2013 HOUSE INDUSTRY, BUSINESS, AND LABOR

HB 1454

2013 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1454
February 5, 2013
Job 18270

☐ Conference Committee

Explanation or reason for introduction of bill/resolution:

Dental therapists

Minutes: Testimony 1, 2, 3, 4, 5, 6, 7, 8

Hearing opened on HB 1454.

Representative M. Nelson introduced the bill and submitted testimony (Testimony 1, Testimony 2).

Representative Becker: What is the training and where does it take place?

Representative M. Nelson: Currently, there are two schools in Minnesota. In the Washington study, they found that dental school cost $190,000 in tuition and dental therapy cost $35,000.

Chairman Keiser: What would be the differences in the training between a dental therapist and a dental program?

Representative M. Nelson: It's a matter of who far the training goes. A dental therapist would not be trained in the advanced levels of care. The key is that they stay within their field of practice. In addition, the dental therapists are under the direct supervision of a dentist. An advanced dental therapist can operate under general supervision, where they have a relationship with the dentist but they are not necessarily right in the same office.

Representative Ruby: What if no dentists are willing to sign an agreement with a dental therapist? Do they carry the liability of any mistakes that therapist makes?

Representative M. Nelson: They carry their own professional malpractice insurance. I would guess that the dentist would be liable if his supervision was substandard.

Representative Ruby: On page 9, it talks about dispensing antibiotics and other medications. If they are under supervision, couldn't that stay within the dentist's authority?

Representative M. Nelson: I suppose that could be. These are not narcotics. I don't think there has been a problem with the limited prescriptive abilities of the dental therapists in other areas. The dentist himself, as a supervisor, can limit that.

Representative Gruchalla: Are you trying to solve the problem of not being able to get a dentist to come to your area?

Representative M. Nelson: Yes, basically. In the current situation, we are short. When PPACA comes into effect, we will have dental health care coverage included in insurance for all children which will increase utilization. The Medicaid expansion includes dental care for children. It has been a severe problem to find people to provide care for children on Medicaid.

Representative Gruchalla: Some small communities have been able to entice dentists by using incentives or setting up the office for them to limit their expense. Have you looked at that in your community?

Representative M. Nelson: Certainly. There are always possibilities.

Representative Becker: Do you have a theory on why it is difficult to find dental care for children on Medicaid?

Representative M. Nelson: The most common complaint is that the rate the state pays is too low.

Representative Becker: My understanding was that a significant reason was the extremely high rate of no-shows for patients on Medicaid. I wonder if the two reasons support the concept that expanding Medicaid doesn't actually increase access to care?

Representative M. Nelson: Part of the reasoning behind the no-shows is that appointments are made a month in advance and that they have to travel so far.

Representative Frantsvog: You state there aren't a lot of dental therapists trained and ready to come to ND. If we pass this legislation, how will that change?

Representative M. Nelson: You have to start. People are not going to go to school for a profession that does not exist.

Representative Frantsvog: Your primary problem is that you don't have the dentists needed to supervise these employees, correct?

Representative M. Nelson: Yes. We went through the same thing with dental hygienists.

Representative Frantsvog: Does your county have incentives to get dentists to come in and work in your communities?

Representative M. Nelson: There is nothing formal.

Representative Kreun: Is the hierarchy the dentist, the dental therapist, and then the hygienist?

Representative M. Nelson: Yes.

Representative Kreun: Is the responsibility higher with the dental therapist than the hygienist?

Representative M. Nelson: Yes. The therapist has more training than the hygienist.

Representative Vigesaa: If a dental hygienist would like to move up to a dental therapist, are their classes they could take to upgrade, or would they have to take the whole program?

Representative M. Nelson: In Minnesota Metropolitan, they are required to be a hygienist first. In some states, such as Kansas, they use an upgraded hygienist to fill the gap. The University of Minnesota doesn't require them to be a hygienist first.

Representative Kasper: What is general supervision?

Representative M. Nelson: It is not direct supervision. A person could potentially be in a separate office.

Representative Kasper: Would general supervision allow someone to be located away from the actual location where the dentist is?

Representative M. Nelson: Yes. It is similar to how the original dental therapists in Alaska were in remote villages with no dentist but were functioning under the general supervision of the dentist.

Representative Kasper: What is the difference between general supervision and indirect supervision?

Representative M. Nelson: General is a looser term, and indirect would be intermediate between that.

Representative Kasper: Could indirect supervision be located at a satellite location?

Representative M. Nelson: I don't believe so, but I'd have to check on that.

Representative Kasper: Under indirect supervision, are the therapists performing all of the duties that a dentist normally does?

Representative M. Nelson: It's not talking about more complicated extractions. If it needs to be clarified more, that could be done.

Representative Kasper: In reference to the advanced dental therapists' scope of practice, it allows for non-surgical extractions of permanent teeth. Is this a more advanced practice of dentistry?

Representative M. Nelson: Yes, it is more advanced and requires more training.

Representative Kasper: In the geographic area of 20 or 30 miles from your location, how many dentists are there?

Representative M. Nelson: Including Indian Health Services, there is a maximum of five.

Representative Kasper: Excluding Indian Health Services, how many are there?

Representative M. Nelson: One.

Representative Kasper: How far is Canada from where you're at?

Representative M. Nelson: Approximately ten miles.

Representative Kasper: Does Canada have a substantial dental office close to Rolla and Belcourt?

Representative M. Nelson: Yes.

Opposition:

Dr. Rob Lauf, North Dakota State Board of Dental Examiners (31:17) testified in opposition of the bill (Testimony 3).

Representative M. Nelson: Is there anything in the bill that would prevent the board from coming up with proper disciplinary procedures?

Dr. Lauf: Any time you deal with the practice act and the regulation thereof, it really needs to be concise and included in the bill.

Representative Becker: I think that mid-level is the way of the world and will be coming. It has its role. As Obamacare is instituted, the number of people on entitlement programs will increase. They are already underserved. The number of people having a difficult time finding care will be ameliorated by mid-level practitioners, which is less costly. My thought is that this is coming and will not be limited geographically. What is your view?

Dr. Lauf: Dentistry is not medicine. As far as a dental therapist, they could be in Rolla and the overseeing dentist could be in Fargo. It is not proven to save money or to be efficient. The model we have has worked very well. We have an over-saturation of hygienists. We do not have a shortage of dentists; we have a mal-distribution. There are between 15 and 20 new dental schools being added.

Chairman Keiser: When we created the nurse practitioner program, was it specific to location and need or was it a program that was developed statewide?

Dr. Lauf: Statewide. They are under the auspices of a physician that reviews every case they have done. Direct supervision means that the dentist is within the facility and the dentist evaluates. With general supervision the dentist has authorized the procedures and they are carried out in accordance with the dentist's diagnosis, but the dentist is not required to be in the treatment facility. With indirect supervision, the dentist is in the dental office or treatment facility and remains there as the procedures are being performed, but they do not check the finished procedure.

Representative M. Nelson: What can we do as a legislature to fix the misdistribution of dentists in ND?

Dr. Lauf: Some areas of the state are not densely populated and you need to have a population that can support a dentist. In rural areas, the biggest dent would come from an increase in Medicaid reimbursement. It is recruitment. We already have loan repayment programs. Repayment of education is a big thing, and there has to be a patient based to support a dentist.

Representative M. Nelson: How many patients would it take to support a dentist?

Dr. Lauf: It depends. Do they come in only when they have a problem? Are there a large number of no-shows? It is difficult to pinpoint a number. In an area of 15,000 people, five dentists should do it or even one if patients only come in when they have a problem.

Representative M. Nelson: How many dentists are practicing in North Dakota?

Dr. Lauf: There are approximately 330-350. We have more that are licensed but not practicing. If you are in Indian Health Services, you are not under the auspices of our state regulatory board.

Chairman Keiser: We may need to study mid-level more. The Sanford West Emergency Room Director testified last summer that 6% of the cases in the emergency room are dental only, and there is not a thing we can do in the emergency room for those people. Do you think that impact on health care costs is a problem?

Dr. Lauf: Absolutely, but that is not tied to a shortage of dentists or mal-distribution. That is tied to the mindset of the patients. It is a concern, but things need to be taken slowly and you need to look at what is right for the public.

Dr. Brent Holman, pediatric dentist, past-President of the North Dakota Dental Association and founding President of the Red River Valley Dental Project (1:00:38) testified in opposition to the bill (Testimony 4).

Representative Kreun: Has there been a study to look at using interactive TV in rural communities like what is used for rural health? Is that a possibility?

Dr. Holman: There is no good evidence for most of these issues raised today. There are a lot of studies that portent to show things which often are not transferable to a state like North Dakota. Dentistry is different than medicine. Almost everything we do is surgical in nature. When it comes to actual treatment, you have to have skills that have been obtained through experience.

Representative Kreun: Do you think it would be relevant to do a study?

Dr. Holman: Yes. Anything you can do to gain more information on determining the most effective thing is important to do.

Dr. Anthony Malaktaris, President-Elect for the North Dakota State Board of Dental Examiners (1:12:29) testified in opposition of the bill. I am the past-president of Central Regional Dental Testing Services Inc., which was involved in developing the examination for dental therapists in Minnesota. We have currently tested approximately 25 of these candidates in Minnesota, 22 have passed the exam and 18 are working in Minnesota. At this time, the Minnesota Board is assuming they are working primarily in large clinic settings providing primarily hygiene services. The study is out there, but it has not been completed yet to determine what kind of procedures they are doing and whether it is impacting the problem in Minnesota. Fees probably won't be any different than a dentist. We have had a huge influx of dentists into our state, so the problem is not numbers but distribution.

Representative Becker: What is the basis for your thought that reimbursement would be the same?

Dr. Malaktaris: The studies we are getting that show what these individuals are paying for their education. The advanced therapist program is very new. There is only one that has achieved that level. The others are simple dental therapists. What they are paying for that training is significant compared to a 2 year hygiene degree. It is near what a dentist pays for their education. The argument in Minnesota asked if these individuals could enter the workforce and pay back their debt with any reduction in fees to what dentists are charging. The answer was no. I don't know how you could charge less for the same services.

Chairman Keiser: Blue Cross Blue Shield would not pay the same. They do not for nurse practitioners. What is your argument for dentists that would make it different from medical offices?

Representative M. Nelson: Do you feel that the Minnesota test adequately tests those therapists?

Dr. Malaktaris: Yes. In the Minnesota model, the state board of dentistry had a lot of input on what these candidates would be tested on. However, the failure rate is significantly higher the first time they take the test.

Alison Fallgatter, orthodontist and President of the North Dakota Dental Association (1:21:08) testified in opposition of the bill (Testimony 5).

Marsha Krumm, President of the North Dakota Dental Assistants Association (1:28:26) testified in opposition of the bill (Testimony 6).

Dr. Dale Brewster, dentist in Stanley (1:29:52) testified in opposition of the bill. From the standpoint of shortage, there are many new dental schools starting. I think the problem of shortage is being solved. The problem is retention of dentists, and that is an administration issue. In Alaska, for every opening, there are 4-5 dentists applying. Repayment of education is very important in attracting and retaining dentists. A simple extraction does not exist.

Representative Becker: The scope of practice for a dental therapist seems extensive. What percent of your workload would be covered under that scope?

Dr. Brewster: I do a tremendous amount of surgery in Stanley. But fillings and crowns would fall under that scope.

Representative Kreun: Is there a problem with dentistry on the reservation, or is it a problem with the culture that develops that problem? Can you fix the dentistry problem if the cultural problem isn't fixed first?

Dr. Brewster: I agree. The failure rate at New Town is around 50%.

Representative Kreun: What are administrative challenges in the clinic?

Dr. Brewster: I see administrative challenges at our clinic in Belcourt. I want to know why we have lost 7 dentists, 2 of whom had bought houses in the area already.

Representative Kreun: You're indicating that the rates are relatively stable, so it is not a payment problem?

Dr. Brewster: The rates go to IHS. We are on a salaried basis.

Neutral:

Dana Schmit, President-Elect of the North Dakota Dental Hygienists' Association (1:36:28) testified neutrally to the bill (Testimony 7).

Representative Becker: Did either of the studies you cited reference a complication rate?

Dana Schmit: I am unaware if there was a failure rate assessed in the study.

Kathy Menscouw distributed testimony (1:42:45) on behalf of Rhonda Edwardson, Allied Dental Department Chair and Dental Hygiene Program Director, North Dakota State College of Science (Testimony 8).

Hearing closed.

Chairman Keiser: I don't think North Dakota is ready to pass this bill. I think we need to do some studies.

Representative Vigesaa: Move a Do Not Pass.

Representative Gruchalla: Seconded.

Representative Becker: This is something that deserves study. It is unfortunate that assistants and dentists weren't involved. Hopefully if this is going to be looked at, dentists would be interested in providing positive feedback rather than a complete barrier.

Representative M. Nelson: I would ask the committee to resist a Do Not Pass at this time. I would like time to draft a study resolution to put in front of the committee.

Representative Vigessa and Representative Gruchalla withdraw the motion.

Representative Frantsvog: I want to comment on proposed study resolution. I'd hope that it would go beyond dentists and would include hygienists and assistants so that it can be all-encompassing.

Chairman Keiser: The department of health should also be included in the study because they have an oral health division. The Board of Dental Examiners and the Dental Association need to be included in the study, as well as the Hygienists' Association. I want to reinforce that mid-level is the future. You can continue not to move forward on it, or you can choose to participate and do the best we can.

Committee adjourned.

2013 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1454
February 6, 2013
Job 18425, starting at 10:35
Recording contains committee action on various bills

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Dental therapists

Minutes: Attachment 1

10:35 Chairman Keiser asks committee member to turn to HB 1454 for continued discussion.

10:40 **Representative M. Nelson:** (audio faint) I had an amendment drawn up and whenever everyone receives it, I would move the amendment. (Attachment 1, amendment 13.0279.01001) Having heard the testimony on the bill and looking ahead, I think we are not quite ready for prime time with what I was trying to do. I do believe that mid-level providers are the way it is. I think we really need to take a look at in North Dakota for how to best serve our people. We do have shortages. We have a problem with distribution, and whether it be mid-level providers, whether it be some incentives, we need to look at it. There was also mention of Medicaid and concerns about the reimbursement level. I would move this amendment so that we could in the interim study it and have a well thought out way to manage dental care in this state.

Representative M. Nelson **moved the amendment**. Ruby seconded the motion to adopt the amendment.

12:52 Chairman Keiser differentiated between "shall study" and "shall consider studying." Outlined the selection process done by Legislative Management for studies. This "shall consider studying" is the more standard approach, but it does not mean that what we are proposing will be accepted for a study.

14:10 Representative M. Nelson: As was testified, a lot of emergency room visits are strictly for dental care where they cannot really receive help. It is costing us a lot of money, and we need to do something about it to reduce the costs overall. There are a lot of people who are not receiving quality dental care at this time. As we look ahead, there is a move to have North Dakota controlling our own healthcare. This is such an important part of that that we need to get a handle on that. I would ask for the committee's favorable recommendation.

Voice vote on adoption of amendment. **Motion carries.** The amendment is on the bill

Representative Boschee **moves a do pass as amended.** Representative Kreun seconds the motion.

15:30 **Chairman Keiser:** You heard a lot of discussion during the hearing. This is an issue, and I do not know that we have a solution, but I think we should sure study it. I don't know if you can appreciate the implication that 6% of the cases that walk into the emergency rooms in Bismarck are dental only. They have to come through receiving. They have to go in, have their vitals taken, have a nurse do the intake, have a physician see them and make the determination. The irony is that they are not treated; they are given pain medication, which is expensive, and they leave. I know a lot of people say they could go to a dentist off hours. The reality is they cannot get in.

16:28 **Representative Vigesaa:** I'll vouch for that. My son is an ER physician at Sanford in Fargo, and he hands out a lot of pain medication for toothaches.

16:38 **Representative N. Johnson:** I am going to support this motion and this bill. I think most or all the groups that came in to testify said that we need to study it, even if they were opposed to the bill as written.

Chairman Keiser: I do think that we shouldn't adopt Minnesota's law verbatim. If that is the direction we want to go or should go, we should rewrite it for North Dakota.

Roll call vote on the motion for a do pass as amended. Motion carries.

Yes = 14
No = 0
Absent = 1

Carrier: Representative Amerman

VK
2/6/13

13.0279.01001
Title.02000

Prepared by the Legislative Council staff for
Representative M. Nelson
February 6, 2013

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1454

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of access to dental services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - ACCESS TO DENTAL SERVICES. During the 2013-14 interim, the legislative management shall consider studying how to improve access to dental services and ways to address dental service provider shortages, including the feasibility of utilizing mid-level providers, whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access, and whether the state's medical assistance reimbursement rates impact access to dental services. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fourth legislative assembly."

Renumber accordingly

Date: 2-5-2013

Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1454

House Industry, Business, and Labor Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☑ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider ☐ Consent Calendar

Motion Made By Vigesaa Seconded By Gruchalla

Representatives	Yes	No	Representatives	Yes	No
Chairman George Keiser			Rep. Bill Amerman		
Vice Chairman Gary Sukut			Rep. Joshua Boschee		
Rep. Thomas Beadle			Rep. Edmund Gruchalla		
Rep. Rick Becker			Rep. Marvin Nelson		
Rep. Robert Frantsvog					
Rep. Nancy Johnson					
Rep. Jim Kasper					
Rep. Curtiss Kreun					
Rep. Scott Louser					
Rep. Dan Ruby					
Rep. Don Vigesaa					

Total Yes _____ No _____

Absent _____

Floor Assignment _____

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

Motion withdrawn

Date: 2-6-2013
Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1454

House Industry, Business, and Labor Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 13.0279.01001

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☑ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Nelson Seconded By Ruby

Representatives	Yes	No	Representatives	Yes	No
Chairman George Keiser			Rep. Bill Amerman		
Vice Chairman Gary Sukut			Rep. Joshua Boschee		
Rep. Thomas Beadle			Rep. Edmund Gruchalla		
Rep. Rick Becker			Rep. Marvin Nelson		
Rep. Robert Frantsvog					
Rep. Nancy Johnson					
Rep. Jim Kasper					
Rep. Curtiss Kreun					
Rep. Scott Louser					
Rep. Dan Ruby					
Rep. Don Vigesaa					

Total Yes 14 No 0

Absent

Floor Assignment

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

Date: 2-6-2013
Roll Call Vote #: 2

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1454

House Industry, Business, and Labor Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 13.0279.01001

Action Taken: ☑ Do Pass ☐ Do Not Pass ☑ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Boschee Seconded By Kreun

Representatives	Yes	No	Representatives	Yes	No
Chairman George Keiser	✓		Rep. Bill Amerman	✓	
Vice Chairman Gary Sukut	✓		Rep. Joshua Boschee	✓	
Rep. Thomas Beadle	✓		Rep. Edmund Gruchalla	✓	
Rep. Rick Becker	✓		Rep. Marvin Nelson	✓	
Rep. Robert Frantsvog	✓				
Rep. Nancy Johnson	✓				
Rep. Jim Kasper	AB				
Rep. Curtiss Kreun	✓				
Rep. Scott Louser	✓				
Rep. Dan Ruby	✓				
Rep. Don Vigesaa	✓				

Total Yes 14 No 0

Absent 1

Floor Assignment Amerman

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

REPORT OF STANDING COMMITTEE

HB 1454: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1454 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of access to dental services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - ACCESS TO DENTAL SERVICES. During the 2013-14 interim, the legislative management shall consider studying how to improve access to dental services and ways to address dental service provider shortages, including the feasibility of utilizing mid-level providers, whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access, and whether the state's medical assistance reimbursement rates impact access to dental services. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fourth legislative assembly."

Renumber accordingly

2013 SENATE HUMAN SERVICES

HB 1454

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1454
3-20-13
20230

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

To provide for a legislative management study of access to dental services.

Minutes: "attached testimony."

Chairwoman J. Lee opens the hearing for HB 1454

Marvin E. Nelson introduces HB 1454 to the committee. See attached **testimony #1** Senator Dever asks for clarification of the map **Chairwoman J. Lee** discusses demand of dentists, training and education programs. **Senator Larsen** wanted clarification of the advanced dental hygienist.

Kathleen Mangskau representing the North Dakota Dental Hygienists" Association, testified in favor HB 1454. See attached **testimony #2 Chairwoman J Lee** asks for more information on the chart included in testimony #2

Joe Cichy with ND Dental Association testifies in favor of HB 1454. The ND Dental Association shares that they working to improve the oral heal for the state of North Dakota and talks about other dental programs around the state they support. Talks about mid-level dental hygienist, and the study. Mr. Cichy talks about study done in Alaska. Mr. Chichy shares concerns with the IHS system. **Chairwoman J lee** Asks Joe to share about free clinics that ND Dental Association did. **Senator Dever** if the dentists have considered this as an option. There is a discussion about level of care.

There is no other testimony

Kimberlie Yineman North Dakota oral health director shares with the committee about free dental service events that are being provided by the Dept. of Health. **Senator Larsen** asked about the information about the dental profession at the events.

Vice Chairman Larsen closes the public hearing on 1454.

Senator Anderson motions for a Do Pass

Senator Larsen seconds

Do Pass 5-0-0

Senator Dever will carry

Date: 3-20
Roll Call Vote #:

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1454

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken: ☑ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen Anderson Seconded By Sen Larsen

Senators	Yes	No	Senator	Yes	No
Chariman Judy Lee	✓		Senator Tyler Axness	✓	
Vice Chairman Oley Larsen	✓				
Senator Dick Dever	✓				
Senator Howard Anderson, Jr.	✓				

Total (Yes) 5 No 0

Absent

Floor Assignment Sen. Dever

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

REPORT OF STANDING COMMITTEE

HB 1454, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1454 was placed on the Fourteenth order on the calendar.

2013 TESTIMONY

HB 1454

(1) HB 1454
2-5-2013

Testimony of Representative Marvin E. Nelson, House IBL Committee, 2/5/13

Chairman Keiser and members of the committee,

HB 1454 is about the profession of dental therapists in North Dakota. For those not familiar with the terminology, a dental therapist is much like a physician assistant only doing dentistry.

This is a relatively new profession in the US though it has been in longer use in other countries. Alaska was the first state with a program to get dental therapists to provide much needed dental care in remote villages. Recently, Minnesota became the second state to approve dental therapists and many others are now examining the issue. Minnesota now has two schools offering dental therapy, the Univ. of Minn. and Metropolitan State University.

Other states are tackling the problem slightly differently; sometimes it seems to me only the names change. Kansas for instance is using Registered Dental Practitioners. These people are basically advanced hygienists who receive more training and are able to provide services such as fillings, cavity preparation, extraction of baby teeth, and extractions of already loose permanent teeth.

Indeed, it wasn't long ago hygienists were new to a lot of people; I can remember when dental hygienists were rare indeed. Now, they are an accepted and important part of dental care. I think most people would have a hard time imagining a dentist office without hygienists today.

The problems are a shortage of dental service providers, there just are not enough dentists in much of ND, plus, costs of receiving care often has people putting off seeing a provider. The hope would be that mid-level providers could in the near future provide some relief in both categories.

I include a recent, though I fear already somewhat out of date chart showing areas in ND identified as short of dentists from the Center for Rural Health as UND. I say somewhat out of date because things are changing so fast in western ND. I would note Dickinson, Williston and Minot all don't show shortages, but people are telling me they are waiting months in some cases for appointments in those cities.

There are four types of shortages, designated shortage areas, proposed shortage areas, areas of shortage for low income, and facility shortages. We need more people.

One thing that encouraged me to put forward the dental therapist profession is that there is a clause in the Indian Health Act portion of PPACA that allows dental therapists in tribal health centers, but only if the state in which they are located allow them. Since the shortage of dentists in Indian Health Services tends to run about 35%, any help in keeping our openings filled is a help.

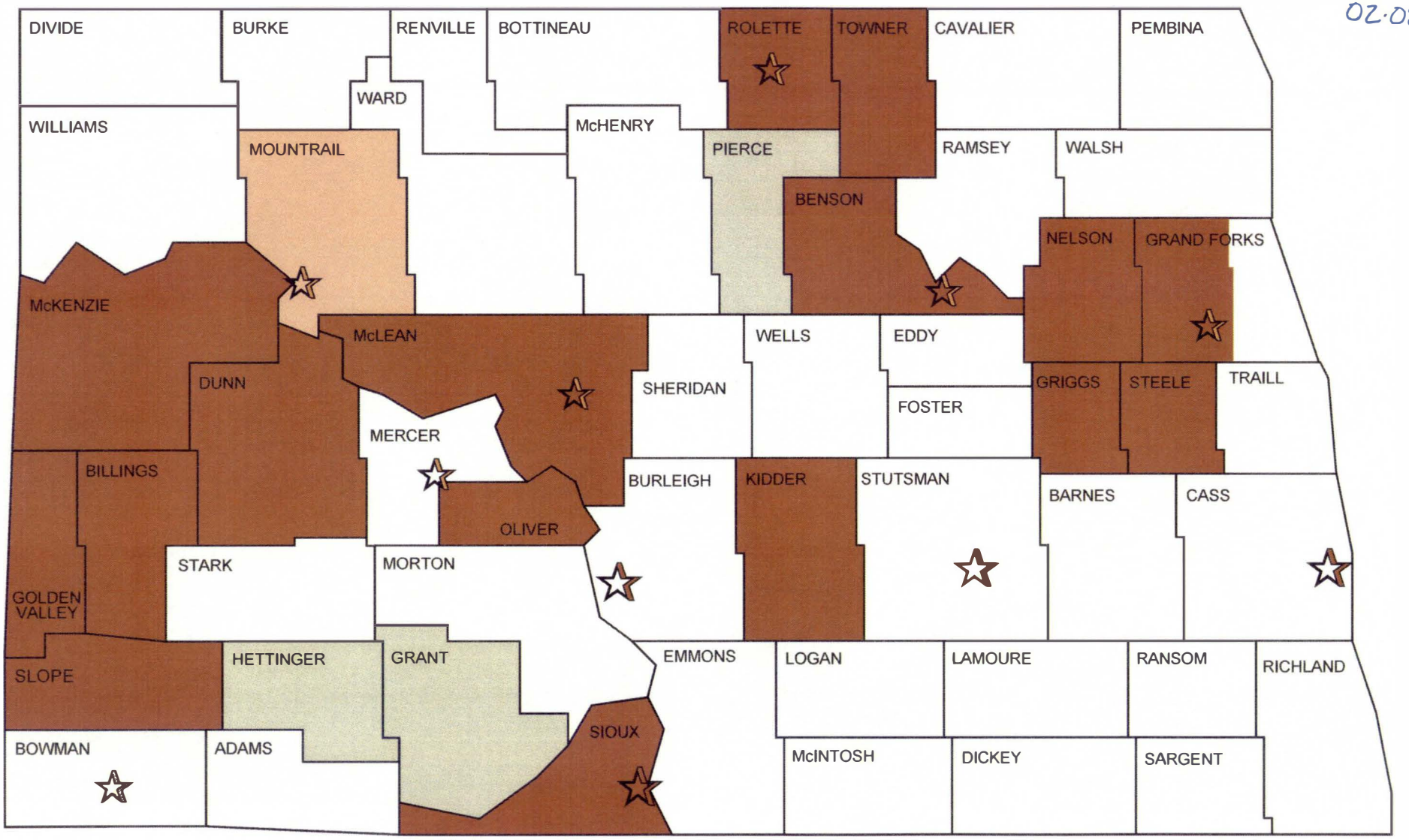
One objection you are likely going to hear is that there aren't a lot of dental therapists out there trained and ready to come to ND. That is true, why would a person be trained for a profession that doesn't exist? It's a chicken and egg scenario. At the same time this puts us in the situation that we can work

into the profession and the changes and such that are always necessary can be done when it doesn't affect large numbers of workers. All professions change over time.

Another criticism is that it will create a two level quality of care system. Evidence is overwhelming it does not do so. Quality of care from mid-level providers has not been shown to be substandard. Indeed, their use would help eliminate the currently existing inequities in care that result from shortages.

North Dakota Dental Health Professional Shortage Areas

(2)
HB 1454
02.05.2013



Center *for* Rural Health
The University of North Dakota
School of Medicine & Health Sciences

Designated Geographic Dental HPSAs
Proposed Geographic Dental HPSAs
Low-Income Dental HPSAs
Designated Facility Dental HPSA

1/12

For further inform[illegible]n health professional shortage areas, contact Terri Lang at terri.lang@[illegible]d.edu

North Dakota State Board of Dental Examiners

3

HB 1454
2-5-2013

Testimony of the North Dakota State Board of Dental Examiners

Re: House Bill 1454

Tuesday , February 5, 2013

Before the Business, Industry & Labor Committee

Presented by
Rob Lauf, DDS
Member, NDSBDE

Good morning Chairman Keiser and Members of the Committee. My name is Dr. Rob Lauf. I currently serve on the North Dakota State Board of Dental Examiners (NDSBDE). I am here today to testify in opposition of House Bill 1454 which proposes to enact a new chapter within dental statute that would create a new category of dental health provider in North Dakota. The NDBODE is not opposed to working to implement safe and efficacious solutions to problems that create barriers to dental care within our state. However, this particular bill proposes ways to regulate new dental care providers in ways that are not consistent with regulatory and safety measures currently in place for ND dental health care providers.

It is the understanding of the Board of Dental Examiners that HB 1454 is being proposed as a solution to a problem. The problem, as we understand it, relates to the inability of the Turtle Mountain Indian Health Service to hire and retain dentists in the IHS clinic located in Rolette County. The

introduction of dental therapists (individuals with approximately two years of dental education) to provide a limited scope of dental care originated a number of years ago in Alaska where Native American and/or Eskimo populations live in remote and sparsely populated areas of the state. More recently, Minnesota also mandated the creation of a similar type of dental technician, also with a limited scope of dental procedures they may provide. In both instances, the intent has been to address difficulties faced by pockets of each state's residents who found access to comprehensive dental care difficult either because of geographic barriers (as in Alaska) or due to economic barriers (as in Minnesota). We recognize that economic as well as other barriers to care also exist in North Dakota and are multifaceted. Though no doubt well intended, HB 1454 unfortunately is misguided in its attempt to address the Turtle Mountain IHS dental clinic's problems by means of a collision of statutory language taken from MN laws regarding dental therapists there and existing ND statute regarding dentists and hygienists here. Structural problems which I will elaborate on with this bill include:

1.) It fails to focus solutions in geographic areas of need.

2.) It creates licensing criteria that include educational accreditation standards inconsistent with those for existing licensees in our state.

3.) It proposes introduction of dental health care providers developed in other states for which studies to affirm or refute their efficacy and public safety have not yet been completed.

4.) This bill has not been developed taking into account existing ND statute and regulations designed to regulate the practice of dentistry with any consultation with the Board of Dental Examiners appointed by the state to oversee such activity.

Lets talk about focusing on **geographic areas of need** first. To date North Dakota's regulatory board for dentistry (NDSBODE) responsible for the licensure of individuals providing dental care as well is for the safety of the public related to such care has received no contact from anyone regarding the need for dental therapists or advanced dental therapists or regarding an appropriate way to insure that therapists of any kind might best be educated, evaluated, licensed or regulated. Instead, a process from another state with needs in densely populated urban settings, with different regulations, different demographics and different populations is being offered as a state-wide solution for geographically specific area within our state. The MN statute intended to target areas of need clearly identified as "low-income, uninsured, and underserved patients in a dental health professional shortage area". Minnesota goes on to provide a clear definition of what constitutes a professional shortage area as well as a definition for

"underserved and uninsured" persons in their state. [See reference material attached]. HB 1454 contains no such language. These parts of the MN statute were purposefully omitted evidently. Why they were omitted is not clear. Whether on not they should be omitted or replaced with other language more pertinent to the needs of North Dakota is also not clear. The Board of Dentistry feels strongly that changes in ND's dental statute should be based on need as well as the potential to safely address need through proposed changes and further, that any such changes should be well conceived and thoroughly vetted by the NDSBODE and other groups of interest.

How about **the issue of licensing** this new category of dental provider? Statutory requirements for licensure utilized to insure minimal competency for ND existing practitioners cannot be found in HB 1454. Requirements for licensure for dentists and dental hygienists in North Dakota include, without exception, successful completion of an examination administered by the Joint Commission on National Dental Examinations. A national board does not exist and has not been written for the dental therapist. The absence of standardized way of testing the knowledge of the dental therapist poses difficulty for the NDBODE to assure competence. The NDBODE would need to determine a suitable alternative to insure the vetting of dental therapist candidates for licensure. Although ND dentists and dental hygienists must

hold a diploma from a program accredited by the Department of Education's Council on Dental Accreditation (CODA), advanced dental therapists programs in MN (and therapists as proposed in this bill for ND) are not accredited by anyone except the MN Board of Dentistry. ND's Board of Dental Examiners has no such accrediting program.

Safety and Efficacy? HB 1454 suggests MN's change to address ND's need, a proposal for which a study of its safety and efficacy will not be reported to the MN legislative committees with jurisdiction over health care until January 15, 2014. To date, only one (1) advanced dental therapist has completed the "certification test" administered by the MN Board. Significant data regarding the geographic settings where dental therapists are practicing or the populations being served remains unknown. The report due next year must include the number and types of complaints filed against dental therapists as well as the number of disciplinary actions taken against therapists. The MN legislature further wants to know the number and type of dental services performed by dental therapists and reimbursed paid by the state under the MN state health care programs for the 2013 fiscal year. MN (legislature) also mandates an evaluation process that focuses on assessing the impact of dental therapists in terms of patient safety, cost effectiveness, and access to dental services. In the absence of this data, both the potential efficacy

and public safety of dental care provided by the Minnesota model of dental therapists has not been adequately established. The NDBODE feels the introduction of therapists in North Dakota is premature without the completion of additional studies as the MN legislature has wisely mandated.

Why collaborate to find solutions to access issues? The Board is aware that regions of the State encounter varying circumstances which hamper certain segments of the population from receiving dental care. There are a variety of barriers to care for which there is no single, all encompassing solution. The poverty, disparity, and lack of preventative services required to address the issues in the Native American population, may not be the same needs as an areas surrounding Williston where thousands of temporary homes or man-camps are found currently. In the past year ND Board of Dentistry representatives collaborated with the DentaQuest Task force aimed at identifying barriers to care and their potential remedies. After a multitude of discussions with dental stakeholders including the ND Oral Health Program Director, the Board of Dentistry in the 2009 Legislature introduced new language that broadened the scope of practice for dental hygienists, now permitting them to advance the Oral Health Department's fluoride varnish program and sealant program in under-served and low income areas of the state. By redesigning the language for general supervision safety net clinics

in our state may now expand dental services into nontraditional settings such as nursing homes. We know preventive strategies and education are working. The Bridging the Dental Gap clinic (Bismarck) currently utilizes hygienists practicing under general supervision rules in nursing home settings as a result of the 2009 legislative efforts. Other such clinics are also exploring this opportunity. Dental practitioners are considering other means to deliver oral health education, preventative services, and partnerships collaborating with other practitioners with the goal to improve oral health and educate citizens of North Dakota who would otherwise not have preventative services. These are only a few examples of how through a collaborative and cooperative effort, barriers to dental care are being addressed. These efforts have been successful in part because of the Board of Dentistry's desire to identify problems and work with parties of interest to find solutions. North Dakotans know and understand North Dakota's needs best and can formulate solutions that address those needs. Unfortunately, the Board of Dentistry has not had the opportunity to work with the party or parties who have constructed this bill drawn largely statue from another state. We would, however welcome the opportunity to work with the Turtle Mountain IHS, the ND Native American Commission and all other entities who wish to assist in improving access and quality of care in safe and effective ways.

It is notable to point out that the Board of Dentistry first learned of HB 1454 approximately two weeks ago. Unfortunately, stakeholders of interest did not convene to promulgate HB 1454. The NDSBDE was never petitioned, alerted or contacted regarding any discussion related to HB 1454 and as a result has had no opportunity to discuss or provide input regarding the complexities of the dental therapist. It has not been permitted to adopt a formal position regarding the therapist or recommend any requirements for education, licensure or regulation of the entity. The ND Board of Dentistry cannot defend or support any aspect of HB 1454 as the proposed bill lacks 1) the systematic elements required of all other licensees (such as the educational requirements), 2) lacks the comprehensive elements of recourse or disciplinary action, and 3) requirements for licensure have not been determined by what would be deemed appropriate by the State Board which governs dentistry but rather by statute contained in MN laws.

Add to this 4) the mechanics of the bill. The organization of language in HB 1454 contains several deficiencies in existing requirements for dentists, hygienists and dental assisting regulations. The ND Board, working with the North Dakota Assistant Attorney General appointed to the Board, have worked diligently to clean up, organize, and remove regulation that should be found in the Administrative Rules rather than statute. Some of the language in HB 1454 may be inappropriate because of existing definitions in

rule regarding supervision. For example, the collaborative agreement suggested may be required for an advanced dental therapist working under general supervision but not be required for a dental therapist working under indirect supervision of a dentist. The level of supervision should be determined by the Board based on the scope of practice determined by the level of education and advanced training of the licensee.

It is worth noting here that virtually every dental workforce model incorporates a requirement whereby less educated providers work at varying degrees of proximity and oversight with a dentist. There is good reason for this. In the world of repairing, removing and replacing teeth, there are unexpected things that go wrong. When something goes wrong (not ***if*** something goes wrong, but ***when*** something goes wrong) there are members of the dental team available to address and deal with the unexpected. Some unanticipated events are serious enough to require immediate action to avoid disastrous consequences, where others occurring today need not be sorted out until next Tuesday. It is for this reason the Board of Dentistry carefully assesses various factors related to education, training and skills to determine what types of procedures can safely be carried out by which dental team members, to what extent supervision by the dentist is necessary and what physical proximity the dentist should have with other team members. Such decisions are best made by our own state's

regulatory board; not by legislation or dental boards from other states trying to address geographic or workforce issues that are not consistent with North Dakota's needs. This bill proposes to put Minnesota's square peg into the round hole of North Dakota without the involvement of our state's regulatory board. This is a mistake. Please do not be lulled into the belief that the collaborative agreement outlined in this bill provides comfort that nothing to could go wrong with treatment provided by a therapist that could not be addressed by another state's collaborative agreement.

The North Dakota State Board of Dental Examiners cannot support a bill regulating a new provider where the requirements for licensure are one half the requirements of existing statute for other licensed providers and at the same time little is known about the safety and efficacy of those services provided by dental therapists. Data and outcomes are not currently available from the MN therapist programs and will not be until 2014. The NDSBDE works to remain nimble toward regulation of evolving changes in the delivery and marketing of dental healthcare. But, it has concern that the addition of this bill is not timely, and the regulation of the dental therapist has not been given the consideration that would be required to introduce an entirely new practitioner into statute, and administrative rule. Several options exist for workforce models and opportunity may exist for further expanded functions of auxiliary. The Board is supportive of discussions

regarding these options. The NDSBDE recommends a "do not pass" vote for House Bill No. 1454.

Thank you for the opportunity to testify this morning and with that, I would be happy to answer any questions you may have.

the rules of the board~~; said~~. The work order shall be made in duplicate form, a duplicate copy to be retained in a permanent file ~~in~~ of the ~~dentist's office~~ dentist or dental therapist at the practice setting for a period of two years, and the original to be retained in a permanent file for a period of two years by ~~such~~ the unlicensed person in that person's place of business. ~~Such~~ The permanent file of work orders to be kept by ~~such~~ the dentist, dental therapist, or by ~~such~~ the unlicensed person shall be open to inspection at any reasonable time by the board or its duly constituted agent.

Sec. 23. Minnesota Statutes 2008, section 150A.10, subdivision 4, is amended to read:

Subd. 4. **Restorative procedures.** (a) Notwithstanding subdivisions 1, 1a, and 2, a licensed dental hygienist or a registered dental assistant may perform the following restorative procedures:

(1) place, contour, and adjust amalgam restorations;

(2) place, contour, and adjust glass ionomer;

(3) adapt and cement stainless steel crowns; and

(4) place, contour, and adjust class I and class V supragingival composite restorations where the margins are entirely within the enamel.

(b) The restorative procedures described in paragraph (a) may be performed only if:

(1) the licensed dental hygienist or the registered dental assistant has completed a board-approved course on the specific procedures;

(2) the board-approved course includes a component that sufficiently prepares the dental hygienist or registered dental assistant to adjust the occlusion on the newly placed restoration;

(3) a licensed dentist or licensed advanced dental therapist has authorized the procedure to be performed; and

(4) a licensed dentist or licensed advanced dental therapist is available in the clinic while the procedure is being performed.

(c) The dental faculty who teaches the educators of the board-approved courses specified in paragraph (b) must have prior experience teaching these procedures in an accredited dental education program.

Sec. 24. **[150A.105] DENTAL THERAPIST.**

Subdivision 1. **General.** A dental therapist licensed under this chapter shall practice under the supervision of a Minnesota-licensed dentist and under the requirements of this chapter.

Subd. 2. **Limited practice settings.** A dental therapist licensed under this chapter is limited to primarily practicing in settings that serve low-income, uninsured, and underserved patients or in a dental health professional shortage area.

Subd. 3. **Collaborative management agreement.** (a) Prior to performing any of the services authorized under this chapter, a dental therapist must enter into a written collaborative management agreement with a Minnesota-licensed dentist. A collaborating dentist is limited to entering into a collaborative agreement with no more than five dental therapists or advanced dental therapists at any one time. The agreement must include:

(1) practice settings where services may be provided and the populations to be served;

(2) any limitations on the services that may be provided by the dental therapist, including the level of supervision required by the collaborating dentist;

(3) age and procedure specific practice protocols, including case selection criteria, assessment guidelines, and imaging frequency;

(4) a procedure for creating and maintaining dental records for the patients that

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HB 1454

ND House Industry, Business, and Labor Committee

Chairman: Representative George Keiser

RE: Testimony in opposition of HB 1454

Chairman Keiser, and members of the committee, my name is Dr Brent L Holman. I am a pediatric dentist with 34 years of experience from Fargo. I am a past-President of the North Dakota Dental Association and founding President of the Red River Valley Dental Access Project in Fargo that sees 800 indigent patients a year for walk-in humanitarian relief of pain. We were privileged to help organize a "Pediatric Dental Day" at Spirit Lake Reservation on September 30, 2011 where North Dakota dentists provided over $100,000 of donated specialty care to 232 children. We are also helping organize a 2-day Pediatric Dental Days event at Standing Rock on October 11-12, 2013, where dentists plan to provide specialty care to over 300 kids. We have also been fortunate to witness many of the access to care accomplishments over the last 20 years listed in Attachment A to this testimony. Highlights include a 45% increase in the number of Medicaid dental services completed for children since 2008, large percentages of dentist participation in volunteer activities such as Head Start, working in non-profit clinics, and the Donated Dental Services Program. These accomplishments have brought together practicing dentists, dental public health providers, dental non-profit organizations, state oral health resources, and the Oral Health Coalition. North Dakota is the envy of the nation when it comes to our ability to

improve access to care. This is because North Dakota is different. We know each other and can bring all partners together to solve our problems.

With this background, I would like to speak **AGAINST** HB 1454. Everyday as a legislator, you fix **Problem A** by voting for **Solution B**. As in most issues, there are many unknown **Consequences C**. Notwithstanding my opposition to a proposal that may allow a lower standard of care directed at low-income patients, the following possible **Consequences C** of this bill should be studied before making this unprecedented fragmentation of the dental delivery system in our state:

1. Is there a really a need for dental midlevel providers or dental therapists in North Dakota? What would be that need? Workforce has significantly changed in ND in the last 10 years and has that been studied to know if the problem is mal-distribution or lack of dentists?
2. Is there evidence and science to suggest benefit to our state based on precedent in other rural states similar to North Dakota?
3. Given the fact that there are no studies that demonstrate that dental therapists will reduce costs, is there any reason to think that that will happen in North Dakota?
4. Given the overhead structure of dentistry, will midlevels be expected to charge less for procedures than dentists? Is there any evidence for that expectation? Is there a practice model that would allow them to charge less?
5. Are midlevels expected to be employed and supervised by dentists and will that arrangement result in better access or more revenue for the dentist? Should

that be studied first?

6. Will national dental franchisees use these new practitioners to expand their operations in North Dakota and will any alleged cost savings be passed on to patients? What are the negatives of this potential expansion?

7. Will midlevels be expected to live and practice in rural North Dakota communities and if so, why would their lifestyle expectations in that regard be any different than anybody else?

8. Have we adequately staffed and funded our FQHC, IHS, non-profit, and public health dental clinics in North Dakota and further analyzed if those models might be more efficient structures to improve access than the mid-level provider model?

9. A 2010 survey of the Indian Health Service Dental Directors at our 4 tribal communities indicated no need or desire for midlevel dental practitioners in their clinics. Can we help them recruit dentists, dental auxiliaries, and to build partnerships with our North Dakota dental community?

10. Do we know what efficiency costs there would be to add regulatory and licensing functions to the current Board of Dental Examiners in ND? Are we able to manage that with our current regulatory structure?

11. Is the medical model of midlevel providers really transferable to dentistry in a rural state? Is there a difference between the surgical procedures that are done in dentistry and the medical diagnostic process in terms of quality and potential negative consequences? Is that difference measureable?

12. How does a new category of provider affect our current training programs for

dental assistants and hygienists?

13. Has the potential of an expanded function dental assistant (EFDA) in North Dakota been studied and are there efficiencies to be gained with that approach that prevent the fragmentation of the current delivery system and utilize our current educational infrastructure?

14. Is a midlevel provider needed in North Dakota and if so, do we need an expanded function dental assistant, a community dental health coordinator, an advanced dental hygienist, a dental health aid therapist, a dental therapist, an advanced dental therapist or one of the other myriad models that are in the wind?

15. Since studies show that **North Dakota leads the nation in the number of dental school applicants per current dentist in the state**, does it not appear that the future number of North Dakota kids coming back to practice in the state after dental training will increase in the future?

16. Is it worth potentially destroying the unique partnership we have in the public and private dental community in North Dakota whose accomplishments in solving access problems are nationally known?

This issue needs study before laws are enacted that will result in an unprecedented restructuring of the delivery of dental care and resultant regulatory chaos. It would be prudent to make sure the **Consequences** are thoroughly studied before addressing this issue in legislation. Your task should be the same as those of us that are dentists.....first do no harm. Please vote NO on HB1454. Thank you.

Attachment A

North Dakota Access to Dental Care-Facts

Brent L Holman DDS

1. The number of ND children receiving Medicaid dental services as well as the number of services has increased by 45% since 2008. (ND Department of Human Services)
2. The net number of licensed dentists in the state has been increasing over the last 5 years. (ND State Board of Dental Examiners)
3. Overall ND dentist/population ratio is "adequate"(UND Center for Rural Health). Problem areas include western part of state where oil boom is occurring as well as counties that include the 4 American Indian reservations.
4. There are now twice as many North Dakota students enrolled in dental schools around the country than 10 years ago (State Health Department).
5. 10 of the 14 ND Head Start programs report minimal problems getting needed exams and treatment completed in the school year for their children. Challenges are focused primarily in the 4 American Indian Head Start programs.
6. All 4 ND Indian Health Service Dental Directors in 2010, as a part of a Head Start Dental Home Initiative survey, indicated no need or desire for mid-level dental practitioners in their IHS clinics.
7. North Dakota leads the nation in the number of dental school applicants from the state as a percentage of the number of dentists in the state, and ND is second in the nation in the number of dental school applicants as a percentage of population. Given the fact that there is no dental school in the state, these numbers are impressive and project a positive future pipeline for new dentists. ("Dental School Applicants by State Compared to Population and Dentist Workforce Distribution", Mentasti and Thibodeau, Journal of Dental Education, Nov 2008)
8. There has been a dramatic increase in volunteerism, collaboration and partnerships in improving oral health in the state:
    a. Expansion and support of the dental safety net clinics in the state through

increased funding, staffing, and volunteerism

b. Increase in the number of dentists willing to see Head Start children as documented by the Head Start Dental Home Initiative
c. Expansion, development, and collaboration of the ND Oral Health Coalition with resultant legislative success in achievement of goals.
d. Unprecedented grant support of ND oral health initiatives through the State Oral Health Program
e. Successful volunteer activities of the Head Start Dental Home Initiative including the Spirit Lake Pediatric Dental Day on September 30, 2011. 232 kids received $107,000 worth of free dental services by 9 pediatric dentists, 5 general dentists, 2 oral surgeons, and 40 dental staff. 35 children needing general anesthesia by a pediatric dentist were referred from this effort.
f. 90 patients received $301,341 worth of dental services in the last year through the Donated Dental Services Program. 132 North Dakota dentists volunteer for this program, which is one of the highest levels of participation in the nation.
g. 45 dentists volunteer their time in Fargo to provide an urgent care walk-in clinic that provides humanitarian relief of dental pain for about 1,000 low-income patients per year as a part of the Red River Valley Dental Access Project (www.rrdentalaccess.com). This clinic is in its 11th year if operation.
h. Development of the Ronald McDonald Care Mobile to provide dental care to children in western North Dakota
i. Expansion of Give Kids a Smile Programs (ADA-sponsored) every February

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HB 1454
House Industry Business and Labor Committee
Chairman: Representative George Keiser

RE: Testimony in opposition of HB 1454

Good morning Chairman Keiser and members of the House Industry Business and Labor Committee. My name is Alison Fallgatter. I am an orthodontist and am also the President of the North Dakota Dental Association (NDDA). I live outside of Steele on my family's farm and my practice is in Jamestown. I appear here on behalf of over 300 members of the NDDA and in opposition of HB 1454.

The NDDA is working with many oral health stakeholders in North Dakota to remove barriers to receiving oral care for residents of our state. Adding another dental workforce provider model like the one proposed in HB 1454 is not a viable solution.

This bill is an over reaction to a perceived workforce shortage in the oral health care system by creating a new workforce model in statute. This will not solve the challenges being faced on the reservations. There are many barriers to accessing oral health care besides a perceived workforce shortage. These barriers include; poverty, geography, lack of oral health education, language, cultural barriers, fear of dental care and the belief that people who are not in pain do not need dental care. There are other barriers particular to the reservations including federal funding and administrative challenges in the clinics themselves.

For the past decade the NDDA has been working to reduce barriers to care with many partners including the state legislature. The association worked with past legislatures to allow non dentist ownership of the Ronald McDonald Care Mobile, supported legislation to allow medical personnel to apply fluoride varnish, worked to expand the scope of practice for hygienists, modified their supervision by dentists to allow hygienists to go into schools, public health settings, and long term care facilities to work within their scope of practice providing cleanings, sealants, and fluoride varnish. The legislature has through the funding of the dental loan repayment program encouraged dentists to practice in rural areas of our state and this program has been very successful in providing dental care in rural communities.

The association supports the public health clinics in the state and we believe they are an integral part of the states oral health delivery system. Our members organized a pediatric dental day on the Spirit Lake Reservation in September of 2011 where 232 children were seen and $107,000 of free dental care was provided. The NDDA is now in the process of helping plan another pediatric specialty dental event this fall. This year it will be in October on the Standing Rock Reservation in collaboration with South Dakota

Dental Association and will be a 2-day event for children to age 18. We hope to provide oral health services to over 300 children with a value in excess of $200,000.

Dental Medicaid services have increased, with the help of legislative funding and the association's Donated Dental service program has provided nearly $1.5 million in free dental care to disable people who do not qualify for government programs.

Our association with the financial support of the American Dental Association has developed an American Indian Oral Health Care Initiative. Through this project we are trying to work with the Tribal Nations in our state to improve the oral health of the people on the reservation. We have hired KAT Communications of Bismarck to facilitate this effort and have conducted a Dental Oral Care Workshop this past fall here in Bismarck to help us assess the oral health needs on our state's reservations. All the Tribal Nations were represented at this workshop and it was determined that need exists for oral health education, preventative services and restorative work. The workforce issue that surfaced during this meeting was the inability to retain dentists for a variety of reasons including inadequate funding for the positions that are authorized. There was no pressing need for an additional workforce model. The participants felt that there were administrative and organizational barriers that affected the delivery of oral health services on the reservations and not the need to expand the workforce.

This bill does not get to the root of the problem and we believe is poorly thought out and will have the unintended consequence of fractionalizing the dental team. We understand that the intent is to be able to hire dental therapists out of Minnesota or Canada. We believe that there has not been enough investigation to determine if this is necessary or even feasible. Of the 18 dental therapists that have graduated from Minnesota's dental therapy schools only one has gone into a rural public health area. The dental therapist's school in Saskatchewan closed in November of 2011 and there are only 283 dental therapists in all of Canada. The ability to recruit these providers will be much more difficult and problematic than it would be to hire the already available dentists and hygienists that are needed on the reservations.

This bill is not needed in North Dakota. There is an adequate workforce of dentists and hygienists. In the past decade there has been a 15% increase in dentists practicing in our state. North Dakota has the highest "dental student" to "dentist" ratio in the country, so future dentists are in the pipeline.

The NDDA works closely with the states Oral Health Division in the state health department. That division received a Denta Quest grant to survey the state to assess the oral health needs of its residents. The NDDA, with other stakeholders, fully participated

in this process and in the public forums that were held around the state. The group determined that the two priorities are, to develop dental/medical collaboration which will facilitate education and prevention among children and second to provide oral health care in long term care facilities. We continue to work with the Health Department and the other stakeholders in the implementation of the grant and develop the programs that were identified during the year long process.

The NDDA works with and supports the Ronald McDonald Care Mobile, supports the initiative of Bridging the Dental Gap in Bismarck to develop a work plan so that dentists and hygienists can provide care in long term care facilities, and supports the state heath department's fluoride and school sealant programs which reach underserved and economically disadvantaged children. You may have heard that the Pew Foundation gave North Dakota an "A" for its sealant program only one of four states to receive such a rating. Pew has also given North Dakota one of the highest ratings in the country on the overall oral health of our state. With the help of our many partners we are addressing our oral health issues.

This bill should not be approved. It lacks appropriate thought and research. Any solution must be tailored to the needs and resources of our state. We must not blindly follow something that was enacted in Minnesota and has yet to demonstrate improvement of the oral health care in rural areas of that state.

We do not believe it is good public policy to expand a professional workforce without a thorough review of the efficacy of the change. We believe, while well intentioned, this bill is not right for North Dakota. Therefore, we ask for a committee recommendation of do not pass.

Thank you, I would be happy to answer any questions.

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North Dakota Dental Assistants Association

Feb. 5, 2013

HB 1454
House Industry Business and Labor Committee
Chairman: Representative George Keiser

Testimony by: Marsha Krumm
President North Dakota Dental Assistants Association

Representative Kaiser and members of the Committee, I am Marsha Krumm, President of the North Dakota Dental Assistants Association, and I represent over 130 Dental Assistants in North Dakota. We oppose HB 1454 and urge you to vote NO. We feel dental patients are best served in our state by having a licensed dentist, as currently defined in the Dental Practice Act, perform irreversible dental procedures and direct the dental team in all aspects of patient care. We feel ALL dental patients deserve the highest educational standards when it comes to high quality dental care, regardless of income.

Thank You,

Marsha Krumm

NDDAA President

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Testimony
HB1454
House Industry, Business and Labor Committee
February 5, 2013

Good morning Chairman Keiser and members of the House Industry, Business and Labor Committee. I am Dana Schmit, president-elect of the North Dakota Dental Hygienists' Association (NDDHA). We represent 156 hygienists in the state of North Dakota. I am testifying neutral on HB1454. The NDDHA was not aware of this bill until its introduction and we have not had an opportunity to discuss the provisions of this bill with all our members. We support the concept of the mid-level practitioners and other new delivery models and expanded functions that can improve access to care for underserved populations in a safe and effective manner. The NDDHA has not determined the scope of practice that would best serve North Dakota, nor have we assessed the educational pathways that would be required and also feasible to implement the use of advanced practitioners in the state.

The NDDHA recognizes that there are many areas of North Dakota where access to dental care is a major challenge due the limited number of dentists in the rural and frontier areas of the state, the lack of dentists accepting Medicaid patients, and patient challenges of no insurance or ability to pay for care, transportation issues and parent's unable to take time off work to go to the dentist or take their children to the dentist. According to the Health Resources and Services Administration, Bureau of Primary Health Care, seventeen counties/geographical areas in the state are designated as dental health professional shortage areas and three counties are designated low-income dental health professional shortage areas in North Dakota. Fifteen facilities across the state including rural health centers, community health centers, Indian Health Service clinics and the State Penitentiary and James River Correctional Center are designated as dental health professional shortage areas. (UND School of Medicine and Health Sciences, 2012). The burden of oral diseases is not spread evenly throughout North Dakota. Serious disparities exist, especially among low-income populations. Children and adults living in poverty suffer more tooth decay and their disease if more likely to go untrested.

In 2012 the ND State Board of Dental Examiners reports indicate there were 372 active dental licenses and 518 active dental hygiene licenses in state. Currently there is a surplus of dental hygienists in a North Dakota and many are unable to find employment. Development of an advanced dental hygiene practitioner model could open up additional employment opportunities for hygienists interested in advancing their skills under a dental therapist type program. A dental therapist can provide services beyond those provided by a dental hygienist such as fillings and simple extractions and other services as described on pages 6 and 7 of the bill. Currently two states, Minnesota and Alaska, have laws regulating dental therapists. In Alaska dental therapists can practice on tribal lands and Minnesota dental therapists can practice in underserved areas. In addition, there are dental therapist pilot projects and legislation pending in a number of states across the country. The states of Vermont, New Hampshire, Maine, and New Mexico have pilot programs or legislation pending. We have also

heard that Washington, Kansas and Ohio are considering legislation in this area. A chart outlining some of the current and proposed models is attached.

HB 1454 is very similar to current legislation in Minnesota. However, the bill would allow the dental therapist to practice in all areas of the state, not just the underserved areas. The educational pathways defined are currently not available in North Dakota and students would need to go to Minnesota to acquire this education. In discussions with the two schools in Minnesota, they have indicated they will accept North Dakota students that have the proper prerequisites. The program at Metropolitan University offers a Master of Science Degree in Advanced Dental Therapy. The University of Minnesota offers a Bachelor of Science in Dental Therapy and a Master in Dental Therapy degree.

A recent systematic review published in the January 2013 issue of the Journal of the American Dental Association found that midlevel providers improve access to care and population health outcomes. The study found that therapists are no different than dentists with regard to their impact on disease increment; in populations served by teams that include dental therapists there is less untreated disease, and there is not sufficient evidence to address the cost-effectiveness of therapist utilization. A 2012 study by the W.K. Kellogg Foundation found that dental therapists offer treatment that is "technically competent, safe, and effective," especially for children.

The NDDHA is willing to work with the sponsors, the ND Board of Dental Examiners and the ND Dental Association to develop scope of practice and educational requirements for advanced dental hygiene practitioners or similar positions that would best serve the citizens of North Dakota.

We request the Committee consider a study resolution to further investigate opportunities for a model to expand access to oral health care in our state. Thank you for the opportunity to testify on this bill. I would be happy to answer any questions you may have for me at this time.

American Dental Hygienists' Association

Oral Health Care Workforce – Current and Proposed Providers

	Advanced Dental Hygiene Practitioner (ADHP)	Alaskan Dental Health Aide Therapist (DHAT)	Minnesota Dental Therapist /Advanced Dental Therapist (DT/ADT)	Community Dental Health Coordinator (CDHC)
Developed by	American Dental Hygienists' Association www.adha.org/adhp	Alaska Native Tribal Health Consortium (ANTHC) – Community Health Aide Program www.anthc.org	Minnesota State Statute and Rules www.dentalboard.state.mn.us	American Dental Association www.ada.org
Stage of Development	ADHP educational competencies were finalized in 2008. The first educational program based on ADHP competencies began in Fall 2009.	DHAT practice began in Alaska in 2004. The first graduates from the U.S.-based DENTEX program began practice in 2008.	Educational programs for the DT (at the University of Minnesota School of Dentistry) and ADT (at Metropolitan State University) began in Fall 2009.	Curriculum complete and initial educational pilot program began in Winter 2009.
Education/Training	Master's level education at accredited institution; open to individuals currently licensed as dental hygienists who have a Bachelors degree	24 month program administered by ANTHC in partnership with the University of Washington DENTEX program	DT – minimum Baccalaureate degree ADT – Master's degree	Completion of 18 months of training.
Regulation/Licensure	Providers are already state licensed dental hygienists. ADHP is envisioned to be state licensed and regulated.	Providers are certified and regulated by Indian Health Service's Community Health Aide Program	Providers required to hold state license; can be dually licensed as a dental hygienist and administer dental hygiene scope.	Providers envisioned to be certificated; no formal state licensure
Proposed Settings	Community and public health settings, possibly private practice	Remote Alaskan villages	Settings that serve low-income and underserved patients, or are located in designated dental health professional shortage areas.	Community and public health settings
Proposed Supervision	Collaborative arrangement envisioned with strong communication and referral networks; presence of a dentist not required; use of teledentistry.	Remote/general supervision of a dentist; presence of a dentist not required; use of teledentistry	**DT** – General or indirect supervision depending on service **ADT** - Collaborative management agreement with dentist, presence of a dentist not required for most services	Onsite or general supervision, depending on service

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Other Relevant Information	ADHA convened an ADHP Task Force, an ADHP Advisory Committee, and sought input from approximately 200 stakeholder groups in developing ADHP competencies.	Formal evaluations of DHAT practice have demonstrated that irreversible dental procedures can be safely and effectively delivered by non-dentists.	Minnesota is the first state to legislate new, mid-level oral health providers, the DT and ADT. A thirteen-member workgroup, comprised of various stakeholders, made recommendations on scope, supervision and education.	The ADA convened an internal workgroup to develop CDHC curriculum
	Several national stakeholders, including the National Rural Health Association and National Rural Education Association, support the ADHP model	Dental therapist models are prevalent in more than 50 counties internationally.	The ADT education program at Metropolitan State University is guided by the ADHP competencies, competencies for the New General Dentist, and requires students to be licensed and actively practicing as a dental hygienist.	The ADA and ADA Foundation have committed nearly $7 million to fully fund CDHC pilot programs over five years.
	Language in the report accompanying the FY 2006 Labor/HHS Appropriations encourages federal agency support of the ADHP	DHAT providers are often Alaskan Natives who reside or grew up in the remote villages they serve.	The DT program at the University of Minnesota does not require an oral health-based baccalaureate degree or licensure as a dental hygienist for admission to the program.	The University of Oklahoma, UCLA (in conjunction with Salish Kootenai College in Montana) and Temple University in Philadelphia are CDHC pilot sites.
	Metropolitan State University is the first education program to begin guided by ADHP competencies. Eastern Washington University and the University of Bridgeport Fones School of Dental Hygiene have formal commitments to begin ADHP programs.	The Kellogg Foundation began a comprehensive two-year study to evaluate effectiveness in 2008.	Initial graduates of DT/ADT programs are anticipated to enter the workforce in mid-2011.	CDHC trainees are recruited from the communities the provider is intended to serve.

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Preventive Scope	- Oral health and nutrition education - Full range of dental hygiene preventive services, including complete prophylaxis, sealant placement, fluoride treatments, caries risk assessment, oral cancer screenings - Expose radiographs - Advanced disease prevention and management therapies (e.g. chemotherapeutics)	- Oral health and nutrition education - Sealant placement - Fluoride treatments - Coronal polishing - Prophylaxis - Expose radiographs	- Oral health and nutrition education - Sealant placement - Fluoride varnishes - Coronal polishing - Oral cancer screenings - Caries risk assessment - Expose radiographs	- Oral health and nutrition education - Sealant placement - Fluoride treatments - Coronal polishing - Scaling for Type I Periodontal patients - Collection of diagnostic data
Periodontal Scope	-Provide non-surgical periodontal therapy.	-Provide non-surgical periodontal therapy	N/A	N/A
Restorative Scope	- Preparation and restoration of primary and permanent teeth -Placement of temporary restorations - Placement of pre-formed crowns -Temporary recementation of restorations -Pulp capping in primary and permanent teeth -Pulpotomies on primary teeth - Uncomplicated extractions of primary and permanent teeth -Place and remove sutures -Provide simple repairs and adjustments on removable prosthetic appliances	- Restorations of primary and permanent teeth - Placement of pre-formed crowns - Pulpotomies - Non-surgical extractions of primary and permanent teeth	- Restorations of primary and permanent teeth - Placement of pre-formed crowns - Placement of temporary crowns - Extractions of primary teeth - Nonsurgical extractions of permanent teeth (ADT only) - Direct /Indirect Pulp Capping - Pulpotomies on primary teeth - Atraumatic restorative therapy	- Palliative temporization (with hand instrumentation only) - Placement of temporary restorations
Additional Competencies	- Local anesthesia and nitrous oxide administration - Diagnosis within scope of practice - Limited prescriptive authority (for	- Local anesthesia administration - Patient referral	- Local anesthesia nitrous oxide administration - Dispense analgesics, anti-inflammatories, and	- Development and implementation of community-based oral health programs

	prevention, infection control and pain management) - Triage - Case management - Healthcare policy and advocacy -Health promotion for individuals, families, communities - Patient referral	antibiotics - Provide, dispense, administer analgesics, anti-inflammatories, and antibiotics (ADT only) - Assessment and treatment planning as authorized by collaborating dentist (ADT only) - Repair of defective prosthetic devices - Placement and removal of space maintainers - Stabilization of reimplanted teeth	- Case coordination - Administrative/office management procedures - Triage

8 HB 1454
2-5-2013

Date: January 29, 2013

To: Chairman Keiser and Members of the Industry, Business and Labor Committee

From: Rhonda Edwardson, BA, RDH

North Dakota State College of Science (NDSCS)
Allied Dental Department Chair / Dental Hygiene Program Director
800 6th St. N.
Wahpeton, ND 58076

Re: House Bill No. 1454

Good afternoon, my name is Rhonda Edwardson, I represent the North Dakota State College of Science (NDSCS) as Allied Dental Department Chair and Dental Hygiene Program Director. My testimony to House Bill No. 1454 is neutral; I am only providing information regarding the educational aspect listed in the bill.

NDSCS is a two-year college, granting diplomas, certificates, and associate degrees. The Allied Dental Department graduates about twenty-five students per year with an Associate in Applied Science Degree in Dental Hygiene. A great majority of those students also receive an Associate in Science Degree in Liberal Arts. In addition, our graduates have access to an online Bachelor in Dental Hygiene Degree Completion through an articulation agreement with Minnesota State University – Mankato.

Currently NDSCS cannot offer the bachelor or master level education specified in House Bill No. 1454 for the Dental Therapist or Advanced Dental Therapist Degree, however, we are open to partnering with an institution in ND that can provide this degree.

The majority of our dental hygiene clinical education takes place in our dental clinic supervised by faculty and a dentist. A high percentage of our patients are low income, Medicaid recipients or have no dental insurance. We provide preventive care such as cleanings, fluoride, radiographs and sealants; with some requests for emergency or palliative care.

NDSCS is open to being part of any collaborative effort between the ND Board of Dental Examiners, the ND Dental Association, and the ND Dental Hygienists' Association in discussing access to dental care and developing a model that best fits the needs of the citizens of ND.

Thank you, If there are any questions regarding our educational opportunities regarding this bill, I can be reached at (701) 671-2334.

13.0279.01001
Title.

Prepared by the Legislative Council staff for
Representative M. Nelson
February 6, 2013

2-6-2013

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1454

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of access to dental services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - ACCESS TO DENTAL SERVICES. During the 2013-14 interim, the legislative management shall consider studying how to improve access to dental services and ways to address dental service provider shortages, including the feasibility of utilizing mid-level providers, whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access, and whether the state's medical assistance reimbursement rates impact access to dental services. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fourth legislative assembly."

Renumber accordingly

Testimony of Representative Marvin E. Nelson on HB 1454 in front of Senate Human Services Committee 3/20/13

HB 1454 requests a study of the delivery of dental services throughout the state of ND. Many areas are underserved, I include a map of ND put out by the Center for Rural Health showing shortages.

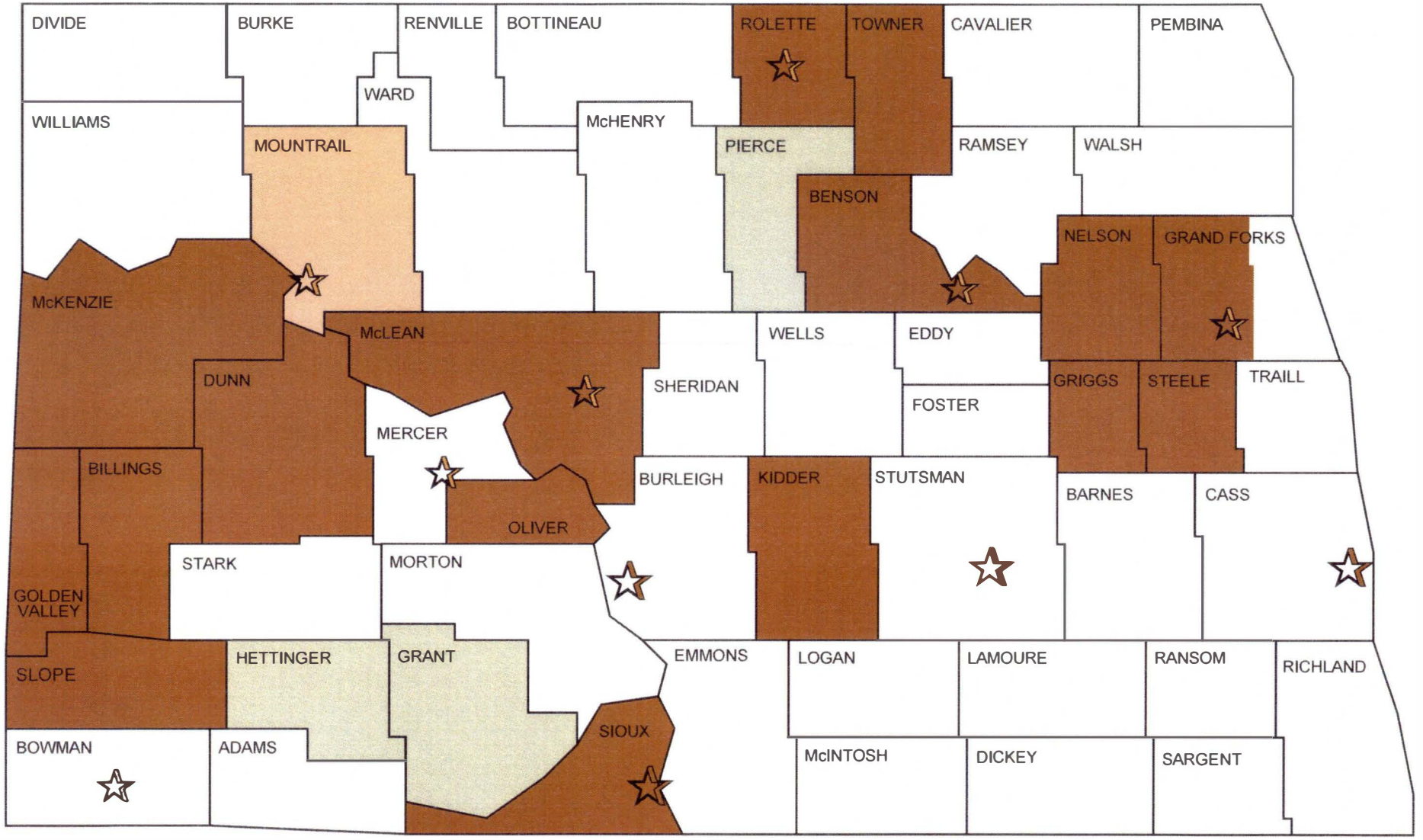
The question is what if anything does the state do. There is the question of adding mid-level providers to the dental professions. Alaska and Minnesota now have dental therapists. Other states, such as Kansas, have gone to advanced dental hygienists.

We have a problem with Medicaid patients in ND. Reimbursement rates are lower and many dentists won't take many if any Medicaid patients. This results in difficulty getting necessary dental care for children. The child and the dentist are often far apart and there is difficulty getting the services. So we might be best bringing the dental care to the patient.

There is also the oil field with the great changes and the problems with recruiting professionals to serve that population.

With the many difficulties facing the state in the delivery of dental services to our citizens, I ask for you approval of HB1454 to study the situation and see what we can do to improve the dental care of our citizens.

North Dakota Dental Health Professional Shortage Areas



Center *for* Rural Health
The University of North Dakota
School of Medicine & Health Sciences

Designated Geographic Dental HPSAs
Proposed Geographic Dental HPSAs
Low-Income Dental HPSAs
Designated Facility Dental HPSA

1/12

For further information on health professional shortage areas, contact Terri Lang at terri.lang@med.und.edu

Testimony
HB1454
Senate Human Services Committee
March 20, 2013

Good morning Chairwoman Lee and members of the Senate Human Services Committee. I am Kathleen Mangskau and I am representing the North Dakota Dental Hygienists' Association (NDDHA). We represent 156 hygienists in the state of North Dakota. I am testifying in support of HB 1454.

The NDDHA recognizes that there are many areas of North Dakota where access to dental care is a major challenge due the limited number of dentists in the rural and frontier areas of the state, the lack of dentists accepting Medicaid patients, patient challenges of no insurance or ability to pay for care, transportation issues and parent's unable to take time off work to go to the dentist or take their children to the dentist, as well as low oral health literacy among many parents/care givers. According to the Health Resources and Services Administration, Bureau of Primary Health Care, seventeen counties/geographical areas in the state are designated as dental health professional shortage areas and three counties are designated low-income dental health professional shortage areas in North Dakota. Fifteen facilities across the state including rural health centers, community health centers, Indian Health Service clinics and the State Penitentiary and James River Correctional Center are designated as dental health professional shortage areas. (UND School of Medicine and Health Sciences, 2012). The burden of oral diseases is not spread evenly throughout North Dakota. Serious disparities exist, especially among low-income populations. Children and adults living in poverty suffer more tooth decay and their disease is more likely to go untreated. Nationwide, North Dakota ranks in lowest quartile for the percentage of children receiving preventive dental services in the Medicaid program. In 2010, only 30 percent of enrolled children received

preventive dental services and only 16 percent received a dental service. While ND has made strides in improving access to care in the last decade, the problem is not resolved and much more remains to be done.

A number of states across the country are looking at various service delivery models to improve access to care in their state. There are pilot projects and legislation pending in Vermont, New Hampshire, Maine, and New Mexico. We have also heard that Washington, Kansas and Ohio are considering legislation in this area. A chart outlining some of the current and proposed models is attached. The NDDHA has not determined the scope of practice or delivery models that would best serve North Dakota, nor have we assessed the educational pathways that would be required and also feasible to implement changes in delivery models. A study of access to care would allow time to look at what is working in other states and allow North Dakota to look at models which would work best to serve our at-risk populations.

The NDDHA is willing to work with the North Dakota Legislature, the ND Board of Dental Examiners, the ND Dental Association and the ND Dental Assistants Association to develop scope of practice or service delivery models that would best serve the citizens of North Dakota.

We urge Committee support for this legislative management study to further investigate opportunities to improve access to oral health care in our state.

Thank you for the opportunity to testify on this bill. I would be happy to answer any questions you may have for me at this time.

American Dental Hygienists' Association

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