therapists have narrower scopes of practice than dentists, whose programs require them to train more broadly.

– continued –

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Tiers. Rebuffing concerns about quality debunks another objection: Licensing dental therapists would create a two-tiered system of care, in which patients with private insurance or cash obtain care from dentists and Medicaid patients obtain care from dental therapists. The truth, however, is North Dakota already has a two-tiered system – a system of "haves" and "have nots." North Dakota's "have nots" can be found among the more than 66,000 people, almost 10 percent of the population, living in 35 federally designated dental health professional shortage areas. According to the state's own Center for Rural Health at the University of North Dakota School of Medicine & Health Sciences, "have nots" also include approximately 37,000 children out of 51,000 children eligible for Medicaid (72 percent) who did not receive preventive dental care in 2015. An additional 65 percent of Medicaid children "went without any dental or oral health service" that year, according to the Center.[4] Blocking dental therapy would preserve North Dakota's two-tiered system.

Distribution. One opponent told The Heartland Institute dental therapists in Minnesota "are not going to remote rural areas." A map provided by the University of Minnesota School of Dentistry in November 2016, however, shows 48 percent of employed therapists practice outside the greater metro area. This share exceeds the share of the population living in those non-metro regions, thus disproportionately benefiting residents in those regions. Moreover, North Dakota's own Center for Rural Health has found the state's oral care professional shortage can present in urban areas, such as among respondents to a survey of long-term care facilities. The survey found 41 percent of respondents were unable to offer residents a list of area providers, compared to just 20 percent of rural respondents.[5]

Hygienists. Multiple opponents of dental therapy told North Dakota lawmakers in September 2016 dentists who want to expand their practices may already do so by employing dental hygienists and assistants. This is hardly a reason to block dental therapy. The persisting shortage implies the benefits of expanding practices with only hygienists and assistants do not always outweigh dentists' perceived costs of doing so. Licensing dental therapists would improve this calculus. Dental therapists and hygienists have separate scopes of practice. Unlike hygienists, therapists can perform certain extractions and fillings, two procedures especially influential to an individual's overall health (not just oral health). Neither this committee nor dentists need choose between hygienists and therapists. Each kind of professional would typically work alongside each other as complementary members of a dental team. Licensing dental therapists would simply give dentists another option for building their dental dream teams.[6]

Demand. A rising refrain among opponents is: "Dentists in North Dakota don't want to hire dental therapists, so there is no point in licensing them." On the contrary, if dentists won't hire therapists, there is no point in blocking their licensure. That opponents finally acknowledge the vital role dentist choice would play in the spread of dental therapy in North Dakota comes as a welcome relief. By allowing dental therapists to obtain licensure, this body would expand the liberty of dentists to exercise their judgment as licensed dentists and owners of their practices. Dentists not enticed by the dental therapy model would remain free not to hire therapists. Entrepreneurial dentists would gain the option. Liberty is not the villain opponents pretend it is.

– continued –

Socialism. Some object dental therapy is a mark of socialism, because some of the more than 50 countries in which dental therapists are practicing have socialist economies. This is like saying the presence of tequila in Bismarck makes Bismarck the capital of Mexico. We must distinguish the inherently socialistic from the fruits of society that socialists have hijacked—fruits that will blossom more fully in a free market. Depriving dentists of the right to choose their employees, and robbing patients of the ability to choose which providers offer the best value for their time and money, is central planning of the rankest kind. Lawmakers should end this practice by allowing dental therapists to start practicing under the supervision of dentists who freely choose to employ them.

Contrary to the many red herrings fished out by opponents of dental therapy, the question facing North Dakota lawmakers is not whether dental therapists give high-quality care (although they do), whether dental therapists would increase Medicaid patient access (although they would), whether rural or urban patients would benefit (although both would), or whether hygienists would remain employable by dentists (although they would).

The question really facing North Dakota lawmakers is simple: "Does licensing dental therapists in North Dakota pose a risk to public health great enough to justify depriving (1) dentists of their right to employ and supervise dental therapists if they choose and (2) patients of their right to access providers of their choice?" The answer is clearly "No." Licensing dental therapists would only help.

Thank you for your consideration.

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[1] Michael T. Hamilton, Bette Grande, and John Davidson, "The Case for Licensing Dental Therapists in North Dakota," *Policy Brief*, The Heartland Institute and Texas Public Policy Foundation, January 13, 2017.

[2] Matthew Glans, "Licensing Dental Therapists in North Dakota," *Policy Tips*, The Heartland Institute, January 13, 2017.

[3] Mary Tillotson, "States Consider Authorizing Dental Therapy to Expand Access," *Health Care News*, The Heartland Institute, November 2016. See also Hamilton, Grande, and Davidson, *supra* note 1, p. 18.

[4] Center for Rural Health, "Oral Health among North Dakota Medicaid Recipients," Fact Sheet 8, School of Medicine & Health Sciences, University of North Dakota, December 2016, https://ruralhealth.und.edu/pdf/oral-health-nd-medicaid-recipients.pdf. Accessed December 30, 2016. See also Hamilton, Grande, and Davidson, *supra* note 1, pp. 3–4.

[5] Shawnda Schroeder, "Oral Health Care in North Dakota Long Term Care Facilities, Fact Sheet 2, Center for Rural Health, School of Medicine & Health Sciences, University of North Dakota, June 2016. https://ruralhealth.und.edu/pdf/north-dakota-oral-health-long-term-care.pdf. Accessed December 30, 2016. See also Hamilton, Grande, and Davidson, *supra* note 1, p. 6.

[6] North Dakota Legislative Assembly, Health Services Committee, Minutes of the Health Services Committee, 64th Assembly, Interim Session, September 21, 2016, pp. 2–6. See also Hamilton, Grande, and Davidson, *supra* note 1, pp. 13–14.

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Policy Brief

TEXAS PUBLIC POLICY FOUNDATION | THE HEARTLAND INSTITUTE FREEDOM RISING

January 13, 2017

The Case for Licensing Dental Therapists in North Dakota

By Michael T. Hamilton, Bette Grande, and John Davidson*

Introduction

The question of whether North Dakota should permit the licensing and practice of midlevel providers of oral care known as *dental therapists* is frequently posed to lawmakers as a choice between high standards of patient care and greater access for underserved patients.[1]

Proponents of licensing dental therapists reject this quality vs. access dichotomy.[2] Opponents embrace it.[3]

This policy brief frames the decision more starkly. The question really facing North Dakota lawmakers is, "Does licensing dental therapists in North Dakota pose a risk to public health great enough to justify depriving (1) dentists of their right to employ and

Contents

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[1] North Dakota Legislative Assembly. Health Services Committee, *Minutes of the Health Services Committee,* 64th Assembly, Interim Session, September 21, 2016, pp. 2–6.

[2] John Powers, Letter to Interim Health Services Committee, North Dakota Legislative Assembly, November 21, 2016, https://www.heartland.org/publications-resources/publications/letter-praising-dental-therapy-from-dr-john-powers-to-nd-interim-health-services-committee (January 3, 2017).

[3] North Dakota Legislative Assembly, *supra* note 1, Appendix I.

supervise dental therapists and (2) patients of their right to access providers of their choice?"

The answer is clearly no. The imagined risk of licensing dental therapists does not justify depriving North Dakota dentists and patients of their rights. Moreover, far from jeopardizing the public health, licensing dental therapists would likely expand patient access to high-quality oral care services and reduce oral care costs in North Dakota.

Failing to permit the licensure of dental therapists would unjustly diminish provider liberty, patient access, and sound stewardship of North Dakota tax dollars.

This policy brief first examines the harm oral care shortages do to North Dakotans of various ages, locations, and income levels. Next, the authors review the scope of practice, education, and training requirements of dental therapists practicing in other states. We then demonstrate dental therapy's proven track record of expanding oral care access for underserved patients, as well as dental therapy's potential to increase efficiency for dental practices and savings for the state. Finally, we rebut common objections to dental therapy, concluding that failing to permit the licensure of dental therapists would unjustly diminish provider liberty, patient access, and sound stewardship of North Dakota tax dollars.

1. North Dakota's Oral Care Shortage

The value North Dakota officials place on oral health care would seem evident by the placement of the statement, "Oral health is essential to general health and well-being at every stage of life," atop the Department of Health (NDDoH) website, quoting the U.S. Surgeon General's "National Call to Promote Oral Health."

Unfortunately, these aspirations to promote affordable access to oral health care do not necessarily translate into an effective policy reality, as North Dakotans young and old, rural and urban, on Medicaid and off, are experiencing.

Aging Population

Illustrating this disparity between intention and reality is NDDoH's *Smiles for Life*, an online oral health training curriculum for which physicians, physician assistants, pediatricians, and nurses can obtain continuing medical education (commonly "CME") credit.[4]

When surveyed by the Center for Rural Health (Center) at the University of North Dakota School of Medicine and Health Sciences in 2016,[5] only 14 percent of operators of long-term care (LTC) facilities, including skilled nursing and basic facilities, said they had heard of *Smiles for Life* in 2016, even though 78 percent of LTC facilities operators said they provide oral care training to staff.

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[4] North Dakota Department of Health. Oral Health Program, "Smiles for Life Online Training," 2015, http://www.ndhealth.gov/oralhealth/NDSmilesForLife.htm. Accessed December 30, 2016.

[5] Shawnda Schroeder, "Oral Health Care in North Dakota Long Term Care Facilities, *Fact Sheet* 2, Center for Rural Health, School of Medicine & Health Sciences, University of North Dakota, June 2016. https://ruralhealth.und.edu/pdf/north-dakota-oral-health-long-term-care.pdf. Accessed December 30, 2016.

Put differently, more than four out of five LTC facilities responding to the Center's survey had not heard of NDDoH's oral care curriculum. More than one out of five LTC facilities do not train staff with any oral care curriculum.

LTC facilities are (and should remain) free to choose their own high-quality oral care training materials. But these facilities generally exhibit a lack of preparedness to identify, prevent, and address oral health needs as they arise. LTC facilities would therefore benefit from having another staffing option for giving residents needed care.

Long-term care facilities generally exhibit a lack of preparedness to identify, prevent, and address oral health needs as they arise.

Only 7 percent of facilities responding to the Center's survey said a dental professional completes residents' initial oral health exams. This low percentage undermines the stated intentions of the 72 percent of LTC facilities operators who say they highly prioritize oral health for residents. When oral care needs arise, approximately 75 percent of basic care and 43 percent of skilled nursing facilities lack a written plan for dealing with them.[6]

The potential for LTC facilities operators, even those who consider oral health a "high" or "essential" priority, to overlook or undertreat residents' needs is alarming, considering more than one-third of all elderly North Dakotans (aged 65 and older) with teeth needed "early or urgent dental care" in 2016, according to a separate analysis by the Center.[7]

Medicaid Adults and Children

North Dakotans of all ages enrolled in Medicaid disproportionately suffer from the state's oral health care shortage.

Of the almost one-third of nursing home residents who "had total tooth loss" in 2016, almost two-thirds were Medicaid enrollees. Nursing home residents on Medicaid can fare worse than those without dental insurance or with private health insurance. Medicaid enrollees are likelier to "be edentulous [i.e., lack teeth]; have substantial tooth loss; experience untreated decay; have prevalence of root fragments; have severe gingivitis; and, need periodontal care," a fact sheet from the Center states.[8]

North Dakota's oral care shortage is best illustrated, however, by the state's child Medicaid population – starting with pregnant mothers. "A higher proportion of Medicaid (69%) than non-Medicaid (52%) recipients did not go to the dentist during their pregnancy" in 2002, the birth year of children around age 14 today, according to the NDDoH report *Oral Disease in North Dakota: Burden of Disease and Plan for the Future, 2012–2017.*[9]

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[6] *Ibid.*

[7] Shawnda Schroeder, "Oral Health among North Dakota Elderly," *Fact Sheet* 9. Center for Rural Health, School of Medicine & Health Sciences, University of North Dakota. October 2016, https://ruralhealth.und.edu/pdf/oral-health-nd-elderly.pdf. Accessed December 30, 2016.

[8] *Ibid.*

[9] North Dakota Department of Health. Division of Family Health. Oral Health Program, *Oral Disease in North Dakota: Burden of Disease and Plan for the Future, 2012–2017, 2013,* pp. 46–7,

Out of 51,281 "children" (i.e., aged 20 and younger) enrolled in North Dakota's Medicaid program, approximately 36,922 "had no preventive dental visit" in 2015, the Center states.[10] In other words, 72 percent of children did not use preventive dental care for which they were eligible, a failure rate virtually unchanged since 2013. North Dakota's failure rate in this category ranks as third-worst in the country.

Almost as many Medicaid children – 32, 999, or 65 percent of those enrolled – "went without any dental or oral health service" in 2015, the Center states.

An especially interesting note for lawmakers hesitant to embrace dental therapy is that 25 percent of Medicaid children received oral health care services from a "non-dentist provider" – i.e., a qualified health care practitioner such as a nurse or medical aide who is not a dentist or dental hygienist, assistant, or therapist. Those who fear authorizing the profession of dental therapy in North Dakota will diminish the quality of care should consider the quality of oral care one in four Medicaid children already receive from non-dentist providers.

Leading Medicaid from Behind

Access to dental health services is an acute problem for North Dakota's Medicaid population, especially enrolled children, despite three factors that, on the surface, might lead one to expect better results from the state.

Access to dental health services is an acute problem for North Dakota's Medicaid population, especially enrolled children.

First, 83 percent of North Dakota dentists signed up to participate in Medicaid for children in 2014 – almost twice the national rate of 42 percent, according to the American Dental Association. In 2015, dentists in the state self-reported a lower Medicaid participation rate, 56 percent, which nevertheless also surpasses the national average, according to the Center. (The share of dentists accepting "any and all Medicaid patients," as opposed to only patients with emergencies, was 17 percent.) [11]

Second, North Dakota's reimbursement rate for dentists was among the highest in the country in 2014. Medicaid reimbursed North Dakota dentists for 63 percent of what the dentists billed Medicaid, compared to a national Medicaid reimbursement rate averaging 49 percent, according to the Center.

Third, North Dakota had the second-highest ratio of Medicaid reimbursements for adult dental care services compared to commercial insurance reimbursements. The American Dental Association uses this ratio to measure how well Medicaid reimbursements are keeping up with market rates. Although Medicaid pays dentists less than insurers do, North Dakota's 60.2 percent

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http://www.legis.nd.gov/files/committees/63-2013nma/appendices/2012-2017_Oral_Health_State_Plan.pdf. Accessed December 30, 2016.

[10] Center for Rural Health, "Oral Health among North Dakota Medicaid Recipients." *Fact Sheet* 8. School of Medicine & Health Sciences, University of North Dakota, December 2016, https://ruralhealth.und.edu/pdf/oral-health-nd-medicaid-recipients.pdf. Accessed December 30, 2016.

[11] *Ibid.*

reimbursement rate compared to insurers was second only to Arkansas' (60.5 percent) and ahead of Alaska's (58.4 percent).[12]

High provider participation rates, high Medicaid reimbursement rates, and a high Medicaid-to-commercial insurance ratio have not solved North Dakota's oral care shortage.

Gender and Tribe

Oral disease is no respecter of gender, tribe, or urban-rural divisions in North Dakota.

Although periodontal disease presents more frequently in men than women nationally, "[o]ral disease is associated with chronic disease among all populations and may cause birth complications for pregnant women," according to NDDoH's 2012–2017 report.[13]

During their last pregnancy, more than half of North Dakota women did not visit a dentist or dental clinic, and only one-third spoke with a dental or heath care professional about oral care, NDDoH reported. This share dropped to 16 percent among American Indian women, who "were three times more likely not to visit a dentist or dental clinic" while pregnant than white women.

North Dakota's oral care shortage is ubiquitous. Approximately 66,663 North Dakotans live in 35 areas designated as having a dental health professional shortage.

Rural and Urban Areas

North Dakota's oral care shortage is ubiquitous. Approximately 66,663 North Dakotans live in 35 areas designated as having a dental health professional shortage, according to HHS's Health Resources & Services Administration's (HRSA) Data Warehouse.[14] Of these 35 health professional shortage areas (HPSAs), 14 are geographic regions with population-to-provider ratios of at least 5,000:1. Two are population groups outnumbering providers at least 4,000:1. The remaining 19 HPSAs are federally qualified health facilities or correctional facilities.[15]

Despite having fewer HPSAs than every other state in the region besides Wyoming (29), North Dakota has one of the lowest "Percentage of Need Met"[16] scores, at 33 percent. Only South

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[12] Kamyar Nasseh, Marko Vujicic, and Cassandra Yarbrough, *A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services*. Health Policy Institute, American Dental Association, October 2014, http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_3.ashx. Accessed December 30, 2016.

[13] North Dakota Department of Health, *supra* note 9.

[14] U.S. Department of Health and Human Services. Health Resources & Services Administration. Data Warehouse, "Shortage Areas." http://datawarehouse.hrsa.gov/topics/shortageAreas.aspx, 2016. Accessed November 22, 2016.

[15] U.S. Department of Health and Human Services. Health Resources & Services Administration. Data Warehouse, "Designated Health Professional Shortage Areas Statistics," 2016, https://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=PDF. Accessed November 22, 2016.

[16] "The percentage of need met is computed by dividing the number of dentists available to serve the population of the area, group, or facility by the number of dentists that would be necessary to reduce the population to provider ratio below the threshold for designation so that it would eliminate the designation as a dental HPSA." *Ibid.*

Dakota has a lower "Need Met" percentage (26 percent), among 63 shortage areas. Montana's need is 34 percent met despite having 84 HPSAs; Colorado's need is 36 percent met despite having 97 HPSAs; Utah's need is 60 percent met despite having 52 HPSAs; and Wyoming's need is 63 percent met despite having 29 HPSAs.[17]

North Dakota's oral care shortage restricts the access of both rural and urban residents. Rural residents sometimes bear the brunt of these shortages, such as pregnant women who were less likely to visit a dentist or dental clinic than pregnant women living in urban areas in 2002.

North Dakota's oral care shortage restricts the access of both rural and urban residents.

In other cases, such as North Dakota's nursing home population, the incidence of oral health needs was basically equal in urban and rural settings, the Center for Rural Health found in 2016.

In still other cases, urban areas evince greater shortages than rural communities. Residents of urban LTC facilities, for instance, had longer wait times to see dentists than rural LTC residents, the Center found. Only 59 percent of urban LTC facilities surveyed could offer residents a list of area dentists for referral, compared to 80 percent of rural LTC facilities.[18]

Solution Within Reach

Fortunately, North Dakota beats four out of five states in the region in the most important dental health professional shortage area category: the minimum number of new practitioners mathematically required for the state to eliminate all 35 of its HSPAs and meet 100 percent of its need.

Based on HRSA's projections – which are inaccurately low – North Dakota would need eight more practitioners at present, and 34 practitioners by 2025, to eliminate its oral health care shortages, because of overlap among its shortage area populations. (Wyoming would require at least six at present; South Dakota 25; Montana 27; Utah 59; and Colorado 99.)[19]

Unfortunately, the actual numbers of shortage areas and dentists needed are likely much higher than HRSA estimates. The patient/dentist ratios HRSA uses to calculate area shortages (4,000:1 and 5,000:1) are higher than a typical dentist's patient load of 1,500 to 2,500 patients per year, and HRSA's numbers are based on current utilization rates, not the number of people who should be obtaining oral care.

Even if North Dakota had a supply of new dentists willing to open up practices or take jobs under other dentists in the state tomorrow, perfectly placing these dentists would be impossible for a government, organization, or any force other than a free market.

Instead, lawmakers can and should free dentists to expand their practices by hiring dental therapists: high-skilled midlevel practitioners currently authorized in four states. This would

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[17] *Ibid.*

[18] Schroeder, *supra* note 5.

[19] U.S. Department of Health and Human Services, *supra* note 15.

accelerate fulfillment of North Dakota's oral care shortage, increasing patient access to high-quality oral care.

2. Dental Therapy: What It Is, How It Works

Licensing dental therapists to practice in North Dakota would give dentists the option to hire them as members of a dental team equipped to meet scores of oral care needs, under the supervision of a dentist located onsite or offsite.

Dentists who want to grow their practices by employing and supervising dental therapists would be free to do so. Dentists who do not want to hire dental therapists would not be required to.

> Lawmakers can and should free dentists to expand their practices by hiring dental therapists: high-skilled midlevel practitioners currently authorized in four states.

Team Players

A dental therapist is "a licensed oral health professional who practices as part of the dental team to provide educational, clinical and therapeutic patient services. Dental therapists provide basic preventive and restorative treatment to children and adults, and extractions of primary (baby) teeth under the supervision of a dentist," according to the University of Minnesota School of Dentistry.[20] All states with dental therapists allow them to extract adult teeth extremely loosened by disease.

Dental therapists treat patients in conjunction with a dental team, which in most settings also includes a supervising dentist and at least one dental hygienist and dental assistant. In extremely rural regions, a team may consist of only a dental therapist and supervising dentist. The therapist/dentist relationship resembles the relationship between physician assistants or advanced practice registered nurses and supervising doctors.

Like every other aspect of a dentist's practice, the practice's owner – typically the supervising dentist – determines the specific role dental therapists play on the team, the kinds of patients they treat, and the range of services they provide within their legally defined scope of practice.

Dentists dictate these and other terms for dental therapists using "collaborative care agreements" (Alaska),[21] "written practice agreements" (Maine),[22] "collaborative management agreements" (Minnesota),[23] or "collaborative agreements" (Vermont).[24]

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[20] University of Minnesota School of Dentistry, "Dental Therapy: Our Division," 2016, https://www.dentistry.umn.edu/degrees-programs/dental-therapy/our-division. Accessed December 30, 2016.

[21] Sarah Shoffstall-Cone and Mary Willard, "Alaska Dental Health Aide Program." *International Journal of Circumpolar Health* **72** (2013): 21198, http://dx.doi.org/10.3402/ijch.v72i0.21198. Accessed December 30, 2016.

[22] Maine Legislature, *An Act To Improve Access to Oral Health Care*. 126th Legislature, April 28, 2014, http://www.mainelegislature.org/legis/bills/bills_126th/billtexts/HP087001.asp.

[23] Minnesota Legislature. 2009. *Minnesota Session Laws, Chapter 95, Revisor of Statutes, Senate File 2083, Article 3*. 86th Legislature. https://mn.gov/boards/assets/enabling%20Legislation_tcm21-46113.pdf (January 2, 2017).

Education Requirements

The Commission on Dental Accreditation (CODA), the national body accrediting dental schools, released accreditation standards for dental therapy education programs in 2015.[25] Nevertheless, each state must determine the scope of practice, education prerequisites, and training requirements for its dental therapists.

Education and training requirements for dental therapists vary among states. Maine and Vermont, the states most recently to authorize "dental hygiene therapists" and "dental therapists," respectively, require applicants to be licensed dental hygienists. Once licensed, they need maintain only their dental therapy license, not their hygiene license, through a process involving reregistration, continuing education, and renewal fees.[26]

Minnesota's distinction between "dental therapists" and "advanced dental therapists" can help North Dakota lawmakers understand the value each profession offers patients and supervising dentists.

One of Minnesota's two higher education institutions with a master's program in dental therapy requires applicants to hold licenses as hygienists.[27] In 2016, the state's other institution converted its dental therapy program into a dual degree program for a Bachelor of Dental Hygiene/Master of Dental Therapy degree.[28] Like Maine and Vermont, Minnesota requires therapists seeking licensure to have graduated from a higher education dental therapy program approved by the state.

Alaska's educational requirements for "dental health aide therapists" primarily include completion of a two-year post-high school program culminating in certification by the Alaska Native Tribal Health Consortium. The program will award an associate degree starting in 2017.

Training, Scope of Practice

Although states set their own training requirements for dental therapists, Minnesota's distinction between "dental therapists" and "advanced dental therapists" (each of which meets CODA standards) can help North Dakota lawmakers understand the value each profession offers patients and supervising dentists.

Dental therapists in Minnesota are authorized to perform more than 70 services and procedures, including oral evaluations, disease prevention education, and consultation with the pediatricians

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[24] Vermont General Assembly. 2016. *An act relating to establishing and regulating dental therapists.* 2015–2016 Session, June 2. http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT161/ACT161%20As%20Enacted.pdf (January 2, 2017).

[25] Commission on Dental Accreditation, *Accreditation Standards for Dental Therapy Programs,* [2015] 2016, http://www.ada.org/~/media/CODA/Files/dt.ashx. Accessed January 3, 2017.

[26] Maine Legislature, *supra* note 22; Vermont General Assembly, *supra* note 24.

[27] Metropolitan State University, "Advanced Dental Therapy (MSADT)," 2015, http://www.metrostate.edu/msweb/explore/catalog/grad/index.cfm?lvl=G&section=1&page_name=master_science_advanced_dental_therapy.html. Accessed January 2, 2017.

[28] University of Minnesota School of Dentistry, "Dental Therapy," 2016, https://www.dentistry.umn.edu/degrees-programs/dental-therapy. Accessed January 2, 2017.

of patients aged three or younger. Dental therapists may also perform cementation and removal of space maintainers, crown implantation, anesthetization, replacing missing and broken teeth, and suture removal, according to a list of delegated duties of dental therapists posted online by the state Board of Dentistry.[29]

The list grows to 80 services and procedures when counting those reserved for "advanced dental therapists," who gain this designation by graduating from a master's-level dental therapy program, completing more than 2,000 hours of directly or indirectly supervised clinical practice, and passing a board-approved exam for an advanced scope of practice.[30] The two-year Master of Science in Advance Dental Therapy program at Metropolitan State University in St. Paul, Minnesota, consists of 44 credits and includes courses on "Understanding health care needs and the incidence of disease across populations," 31 hours of clinical experience, and a "capstone project."[31]

Contemporary dental therapy descends from a nearly century-long tradition of post-high-school vocational training programs.

Dental therapists without advanced degrees must have earned a baccalaureate degree from a dental therapy program, pass a clinical exam, and pass an exam on Minnesota's dentistry laws and rules.[32]

Tribal governments in Alaska introduced residents of the state to dental therapy in 2003 and 2004 with the profession "dental health aide therapist" (DHAT), which required a high school diploma, 3,160 hours of training and field work over two years, and certification renewal every two years.[33] The current version of the program remains two calendar years long and requires a preceptorship – essentially a medical apprenticeship – of at least 400 hours.[34] Dentists must supervise DHATs "in-person or remotely."[35]

Although a new concept to many in the United States, contemporary dental therapy descends from a nearly century-long tradition of post-high-school vocational training programs lasting two to four years, beginning with the graduation of the world's first "dental nurses" in New Zealand for the express purpose of serving the general public.[36] As of 2012, 54 countries were relying on

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[29] Minnesota Board of Dentistry, "Delegated Duties: Dental Therapists and Advanced Dental Therapists," April 24, 2010, https://mn.gov/boards/assets/Delegated%20Duties_tcm21-46116.pdf. Accessed January 2, 2017.

[30] Minnesota Legislature, *supra* note 23.

[31] Metropolitan State University, *supra* note 27.

[32] Minnesota Legislature, *supra* note 23.

[33] National Governors Association, *The Role of Dental Hygienists in Providing Access to Oral Health Care*, 2014, https://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf. Accessed January 2, 2017.

[34] Alaska Native Tribal Health Consortium, "DHAT Certification and Scope of Practice," 2016, http://anthc.org/dental-health-aide/dhat-certification-scope-of-practice/. Accessed January 2, 2017.

[35] National Governors Association, *supra* note 33.

[36] David A. Nash, Jay W. Friedman, *et al. A Review of the Global Literature of Dental Therapists.* W.K. Kellogg Foundation, 2012, p. 4, https://www.heartland.org/_template-

dental therapists to provide oral care, usually in connection with a school-related children's program.[37]

Midlevel, Top-Shelf

Within their narrower scope of practice, dental therapists' training equals that of licensed dentists, according to Alyssa Beaulieu, operations manager at Children's Dental Services in Minneapolis, Minnesota. "Advanced dental therapists and dental therapists undergo the same licensure tests [as dentists] for the services they provide," Beaulieu told researchers on a site visit to the University of Minnesota School of Dentistry in November 2016.[38]

In fact, dental therapists receive more training than dentists for certain procedures, Dr. Kevin Nakagaki, a dentist at the nonprofit health care organization HealthPartners, told researchers during the same site visit. "Dental therapists are actually doing more of the same kinds of procedures by the time they leave school than dental students, because the dental students spread out," Nakagaki said. "They have to do more kinds of procedures."

Within their scope of practice, dental therapists' training equals that of licensed dentists, and dental therapists receive more training than dentists for certain procedures.

The extensive list of preventative and restorative treatments dental therapists and advanced dental therapists provide reveals "midlevel practitioner" as a potentially misleading descriptor for dental therapists holding master's degrees, as it can be for midlevel practitioners in other fields of care, many of whom hold master's degrees and doctorates despite lacking the letters M.D., D.O., D.D.S., or D.M.D. after their names.[39] The U.S. Justice Department Drug Enforcement Agency uses the term *midlevel* practitioner to identify an "individual practitioner, other than a physician, dentist, veterinarian, or podiatrist" licensed "to dispense a controlled substance in the course of professional practice. Examples of midlevel practitioners include, but are not limited to, health-care providers such as nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists and physician assistants," federal regulations state.[40] (North Dakota lawmakers would not have to allow dental therapists to prescribe drugs or dispense narcotics for the profession to benefit patients and dentists.)

Dental therapists with or without advanced degrees provide "restorative services beyond the scope of preventive services traditionally provided by dental hygienists," states a paper published by the National Governors Association in 2014. In Minnesota, dentists must specifically authorize most dental therapy procedures and be present at the same facility. Advanced dental

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assets/documents/publications/Nash%20Dental%20Therapist%20Literature%20Review.pdf. Accessed January 2, 2017.

[37] *Ibid.*, p. 3.

[38] Michael T. Hamilton, "'Dental Therapist' Teammates Enhance Practices Treating Low-Income Patients," *Health Care News,* The Heartland Institute, January 2016, https://www.heartland.org/news-opinion/news/dental-therapist-teammates-enhance-practices-treating-low-income-patients.

[39] Catherine S. Bishop, "Advanced Practitioners Are Not Mid-Level Providers." *Journal of the Advanced Practitioner in Oncology.* U.S. National Library of Medicine, National Institutes of Health. September 1, 2012, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4093350/. Accessed January 2, 2017.

[40] *Ibid.*

therapists have more leeway, but state law prohibits each from operating except under "a collaborative management agreement in place with a supervising dentist," the paper states.[41]

Patients have gained greater choice of care and easier, more affordable access to care when lawmakers in 50 states expanded the scope of practice of midlevel practitioners in pharmacies,[42] hospitals and clinics,[43] private practices,[44] elder and home care facilities,[45] and out-of-hospital labors and deliveries.[46] Oral care patients in North Dakota should be next in line to benefit from lawmakers' authorization of dental therapist licensure.

The rural nature of North Dakota and inclusion of Native American tribes in the community demand a nuanced solution to the state's oral care shortage.

3. Dental Therapy Expands Patient Access to Quality Care in Shortage Areas

The rural nature of North Dakota and inclusion of Native American tribes in the community demand a nuanced solution to the state's oral care shortage.

Care for Tribes

Alaska's dental therapy program illustrates benefits unique to states with Native American tribes. The Alaska Native Tribal Health Consortium (ANTHC) pinpointed DHATs as a remedy for underserved tribal communities when it established the first dental therapy program in the United States in 2003 and 2004.

In the early years of Alaska's program, dental therapists deployed to villages of at least 800 people to accomplish two specific priorities: (1) relieve oral pain exacerbated by insufficient access to care, and (2) implement preventive measures, including education and outreach, to

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[41] National Governors Association, *supra* note 33.

[42] Edward J. Timmons and Conor S. Norris, "CLIA Waiver Pharmacy Growth: How Does Broadening Scope of Practice Affect the Pharmacist Labor Market?" Mercatus Center, George Mason University. October 18, 2016, https://www.mercatus.org/publications/CLIA-waiver-pharmacy-growth. Accessed January 2, 2017.

[43] Victoria Garment, "Nurse Practitioners and Physician Assistants: Why You Should Hire One (or the Other)," *The Profitable Practice,* May 31, 2013, http://profitable-practice.softwareadvice.com/nurse-practitioners-and-physician-assistants-why-you-should-hire-one-or-the-other-0513/. Accessed January 2, 2017.

[44] Thomas Heath, "Local orthopedist now helps command the biggest practice of its kind in the U.S.," *The Washington Post,* November 6, 2016, https://www.washingtonpost.com/business/economy/local-orthopedist-now-helps-command-the-biggest-practice-of-its-kind-in-the-us/2016/11/06/4f193596-a142-11e6-8d63-3e0a660f1f04_story.html. Accessed January 2, 2017.

[45] Sue Webber, "North Memorial offers TotalCare program for Seniors," *Sun Current* [Minnesota], November 1, 2016, http://current.mnsun.com/2016/11/01/north-memorial-offers-totalcare-program-for-seniors/. Accessed January 2, 2017.

[46] Michael T. Hamilton, "State Laws Force Pregnant Mothers to Rely on Black Market to Find Midwives," *Consumer Power Report,* The Heartland Institute, October 13, 2016, https://www.heartland.org/news-opinion/news/pregnant-mothers-call-the-midwife-in-their-states-black-market. Accessed January 2, 2017.

reduce the incidence of oral disease. The first comprehensive study of the program's benefits was undertaken in 2010 by a team of one M.D., one Ph.D, and three dentists, two of whom also held Ph.Ds. The team found that while treating acute oral pain – the first objective – the dental therapists had earned the respect of the community as "role models." This was vital to creating the necessary inroads for the second objective, because "[e]ffecting change will take significant alterations in the oral health attitudes and behavior of Alaska Natives, and this will likely take years to accomplish. The therapists' cultural awareness and credibility in the villages can help shape changes in behaviors," the authors wrote.[47]

Lawmakers should consult the record of patient satisfaction, not merely the reservations of dentists, when evaluating the viability of dental therapy as a potential solution to oral care shortages.

The 28 DHATs practicing in Alaska as of February 2016 have "expanded much-needed access to dental care and prevention services for more than 40,000 Alaska Native people living in 81 rural Alaska communities" since 2004, ANTHC's website states.[48] An additional 14 individuals were graduates undergoing preceptorship training or students in their first or second year of DHAT schooling in February 2016.[49] Dr. Mary Willard, director of oral health promotion at ANTHC, estimates graduates of the current program will serve more than 80 communities and annually treat an average of 800 patients, *Alaska Dispatch News* reported on November 1, 2016.[50]

Local Problem, Local Solution

Lawmakers should consult the record of patient satisfaction, not merely the reservations of dentists, when evaluating the viability of dental therapy as a potential solution to oral care shortages. We suggest requiring dental therapists to earn their *patients'* trust is a higher standard than asking them to earn *dentists'* trust – and Alaska's DHATs, for example, are meeting that higher standard.

"Our dental therapy program really began as a local solution to a local problem. We just simply did not have access to oral health care," says Val Davidson, former senior director of intergovernmental and legal affairs at ANTHC, in the video *Dental Health Aide Therapists: Investing in Our People.*[51]

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[47] Scott Wetterhall, James D. Bader, Barri B. Burrus, Jessica Y. Lee, and Daniel A. Shugars, *Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska: Final Report*, RTI International, October 2010, http://anthc.org/wp-content/uploads/2016/02/DHAT_2010EvaluationDHATWorkforce.pdf. Accessed January 2, 2017.

[48] Alaska Native Tribal Health Consortium, "Dental Health Aide," 2016, http://anthc.org/dental-health-aide/. Accessed November 9, 2016.

[49] Alaska Native Tribal Health Consortium, "2015–2016 DHAT Map," 2016, http://anthc.org/wp-content/uploads/2016/02/DHAT_Map_2016_v4.pdf. Accessed January 2, 2017.

[50] Alaska Native Tribal Health Consortium, "Bringing preventive dental care to rural Alaska," *Alaska Dispatch News,* November 1, 2016, https://www.adn.com/features/sponsored-content/2016/11/01/bringing-preventative-dental-care-to-rural-alaska/. Accessed January 2, 2017.

[51] Alaska Native Tribal Health Consortium, *Dental Health Aide Therapists: Investing in Our People*, Burness Communications, November 20, 2014, https://www.youtube.com/watch?v=uRzbK7jmSSw. Accessed January 2, 2017.

At least three Native American tribes are following ANTHC's dental therapist model. A Native American tribe in Washington state hired a dental therapist in January 2016, and Oregon authorized two Native American tribes to hire dental therapists in February 2016.[52]

Serving Suburban and Rural Residents

In addition to the state's expansive rural tracts, North Dakota has urban and suburban residents whom dental therapists could well serve.

The free market's dispersion of dental therapists in Minnesota since the program's authorization in 2009 shows dentists naturally tend to grow their practices with these midlevel providers where services are most needed.

Dentists naturally tend to grow their practices with dental therapists where services are most needed.

Minnesota had 63 licensed dental therapists practicing in August 2016, 27 of whom were advanced dental therapists and 22 of whom were dually licensed as hygienists and therapists. Of the 95 percent of these who were employed at that time, 52 percent worked in urban areas, where roughly 70 percent of Minnesotans live. Forty-eight percent of dental therapists were serving suburban and rural communities, where roughly 30 percent of Minnesotans live.

Instead of favoring urban centers with higher concentrations of dentists, dental therapists disproportionately practice in and benefit rural communities. This pattern demonstrates dental therapists are a natural way to expand access for the underserved.

Room for Therapists and Hygienists

Maine and Vermont's legal requirement that dental therapists be hygienists, and Minnesota's developing of that as an education requirement, may prompt lawmakers to ask, "Why not just let dentists expand their practices using dental hygienists?"

One opponent of legalizing dental therapists told North Dakota lawmakers the "high overhead cost of delivering dental services and the rural nature of the state" pose special challenges to solving the state's access problem.

The existence of challenges, however, is hardly an argument against trying new methods, such as licensing dental therapists, to overcome those challenges. The same opponent argued, "rather than untested dental therapist models, the best solutions utilize the current 1,450 dental hygienists and assistants" to reach underserved patients.[53]

Lawmakers should reject this faulty thinking. States don't have to choose whether to reach rural communities with therapists or hygienists. Dentists who think they will do better with hygienists are already free to do so. The continuing existence of an oral care shortage implies the benefits of expanding dental practices with hygienists do not always outweigh dentists' perceived costs of doing so.

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[52] Hamilton, *supra* note 38.

[53] North Dakota Legislative Assembly, *supra* note 1, p. 5.

Moreover, dental therapists and dental hygienists have separate scopes of practice. Dental hygienists are unable to perform extractions and fillings, the two procedures most likely to prevent serious oral health disease, which can lead to other serious health problems. If dental hygienists are a good idea, dental therapists are an improvement on it, because therapists are even better equipped to perform procedures that reduce oral health disease.

4. Dental Therapy's Potential to Increase Providers' Efficiency, Save Taxpayers' Money

Dental therapists can improve the bottom line of for-profit dental practices and increase savings in the state's Medicaid budget.

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Profit Despite Medicaid Shortcomings

Dental therapists' combination of advanced training for some procedures and wages lower than those of an associate dentist enables a for-profit practice such as Dental Associates of Minnesota to treat a higher volume of low-income patients with dental therapists than without them. The practice employs a dental therapist and two advanced dental therapists at its offices in St. Paul and Savage.

"Without dental therapists, our dentists would be booked out for weeks," Dental Director Dr. David Maki told researchers visiting the University of Minnesota School of Dentistry in November 2016.

Dental therapists have been shown to bring in revenue far exceeding the cost of their employment. "In 2012, two dental therapists provided care to 1,352 patients, many of whom received regular access to dental care for the first time," states a 2014 study by The Pew Charitable Trusts. "When compared to the reimbursement value of the care they delivered, the therapists exceeded their costs of employment by a combined $216,000."[54] The preventive care and early treatment of dental problems by one of these therapists stationed in a single village helped save $95,000 in Medicaid expenses in 2012.[55]

The shorter training period and narrower scope of dental therapists make them less expensive to employ than dentists. In low-income communities with large shares of the population enrolled in Medicaid, dental therapists have made it easier for their dentist-employers to profit despite Medicaid's notoriously low reimbursement rate, which varies by state.

A dental therapist in Minnesota who saw 1,756 patients in 2012 cost $136,070 to employ, including her compensation package, her dentist supervisor's time, and supplies, according to the Pew study.[56] The therapist generated $166,920 that year from Medicaid patients, who constituted

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[54] The Pew Charitable Trusts, *Expanding the Dental Team Increasing Access to Care in Public Settings*, June 2014, p. 2, http://anthc.org/wp-content/uploads/2016/02/DHAT_ExpandingtheDentalTeam.pdf. Accessed January 2, 2017.

[55] *Ibid.*

[56] *Ibid.*, p. 5.

65 percent of her patient load, without a dental assistant. The $30,000 surplus she generated solely from treating Medicaid patients would almost have covered the $47,000 cost of hiring a dental assistant, the balance of which might easily be covered by the non-Medicaid revenue she generated serving the other 35 percent of her patients she treated, the study states.[57]

Increasing Efficiency, Retention, Scope

Using lower-wage dental providers has reduced care costs and increased the average productivity of the dental team employed by Children's Dental Services (CDS) in Minnesota, according to Executive Director Sarah Wovcha. Dental therapists earn average hourly wages of $39, advanced dental therapists $46, and dentists $75, Wovcha told North Dakota lawmakers on September 21, 2016. CDS has reinvested the savings from lower labor costs in expanding access by hiring additional providers.[58]

Despite earning just half the wages of a dentist, dental therapists are increasing dentists' retention of patients, *Health Care News,* published by The Heartland Institute, reported in January 2017.[59] Moreover, "[t]hey free dentists to operate at the top of their licenses," Beaulieu of CDS in Minnesota said. In other words, delegating services and procedures to dental therapists creates more time for dentists to perform tasks requiring a dentistry license.

Delegating services and procedures to dental therapists creates more time for dentists to perform tasks requiring a dentistry license.

Markets Improve Medicaid

The demonstrated savings generated by dentists who delegate routine services and procedures to midlevel providers rebuts testimony given to North Dakota lawmakers in September 2016.[60] One opponent objected oral care provider shortages will persist as long as Medicaid reimbursements for dental work remain low. If North Dakota follows Minnesota's model, however, dentists who supervise and are in contract with dental therapists would receive the same Medicaid reimbursement rate for work done by therapists as if the dentists had done the work themselves. In such cases, the cost of care would decrease while the reimbursement stayed the same.

A second opponent, a Minnesota dentist, cited his experience employing a dental therapist whose training he eventually judged unsatisfactory to perform procedures the dentist had hoped to delegate.[61] Consequently, this dentist paid therapist wages for work he said was better left to dental assistants, whose wages are lower. Dr. John Powers, a dentist in Montevideo, Minnesota, countered this testimony in a revealing letter to state Sen. Judy Lee (R-West Fargo), chairman of the Health Services Committee, on November 1, 2016:

> The fact is that the dental therapist [the opponent] refers to is the same person I hired part time at my office. The therapist has done an excellent job in my practice, and I have the

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[57] *Ibid.*, p. 6.

[58] North Dakota Legislative Assembly, *supra* note 1.

[59] Hamilton, *supra* note 38.

[60] North Dakota Legislative Assembly, *supra* note 1.

[61] *Ibid.*, pp. 5–6.

> utmost confidence in his ability to effectively care for our patients. However, he has described to me a situation at [the opponent's] office where he is only allowed to do the most menial of tasks, resulting in an inefficient and ineffective use of his skills as a dental therapist. ...[62]

The opponent's experience also conflicts with the positive experiences of other dentists who saved money by delegating routine services and procedures to dental therapists in nonprofit practices in Minnesota, as noted earlier.

It seems unwise for this opponent to hire a dental therapist in the future. It would be equally unwise to assume his management or hiring woes justify imposing his preference on all dentists in the state.

Not in Kansas ... Yet

It is reasonable to expect that in most cases, delegating lower-skill tasks to less-skilled but well-trained individuals will free specialists to perform higher-skill tasks.

Blocking dental therapy undermines licensed dentists' liberty to treat patients to the best of their abilities as determined by the dentists' consciences and professional judgment.

Appreciating the savings likely to ensue from such an arrangement, three dentists in private practice have petitioned the Kansas legislature to license midlevel dental providers comparable to dental therapists, termed registered dental practitioners (RDPs).[63] "Lawmakers can help by passing the RDP legislation, allowing us to hire more Kansans, expand our practices and provide care to more patients," they wrote. "This system is working in the medical field between physicians and physician assistants and nurse practitioners."[64]

5. The Status Quo Diminishes Provider Liberty, Patient Access, and State Savings

Opposition to licensing of dental therapists in North Dakota does more than limit patient access to affordable care. Blocking dental therapy undermines licensed dentists' liberty to treat patients to the best of their abilities as determined by the dentists' consciences and professional judgment. Ironically, opponents of dental therapist licensing would also diminish licensed dentists' ability to grow their practices.

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[62] Powers, *supra* note 2.

[63] Kansas Dental Project, "Registered Dental Practitioner," 2016, http://www.oralhealthkansas.org/pdf/KAMU%20Advocacy%202.pdf. Accessed November 9, 2016.

[64] David Hart, Melinda Miner, Daniel Minnis, "Letter: Support dental practitioners," *The Topeka Capital-Journal,* December 11, 2012, http://cjonline.com/opinion/2012-12-11/letter-support-dental-practitioners. Accessed January 2, 2017.

Disruptive Innovation

Fear of change is a common malady, and those opposing dental therapist licensing are pressing lawmakers with their worries. "I believe the program has merit," one North Dakota lawmaker told us.[65] The same lawmaker, added, however, "My dentists do not want an additional layer of providers, which I guess is not surprising in the greater scheme of things. This reaction is common among the medical profession."

Such reactions by long-established players in the health care industry, however, are a common impediment to innovation. The conventional wisdom of entrenched interests is inadequate counsel for lawmakers who want to change the status quo and improve access to needed services.

The conventional wisdom of entrenched interests is inadequate counsel for lawmakers who want to change the status quo and improve access to needed services.

Fearing one's own service, product, or business model could become obsolete is an uncomfortable byproduct of progress. Established players who resist disruptive change introduced by risk-taking entrepreneurs are often motivated by fear of new competition, not concern for consumers. For example, after dentists complained to the North Carolina State Board of Dental Examiners that "nondentists were charging lower prices for [teeth whitening] services than dentists did, the Board issued at least 47 cease-and-desist letters to nondentist teeth whitening services providers and product manufacturers, often warning that the unlicensed practice of dentistry is a crime," writes United States Supreme Court Justice Anthony Kennedy in the Court's opinion of *North Carolina Board of Dental Examiners* v. *Federal Trade Commission* (2015).

The Board's fear and fear tactics were out of line. The Federal Trade Commission (FTC) filed a complaint against the Board for anticompetitive behavior. The Fourth Circuit Court of Appeals upheld the complaint, as did the U.S. Supreme Court.[66]

Beneficial to Dentists

Discrimination against dental therapy in North Dakota, like the North Carolina dentistry board's villainization of nondentist tooth whitening services, is ill-advised. The FTC urged the CODA director "to finalize and adopt accreditation standards for dental therapy education programs, which will likely benefit consumers," states a 2014 FTC press release.[67] CODA released its standards in 2015.[68]

Dentists would benefit from any competition introduced by licensing dental providers in North Dakota: Because therapists practice exclusively in the employment of supervising dentists, any competitive advantage gained by employing therapists would accrue to the dentists.

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[65] Bette Grande, personal correspondence, October 31, 2016.

[66] *North Carolina State Board of Dental Examiners* v. *Federal Trade Commission*, 574 U.S. 2015.

[67] Federal Trade Commission, "FTC Staff Urges Dental Accreditation Commission To Adopt Dental Therapy Accreditation Standards," December 1, 2014.

[68] Commission on Dental Accreditation, *supra* note 25.

Invisible Superiority?

Those who cite concerns about quality of care as justifying opposition to dental therapy assume ordinary patients are unable to distinguish superior care from inferior care.[69]

This line of argument actually undermines their opposition and affirms proponents' view: Any quality gap separating dentists from dental therapists would be virtually untraceable in the realm of care in which North Dakota dental therapists would treat patients. Moreover, dentists who employ dental therapists have a strong incentive to ensure those working in their practices are providing excellent care.

Dentists Retain Control

Some dental therapy opponents argue that because patients cannot discern the surpassing quality of dentistry over dental therapy, dentists must do so for them, not by proving their worth but through a government ban on dental therapy. This scorched-earth approach to promoting high-quality dental care is irrational and counterproductive.

A dentist who chose to hire dental therapists would retain complete freedom to direct the care given by each midlevel provider in his or her office, including care by dental therapists, just as dentists currently direct the work of dental hygienists.

Once licensed by the state, dental therapists would practice exclusively under the supervision of a licensed dentist. A dentist who chose to hire dental therapists would retain complete freedom to direct the care given by each midlevel provider in his or her office, including care by dental therapists, just as dentists currently direct the work of dental hygienists. The dentist's authority, responsibility, and autonomy would remain paramount. For this reason, as one Michigan state lawmaker told The Heartland Institute in September 2016, "I put the concern over quality right back in the dentists' laps."[70] Dentists would keep the full measure of quality assurance and responsibility they now have.

This fact exposes the greatest gaping cavity at the core of opponents' arguments against licensing dental therapists. Dentists who would block dental therapist licensure claim it would dilute care quality and raise care costs, even though these same dentists would maintain complete control over the spread of dental therapy in North Dakota if lawmakers authorize licensure. And although dental therapists would have to work under the supervision of and employment by a dentist, no dentist would be coerced into hiring a dental therapist.

Consequently, dental therapists will gain traction in North Dakota to the exact extent individual dentists allow. Only dentists who perceive the value dental therapists offer their businesses and patients would hire these midlevel providers. These entrepreneurial dentists deserve a voice and a choice. If opponents of dental therapy stake their credibility on the letters D.D.S. after their name, surely proponent dentists may do the same and expect lawmakers to respect their judgment equally.

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[69] North Dakota Legislative Assembly, *supra* note 3.

[70] Mary Tillotson, "States Consider Authorizing Dental Therapy to Expand Access," *Health Care News,* The Heartland Institute, November 2016.

Blockading dental therapy denies the rights of dentists confident they can serve North Dakota patients better than the entrenched model allows. After the state's thousands of underserved patients, dentists themselves will be the biggest losers if lawmakers allow North Dakota's *de facto* ban of dental therapists to continue.

Conclusion

The oral care shortage affecting North Dakotans of various ages and income levels warrants the entry of midlevel dental providers yet untried in the state. North Dakota lawmakers should act now to pass legislation authorizing the licensure of dental therapists.

Dental therapy is a 95-year-old profession with proven success at increasing oral care access for underserved patients in more than 50 countries, including the United States. Permitting dental therapists to obtain licenses in North Dakota would expand access for populations rural and urban, young and old, on Medicaid and off Medicaid. Dentists, who are currently obstructed from hiring dental therapists, would gain the freedom to grow their practices by building their dental dream teams.

Permitting dental therapists to obtain licenses in North Dakota would expand access for populations rural and urban, young and old, on Medicaid and off Medicaid.

North Dakota lawmakers have excellent examples from which to draw in crafting dental therapy legislation. Requirements for dental therapist education, training, and scope of practice could resemble the laws of Maine, Minnesota, and Vermont. North Dakota's lawmakers could extend this flexibility to Native American tribes, encouraging them to adapt dental therapy licensure requirements similar to those adopted by the Alaska Native Tribal Health Consortium.

North Dakota should take advantage of the knowledge provided by other states' laboratories of democracy, making North Dakotans heirs and pioneers of the free market's successful experiments with dental therapy.

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About the Authors

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Bette Grande (bgrande@heartland.org) is a research fellow at The Heartland Institute. Prior to coming to Heartland, she served as a North Dakota state representative from 1996 to 2014, representing the 41st district. As a lawmaker, she served as chairman of the Employee Benefits Programs Committee and as a member of the House Appropriations Committee and the Education and Environment Division. Grande holds a bachelor of science degree in education from the University of North Dakota and resides in Fargo.

John Davidson (jdavidson@texaspolicy.com) is a senior fellow at the Texas Public Policy Foundation, formerly serving as director of the foundation's Center for Health Care Policy and executive editor of Issue Media Group, whose 19 publications cover the creative economy, business innovation, and urban development. A graduate of Hillsdale College, Davidson is a 2013 Lincoln Fellow of the Claremont Institute. His writing has appeared in *The Wall Street Journal*, *National Review*, *Texas Monthly*, *Forbes*, *First Things*, the *Claremont Review of Books*, the *LA Review of Books*, *n+1*, and elsewhere. Davidson has coauthored policy briefs in support of legislation authorizing dental therapy in Michigan and Texas.

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The Heartland Institute is a national nonprofit research and education organization. Founded in Chicago, Illinois in 1984, Heartland's mission is to discover, develop, and promote free-market solutions to social and economic problems. Its activities are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

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Att. 10
HB1256
1-18-17

NDNPA
NORTH DAKOTA
Nurse Practitioner Association

TESTIMONY TO:

HOUSE HUMAN SERVICES COMMITTEE

65TH NORTH DAKOTA LEGISLATIVE ASSEMBLY

House Bill 1256 1/18/2017

Chairman Weisz and Committee Members:

I am Jenna Herman, Family Nurse Practitioner (FNP) and the American Association of Nurse Practitioners (AANP) ND State Rep and an officer in that same role for the North Dakota Nurse Practitioner Association (NDNPA). I am here to testify in support of House Bill 1256.

In 2011 the Advance Practice Registered Nurses (APRN) gained full scope of practice in North Dakota. This full scope of practice has increased access and decreased barriers to health care in our state. Years of research collected by the AANP has demonstrated quality care provided by APRNs.

In practice APRN's have identified barriers to dental care in our state. Young children as well as elderly wait for appointments and do not have timely dental care. I have seen an elderly resident in an assisted living facility wait for over a month to have a tooth extracted. This caused increased unnecessary pain and anxiety to this resident. In addition, I often see underserved patients in the emergency room who need tooth extractions and can only provide temporary

relief with dental blocks or antibiotics and anti-inflammatory medication until a dentist, which often takes a long time for this population to get in, can see them.

This bill provides clear education and competency prior to practice for the dental therapist. It establishes at least 500 hours of clinical time and a collaborative agreement with a dentist to provide supervision.

Jenna Herman, DNP, APRN, FNP-BC 701-355-8116 jmherman@umary.edu

Att. 11 1-18-17
HB 1256

Testimony on House Bill HB1256
2017 Legislative Session
January 18, 2017
Rep. Weisz House Human Services Chairperson

Good morning, Chairman Weisz and members of the committee. My name is Donene Feist and I am the Executive Director for Family Voices of North Dakota.

Family Voices of North Dakota is statewide health information and education center who serves families of children with special health care needs in ND. We provide emotional and informational support to many families across North Dakota who have a child who has an ongoing medical diagnosis such as asthma, heart conditions, physical disabilities, and emotional/behavioral issues. Our staff provides assistance and care coordination to families by helping them access and navigate services, understand what these services mean, how systems work, where does the funding come from and by providing emotional, informational and educational support information to assist with their unique and individual needs.

Children with special health-care needs are defined as children who have, or are at increased risk for, chronic physical, developmental, behavioral or emotional conditions, and who also require health and related service of a type and amount beyond that required by children generally.

In North Dakota, about 13.9 percent of children (19,750 children) from birth to age 17 have special health-care needs. (Data Resource Center)

Oral health care is the most prevalent unmet health-care need among U.S. children and adolescents with special health-care needs (SHCN) ages 17 and younger, just as it is for all U.S. children and adolescents. Oral diseases can have a direct and devastating impact on the health of children and adolescents with certain systemic health problems or conditions.

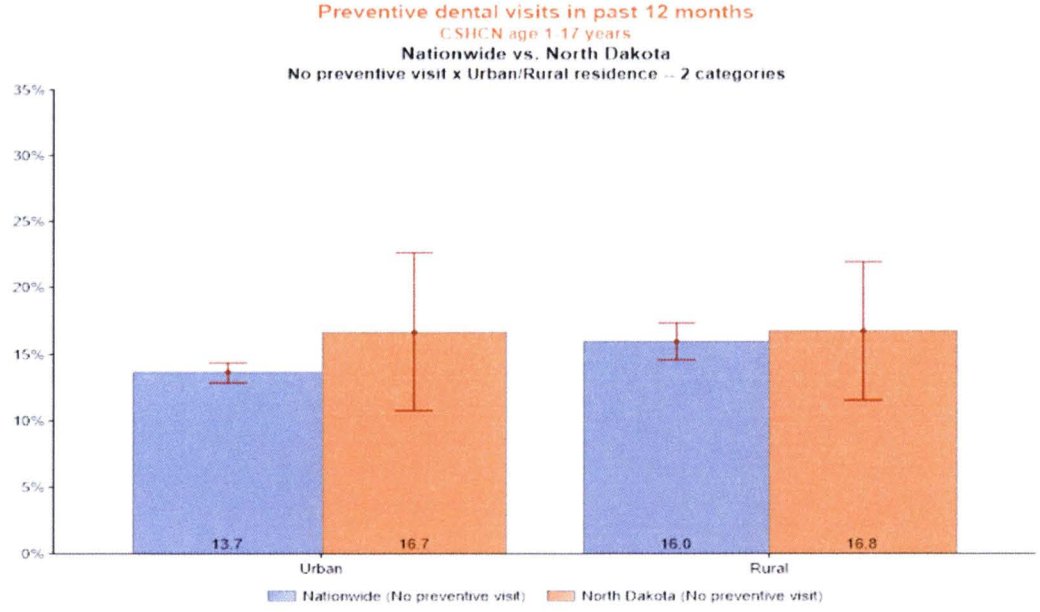
Only about 18 percent of children and adolescents with SHCN receive oral health services in a high-quality service system that meets all six Maternal and Child Health Bureau quality indicators which are: decision making and satisfaction, medical home, adequate health insurance, screening and surveillance, ease of use and effective transition planning.

Children and adolescents with SHCN who have public insurance are almost twice as likely to have unmet oral health care needs as those with SHCN who have private insurance

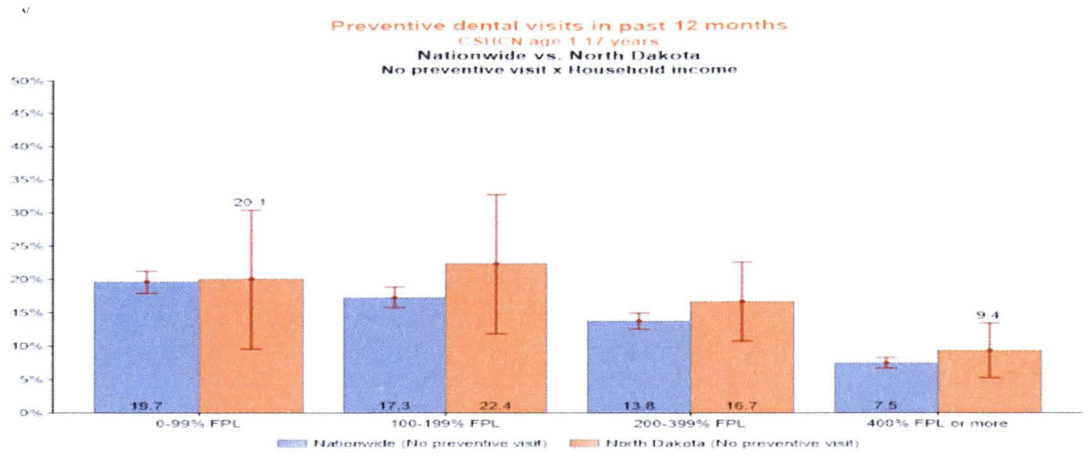
Children and adolescents with SHCN from families with incomes at up to 200 percent of the federal poverty level (FPL) are four times more likely to have unmet oral health care needs than are those with SHCN from families with incomes at 400 percent of the FPL or more.

Oral health care remains the most frequently cited unmet health care need for children and adolescents with SHCN. Children and adolescents with SHCN from families with low incomes, without insurance, or with insurance lapses, or who were more severely affected by their conditions, had more unmet oral health care needs than other children and adolescents with SHCN. Adolescents with SHCN had more unmet oral health care needs than children with SHCN.

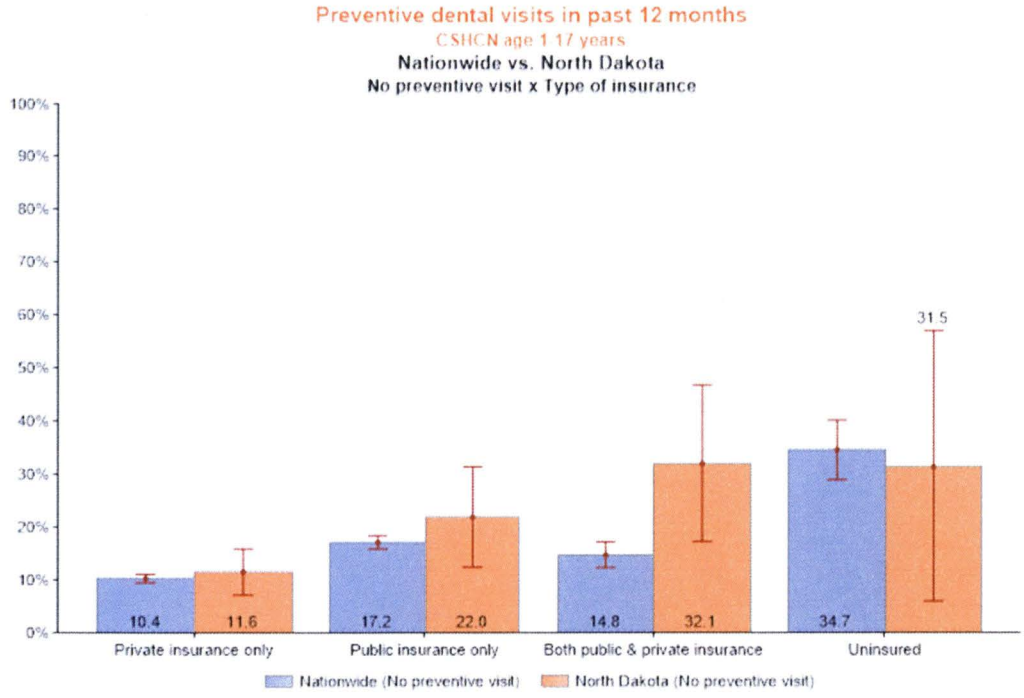
One of the most common things we hear from our families is an inability to find dental care and dentists who will serve them. Many of our families are denied access as the provider is taking only a certain amount of clients who are on public assistance. We also here from families on the extended wait time to see a dentist, which puts many of our children in a crisis at times. Some providers are not willing to take a child with special health care needs whether they be insured by private or public insurance. In other scenarios, families are being asked to pay for services upfront, before they may even be able to get into the door. These families often have few resources to be able to pay upfront for services that they may receive.



In North Dakota, we are slightly higher than the national average in both urban and rural areas for having no preventative dental visits in the last 12 months (Data Resource Center for Children and Adolescent Health)

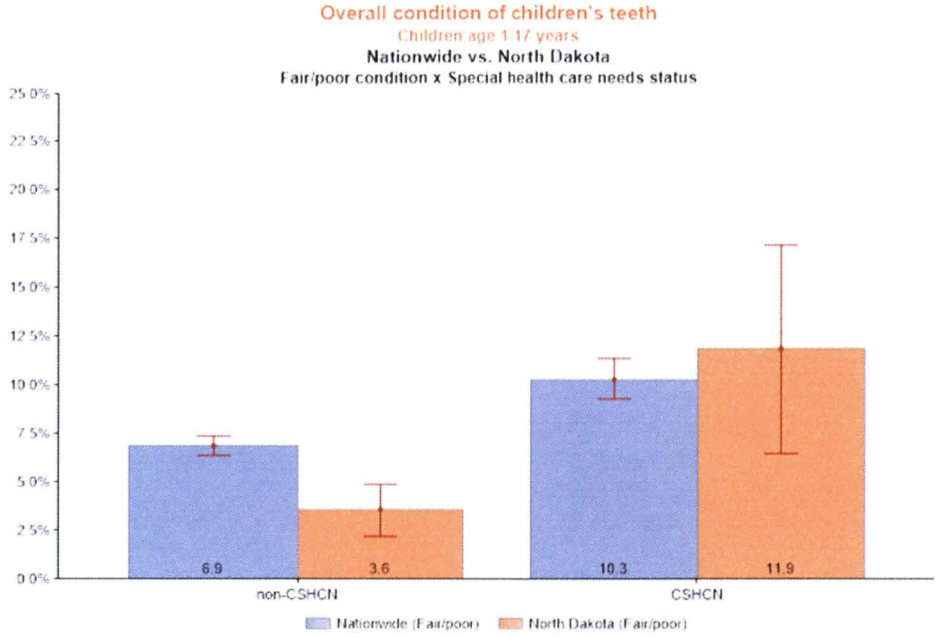


Children and Adolescents with special health care needs in North Dakota are also higher than the national average in having no preventative care by federal poverty level.



In the diagram above, you can see no preventative care in ND, how families fare, having private insurance, public insurance, both private and public and the uninsured. Additionally, in the graph below, you will see that children with no special health care needs fare much better in

having fair/poor oral health than do their counterparts with special health care needs.



Our organization helps families find healthcare and navigate the healthcare landscape, but there is a shortage of destinations to point them to. We know that our state's Medicaid reimbursement rate is among the highest in the country yet even then, most dentists refuse to see our children.

We cannot keep going like this. One of our staff at FVND had the following experience.

> "My son Chandler is now 14, and has been receiving dental care from MA providers his whole life. We started with a provider in Hawley (MN provider, at the time was the only provider willing to take new MA patients). We tried a family practice dentist, but because of his autism, and some sensory issues, we were referred to a pediatric dentist. There are options for Pediatric and Family Dentists here in Fargo, but hardly any willing to take NDMA.
>
> We did find one that was willing to see him but because of his difficulty in routine exams, it was recommended he not be seen every 6 months, like his siblings, but rather put under general anesthesia every couple years for X-rays, cleaning, and necessary work, and preventatives such as sealants.
>
> This is a traumatic experience for both parents and child, and doing it more often than necessary is costly, and difficult to access, especially for rural patients. Once he aged past 12, and had all of his permanent teeth, I tried to make a routine appointment, more than once in 2015, and was given several reasons why I couldn't make one, finally being told he would need a referral to return. Even after I explained he had been in pain

for what I believed to be days, if not longer, as it is often hard to gauge with nonverbal patients. I had no dentist that would take him to make a referral, and even if they did, our dentist was suggesting he go to Minneapolis for care. We reached out to P&A in March of 2016 who sent a letter of support to this dental office, and received the same response. They suggested because of his age (13) he begin looking for a non-pediatric dentist.

After reaching out to Senator Judy Lee and the dental association, I did find a dentist willing to see him, and schedule a hospital room (which often takes considerable time). In October 2016, when the dentist came out of the OR, he explained to us, that indeed there was much decay in the adult tooth, so much that it was into the pulp and had to be extracted. There was no alternative to a situation I feel could have been avoided by easier, and more frequent access to care.

Please consider expanding access to care, as it is an issue in both rural and urban areas, with minimal options for families dealing with any number of special healthcare needs."

Representative Weisz and members of the committee, if we as savvy advocates cannot obtain access with the knowledge and skillset that we have, how are families in the general population faring, or other families who have a child with a special health care need. We desperately need expanded dental care in our state and are here today to support HB 1256. By allowing dentists to hire dental therapists and see our children in their offices, North Dakota will make a strong statement putting our children first. This is a proven and commonsense solution will open the doors for more children and more families.

In closing, let us remember as each of us makes decisions that will affect children—whether we are parents, educators, health professionals, or government officials—it is our duty to consider if that decision either affirms or denies a child's most basic human rights.

Chairman and members, please support this necessary legislation.

Donene Feist
Family Voices of North Dakota
701-493-2634
fvnd@drtel.net

Att. 12
HB 1256
1-18-17

House Human Services
HB 1256
January 18, 2017

Chairman Weisz and members of the committee, thank you for the opportunity to testify today in support of HB 1256. My name is Renee Stromme and I'm the executive director of the North Dakota Women's Network (NDWN), a statewide women's advocacy organization.

At the North Dakota Women's Network (NDWN) our goal is to improve the lives of women. The bill before you does so in two different ways. First, it will make it easier for women and their families, mothers and children alike, to get the oral health care they need to live productive and healthy lives. Second, it will improve the economic health of women and their families across North Dakota by providing an additional career option that pays well, including in rural areas.

HB 1256 would allow dentists to hire dental therapists, who are treatment providers similar to physician assistants in medicine. In Minnesota, dental therapists already work under the supervision of dentists and have helped them grow their practices while extending quality, routine dental care to people who currently don't have access, such as the young, the poor and the elderly.

In North Dakota, this could include poor children and pregnant mothers on Medicaid, both of whom are eligible for dental benefits. It also includes other Medicaid recipients eligible for dental care: children in foster care or subsidized adoption, children with disabilities, women with breast or cervical cancer, workers with disabilities, other blind and disabled individuals, and seniors who are low-income *Medicare* beneficiaries (so-called "dual-eligibles").

All across North Dakota there are many who don't have access to the dental care necessary to lead healthy, productive lives. In fact, nearly half of North Dakota counties have no dentists or just one and two thirds of kids on Medicaid aren't getting the care they need – ranking us at third worst in the nation.[i] With only 56% of dentists in the state accepting Medicaid it is clear there is a lack of access to care. Medicaid.[ii]

Pregnant women often don't receive dental care for many reasons. Some women pass up dental care because they mistakenly think oral health doesn't have long-term implications for the health of their baby. Many times, they haven't been able to get dental care previously, making it difficult for them to learn about the importance of oral health. Many also have trouble finding a dentist, or they don't have the means or the time to get to the dentist's office, especially if they have to rely on public transportation. And in some rural areas, there just are not dentists to offer service. Whatever the reason, lack of access to oral healthcare for pregnant women has negative repercussions for not only their health, but also that of their children.

However, with HB 1256 we can increase access to dental care and also expand economic opportunities for North Dakotans.

As I mentioned earlier, there is another key benefit to allowing dental therapists in North Dakota: improving the economic health of women and their families across our state by providing an additional career option that pays well, especially in rural areas. Almost 96% of dental hygiene students are women, and HB 1256 offers a career ladder with additional education and training for them that would increase their salaries.[iii] Dental therapists make between $35 and $45 per hour in Minnesota, including in rural areas, and in Minnesota 90% of dental therapists are female.[iv]

The evidence is clear. HB 1256 is a win for everyone in North Dakota, including women and children. We urge this Committee to help North Dakotans live better and healthier lives by authorizing dental therapists.

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[i] UND Center for Rural Health, "Dental Workforce in Rural and Urban ND," June 2016; UND Center for Rural Health. Oral Health among ND Medicaid Recipients. December 2016.

[ii] UND Center for Rural Health. Oral Health among ND Medicaid Recipients. December 2016.

[iii] American Dental Association, 2012-13 Survey of Allied Dental Education.

[iv] Wovcha S, Pietig E. Dental Therapy in Minnesota: A Study of Quality and Efficiency Outcomes. http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/Senate Health and Welfare/Bills/S.20/Witness Testimony/S.20~Sarah Wovcha~Dental Therapy in Minnesota- A Study of Quality and Efficiency Outcomes~2-11-2015.pdf. Published February 11, 2015. Accessed November 27, 2016; Expanding the Dental Team: Increasing Access to Care in Public Settings. Washington, DC. The Pew Charitable Trusts. http://www.pewtrusts.org/en/research-and-analysis/reports/2014/06/30/expanding-the-dental-team. Published June 2014. Accessed November 27, 2016; Expanding the Dental Team: Studies of Two Private Practices. Washington, DC. The Pew Charitable Trusts. http://www.pewtrusts.org/en/research-and-analysis/reports/2014/02/12/expanding-the-dental-team. Published February 12, 2014. Accessed November 27, 2016; Minnesota Department of Health, Office of Rural Health and Primary Care, Minnesota's Dental Therapist Workforce, 2015. http://www.health.state.mn.us/divs/orhpc/workforce/oral/2016dt.pdf

a H. 13 HB1256
1-18-17

North Dakota
Dental Hygienists' Association

TESTIMONY TO:

HOUSE HUMAN SERVICES COMMITTEE

65TH NORTH DAKOTA LEGISLATIVE ASSEMBLY

House Bill 1256 1/18/2017

Chairman Weisz and Committee Members:

This testimony is in support of HB No. 1256 relating to the regulation of dental therapists in North Dakota. My name is Dana Schmit. I am a licensed Dental Hygienist in ND and President of the ND Dental Hygienist Association (NDDHA). I am a graduate of the ND State School of Science with an associate degree in dental hygiene. I am currently employed in a dental practice in rural western North Dakota and have practiced there for 6 years. I have also practiced in Wahpeton and in Fargo for three years working as a temp in various offices. I am also a mother of twins and unable to be here today due to work and home commitments.

The NDDHA is in full support of the addition of the Dental Therapist to the providers for dental services in our state. I have seen firsthand the need for another level of provider in my community and area of the state. During the most recent oil boom many of the people who came to our state did not have access to care. The dentists in the larger communities would not accept Medicaid patients or any other new patients and therefore these patients would go unserved. Fortunately, we saw many of these patients with tooth aches and unmet dental needs. Unfortunately, many of these patients ended up in the emergency room for dental care.

The addition of the Dental Therapist could provide the much needed education, evaluation, instruction, x-rays, simple extractions and provide the Dentist with the time to complete the more complex and higher level dental procedures. Keep in mind this professional would be licensed and under the supervision of the dentist.

HB 1256 would help meet the demand for affordable, routine dental care by authorizing dental therapists to be licensed by the Board of Dental Examiners to perform routine procedures under the supervision of a dentist. In fact, they would only work as part of the dental team led by a dentist. For your reference, I am including two versions of a chart which give you an indication of how many procedures a dental therapist can do compared to a dentist, hygienist, and registered dental assistant in North Dakota. As you can see, a dentist can do nearly 400 procedures compared to 94 for a dental therapist, 46 for a hygienist, and 30 for a registered dental assistant. Thank you so much for your time.

Thank you so much for your time. Please contact me with questions.

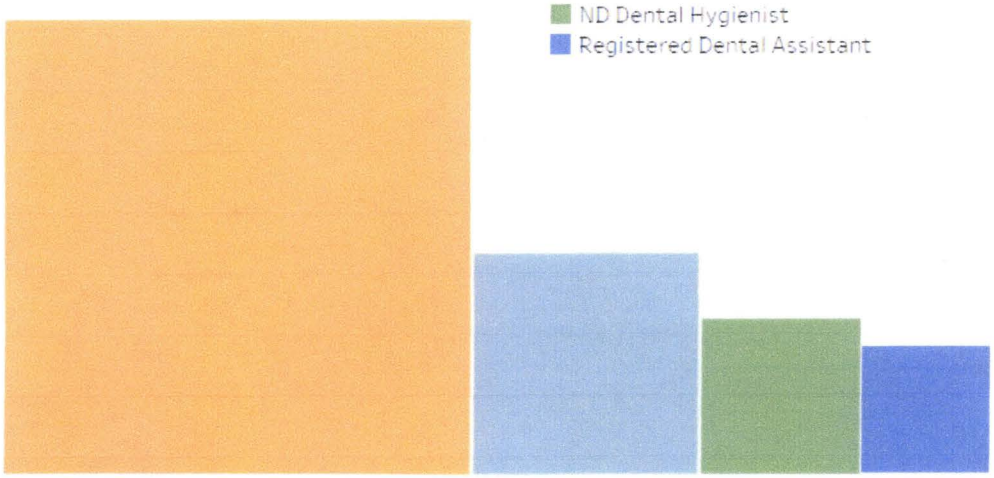
Dana Schmit RDH

President and Legislative Chair NDDHA

Email: danaschmitrdh@hotmail.com

Scope Comparison of ND Providers

- Colors represent the provider type; box size represents the number of allowed billable codes



Provider	# Codes
Dentist	398
ND Dental Therapist	94
ND Dental Hygienist	46
Registered Dental Assistant	30

Data sources: 2016 American Dental Association Codes on Dental Procedures and Nomenclature, ADA Commission on Dental Accreditation 2015 Accreditation Standards for Dental Therapy Programs, and North Dakota Admin. Code 20-01 through 20-05 (via the ND Board of Dental Examiners) current as of April 1, 2015.

Responses to Statements by the ND Dental Association

North Dakota has a steady supply of new dentists to replace retiring dentists. In fact, ND led the nation in dentist "in-migration" from 2011-'16.

- Response: Unfortunately, while no specific numbers are mentioned above, this has not helped the 65% of kids on Medicaid who didn't see a dentist in 2015[i] or 1 in 3 seniors that report dental problems,[ii] among the many other North Dakotans who are not able to get care. In addition, nearly half of counties still have no dentists or just one[iii], and a 2013 survey indicated that 1 in 3 dentists planned to retire in the next 15 years.[iv]

A record 6 new dentists received loan repayment awards through the North Dakota Dental Loan Repayment program in 2016. Loan repayment is awarded to dentists that practice in non-profit public health clinics, rural areas, and see Medicaid patients.

- Response: As mentioned, nearly half of counties still have no dentists or just one.[v] And 65% of kids on Medicaid weren't able to see a dentist last year—3rd worst in the nation.[vi]

North Dakota is expanding the number of children who receive sealants in school-based outreach programs, sponsored by the State Department of Health. In the 2015-16 school year, 3,124 children received 7,831 sealants in 42 North Dakota schools. In addition to the Department of Health program, 8 dental practices and non-profit dental clinics are signed up to participate, and may utilize new portable equipment provided through a North Dakota Dental Foundation grant.

- Response: This is a good thing, but unfortunately it will not help those who need a routine filling and can't find a dentist to treat them either because they're on Medicaid or there isn't one nearby. 1 in 4 third graders in ND have untreated tooth decay, including half of American Indian kids.[vii] Further, grants are not guaranteed in the future.

The North Dakota Dental Association surveys members quarterly to recruit volunteer dentists for non-profit clinics and Indian Health Service clinics. After the Spirit Lake Clinic lost its IHS dental provider in summer 2016, NDDA recruited 4 dentists to fill in until a new full-time dentist was hired.

- Response: I commend NDDA for this specific effort, but it is also important to recognize that the waiting list for a dentist on reservations can be as long as six months.[viii]

In Minnesota, dentists who have utilized dental therapists are questioning the effectiveness and sustainability of the model in private practice and its actual benefit to patient care.

- Response: Over 60 dental therapists are successfully practicing under the supervision of dentists throughout Minnesota, with the number slated to increase in the coming years. This claim refers to one specific dentist, and as with any small business or profession, dental therapists are not a fit for every practice. However, the dental therapist that this dentist had on staff part-time has been a great fit for another practice in the area that actually continues to receive Medicaid patient referrals from the other.[ix]

The nearly 60 dental therapists (DT) licensed in Minnesota continue to be the only practicing DT's in the lower 48 states. Only 7 of them are located north of I-94 in the rural part of Minnesota.

- Response: 48% of dental therapists practice in "Greater Minnesota" compared to 52% in the Twin Cities Metro Area. Compare this to the distribution of dentists in MN: 63 percent urban, 37 percent rural.[x,xi] The "7" number above ignores dental therapists working for dentists in the large rural area south of I-94[xii], as well as the fact that a huge portion of northern Minnesota is covered by state and national forests.

After 7 years of allowing the dental therapy model to work, 44% of low-income children in Minnesota still struggle to access dental care. In North Dakota, only 7% of children have difficulty accessing dental care.

- Response: 1 in 4 third graders in ND have untreated tooth decay[xiii] compared to 17% in Minnesota.[xiv] ND is also 3rd worst in the nation (after Ohio and Wisconsin) at providing dental care to low-income/Medicaid-enrolled kids, with 65% *not* seeing a dentist in 2015 – despite one of the most generous reimbursement rates in the nation.[xv]

In fall 2016, the University of Minnesota Dental Therapy Program was modified to become a dual dental hygiene/therapy program, requiring just 32 months of actual dental training.

- Response: The dental hygiene/dental therapy program at the University of Minnesota is year round, not an academic year, and the statement above leaves out a year of pre-requisite courses. By going year round, the 32 months (or about 3 years) combined with the pre-requisite year is able to condense the overall program from 6 to 4½ years. Most dentists receive four academic years of dental training after earning a bachelor's degree, but they can do hundreds more procedures than a dental therapist can do. Finally, the Commission on Dental Accreditation, which accredits dental schools, only requires three academic years for dental therapy due to the narrow scope of duties.

Despite software transition problems with Dental Medicaid in 2015, the North Dakota Dental Association is still committed to recruiting and supporting North Dakota's dental Medicaid provider network.

- ND is 3rd worst in the nation at providing dental care to low-income/Medicaid-enrolled kids, with 65% *not* seeing a dentist in 2015. This is despite one of the most generous reimbursement rates in the nation.[xvi]

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[i] UND Center for Rural Health. Oral Health among ND Medicaid Recipients. December 2016

[ii] UND Center for Rural Health, "Oral Health among the North Dakota Elderly," October 2016, Schroeder S, UND Center for Rural Health, "Oral Health Services Provided and the Perceived Barriers to Providing Services in LTC Facilities," (Presented at AcademyHealth Annual Research Meeting, Boston, MA), June 27, 2016.

[iii] UND Center for Rural Health, "Dental Workforce in Rural and Urban ND," June 2016.

[iv] UND Center for Rural Health. ND Oral Health Report: Needs and Proposed Models, December 2014.

[v] UND Center for Rural Health, "Dental Workforce in Rural and Urban ND," June 2016.

[vi] UND Center for Rural Health. Oral Health among ND Medicaid Recipients. December 2016

[vii] Njau G and Yineman K, "Findings and Lessons from the 2014-2015 ND Oral Health Third Grade Basic Screening Survey," ND Department of Health, (Presented at the Dakota Conference on Rural and Public Health, May 16, 2016).

[viii] UND Center for Rural Health. ND Oral Health Report: Needs and Proposed Models, December 2014.

[ix] Letter from Dr. John Powers to ND Interim Health Services Committee, November 2016.

[x] Schoenbaum, M. Dental Therapists in Minnesota: State-level Overview. Sept. 12, 2016, The George Washington University/Texas Medical Center Health Workforce Innovations Meeting

[xi] MN Department of Health geocoding and analysis of August 2015 Minnesota Board of Dentistry address data, from the 2014-2015 Dentist Workforce Survey.

[xii] Dr. Karl Self, University of Minnesota School of Dentistry, "MN Dental Therapy," August 2016.

[xiii] Njau G and Yineman K, "Findings and Lessons from the 2014-2015 ND Oral Health Third Grade Basic Screening Survey," ND Department of Health, (Presented at the Dakota Conference on Rural and Public Health, May 16, 2016).

[xiv] MN State Oral Health Survey 2014-2015, CDC NOHSS; CMS EPSDT 2015 data, children aged 1-20 enrolled 90 days.

[xv] UND Center for Rural Health. Oral Health among ND Medicaid Recipients. December 2016.

[xvi] UND Center for Rural Health. Oral Health among ND Medicaid Recipients. December 2016.

Att. 15 1-18-17
HB 1256

House Human Services Committee
Honorable Representative Robin Weisz, Chairman

January 18, 2017

HB 1256 Testimony by Senator Brad Bekkedahl

Chairman Weisz and Committee,

For the record, I am Brad Bekkedahl, Senator from District 1, city of Williston. I stand before you today to present testimony in opposition to House Bill 1256. To give some background, I have been a licensed Dentist in North Dakota and Minnesota for 33 years. In June of 2015, I sold my practice to a ND native that had been practicing in a clinic in Minnesota. With this sale, I retired from full time patient care, and assist the office part time as requested. I primarily treat Medicaid patients, as I have throughout my career.

Today you will hear testimony about successful North Dakota solutions to our dental health delivery system. The message from last session has been clear. Our profession needs to do better, and the testimony you will be given after mine will show we have responded to partner with the State and others to make improvements to access and treatment issues. We have witnessed a Great Migration of dental practitioners into our State. The statistics of the increase in dentists and the young age of this immigrating workforce show market conditions helping solve issues of access to care statewide. The dental loan repayment program has incentivized new dentists to locate in our smaller rural communities, work in community clinic settings, and treat more Medicaid patients. As a profession, we are engaged. This message of how North Dakota citizen Dentists have cooperated to bring locally generated solutions to the access to care issue stands in stark contrast to the out of state interests you have seen today and their attempts to force a delivery model upon our citizens as "what's best for you" in order to promote their own national agenda.

You will also hear about quality of care issues, which are paramount among my concerns. I am a Doctor of Dental Surgery, and the procedures I provide to my patients in most cases are difficult and technically challenging to do well, even with my advanced experience level. Dentists are doctors providing treatment, as well as small business owners in your communities. I have always focused on my patient care above my business performance. I do not believe the current education and training regimen for the dental therapist model is sufficient to provide quality care, especially with some of the irreversible treatment options they can be licensed for. When I owned and operated my solo dental office, my staff would frequently ask me questions about a specific care issue for a patient. I told them to ask themselves this question – "Is it best for the patient?" And, if they answered themselves "Yes", then they had my answer as well. I can tell you today that my research and knowledge of this Dental Therapist licensing model has me asking myself the same question relative to the quality of care issues – "Is it best for the patient?". Unequivocally, at this time, I must answer this question "No".

The testimonies presented about local North Dakota solutions today lead me to oppose House Bill 1256, and support the recommendation to focus on quality of patient care, and not the promotion of out of state agendas for a national campaign. I ask you also to support the 95% of practicing Dentists in our North Dakota communities that oppose this bill today. We can be deliberative and diligent, as we usually are in North Dakota, and implement the right changes when it is best for our citizens and patients.

Thank you for your kind attention to my testimony. I am honored to stand before you now for any questions the Committee may have.

GH. 16 1-18-17
HB 1256

HB 1256 House Human Services Committee

Dr Katie Stewart

North Dakota Dental Association

January 18, 2017

Chair Weisz and members of the committee, my name is Dr. Katie Stewart, President, North Dakota Dental Association. I was born and raised in Bismarck, and after receiving my dental degree from the University of Minnesota, I returned home to Bismarck, where I have practiced for nine and a half years. Like many of our state's dentists, I provide care to help those in need whenever possible. Most recently, I participated in last summer's Mission of Mercy, held in partnership with the Minnesota Dental Association, which provided free dental care to 1,200 patients over two days.

I am here today to testify in opposition to House Bill 1256 on behalf of the North Dakota Dental Association. The benefits of dental therapy have been oversold, with no evidence to show it will work as promised in North Dakota.

Let me discuss some of our concerns directly:

1. **NEW RESEARCH SHOWS THERE ARE ENOUGH DENTISTS.**

   Bill proponents cling to an outdated opinion that there is a dentist shortage. This is false. A recent Health Policy Institute study found the number of dentists is *increasing* and will soon outpace demand. Over the last five years North Dakota has actually led the nation in attracting new dentists. (See attached "DDS Migration Across State Lines" chart).

   To encourage new dentists to practice where they are most needed, North Dakota's dental loan repayment program is available to those who practice in non-profit public health clinics, rural areas and who see Medicaid patients. The program awarded payments to a record six new dentists last year.

What research has shown is we must be better at getting patients to the dentist and keeping appointments. Unfortunately dental therapy is not the solution and has distracted the state from pursuing proven solutions.

2. **THESE PROGRAMS DO NOT SAVE MONEY FOR ALL PATIENTS.**

Dental therapists are frequently cited as making dental care more affordable. This is false. Insurers and states pay set fees for dental procedures, regardless of who performs them. There is *zero* cost savings under this model to either the patient or the state.

The program also fails to provide any financial relief by bringing care to those who are most in need. After eight years with the Minnesota program, patients are still seeking dental treatment in emergency rooms at cost to taxpayers and community hospitals. According to the Minnesota Dental Association, cost of dental-related visits to hospital emergency rooms in Minnesota has been estimated at $148 million in the past three years.

In reality, the few midlevel programs in the United States exist because they are either directly supplemented by taxpayer dollars or subsidized through the foundation community. Midlevel programs fail without significant government spending or outside support. As an example, the Vermont law allowing for midlevels has received hundreds of thousands of dollars from the WK Kellogg Foundation to develop a program in that state—even after proponents of the bill touted the plan as "revenue neutral".

Minnesota appropriated $135,000 to implement the new dental therapy legislation in FY 2010-2011. Minnesota has also incurred costs through the State Health Department for analysis and progress reports. While difficult to predict costs in ND, it is likely there will be substantial increases in license fees to cover regulatory costs, determining training standards, and the costs of adding two Board members. The fiscal note for SB 2354 which failed in 2015 was $145,000.

The Canadian midlevel program that began in 1972 was fully subsidized by the government. Students paid no tuition and patients were not charged. Nearly 40 years later, it still was not self-sustaining and the program ended after government subsidies ended.

3. **TOO FEW DENTAL THERAPISTS LIVE OR PRACTICE IN RURAL AREAS.**

The data from the Minnesota and Canada programs have consistently shown that dental therapists concentrate in cities, not in rural areas. Proponents of dental therapy in North Dakota are trying to sell a program that has done little to help underserved rural communities.

According to the Minnesota Dental Board Licensure Verification, there are 52 licensed dental therapists in Minnesota. Only seven are working in a Census-designated rural area. This has failed rural communities and echoes the pattern of the Canadian program where practitioners abandoned rural communities to seek higher wages in urban areas. In fact, in Minnesota, dental therapists are in metropolitan areas at a higher rate than the general population and other practitioners.

4. **OF THE PROGRAMS THAT EXIST, NONE ARE ACCREDITED.**

The Commission on Dental Accreditation created a dental therapy standard out of concern that lobbyists and interest groups, without dental background or training, were filling a void and creating dental therapy curriculums with insufficient rigor and education for the clinical skills proposed for dental therapists. Currently there are no CODA-accredited dental therapy education programs in the United States.

5. **THEY ARE INCONSISTENT IN SCOPE, EDUCATION AND OVERSIGHT.**

The definition of a dental therapist varies wildly depending on where you are. The inconsistencies in scope, required training and supervision for dental therapists make it difficult to make accurate predictions of the potential success or failure of a new state program (see attached "Patchwork" chart titled "What is a Dental Therapist"). The University of Minnesota program requires a dual Bachelor's degree in dental hygiene and a Master's in dental therapy while the Alaska program

requires an 18 to 24-month community college program with 400 clinical training hours. The recently passed Vermont program requires graduation from a CODA-accredited program (of which none exist) and have 1,000 hours of clinical practice with direct supervision. Supervision requirements during irreversible procedures vary across states from "none" to "indirect" to "direct." With only a preliminary review, we see at least 15 specific language/conflict problems within the bill draft of HB 1256 that makes it ill-advised to proceed without extensive changes. In short, this bill, and the dental therapy model are still very much a pilot program; chaos reigns in determining regulatory standards.

Dental therapists are also often compared to a nurse practitioner. This is false. Dental therapists have less training than both dentists and nurse practitioners, but are allowed to perform irreversible surgery. Nurse practitioners, with a minimum of three years additional training beyond dental therapists, are not allowed to perform surgery. Dental therapists are "procedurealists" and thereby adequate training experience is critical. This is a big deal.

6. **DENTAL THERAPY IS NOT A SILVER BULLET TO SOLVE ACCESS ISSUES. THERE ARE BETTER, PROVEN SOLUTIONS.**

Cost or lack of coverage, education, geography, transportation, language and other barriers to care make it difficult for patients to get dental care.

Rather than waste time, energy and scarce state funds on a program like this, I would like to see our state support strategies that more appropriately address North Dakota's unique needs, including: emergency room referral programs to get people out of the ER and into a dentist's chair; deployment of community dental health coordinators to provide community-centered, culturally appropriate dental health education and navigation to patients seeking to connect with dental care; making use of technology to provide teledentistry programs to those in rural areas; and attracting recent dental school graduates by helping them pay off student loans.

North Dakota dentists are already implementing solutions that make a positive impact on our residents:

a) In collaboration with the state's oral health program, oral health professionals and private practices, we've steadily increased the number of children who receive sealants in school-based outreach programs to more than 3,000 low-income children in 42 schools during the 2015-2016 school year. The success of the program over the last few years has inspired a growing number of private practices to participate and sponsor the program. Eight dental practices and three non-profit dental clinics have now signed on to provide services through the program, and we expect the number of children to be served in the 2016-2017 year to exceed the previous school year's total.

b) We recruit dentists to serve in non-profit clinics and Indian Health Clinics as needed, including last summer, when we helped secure four dentists to fill in at the Spirit Lake Clinic until they were able to hire a new provider.

c) We support outreach opportunities that directly benefit seniors. In 2001, we established the Donated Dental Services program in North Dakota. Since then, the program has provided almost $2.9 million of care to vulnerable seniors. There are currently 137 dentists participating in the program in our state.

d) We support mobile outreach to underserved communities through programs including the Ronald McDonald Care Mobile, and we are actively exploring teledentistry programs, which would further expand our ability to provide quality care to sparsely populated areas of the state.

I welcome those on this committee, and the rest of the North Dakota State Legislature, to join us in discussion of a broader approach on proven solutions rather than revisit a program that has already been rejected by this body and that is failing in other states.

Att. 17 1-18-17
HB1256

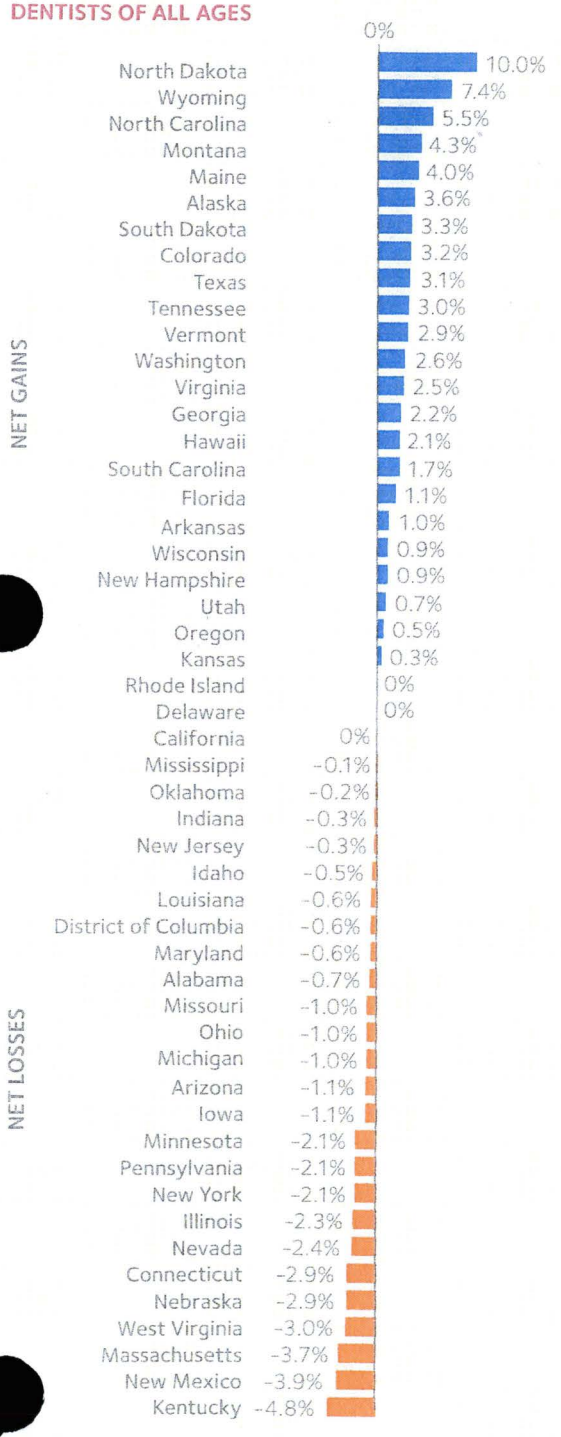
HPI Health Policy Institute

ADA American Dental Association®

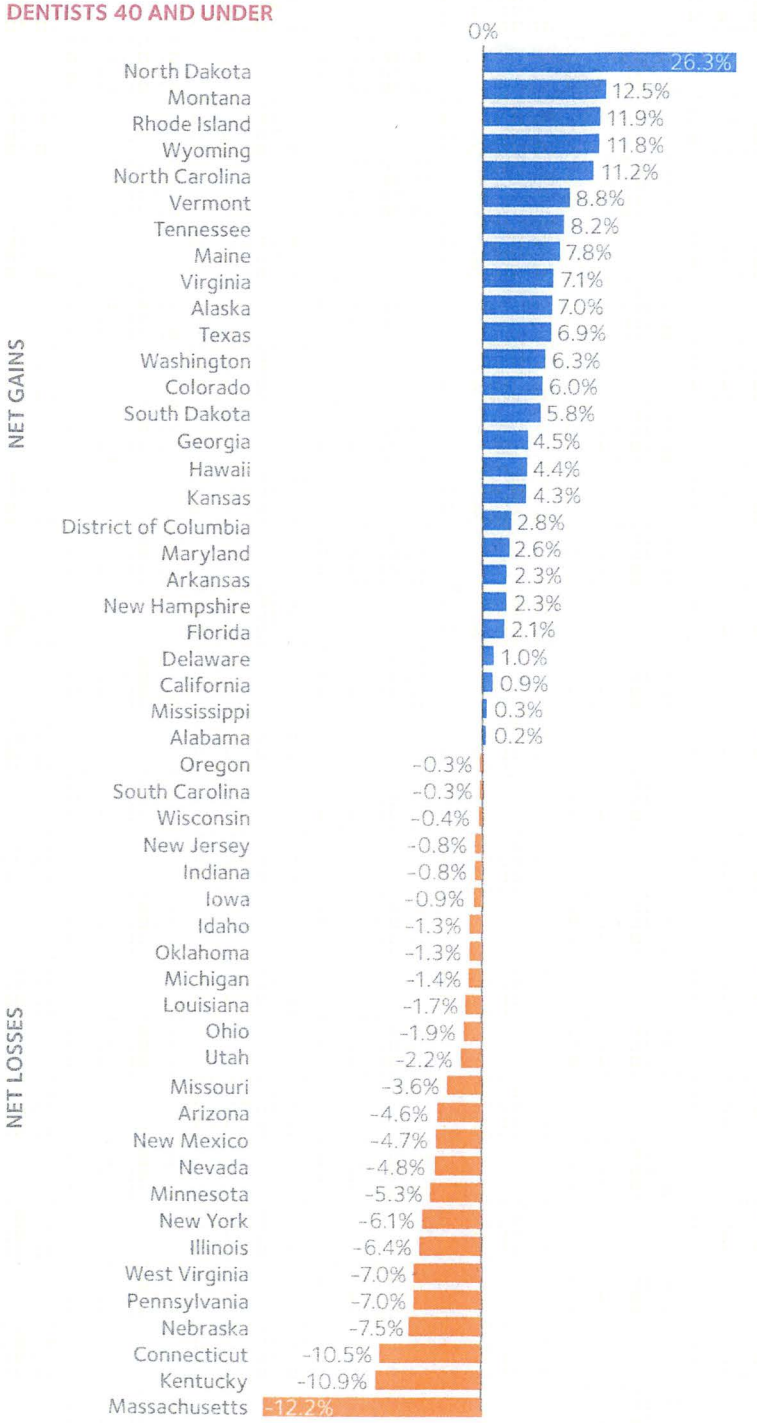
Dentist Migration Across State Lines

ABOUT 1 IN 18 DENTISTS (5.5%) moved to a different state between 2011 and 2016. Dentists 40 years or younger were much more likely to move, with about 1 in 8 (12.6%) migrating across state lines.

DENTISTS OF ALL AGES



DENTISTS 40 AND UNDER



Note: Percentages in the figures refer to net migration of practicing dentists between January 2011 and January 2016 (i.e., the number of dentists who entered the state minus number of dentists who left the state) divided by the number of practicing dentists in the state in January 2011. Age is calculated as of January 2011. Sample includes all dentists in the United States who were practicing in both January 2011 and January 2016. Based on HPI analysis of the ADA masterfile.

Download the **detailed data** on the number of dentists migrating from each state to all 49 other states.

What [redacted] DENTAL THERAPIST?

It depends on where you are. The definition of a dental therapist varies wildly depending on where you are. The inconsistencies in scope and supervision and required training for dental therapists make it difficult to make accurate predictions of the potential success or failure of a new state program.

	NEW ZEALAND 1921	CANADA 1972	ALASKA 2004	MINNESOTA 2009	MAINE 2014	VERMONT 2016
	"Dental Therapist"	"Dental Therapist"	"Dental Health Aide Therapist"	"Dental Therapist"	"Dental Hygiene Therapist"	"Dental Therapist"
TRAINING	Bachelor's Degree from a recognized program[1]	20 months of training, including pre-clinical components[2]	18- to 24-month community college program with 400 clinical training hours[3]	A Bachelor's degree in dental therapy [4,5]	An associate's degree in dental hygiene, Bachelor of Science from CODA-accredited* program (none exist) and 2,000 hours clinical practice[6]	Graduate from CODA-accredited* program (of which none exist) and have 1,000 hours clinical practice with direct supervision[7]
SCOPE	Can only provide surgical procedures for children, not adults[8]	Can perform surgical procedures without a supervising dentist on-site[9]	Can perform extractions of adult teeth emergency situations where a dentist has been consulted and only can practice on tribal lands[10]	Can perform surgical procedures with indirect supervision from an on-site dentist. Advanced dental therapists can dispense certain medications[11, 12]	Can only provide care and surgical procedures under direct supervision of a dentist[6, 13]	Can perform surgical procedures without a supervising dentist on-site[7]
DENTAL SHORTAGE AREA PRACTICE REQUIREMENT	None[8]	None. Instead of working in rural communities, more than 75% worked in more populated areas where they could earn a higher wage.[14]	None[10]	Just 7 DTs practice in rural areas although law requires DTs to practice in underserved areas or serve low-income patients.[25]	May only practice in hospitals, public schools, FQHCs or a private practice that serves 50% Medicaid patients.[6, 13]	None[7]
DENTAL DISEASE RATE SINCE DTs	↑ [15]	↔ [16]	↑ [17, 18]	↔ [19]	?	?
COST	Over-budget[20]	Over-budget[21]	Over-budget[22, 23]	Over-budget[24, 25]	Never funded[6]	Never funded[26]
EFFECT	New Zealand continues to have untreated tooth decay in 20% of school-aged children – identical to the levels of U.S. children.[27] It also has a significantly aging dental therapist workforce.[32]	The program was not viable without continual government funding. When that funding ended, so did the program.[21]	Available research in Alaska has vastly overstated the degree of impact DHATs have delivered, and failed to produce a comparison of costs before and after being employed.[22, 23]	Seven years later, just 52 therapists are practicing[25] and patients are still seeking dental treatment in ERs at cost to taxpayers and community hospitals.[28]	Two years after passage of enabling legislation, there are no educational programs or therapists. Proponents have already tried and failed to expand the scope of the law. [29]	Vermont is already a leader in oral health, with many access indicators well above the US average,[30] most notably the percentage of Medicaid-eligible kids who saw a dentist in 2013.[31] This program diverts funding from proven, effective solutions.

1. New Zealand Dental Council, Health Practitioners Competence Assurance Act 2003, Prescribed Qualifications for Dental Therapists, 2016
2. Accreditation Canada, National School of Dental Therapy (NSDT), February 2011
3. Alaska Native Tribal Health Consortium, DHAT Curriculum & Application Certification, 2016
4. Minnesota House of Representatives, Loan Forgiveness for Dental Therapy: Dental Therapy Fact Sheet, January 2015
5. Minnesota Dental Association, Dental Therapy in Minnesota Issue Brief, July 2013
6. State of Maine, Maine H.P. 870 – L.D. 1230, April 2014
7. Vermont State Legislature, S. 20, 2016
8. New Zealand Dental Council, Health Practitioners Competence Assurance Act 2003, Scope of practice for dental therapy, 2016
9. College of Dental Surgeons of British Columbia, Dental Therapists Scope of Practice
10. Alaska Native Tribal Health Consortium, DHAT Certification & Scope of Practice, 2016
11. Minnesota Office of the Revisor of Statutes, 2015 Minnesota Statutes, 2015
12. Minnesota Board of Dentistry, 2009 Session Laws: Dental Therapist Scope Of Practice, 2009
13. The American Dental Education Association, ADEA State Update, May 2014
14. Journal of Dental Education, Influence of Private Practice Employment of Dental Therapists in Saskatchewan on the Future Supply of Dental Therapists in Canada, August 2012
15. New Zealand Ministry of Health, 2009 New Zealand Oral Health Survey, December 2010
16. Canadian Ministry of Health, Summary Report On The Findings Of The Oral Health Component of the Canadian Health Measures Survey 2007-2009, April 2010
17. American Journal of Public Health, Improving the Oral Health of Alaska Natives, May 2005
18. Alaska Department of Health and Social Services, Division of Public Health, Alaska Oral Health Reports,
19. Minnesota Department of Health Oral Health Program, The Status of Oral Health in Minnesota, September 2013
20. Dental Council Of New Zealand, 2010 Annual Report, March 2010
21. Journal of Dental Education, Influence of Private Practice Employment of Dental Therapists in Saskatchewan on the Future Supply of Dental Therapists in Canada, August 2012
22. Alaska Native Tribal Health Consortium, Support the DHAT Educational Program, 2016
23. Alaska Business Monthly, Alaska Native Tribal Health Consortium to Receive $3 million in Appropriations from Federal Government, December 2009
24. Minutes of the Minnesota Board of Dentistry 2010-2014
25. Minnesota Dental Board, Licensure Verification, March 2016
26. Vermont Legislative Joint Fiscal Office, S. 20 Fiscal Note, 2016
27. Untreated Decay: New Zealand Ministry of Health, 2009 New Zealand Oral Health Survey, December 2010
28. Minnesota Department of Health, Minnesota Oral Health Plan, January 2013
29. Maine Office of the Governor, Supplement No. 9: Governor Paul LePage Veto, April 2016
30. American Dental Association Health Policy Institute, State-by State Analysis Vermont's Oral Health Care System, December 2015
31. American Dental Association Health Policy Institute, State-by-State Analysis Vermont's Oral Health and Well-Being, June 2016
32. Dental Therapy Technical Advisory Group, Recruitment and Practice of Dental Therapists, June 2004

Att. 18
HB1256
1-18-17

Testimony of Anthony J Hilleren DDS

ND House Human Services Committee

HB 1256

Bismarck, North Dakota

January 18, 2017

Rep Weisz and members of the committee. My name is Dr Anthony Hilleren. I am a 1999 graduate of the University of Minnesota School of Dentistry. I have also served as a Dental Officer with Charlie Company 134th Forward Support Battalion after having served some years enlisted in an infantry unit of the Minnesota Army National Guard. I was awarded the National Society of Dental Practitioners Law and Ethics Award in Dentistry. In my spare time, I raise hay and have a cow/calf operation. In 2013 we decided to hire a Dental Therapist. In 2015 we hired a Dentist.

I came here today to share my experiences in working with a Dental Therapist. I want to disclose that I have never accepted travel expenses or compensation for testimony. I would like to see the Dental Therapy model receive some honest evaluation and I question whether that is occurring.

Allow me to share some of my reasons for hiring a Dental Therapist:

1. I wanted to make an impact in my community and wanted to do a better job of caring for the underserved. I have a stepdaughter with special needs.

2. My confidence was bolstered when the University of Minnesota School of Dentistry (my alma mater) took the lead in initiating a Therapy program. I expected a Therapist to be trained to perform select procedures with the competency of a dentist.

I hired a Therapist in 2013. Certainly, I knew the Therapist would need time and guidance to become proficient. It was immediately evident that the dental experience of the Therapist was limited. I took it upon myself to give as much attention as possible. As a result, I was unable to care for as many patients myself. As I became aware of the Therapist's limited dental experience, I was inclined to provide more supervision. The number of procedures I was comfortable allowing the Therapist to perform narrowed.

I was able to recruit an associate Dentist from the same University. There is a profound contrast in the skill levels and ability within the same procedures. The Dentist required very little help or supervision immediately. The experience and training were far superior even when comparing competency in the same simple procedure mix that overlaps within the two professions. It is beneficial that the Dentist can address all needs in my very rural practice.

Due to the narrow scope of the dental therapist, I struggled to find enough appropriate procedures to keep fully engaged. At least 75% of the therapist's time was spent providing cleanings for children, which is within the scope of training for my registered dental assistants.

The typical office would have a fairly standard procedure mix of work each day. Picture an apple pie. Slice it into 8 pieces. One of those slices of pie may roughly equate the simple procedures that a Therapist can perform. The rest of the pie represents things that require a Dentist's expertise and training.

Let's discuss the economic effects on my practice. A Dental Therapist costs roughly 35-40 dollars per hour and 20 plus dollars an hour for a chairside assistant. Testimony exists referencing 50 dollars an hour for a Therapist. We now have roughly 60 to 80 dollars per hour dedicated to the 1/8 pie slice. With Minnesota's reimbursement, it is impossible to cover basic costs. A beginning Dentist and

experienced assistant combination would cost 80 dollars per hour. It is misleading to claim that this profession will create a significant savings.

I would like to remind you that I am one of the Dentists who decided to swim against the current, try the Therapy model and facilitate more care for the underserved. I wanted this model of care to succeed. It is my observation that Therapists are not having the desired effect on the underserved for several reasons:

1. Many of the patients have complex dental and medical needs and require the skills of a fully trained Dentist. I am also concerned about errors of omission. A Dentist is needed to diagnose cancer in someone's head, neck or mouth. I believe the public makes an assumption that there has been some training.

2. The underserved community is challenging to reach. In the May 2016 Academy of General Dentistry periodical it states that Therapy was promoted as a way to reduce emergency room dental visits. This article also states that there is no evidence of this happening yet. You may be aware of the Canada Dental Therapy experience. The history and discontinuation of Canada's Dental Therapist program is well documented. It was deemed too costly and didn't improve public health measurements of Dental health.

I see dollars being poured into surveys by lobby organizations that are cherry-picking data, skewed, and seeking to cast the current model of Therapy in a positive light. Whatever you are hearing, take care in sifting through this information. You may be hearing some things from practices that have possibly accepted large grants. I was encouraged to apply for a $100,000.00 grant. I did not choose to look into any outside funds. A one-time outside infusion of dollars does not ensure long-term success nor create a viable economic model. I was particularly motivated to come to Bismarck last fall by the last MN State Health Department survey I completed as there was no space for meaningful feedback. Regardless

of what you are hearing today, be assured that the program hasn't delivered as promised and is not as popular as you may be led to believe. The Robert Wood Johnson foundation identifies the greatest poverty rate to exist in central and northern MN. According to the MN Board of Dentistry, as of June 2015, only 3 of the 42 dental Therapists practice in that higher poverty region. 73% practice in the seven county Metro area. Dental Therapy has not solved distribution challenges.

It appears that the entities promoting Dental Therapy as a successful solution have received large amounts of grant and government funding. What is the true cost? How much have the proponents of Therapy financially received as incentives? Will these incentives be available for all who provide? Certainly there is nothing wrong with accepting grants, but full disclosure of all incentive funding for Therapist training, office renovation, or any other incentives should be provided by all organizations promoting Therapy. Will the incentive be available for everyone? Will those of us who wish to provide care to the underserved in our communities be afforded a level playing field.

Minnesota, with our therapy program, ranks near the bottom in the US for providing dental care to the underserved. I came here today to share my experience with you and to ask you to **stop, look** and **Listen**. You have the perfect vantage point to watch safely and see what Minnesota does to improve our situation.

I feel tremendous sympathy for the therapists who have invested in an education and a profession that is unpopular in its home state of Minnesota. They truly deserve some restitution or tuition refund. In an inquiry to dental therapists by the Academy of General Dentistry/Foley & Gardner, rural therapists report significant cite issues finding jobs, long commutes to part time work, being cut after being originally hired because of a grant, and large student debt to name a few items.

Moving forward with the dental therapy model and promoting it without honest evaluation is unfair to the public whom we serve. As long as we pretend that Dental Therapy is a solid answer it will continue

to be a distraction that directs focus away from the underserved. Rest assured that there are hundreds of local Dental offices like mine in rural Minnesota and North Dakota that are desperately searching for a way to serve our community and care for the underserved. At some point our taxpayers will uncover how truly expensive some of these new programs are when compared to your hometown dental office. We all have capacity in our offices. We want to altruistically help. We are exponentially more efficient at providing care. We could all sit down together and find a solution that works.

Thank you for your time.

Additionally I want to share with you a direct statement from my associate, Dr.Marissa Goplen. Dr. Goplen graduated in 2015 from the University of Minnesota.

"During my time at the University of MN School of Dentistry, it was the schools policy that operative patients be shared amongst DDS students and DT students. It was standard protocol for patients to be assigned a Dental Student for their initial visit and to have all of their required dental work planned to be completed by that student. As comprehensive examinations are outside the scope of practice for a Dental Therapist, Dental Therapy students were not assigned any patients for comprehensive care. For a Dental Therapy student to obtain operative experience required the student to personally ask Dental students to let them complete a previously planned restoration on one of their assigned patients. As you can imagine, Dental students are clamoring to gain as much experience as possible (as well as complete their own graduation requirements) and are non-too eager to share work that they have treatment planned with other students. I can say from my time in dental school that Dental Therapy students had a difficult time completing their pre-requisites for graduation and that the number of procedures completed by a Dental Therapy student is far below that completed by a similar dental student."

Dr. Marissa Goplen

Att. 19 HB 1256
1-18-17

HB 1256- House Human Services Committee

Peder Arneson, DDS

January 18, 2017

Chairman Weisz and members of the committee, my name is Peder Arneson and I am currently practicing dentistry on staff at a federally qualified health center in the Fargo-Moorhead area. After finishing dental school in 2010, I knew that I wanted to work with underserved populations. Growing up in a small town in western Minnesota, I understood the need my community had in recruiting and maintaining care providers. Furthermore, my undergraduate and graduate education prepared me to face issues such as access to care. In the past 6 years, I have had a diverse array of experiences working in multiple public health settings which have exposed me to the unique dental problems facing high risk populations. I believe these experiences provide me with a unique background and I would like to express my thoughts and concerns regarding the future of the dental profession and the access issues so many people face. Dentistry as a profession faces increasing challenges providing needed treatment to vulnerable populations lacking access to dental care throughout this country. Frequently, the people directly affected by such barriers need the greatest amount of treatment. Complicating the situation is overutilization of emergency rooms and urgent care facilities which are unable to treat dental needs. The longer I have practiced dentistry, the clearer this dilemma becomes.

I began work as a dentist at Apple Tree Dental in Hawley, MN, shortly after graduation. The predominant population I worked with was 78% medical assistance with an additional 6% on a sliding fee schedule. From providing treatment in Head Start centers to nursing homes throughout the region, I was able to perform comprehensive care on patients with complex needs in a mobile setting. We also had the ability to utilize expanded function assistants and hygienists when appropriate. This approach to care delivery opened my mind to the many possibilities we have at our disposal to improve treatment outcomes.

Whether in a fixed clinic or mobile setting, utilization of expanded function auxiliaries was focused on simple

restorative procedures. An available dentist would complete the irreversible preparation of teeth in a timely manner, then the restoration would be placed by the auxiliary. A perfect match for this approach was the children's outreach and Head Start settings I regularly went to. The auxiliary would assist in anesthetizing when possible, restore prepared teeth, and place sealants. In many circumstances, procedures went as planned and treatment was completed without complications. However, like many other medical specialties, procedures vary on an individual basis and change in a moment's notice. These are times when clinical judgement and problem solving skills become paramount in patient treatment. Having the auxiliary allowed me spend the extra time needed to complete treatment when such instances arose.

Providing care in a mobile nursing home setting proves significantly more difficult due to the complex medical histories of patients, extensive treatment plans, and limited patient mobility. To compound these problems, the average life expectancy, the number of individuals in long term care facilities, and the number of tooth-bearing residents in these facilities are all increasing. As a direct result, the successful management of geriatric patients becomes exceedingly more difficult and they are regularly the most demanding cases a provider sees. I regularly perform restorative and oral surgery treatment in this setting, and, above all else, these procedures are the most difficult I complete. This, coupled with the inability of patients to maintain proper oral hygiene, the high carbohydrate diets of these residents, and understaffing in many facilities, makes it necessary that a dentist manage all treatment for these patients.

In 2013, I began working part-time with Community Health Services, Inc., providing mobile dental services at multiple sites throughout Minnesota and North Dakota. I regularly travel two to three hours in order to reach sites in Willmar, MN, and Grafton, ND. The patients are predominantly migrants who lack a regular and consistent dental home. Due to this, their care needs are often emergent and I have little resources to refer to specialists. Oftentimes, I have found myself performing multiple surgical extractions on patients. Despite consistent improvements in mobile equipment and technology, performing such procedures is never easy. **Similar to long term care facility patients, the needs of those I have seen through Community Health can only be met through treatment by a dentist.**

As I said before, having an open mind to the different treatment modalities we have at our disposal has made it possible for me to improve patient outcomes. I approached dental therapy the same way since they were a new member of the dental team in MN. I had the opportunity this past year to work with a recently graduated therapist during the individual's initial training phase. I, along with my colleagues, selected appropriate treatments and supervised patient care. We would verify the treatment plan and evaluate the preparation and restoration. In many of the cases, multiple preparation and restoration checks were required before achieving acceptable results. In other instances, a dentist needed to step in to complete treatment. During this time, overall patient care at the clinic did slow because additional resources were needed for training. An easy contrast can be made with that of a recent dental school graduate. For a new DDS, performing simple operative procedures do not require supervision, and while clinical speed is not that of a veteran dentist, a steady workflow is maintained from the outset.

In the spring of 2016, an opportunity for a position working with a fellow classmate opened in Fargo-Moorhead at a federally qualified health center. This was a chance to see yet another care model focused on access issues. Since starting in August, I immediately recognized the challenges and problems facing the new patient population I was treating. From extensive treatment plans and difficult procedures, to the lack of dental education so evident in these populations, patient needs test my skills as a provider regularly. In an effort to further reach out within the community, our clinic has recently taken responsibility for a school-based sealant program. Goals of such programs are to provide basic preventive care, identify potential problems, and direct patients in the appropriate direction for care. Such outreach efforts strengthen the connection between dentistry and the community.

Volunteer efforts provide yet another valuable safety net within the dental community. It is for this reason that I regularly volunteer with the Red River Valley Dental Access Project. This clinic addresses emergency dental issues in an effort to alleviate acute problems. This weekly clinic staffs three dentists and provides treatment on a walk-in basis. Rarely will the patient needs be simple and, oftentimes, surgical removal of teeth is required. Once again, **it is evident that the treatment needs of the underserved require a dentist's**

expertise.

I hope the experiences I have outlined shed light on the extensive needs of our underserved populations. **Simply put, the training and schooling a dental therapist receives is insufficient to meet the requirements to provide safe treatment of patients, improve treatment outcomes, and expand access. Combine this with the limited scope in which a therapist practices, and it makes little sense as an alternative care option**. I believe we have an existing infrastructure for care delivery that has great potential to empower providers and improve dental access issues. There are so many dentists wanting to be more involved in their communities' oral health and help to alleviate the barriers many face in seeking care. Efforts that enable such providers to foster patient education, improve communication, and build trusting relationships should be paramount in developing approaches to reach out in our communities. Please work with these dentists and take a constructive approach to help solve the crucial issue at hand.

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1-18-17

HB 1256 ND House Human Services Committee

Dr April Robinson

January 18, 2017

Chair Weisz and members of the committee, My name is Dr April Robinson and I practice dentistry in Dickinson, ND. I grew up in Utah. In 2008 I moved here and began looking for a job as a dental hygienist. It was difficult to find work as a hygienist. After 6 months I was able to piece together full – time work by working in Mott, Hebron and Dickinson. Given this background, for starters, I was attracted to dentistry as a career by the ND dental loan repayment program. In addition I was very impressed by the high level of care patients received in North Dakota because dental offices were owned principally by dentists and not corporate businesses. As a hygienist I had worked in corporate dentistry in other states and had seen how dentist and hygienists were told by office managers, who didn't have formal dental training, what they would diagnose and how treatment would be dictated to patients. This did not sit well with my training or my integrity. These three reasons were why I went back to school to become a dentist. I believe I am an example of how current programs in this state are attracting quality dentists who will remain in the state during the lifetime of their careers.

While I was at school at UNLV my husband, the Upland Game Management Supervisor for the North Dakota Game and Fish ,and I were concerned about the discussion going on about midlevel providers. We were concerned about what effects midlevel providers might have on the standard of care. We were also concerned about whether dental midlevels in the state might entice corporate dental entities to the state at a higher level. I had worked in the dental field for 25 years and was attracted to North Dakota because I wanted to be a business owner and a dentist.

There are not always straight forward answers to problems. Patients are not a tooth or a symptom they are people who want to be treated as whole beings. My first two years of dental school were intense

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medical training. This is crucial because many patients now will see a dentist more often than their primary care physician. I have been trained to look for signs of high blood pressure, stroke, myocardial infarction, diabetes, ulcerative colitis and HIV just to name a few. I work collaboratively with physicians, physical therapists and caretakers to provide complete care for patients. This is the new standard of care and dental therapist do not have this training or education. We must keep in mind that as we all are on the quest to expand access to care we must remember not to lower that standard of care. I believe patients trust would be broken if they expect this level of care and the dental therapist cannot deliver this.

I graduated from UNLV this year and started my new practice in Dickinson. I did receive the dental loan repayment and I am seeing Medicaid patients. In the short time I have been open 86% of my emergency patients have needed extractions or root canals both of which could not be treated by a dental therapist. It has also been my experience that Medicaid patients have more challenging treatment needs.

I understand the financial burdens involved in starting a new practice. Setting up a satellite office with a dental therapist would not be cost efficient because they cannot do all of the procedures that a dentist can. In order to be fiscally responsible an associate dentist would need to be employed.

I am proof that North Dakota is attracting quality dentists who will stay here for the duration of their dental careers because North Dakota is a state that provides incentives for location in areas of need through loan repayment, and is conducive to dentists investing in their communities by starting dental practices that are able to provide the highest quality care.

Att. 1 HB 1256

17.0709.02002
Title.

Prepared by the Legislative Council staff for
Representative Devlin
January 27, 2017

1-31-17

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1256

Page 5, line 6, replace the first underscored comma with "or"

Page 5, line 6, remove ", or general"

Page 6, line 12, after "2." insert "Unless authorized by rules adopted by the board, a dental therapist may not perform the services provided in subsection 1 under the general supervision of a supervising dentist.

3."

Page 6, line 14, replace "3." with "4."

Page 9, line 16, after the underscored period insert "Except as otherwise authorized by rule, a supervising dentist may enter a written collaborative management agreement with no more than five dental therapists at any one time."

Renumber accordingly