15.0848.01000

FISCAL NOTE

Requested by Legislative Council
01/26/2015

Bill/Resolution No.: SB 2354

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.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures				$145,000		
Appropriations						

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

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 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).*

Section 17 of SB 2354 mandates the State Board of Dental Examiners develop and use an evaluation process that focuses on assessing the impact of advanced practice dental hygienists and focuses on specified outcome measures.

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.*

Fiscal Impact of Section 17. STATE BOARD OF DENTAL EXAMINERS STUDY - REPORT TO LEGISLATIVE MANAGEMENT - REPORT TO ADMINISTRATIVE RULES COMMITTEE.

The fiscal impact is estimated to be $145,000 which would likely necessitate a license and registration fee increase for all dentists, dental hygienists and dental assistants, which provide the Board's primary source of revenue to meet budgetary requirements. Obtaining detailed patient information pertaining to insurance coverage, reimbursement, shortage areas, patient wait times etc., and reporting the effectiveness of the practitioners, in addition to surveys, postage and mailing, consumable supply costs and any travel expenses are among the cost drivers. In order to achieve accurate information it will be critical to work with the advanced dental hygiene practitioners to construct a means obtaining timely details in order to produce a report for the 2015-16 and 2017-18 interims. The NDSBDE employs one full time executive director and a part time administrative assistant. Consultants would be required to execute the project. Many costs are unknown and are conditional upon the location of the practitioners, numbers of patients served and amounts of care delivered. Specialized services, computer services, analysis or other direct or indirect costs associated with a proposed study must also be considered. In September of 2014, the University of Minnesota's Dean Dr. Leon Assael stated that gathering of data related to dental therapists in Minnesota has not provided a clear picture of efficacy due to the small numbers of practitioners (27) and the small data samples collected. Although the estimated cost burden would reflect a smaller number of practitioners studied, cost effectiveness and overall impact of the advanced dental hygiene practitioners is the mandated focus of Section 17 therefore it is reasonable to assume the same procedures would be required to complete such a study.

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.*

      No revenue would be provided by SB 2354.

   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.*

      The estimate is based upon discussion and recommendation of Dr. Shawnda Schroeder. Dr. Shroeder was the Project Director of the Center for Rural Health's report, North Dakota Oral Health Report: Needs and Proposed Models, 2014. The Center for Rural Health's report included assessing the existing oral health workforce and service capacity, assessing the potential unmet need for oral health care, and producing a written report of needs, outcomes, and findings was presented to the Health Services Interim Committee. The cost was $145,000. The estimated expenditure is also based upon costs of $137,000 incurred by the MN Board of Dentistry study which mirrors the mandated report in SB 2354.

   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.*

      SB 2354 does not affect appropriation.

Name: Rita Sommers

Agency: NDSBDE

Telephone: 7013917174

Date Prepared: 01/29/2015

2015 SENATE HUMAN SERVICES

SB 2354

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2354
2/10/2015
23588

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to advanced practice dental hygienists and practice on Indian reservations; relating to advanced practice dental hygienists and the practice of dental-related fields on Indian reservations; to provide a penalty; and to provide a report to the legislative management and the administrative rules committee.

Minutes:

Attach #1: Testimony by Rep. Blair Thoreson
Attach #2: Testimony by Mac Zimmerman
Attach #3: Testimony by Rep. Marvin Nelson
Attach #4: Testimony by Rachelle Gustafson
Attach #5: Access to Oral Health Care Document
Attach #6: Testimony by Leon Assael
Attach #7: Testimony by Dr. Donald Warne
Attach #8: Testimony by Josh Askvig
Attach #9: Testimony by Mike Tomasko
Attach #10: Testimony by Dr. David Gesko
Attach #11: Testimony by Sarah Wovcha
Attach #12: Powerpoinit Dental Therapy in Minnesota
Attach #13: Written Testimony by Colleen Brickle
Attach #14: Testimony by Sen. Brad Bekkedahl
Attach #15.1-15.8: Testimony by Dr. Brent L Holman
Attach #15.8-15.27 Testimony by Dr. Paul Tronsgard
Attach #16: Testimony by Brenda Schmid
Attach #17: Testimony by Dr. Robert Lauf
Attach #18: Testimony by Dr. Carrie Orn
Attach #19: email from Rod St. Aubyn

Acronym Definitions
APDH = Advanced Practice Dental Hygienist

Senator Dever (district 32) introduced SB 2354 to the Senate Human Services Committee. This bill proposes to expand dental services in North Dakota by better utilizing more educated dental hygienists who would work under the supervision of a dentist under the rules adopted by the Board of Dental Examiners. This concept has not received universal acceptance. Senator Dever laid out two different scenarios. This bill has been studied by the Interim Health Services Committee. Information was provided by the Center for Rural Health. They found that in 2014, 40% of North Dakota counties had one dentist or less. 70% of children enrolled in Medicaid did not see a dentist in 2013. Native American children had more than twice the need for treatment then their non-native peers. Rural 3rd

graders have significantly oral health than their urban peers. One-Third of all seniors have dental problems far more than any other group. We have seen more dentists coming to the state in the last few years, but they don't necessarily serve in the rural areas and the underserved areas. Senator Dever stated if the bill fails, the statistics will remain the same or possibly get worse. If the bill passes, dentists will see opportunities, they will be more specialized, because they have someone in their office who can handle the simpler functions. Dentists who see this as competition to their practice will oppose it, but those who will see it as an opportunity to expand and extend their practice will embrace it. Senator Dever believes this can be done without compromising quality of care. The most important is that every person in North Dakota has access to quality dental care. Senator Dever further explained the major objection to the bill is in regards to reimbursement - if we pass the bill, some dentists will see opportunity to provide expanded services at a lower cost, and those Medicaid reimbursement they will have found a solution with this bill.

Senator Axness - the interim took this up, but did not put forward a recommendation by the interim committee. Why was it not put forward by the committee?

Senator Dever indicated that he did not know. Deferred.

Senator Howard Anderson, Jr. when pharmacists did pharmacy technicians, not all were in favor of that. Pharmacy association and board of pharmacy were in favor in leading the charge. When most of the dentists are opposed and will have to supervise these people, how will this work.

Senator Dever it is a difficult situation. With pharmacists, they saw need in underserved areas and moved forward. Dentists have not seen that same role at this point, and it would be easier if they were providing solutions rather than barriers.

Representative Blair Thoreson (District 14), testified IN FAVOR of SB 2354 (attach #1). Representative Thoreson distributed and read Letter Americans for Prosperity (Attach #2) (6:48-12:35)

Senator Axness talked about unnecessary restrictions. Some will view these restrictions as quality of care, that people who have the necessary education are providing this service and that equates to quality of care.

Senator Thoreson we want the best care for our citizens. One of the national organizations indicated they approve this level of care, so if we have their support, it makes sure best quality of care for citizens of North Dakota. (attach #19)

Representative Marvin Nelson testified IN FAVOR of SB 2354 (attach #3) (14:20-17:51)

Senator Howard Anderson, Jr. on our Native American reservations one of the biggest problem we have is the credentialing of the providers. Please address. To work in an Indian Health Facility, all someone needs is a legitimate license in some place in the country. If a Native American reservation wanted a dental hygienist who was appropriately licensed in Minnesota, could they practice at the tribes?

Representative Nelson stated he is not an expert and deferred.

Rachelle Gustafson, President of the North Dakota Dental Hygienists Association, testified IN FAVOR of SB 2354 (attach #4). Also provided document North Dakota Public Health Association - Access to Oral Health Care (attach #5) (19:40-26:41)

Senator Howard Anderson, Jr. obviously the dental hygienist in the state think they'll find enough supervising dentists someplace even though most of the dentists that he hears from are against the bill. Please comment.

Ms. Gustafson stated it will take time, but they do believe it will start with a few dentists and grow in popularity.

Senator Dever asked if Ms. Gustafson could share the educational requirements for dental hygienist and what the additional education requirements are for advanced practice.

Ms. Gustafson stated at this point, the education levels will need to be set by the board of dental examiners, so they are unaware of what those criteria will be. We encourage that the board make it a master's degree level of program. North Dakota currently has no program for this in the universities, so they hope to take advantage of surrounding states and follow their standards and education.

Senator Dever how many dentists are there in North Dakota and how many hygienists?

Ms. Gustafson 140 dental hygienists, about 450-500 dentists in North Dakota. (The number of 140 dental hygienists was corrected in later testimony).

Senator Axness this CODA (Commission on Dental Accreditation) was approved last Friday (refer back to attachment #19). How many states have moved forward with this proposal?

Ms. Gustafson there are 2 states have mid-level licensed providers: Minnesota and Maine. Multiple other states that have legislation going through right now. Kansas and New Mexico and a few others are looking at this. Chairman Judy Lee indicated possibly Texas.

Senator Axness followed-up, that testimony given talks about general supervision of a dentist. Please elaborate.

Ms. Gustafson general supervision is the dentist has authorized in advanced to provide treatment. There would be guidelines, which would be set forth in the collaborative agreement as to what the dentist feels comfortable with their advanced practice dental hygienist. The hygienist will be able to do the services without the dentist being on site. They feel it is important that there be a way to communicate with dentist, tele-dentistry for example. Also with general supervision, it would be a dentist who would work with someone they are already comfortable with and understands that person has good judgment.

Dr. Leon Assael, Dean, University of Minnesota School of Dentistry, testified IN FAVOR of SB 2354 (attach #6) (31:25-36:47)

Chairman Judy Lee asked do you find that there has there been additional outreach into northwestern Minnesota?

Dr. Assael affirmed yes, and further testimony will provide a map of Minnesota of areas served. The distribution of dental therapists is far greater to be in underserved areas and into rural areas than dentists. It is an outsized effect. Our goal is for small communities and communities with high disease rates but not high personal incomes to make that dental practice viable and make that dental practice a resource to that whole community that elevates and economically advances that whole community.

V. Chairman Oley Larsen when looking at the procedures in the bill that they can do, in the classroom training, are they doing all of these procedures, or more?

Dr. Assael stated the dental therapists in Minnesota, while the primary treatment is for tooth decay. They are also educated to remove lose teeth, realign dentures, also educated to assess patients and refer to dentists for needs of patient. Historically, the hygienist came as a means for the public taking care of gum disease. A dentist could not afford to do what a dental hygienist does. They would have to charge 3 times the cost compared to dental hygienist. Just as we had this for gum disease, we have this need for tooth decay.

Senator Axness in North Dakota, we have loan repayment program that targets dentists who will serve underserved areas. If we go forward with this program, and hopefully get hygienists to be master's degree, would you see people going the extra education to become a full dentist who would utilize the repayment program in favor of this?

Dr. Assael stated the debt for a dentist is $216,000 in Minnesota, and nationally it is approaching $300,000. The debt for a dental therapy graduate is $54,000. They didn't have the same front end costs. To get into dental school today is at least four years, the average for their dental students is six years before starting dental school and the average dental student is age 25. It is a highly competitive field. Not everyone wants to be a dentist or physician. Some are devoted to the crafts of dentistry, but don't want the responsibility of the dentist. Given privileges to do what you can safely do.

Chairman Judy Lee the interdisciplinary education you do, as a result of that interaction, are there any parallels in dental care and using physicians and nurse practitioners and physician assistants?

Dr. Assael stated it is very similar. Person doing the different health care services may not be done by a physician today. Physicians have not suffered from that system, but have benefited. The doctors still provide most comprehensive service to the patients. 35.4% of age 19-64 saw a dentist in the past year, and if you completed a treatment plan, that would be 50% of those. We have a system that is built for a very small segment of the population. It was the same way with EMT's. In 1986, an EMT could not do CPR. The outcomes allow the physicians to do more specialized work. This can create a better success as a team approach.

Dr. Don Warne, Director, Master of Public Health at NDSU, testified IN FAVOR of SB 2354 (47:20-51:33) testified via phone. (attach #7)

Chairman Judy Lee asked if someone is licensed in another state, can they practice in North Dakota reservations.

Dr. Warne indicated yes, they must be licensed in any state.

Chairman Judy Lee how does this affect this bill

Dr. Warne it opens the door more wide open if we have access to these type of providers. Under Medicaid, we need recognized provider, with tribal sovereignty, it does provide new opportunities. These are the population with the worst health status.

Josh Askvig, AARP, testified IN FAVOR of SB 2354 (attach #8) (ends 54:47)

Mike Tomasko, testified IN FAVOR of SB 2354 (attach #9) (54:47-1:01:36)

Dr. David Gesko, President and dental director of HealthPartners Dental /President of the Minnesota Board of Dentistry, testified IN FAVOR of SB 2354 (attach #10) (1:02-1:08:18)

Dr. Gesko corrected that instead of 140 dental hygienists in North Dakota, there are 740 dental hygienists.

Senator Axness asked how long have the advanced practice dental hygienists been practicing in Minnesota.

Dr. Gesko stated that it the first graduating class was in 2011.

Senator Howard Anderson, Jr. asked the history of where dental board in Minnesota was when regulations were originally passed.

Dr. Gesko was not on the board when this occurred in Minnesota but was present in the state. After it was passed legislatively, it was given to the board of dentistry to see that it became in practicality and that the rule and statute had to be created, that intent became reality.

Senator Howard Anderson, Jr. was the Dental Board opposed in Minnesota?

Dr. Gesko stated that the Dental Board didn't take position on that. Since it was passed through legislature, intent was that it be followed through rule and statute.

Sarah Wovcha, Executive Director, Children's Dental Services in Minnesota, testified IN FAVOR of SB 2354 (1:10:17) (attach #11). Also distributed powerpoint Dental Therapy in Minnesota: A Study of Quality and Efficiency Outcomes (attach #12). (1:10:17-1:17:14)

V. Chairman Oley Larsen looking at handout, 99% had incomes below federal poverty level, and 19% were uninsured. Before a patient comes or after they receive services, are they enrolled into the marketplace for insurance?

Ms. Wovcha we do, we are considered a medical assistance outstation so our outreach workers are training and assisting in obtaining medical assistance. The reality is that there are still a significant number who are uninsured. The consequence of the Affordable Care Act, even though more people are on medical assistance, it has not increased the providers who will provide medical assistance. So some of the most difficult to serve are coming to them.

Chairman Judy Lee clarified that V. Chairman Oley Larsen was referring to the federal exchange and purchasing subsidized insurance which does include pediatric dental care?

Ms. Wovcha we are working with them to get some kind of insurance on the exchange. But not everyone has been eligible and some of the insurances through the exchange are expensive and out of pocket is very high.

Chairman Judy Lee if so many under 100% of poverty, they don't hit the 138% for what the exchange requires, they would be through expanded Medicaid. Correct?

Ms. Wovcha correct.

Written testimony by **Colleen M.Brickle**, Dean of Health Sciences at Normandale Community College in Bloomington, Minnesota (attach #13)

OPPOSITION TO SB 2354

Senator Brad Bekkedahl, District 1, testified OPPOSED to SB 2354 (attach #14) (1:20:50-1:26:20)

Brent L Holman, DDS, Executive Director of North Dakota Dental Association, testified OPPOSED to SB 2354 (attach #15, pages 1 through 8) (1:26:20-1:29:10) **Chairman Judy Lee** interrupted Dr. Holman's testimony, providing a correction to Dr. Holman's testimony, regarding the study and University of North Dakota. Chairman Judy Lee stated that UND did the study, PEW provided the money and had nothing to do with the study at all. They were not given the information; it was an independent study and it is important that the credibility of the UND study not be, in your view, tarnished because there would have been some financial support from PEW. Testimony continued. (1:29:36-1:37:50)

Chairman Judy Lee asked for elaboration with tribal programs. Chairman Judy Lee acknowledged that she appreciates the dentists who have helped. She asked if those are a one-time effort. What has happens to the children regarding regular dental services?

Dr. Holman stated those events are not the solution with the problem. They are a way for developing a relationship and some collaboration with the dental community. In Spirit Lake and Standing Rock, they identified 60-to-70 children who needed specialty care, and in the next year, half of those children were able to get treatment. Besides immediate benefit for

helping those kids, there was some momentum that created renewed motivation to think about dentistry. Is it a solution - not at all, but it is a way to get out there and make some different with a population that drastically needs help. The system is a way to start. We can do what we can. Collaborative solutions are the best at this time.

Senator Axness stated that this bill focuses on workforce development. We've seen student loan repayment program to encourage dentists to go in the rural underserved areas. Do you see this bill to encourage other professionals to go back to underserved population? The bill before us is to expand care but also workforce on reservations, it is an alternative to loan repayment. Do you see that people will utilize this program in North Dakota?

Dr. Holman doesn't know. We can learn from other states before we implement this. The loan repayment is a tangible thing that has benefited North Dakota greatly. We may not have that tool in the future. The loan repayment program has made a huge difference for targeted rural small communities. The results of the marketing is twice as many people from North Dakota are in dental school. There is insufficient evidence for North Dakota at this point to support this bill.

V. Chairman Oley Larsen on the section of bill when talking about tribal sovereignty, and one of the forums to access by credential, will that make it easier for dentists to get on the reservation, or will not help because of the certification paperwork.

Dr. Holman the certification process is an Indian Health Services requirement. Collaboratively, that starts with each tribe. There are ways to make that specific to that tribe and eliminate that barrier.

Chairman Judy Lee section 14 doesn't have to do with Indian Health Services, but recognizing tribal sovereignty so that they can hire licensed professionals who are recognized in jurisdictions other than the State of North Dakota to practice on the reservation.

Paul Tronsgard, President of North Dakota Dental Association, testified OPPOSED to SB 2354 (continued in attachment #15 - Page 8 through 27) (1:44:20-1:49:15). Also provided written testimony from **Brenda Schmid** (attach #16).

Chairman Judy Lee asked a question relating to education and dental assistants. There is a perceived shortage of dental assistants in the state. When asking dentists why this is so, they respond that they have to pay hygienist more. Chairman Judy Lee stated her concern that dental assistants have no requirement for academic training. Find a real paradox that we don't want having someone with a master's level for hygienist but it's okay for dental assistant with no academic requirements.

Dr. Tronsgard responded that the State doesn't require it for the dental assistant. Hygienists do work independently in their office while Dental Assistants is chair side with the Dentist.

Chairman Judy Lee do we know where the new dentists are located? We didn't have information where they are located. Also, are licensed dentists not actively practicing included in the numbers?

Dr. Holman responded in regards to dental assistants having chair-side training versus academic training, North Dakota has been a little different forever because of the rural nature. There was a need for dentist in rural areas for someone to assist them. The concept of an office trained assistant was necessary and mandatory, otherwise there would be no dental services there, so that was the basis of a dental assistant - office dental assistant, but vast majority are registered and certified. There is a program where you can get training, but in many cases, they still require passing the certification. Most dentists will agree there isn't a big difference between those who are certified through education and desk certified. It is not ideal. If they could develop programs that supports the training of assistants, the dentists would all love to see that they have academic training that goes along with their clinical training.

Chairman Judy Lee isn't suggesting that they eliminate dental assistants, but suggesting that when she hears they aren't required to have academic training is because the State doesn't require it, so maybe we need to amend this bill to require academic training for all dental assistants. Why wouldn't the profession step up and say that they recognize that everybody who learns more and do more, and is better at what they do.

Dr. Holman agreed with that, but thinks that a pre-requisite that you have to make sure there are enough assistants in the workforce and programs in the western part of the state to meet that demand so that you can do that in a very efficient pragmatic way. Currently, there is not enough capacity of folks to do that. We need to improve the ability to train for the program before we make those steps.

Chairman Judy Lee stated that we could find Long Term Care facilities and critical access hospitals in the state who would also say, does that apply to LPN's then? How is the argument different?

Senator Axness referred to Chairman Judy Lee question regarding the number of dentists on the map. Does that include those not practicing but still licensed.

Dr. Holman hard to find a good answer to that.

Chairman Judy Lee either a yes or no. Are they practicing or not?

Dr. Holman different ways of looking at the data. If looking at board of dental examiners, they look at number of licenses in the state. It doesn't necessarily mean they are practicing. When he looks at American Dental Association data, they have a definition of those who are actively practicing in dentistry. In talking about this bill, if you have under general supervision a collaborative practice dentist, you may not need to have a practice but just a license. This is a concern.

Chairman Judy Lee you are counting them as a licensed dentist in North Dakota? It appears you get it both ways.

Senator Dever my sponsorship of the bill does not have any intention of any indictment of the dental profession. In Dr. Tronsgard testimony, he stated the best alternative is to challenge the dental profession to produce results with collaborative solutions, and Senator Dever is intrigued by the 10 solutions that were put forward. Is that an ongoing discussion or was that a result of this initiative?

Dr. Holman from a personal perspective, he has been involved in the last 20 years of his career. Those of us who are involved in this and what we have been doing and what we will continue to do, with the evidence we have, those collaborative solutions mean something. This is evolving. Collaborative solutions are better for North Dakota.

Senator Dever in Dr. Holman testimony, would you feel more comfortable if we were 12th or 13th state versus 4th. Are you open the idea at some point?

Dr. Tronsgard regarding this, we have been asked to keep an open mind, and we ask that the proponents also have an open mind. Our message today is that until we see enough evidence to show that it might work in a state like North Dakota with the needs we have here, keeping in mind that Maine hasn't put any into practice yet and take Alaska out of the mix because they have a different model, we are using Minnesota data only to make this decision. We are asking to slow the process down until we have more information to support it. Meanwhile, we have 10 points that we provided in testimony that we need to look at. If we can get collaboration on the 10 points, we can move forward.

Senator Dever stated that with this bill, the dental hygienist would act under the board, licensed standards under the board, they would not work independent of a dentist. Doesn't that put the dentist in the driver seat?

Dr. Tronsgard indicated that it allows an advance practice dental hygienist to work in a remote location with the only tether being that contract or collaborative management agreement with the dentist. It it does not provide the patient a dental home. There is the potential for the patient is not connected to a dentist at all. The number one way to reduce dental morbidity is to get patients in a dental home.

Senator Dever wouldn't that comply that a dentist allowed a hygienist to work in that situation.

Dr. Tronsgard yes it would.

Senator Howard Anderson, Jr. commented, his personal preference would be that the dental association and dental board was bringing this bill forward and written it the way they liked it for the supervision of the advanced practice hygienist. He can see some problems with this bill. Minnesota states you have to serve in underserved population. We would like to see some action proactively to try to solve the problems in the future.

Chairman Judy Lee restated that she appreciate the dentists, no indictment against them, but do ask hard questions in the most respectful way. It shouldn't be hard to find out how many dentists there are practicing in North Dakota. During the interim, many of the

stakeholders on both sides did not listen to what the other side had to say. The people who support and oppose need to listen and collaborate. It is not a reflection in any way for the dentists who do good with outreach.

Rob Lauf, serving as President of the North Dakota State Board of Dental Examiners, testified OPPOSED to SB 2354 (attach #17) (2:06:40-2:13:20).

Senator Warner seems that one of the concerns is the idea that some dentist somewhere would front himself and set up this practice of entirely mid-level practitioners. Would it make any difference to your organization that it be a practicing licensed dentist in North Dakota? Or limit the number of mid-level practitioners to two or three?

Dr. Lauf can't give honest answer - board would have to look at that. In regards to the question, aren't dentists in the driver seat - we have never been in the driver's seat of this issue. We should be in the driver's seat of the issue and look into it rather than respond to it.

Senator Dever acknowledging you are in the driver's seat, are you going to be neutral or against.

Dr. Lauf if passed, we will be forced to be in the driver's seat. This is flawed. His register of dental assistants would be offended if it was said they weren't educated. They are required to have 2,000 hours of office training, and require same hours as those who have certification. Conflicting things - here's the bill, hygienist would like to be master's degree, but no mention of it in the bill. Board of dental examiners will have to respond to make sure we have public safety.

Senator Dever question of master's level or not is in your hands.

Dr. Lauf indicated they would have to ask legislative council, response from attorneys what the intent was. Master's degree would be great. Wahpeton only offers a 2 year program, with roughly 20 hygienists per year. The Dental assistant program has 12 students. A small number of the dental assistants proceed to the hygienist program. There would have to be collaboration with Board of Higher Education to set up curriculum, would have to run through that hoop first. Not something that can be decided in 2 weeks. You could be 3-to-4 years out if this bill passes.

Senator Dever asked if there were amendments, is there an iteration of the bill you could work with.

Dr. Lauf as it stands, no. The Board of Dental Examiners have put administrative rule change to expand the work force with the current work force module that they have with the dental assistants and dental hygienists. The difference between the two of the dental therapists is and dental assistants, we are not doing the expanded workforce is to expand increased efficiency - we are not cutting teeth, we are not doing surgical procedures, we are trying to create efficiency in the dental team. The Board of Dental Examiners has been working for nearly 2 years to increase workforce to help increase the access to care. The other question is who is going to assist the dental hygienist? If we are going to put in

legislation that they (dental assistants) need education, who is going to assist them. You cannot work on a child without an assistant.

Chairman Judy Lee that Dr. Tronsgard mentioned as one of the solutions that one of the barriers was inadequate education of families on good oral health. It is one of the areas that the mid-level feel they can visit with the families and provide further information. Who are the members on your board, how many are dentists?

Dr. Lauf there are 7 members on the Board of Dentistry, 5 are dentists, 1 lay person, 1 dental hygienist. The board was not unanimous; the dental hygienist opposed the board standing.

Chairman Judy Lee the information that she had received about dental accreditation indicates they had the established standards in place for mid-level and they are used in other areas in the world. A dentist wouldn't have to hire an advanced dental professional.

Dr. Lauf absolutely correct, but does that solve the access to care? It doesn't solve that issue. Let's work with the members that we have and expand the functions that we can, and follow national progression.

Senator Dever would it be easier to set an effective date in the future?

Dr. Lauf stated an inferior product will result with a non-obtainable date.

Chairman Judy Lee restated that it does put the responsibility with Board, the details are left to them in a good way. What is the financial reserve balance in the Board?

Dr. Lauf reserves are $300,000. That is what they use to pay for attorneys, disciplinary, legal counsel, etc.

Chairman Judy Lee asked if there are other funds?

Dr. Lauf stated the reserves are now $300,000. The operating budgets have about $218,000. They are front heavy with their income, meaning their income is solely on licensees. **Chairman Judy Lee** stated that is the case with all boards. Dr. Lauf continued - Every two years, it depends when you look at the dollar amounts. They just licensed 458 dentists, they will have a lot of money on February 1 compared to 2 years from now.

Chairman Judy Lee does the board do electronic dental records?

Dr. Lauf the dental profession is not quite there yet with HIPAA.

Dr. Carrie Orn, dentist, testified OPPOSED to SB 2354. (attach #18) (2:25:34-2:30:40)

Senator Dever stated that where he goes for his dental practice, he assumes it is typical to those across the state. If his dental hygienist was able to do more, wouldn't that be a benefit to him.

Dr. Orn true, but this bill is introducing a new position. As Dr. Lauf had stated in his testimony, we are trying to do and implement advanced practice in what we have now. We are not trying to introduce a new therapist. It is extremely hard to find assistants today. One is certified and registered, and one will learn chairside. To compare the procedures of a dental therapist and certified dental assistants is not a clear showing of what would be done. It would help in certain ways. It is too early, brought up different way, and we are trying in different ways that may not be broadcast well today.

Senator Dever if we didn't have the bill, but dental profession had an interest in moving in that direction, would they be more proactive and come forward.

Dr. Orn yes

Senator Dever so you could see an expanded role for a dental hygienist?

Dr. Orn responded that she is not on the dental examiner board so she deferred.

Chairman Judy Lee stated that one of the things proposed for the administrative rule process is an additional procedure that would permitted for dental assistants, and the dental hygienist object. It is a tiny step, cleaning above gum line doesn't necessarily mean as being taken care of below gum line, there is an objection. If you can't find dental assistant, why not hire a dental hygienist.

Dr. Orn responded that it is very hard to find the dental hygienist. Perhaps in Fargo they are there, but looking for assistants and hygienist are very difficult to find.

No More Opposition

NEUTRAL TESTIMONY FOR SB 2354
No neutral testimony provided.

Senator Howard Anderson, Jr. asked, if a tribe in North Dakota or Indian Health Services brought an advanced practice dental hygienist from Minnesota, would that provider be eligible for reimbursement through Medicaid in North Dakota?

Mr. Eric Elkin, deputy Medicaid Director for the Department of Human Services, answered. No. They can only reimburse Medicaid providers who are enrolled in North Dakota to provide services in North Dakota.

Closed public hearing.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2354
2/16/2015
23930

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to advanced practice dental hygienists and practice on Indian reservations; relating to advanced practice dental hygienists and the practice of dental-related fields on Indian reservations; to provide a penalty; and to provide a report to the legislative management and the administrative rules committee.

Minutes:

Attach #1: Proposed Amendment by Sen. Axness
Attach #2: Proposed Amendment #1 by Sen. Dever
Attach #3: Proposed Amendment #2 by Sen. Dever
Attach #4: Proposed Amendment #3 by Sen. Dever
Attach #5: Proposed Amendment #4 by Sen. Dever

These are minutes from Senate Human Services Committee on February 16, 2015.

Chairman Judy Lee invited Dr. Donald Warne to the podium. **Dr. Donald Warne** restated the need for access of dental care in the tribal communities, with a shortage of providers. He commented that having Advanced Practice Dental Hygienists would be a good step to serve the underserved populations. In prior testimony, there was concern about irreversible procedures, but there are non-physician and non-dentist who do irreversible procedures every day, such as emergency medical technicians. There is a huge silent majority who need services and need more access to services.

Chairman Judy Lee asked about the section that addresses the sovereignty of tribes and for reimbursement purposes those who licensed in another state other than North Dakota.

Dr. Warne answered that within Indian Health Services there is reciprocity with licensure, meaning if a provider is licensed in South Dakota, they can work in Indian Health Services in North Dakota or any other state. The challenge is if Medicaid doesn't recognize the provider type in a particular state, even if they are licensed and recognized by Indian Health Services, it is still not billable. We are looking for billable services for advanced practice dental hygienists.

Chairman Judy Lee with the way the law is today, they would not be. **Dr. Warne** confirmed that is correct.

V. Chairman Oley Larsen stated in prior testimony, there was a dentist who was a provider in Trenton. He indicated that his office was going to shut down unless a dentist came up, and the local community supported him to stay. How many on the reservations of the local folks are dental hygienists, how many are going through Wahpeton and want to return to the tribe.

Dr. Warne doesn't know the counts. We have more dental assistants then hygienists, and more hygienists than dentists. By having an additional provider type that is billable is also a training and workforce opportunity for tribal populations.

Chairman Judy Lee as long as they are accredited in some way by the Board of Dental Examiners in North Dakota, they are permitted to practice on the reservations and get reimbursed. But an Advanced Practice Dental Hygienist cannot because they would not be licensed in North Dakota at this point. **Dr. Warne** confirmed yes.

NOTE: In this recording, the Senate Human Services Committee now discusses SB 2066, which is a related bill. (6:24-33:00).

(34:25)
Senator Axness has proposed amendment for discussion (attach #1). Read through the amendment (37:15)

Chairman Judy Lee suggested that the Senate Human Services Committee also take a look at the tribal component which Dr. Warne discussed with the reimbursement. We have no control over what the sovereign nations do but we do have control over how they may be reimbursed.

The Senate Human Services Committee discussed some of the suggestions from **Senator Axness** proposal.

- **V. Chairman Oley Larsen** expressed his concern that under Section 2.d "the dental hygienist may direct bill," the dental hygienist would be under the umbrella of the dentist so they would bill through the dentist. **Senator Axness** agreed.
- **Chairman Judy Lee** reviewed the term indirect supervision versus general supervision.

Senator Howard Anderson, Jr. asked for clarification from the Dental Board in regards to their definition of general versus indirect supervision.

Ms. Rita Sommers, Executive Director of the North Dakota State Board of Dental Examiners, stated that the board does have specific definitions regarding direct, indirect, and general supervision in 20.01.02 statute. She does not see a conflict in the collaborative language. Direct Supervision is the dentist looks at the procedure prior to the procedure being completed and after the procedure. Direct supervision means that dentist is directly there. Indirect supervision means the dentist is in the facility, but not necessarily looking over dental hygienist. General supervision is where dental hygiene and assistant for a few procedures and dentist is off the premises (or hygienist is off the premises). They are authorized to do that under the current statute.

Chairman Judy Lee returned back to the bill. She read through the bill. (ends 52:07)

Recess

Senator Dever provided four additional proposed amendments.

- Proposed Dever Amendment #1 would push back the dental board report. It would remove the requirement for the coming biennium and require the report in the following biennium (attach #2).
- Proposed Dever Amendment #2 delays the implementation of the act, which would allow the Board and the Association more time to work with this and come back in the next legislative session and provide insight in how it will work. (attach #3).
- Proposed Dever Amendment #3 limits the number of Advanced Practice Dental Hygienists to up-to-three APDH hygienists to address large corporate dental organizations (attach #4). **Senator Warner** suggested that it should be practicing dentists and not just licensed.
- Proposed Dever Amendment #4 are technical cleanup language (attach #5).

Senator Warner expressed his concern about restricting the Advanced Practice Dental Hygienists to remove and underserved areas. He thinks this is a poor idea. There are times for close collaboration, working with dentist even in urban settings and then go out. There would be better comfort if they understood each other's abilities and worked together.

Chairman Judy Lee continued on this idea, because in Minnesota, they did put a provision in that stated it has to be in a practice that serves a certain percentage of people who are on Medicaid or uninsured, and it can then become too tiered. This is a restriction on business practice.

Senator Dever noted that nobody wants to compromise quality of care. If we are going to utilize advanced practice dental hygienists, we don't want to over-restrict.

Senator Axness further reviewed his proposed amendment (attach #1). This was drafted in haste, and there are some areas that need to be changed.

- Subsection 2.a - it states the patient would have to see a dentist before they see an advanced practice dental hygienist. That was not his intent. The real intent was that after 12 months of seeing the advanced practice dental hygienist, they then have to be part of the dental home.

Senator Howard Anderson, Jr. asked if there would penalty be toward patient or dentist if they don't show up within 12 months. The committee had no recommendations on resolving this.

Rod St. Aubyn suggested might "may adopt rules" under this section. He suggested that something be included that states the Board must establish rules within some identified timeframe. They would then need the authority where they can change those rules, which is reasonable.

Senator Howard Anderson, Jr. asked for information from **Dr. Warne** regarding instances where the advanced practice dental hygienists are being used on reservations in Minnesota. **Dr. Warne** stated he was unaware of any in Minnesota. He is aware of some

in the State of Alaska under a different model. **Chairman Judy Lee** stated that the State of New Mexico is looking at this for reservations. **Senator Dever** further asked if there have been efforts to establish the advanced practice dental hygienists on reservations in Minnesota. **Dr. Warne** was unaware of any efforts.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2354
2/17/2015
24000

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to advanced practice dental hygienists and practice on Indian reservations; relating to advanced practice dental hygienists and the practice of dental-related fields on Indian reservations; to provide a penalty; and to provide a report to the legislative management and the administrative rules committee.

Minutes:

Attach #1: CODA Approved Educational Standards Comparison Chart
Attach #2: Electronic submission by Cheryl Rising

Rod St. Aubyn provided a handout, Commission on Dental Accreditation (CODA) Approved Educational Standards (attach #1). He explained the columns in the handout:

- First Column are the CODA approved procedures.
- Second Column is if those procedures are considered irreversible
- Third Column that identifies if the CODA procedure is considered to be included in SB 2354, or if it is already in the North Dakota hygienist scope of practice. As explained to the committee, if there was a "YES" in the third column, these are the procedures that are being expanded with SB 2354. There are 14 new procedures in the expanded list; 6 which are irreversible.

Mr. St. Aubyn further indicated that additional education would be required of the Advanced Practice Dental Hygienist before they could do the expanded procedures.

V. Chairman Oley Larsen recalled that we had some testimony from a hygienist that they wanted to practice to the height of their practice. Working at the height of their scope, they still would not be able to do an extraction today.

Mr. St. Aubyn wasn't sure if that would be the anesthetic for adults but not for children. Mr. St. Aubyn reminded the committee that the scope of practice is sometimes limited by the dentists themselves. That would also be true of the advanced practice dental hygienists. It is a collaborative agreement between dentist and hygienist and the dentist has that decision.

Senator Howard Anderson, Jr. questioned if there are any current dental hygienists that have the education and training to qualify for the Advanced Practice Dental Hygienist.

Mr. St. Aubyn answered that we don't. The Dentist Board would need to establish the education credentials. These have not been defined, so this will not happen overnight. A helpful guidance will be the CODA accreditation requirements. There is interest by the dental hygienist to advance into this category.

Chairman Judy Lee noted there are North Dakota students who attend the University of Minnesota who may have interest in returning to North Dakota.

Mr. St. Aubyn agrees, but the board would still have to adopt the rules. **Chairman Judy Lee** indicated they wouldn't have to wait 4 years after the board completes the rules, because those who are in school now will be able to start once the rules are complete.

Mr. St. Aubyn confirmed. There are also practicing dental therapists in Minnesota that are already trained that may elect to provide services in North Dakota once the rules are established.

Chairman Judy Lee then went through discussion on the proposed amendments which were previously discussed as the Dever Amendments (prior committee discussion). (12:33). Suggested changes to these proposed amendments include the following.

- Proposed Dever Amendment #1 would push back the dental board report. It would remove the requirement for the coming biennium and require the report in the following biennium. The committee supported.
- Proposed Dever Amendment #2 delays the implementation of the act, which would allow the Board and the Association more time to work with this and come back in the next legislative session and provide insight in how it will work. The committee recognized that the Legislative Management may need to tweak the sections and language to support this. The committee supported.
- Proposed Dever Amendment #3 limits the number of Advanced Practice Dental Hygienists to up-to-three APDH hygienists to address large corporate dental organizations. It was previously suggested that it should be practicing dentists and not just licensed. Final decision was to leave it as "dentist", as this is the board's definition. The committee supported.
- Proposed Dever Amendment #4 are technical cleanup language. The committee supported.

Senator Dever moved to ADOPT AMENDMENT with the proposed Dever Amendments. The motion was seconded by **Senator Warner**.

Roll Call Vote to Amend
6 Yes, 0 No, 0 Absent. Motion passes.

Chairman Judy Lee then reviewed **Senator Axness** proposed amendments to insure that nothing was missed.

V. Chairman Oley Larsen did like the Axness Amendment letter (e) where the dental hygienist needs professional liability insurance. He is not sure if the dentist carries the umbrella professional liability insurance that would cover the advanced practice dental

hygienist. **Chairman Judy Lee** and committee members indicated it is not required for other professions.

V. Chairman Oley Larsen continued. He questioned if it is clear that the person will be connected to a dental home. **Chairman Judy Lee** stated it relates to SB 2066 with dentist of record. The general supervision by a dentist is already in the bill.

V. Chairman Oley Larsen next discussed if it should be restricted to rural communities or underserved areas. **Senator Warner** restated that he has problems with restricting to rural - restricting to a lesser degree of care versus their need. He prefers the idea of active collaboration with dentist for part of the time and proximity - it is an actual partnership. **Chairman Judy Lee** confirmed that she agrees with Senator Warner. In original bill on page 6, it talks about under general supervision of a dentist, and in accordance with collaborative agreement, that solves that issue. It goes without saying that the dentist will set the rules for the collaborative agreement - if the dentist decides not to have an advanced practice hygienist or to do certain things, that would be up to the dentist.

Senator Axness reiterated that the intent of his proposed amendments was to provide another alternative to utilize and expand services. As far as rural and tribal areas, this bill will go toward solving rural and tribal areas. He doesn't disagree with Senator Warner so he shares the concern, but the focus was on that issue.

Senator Dever indicated that if this passes, it will allow them to work on things for the next session - it will provide a study to work together with legislative committee as they see necessary, and the bill as drafted puts them into the driver's seat.

V. Chairman Oley Larsen moved a DO PASS to SB 2354 AS AMENDED. The motion was seconded by **Senator Warner**.

Discussion

Senator Axness voiced his concern that he was not confident that the delay is sufficient. There are only two other states where this is in practice, and his opinion is that there is not enough time to feel comfortable.

Chairman Judy Lee responded that, as Senator Dever had stated, the bill goes into 2018, where there will be another legislative session between then and now, and provides time for the Board of Dental Examiners to establish rules and still bring forward recommendations to the next legislative sessions.

Senator Dever offered that passing this bill provides a statement that we believe there is an opportunity to expand services and it provides the dentists to be in the driver's seat.

Chairman Judy Lee also reminded the committee that this allows the expansion in the tribal areas if we allow licenses from another state.

Senator Howard Anderson, Jr. reminded the committee that he had asked during the hearing and all following testimony if there was an Advanced Practice Dental Hygienist

practicing on a Minnesota reservation, and no one could affirm. The passage of this bill may be a hope of over anticipation.

Senator Dever responded that if we don't pass, we know it won't happen.

V. Chairman Oley Larsen this continues to come up during his 4 year tenure. In the interim, we did have lady from Alaska on what they are doing. It comes down to you have to get someone on the ground on the reservation. Right now they aren't there. 2018 is another 4 years. V. Chairman Oley Larsen stated how long do we have to wait until we at least let the process go forward.

Roll Call Vote to DO PASS AS AMENDED
4 Yes, 2 No, 0 Absent. Motion passes.

Senator Dever will carry SB 2354 to the floor.

Electronic email submission by **Cheryl Rising** (attach #2)

1 of 2
TD
2/18/15

15.0848.01002
Title.02000

Adopted by the Human Services Committee

February 18, 2015

PROPOSED AMENDMENTS TO SENATE BILL NO. 2354

Page 1, line 7, remove the first "and"

Page 1, line 8, after "committee" insert "; and to provide for application"

Page 6, line 23, after the second "practice" insert "advanced practice"

Page 9, line 29, after "the" insert "advanced practice"

Page 12, after line 3, insert:

"8. Limit the number of advanced practice dental hygienists a dentist may supervise, but may not limit a dentist from supervising up to three advanced practice dental hygienists."

Page 12, remove lines 10 through 30

Page 13, replace lines 1 through 13 with:

"SECTION 17. STATE BOARD OF DENTAL EXAMINERS STUDY - REPORT TO LEGISLATIVE MANAGEMENT.

1. During the 2017-18 interim, the state board of dental examiners shall use the evaluation process designed under subsection 2 to evaluate the impact of the use of advanced practice dental hygienists on the delivery of and access to dental services. Before August 1, 2018, the board, in consultation with the department of human services, shall report to the legislative management:

   a. The number of advanced practice dental hygienists licensed annually by the board;

   b. The settings at which licensed advanced practice dental hygienists are practicing and the populations being served;

   c. The number of complaints filed against advanced practice dental hygienists, the basis for each complaint, and the outcome of the complaint;

   d. The number of disciplinary actions taken against advanced practice dental hygienists and the infractions for which disciplinary action was taken; and

   e. The number and type of dental services performed by advanced practice dental hygienists and reimbursed by the state under any state health care program.

2. The board shall develop an evaluation process that focuses on assessing the impact of advanced practice dental hygienists in terms of patient safety, cost-effectiveness, and access to dental services. The process must focus on the following outcome measures:

a. The number of new patients served, their insurance status, and whether they are located in a dentist shortage area;

b. The reduction in waiting times for needed dental services;

c. The decreased travel time for patients;

d. The impact on emergency room usage for dental care; and

e. The costs and savings to the public health care system.

3. During the 2015-16 interim, the board shall report to the administrative rules committee on the status of implementation of this Act and the status of any administrative rules necessitated under this Act. Until this Act is fully implemented and the board has adopted rules necessitated under this Act, at each meeting of the administrative rules committee held during the 2015-16 interim, the administrative rules committee shall receive a report from the board on the status of implementation of this Act.

SECTION 18. APPLICATION. The board may wait to develop rules necessary to implement and enforce this Act until August 1, 2016, if the board by majority vote determines that additional information necessary to protect the public interest will become available before the date. However, the board shall work diligently to adopt rules to implement this Act."

Renumber accordingly

Date: 02/17 2015
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2354

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: (Dever Amendments): 15.0848.01002 Title .02000

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

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Dever Seconded By Warner

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

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

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

Date: 02/17 2015
Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2354

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0848.01002 Title.02000

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

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Larsen Seconded By Warner

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

Total (Yes) 4 No 2

Absent 0

Floor Assignment Dever

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

REPORT OF STANDING COMMITTEE

SB 2354: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (4 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). SB 2354 was placed on the Sixth order on the calendar.

Page 1, line 7, remove the first "and"

Page 1, line 8, after "committee" insert "; and to provide for application"

Page 6, line 23, after the second "practice" insert "advanced practice"

Page 9, line 29, after "the" insert "advanced practice"

Page 12, after line 3, insert:

"8. Limit the number of advanced practice dental hygienists a dentist may supervise, but may not limit a dentist from supervising up to three advanced practice dental hygienists."

Page 12, remove lines 10 through 30

Page 13, replace lines 1 through 13 with:

"SECTION 17. STATE BOARD OF DENTAL EXAMINERS STUDY - REPORT TO LEGISLATIVE MANAGEMENT.

1. During the 2017-18 interim, the state board of dental examiners shall use the evaluation process designed under subsection 2 to evaluate the impact of the use of advanced practice dental hygienists on the delivery of and access to dental services. Before August 1, 2018, the board, in consultation with the department of human services, shall report to the legislative management:

   a. The number of advanced practice dental hygienists licensed annually by the board;

   b. The settings at which licensed advanced practice dental hygienists are practicing and the populations being served;

   c. The number of complaints filed against advanced practice dental hygienists, the basis for each complaint, and the outcome of the complaint;

   d. The number of disciplinary actions taken against advanced practice dental hygienists and the infractions for which disciplinary action was taken; and

   e. The number and type of dental services performed by advanced practice dental hygienists and reimbursed by the state under any state health care program.

2. The board shall develop an evaluation process that focuses on assessing the impact of advanced practice dental hygienists in terms of patient safety, cost-effectiveness, and access to dental services. The process must focus on the following outcome measures:

   a. The number of new patients served, their insurance status, and whether they are located in a dentist shortage area;

   b. The reduction in waiting times for needed dental services;

c. The decreased travel time for patients;

d. The impact on emergency room usage for dental care; and

e. The costs and savings to the public health care system.

3. During the 2015-16 interim, the board shall report to the administrative rules committee on the status of implementation of this Act and the status of any administrative rules necessitated under this Act. Until this Act is fully implemented and the board has adopted rules necessitated under this Act, at each meeting of the administrative rules committee held during the 2015-16 interim, the administrative rules committee shall receive a report from the board on the status of implementation of this Act.

SECTION 18. APPLICATION. The board may wait to develop rules necessary to implement and enforce this Act until August 1, 2016, if the board by majority vote determines that additional information necessary to protect the public interest will become available before the date. However, the board shall work diligently to adopt rules to implement this Act."

Renumber accordingly

2015 TESTIMONY

SB 2354

Attach#1
SB2354
02/10/2015
#23588

Rep. Blair Thoreson Testimony
"DO PASS" on SB 2354
10:00 a.m.
Tuesday, February 10
Senate Human Services Committee
Brynhild Haugland Room

Chairman Lee and members of the committee, thank you for the opportunity to testify before you today in support of SB 2354 as one of the bill's co-sponsors. As Sen. Dever explained, our state is suffering from a shortage of dentists that denies thousands of North Dakotans access to affordable, routine dental care.

Part of the problem is that our state's current laws limit the ways dentists can meet the increasing demand for dental care because it does not allow for a licensed, mid-level practitioner to perform routine services. That means that every procedure, no matter how routine, must be performed by a dentist. I'm sure you'll hear testimony today from dentists who prefer that way of doing business. And that's fine for them. But what about the dentists who want to expand their practices by hiring a mid-level practitioner? They're not allowed to do so. It's important to remember that dentists in North Dakota are small business owners and should be allowed to expand their practices as they see fit.

SB 2354 would remove unnecessary government regulations that make it difficult for dentists to expand their practices to provide services to underserved populations. Allowing Advanced Practice Dental Hygienists to work in North Dakota gives dentists the opportunity to grow their businesses and meet demand at no cost to the state. It's a free market solution to our state's dentist shortage. It's important to remember that, under SB 2354, dentists would not be required to employ Advanced Practice Dental Hygienists, but they would be permitted to if they feel it is the best way to expand their practices and meet the growing demand for dental care in the state.

If some dentists don't want to hire Advanced Practice Dental Hygienists, that's their choice. But that doesn't mean they should stand in the way of other dentists who want to use mid-level providers to expand their practices. Advanced Practice Dental Hygienists would lead to job creation, business growth and the removal of unnecessary and burdensome government regulations in North Dakota.

SB 2354 is a solution to the dental care shortage that is grounded in the principles of regulatory restraint and the free market. This solution is a win for North Dakota businesses and North Dakota's economy. I would ask the Senate Human Services Committee to give SB 2354 a "DO PASS" recommendation.

AMERICANS FOR PROSPERITY

Attach#2
SB2354
02/10/15
#23588

Testimony to the North Dakota Senate Human Services Committee
February 10, 2015

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

On behalf of the more than 8,000 Americans for Prosperity activists in North Dakota, I urge you to support proposed legislation (Senate Bill 2354) that allows dental hygienists to acquire additional education and expand the services they can provide 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 fit. Senate Bill 2354 seeks to do just that to address 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 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.

Senate Bill 2354 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.

Mac Zimmerman

Director of Policy

Americans for Prosperity

Attach #3
SB2354
02/10/2015
23588

SB 2354 ADHP

Chairman Lee and members of the Senate Human Services Committee, I am Representative Marvin Nelson of District 9.

I would like today to focus on one small part of the whole idea and that is distance and access. One day, not long ago, the Ronald McDonald mobile was in Rolette. Due to a misunderstanding, instead of being in the school parking lot, it was about 6 blocks away. Due to that distance, about ¼ of the children with appointments did not come, because it was further than their parents wanted them to go by themselves. One would think that it's just a few minutes for parents to have taken their children there, but it isn't. Many of those parents work over a half hour away, so they have an hour of driving time minimum plus the time with the dentist.

It gets worse, move the dental care a half hour from the child and now you have two hours of driving time minimum to take your child in for basic preventive care. Many parents do not have jobs with family time available to them. The bottom line is for many parents, the high cost of dental care must include a half day or a full day of work for which they will not get paid. Dental care is not available in the evenings or the weekends or in many areas even on Fridays.

The result is, much dental care that should be done is not done, and so our schools are filled with students who have active dental infections, which often could have been prevented. Once it gets serious enough, then the parents are forced to take action and costs are higher and so on.

Our seniors who are limited in their ability to drive such as nursing homes also have a serious problem with access.

In general, many people other than children and seniors also do not access timely dental care due to cost and time involved.

No one thing is going to take care of every situation or every child, every senior, every person struggling to pay, but ADHP can be one way to provide better care to some. I ask you to remove some of the barriers to timely accessible care by passing SB2354.

Thank you.

Attach #4
SB 2354
02/10/15

23588

Testimony in Support of SB 2354 by Rachelle Gustafson, President of the North Dakota Dental Hygienists Association
Senate Human Services Committee, Senator Judy Lee, Chairman
February 10, 2015

Chairman Lee and members of the committee, thank you for the opportunity to testify before you today. My name is Rachelle Gustafson and I'm the president of the North Dakota Dental Hygienists Association. I'm here today in support of SB 2354.

Currently, thousands of North Dakotans do not have access to affordable, routine dental care. It's hard to understand exactly what that looks like and just how great the need for dental care is in our state until you see it first-hand. As a dental hygienist, I spent the first 10 years of my career working at a private practice with a dentist who regularly saw Medicaid patients. Even the needs of that underserved population paled in comparison to the complications I've seen since moving to a community health center in 2007.

Community health clinics see patients who cannot receive care anywhere else. Often, it is because the care that is available is too expensive, or their local dentists do not accept patients enrolled in Medicaid. Many patients have to travel across the county to receive care at our clinic because it's the only place they can receive treatment.

At the community health clinic where I work, it's not uncommon to see patients who have never seen a dentist or had access to affordable, routine dental care. Many of them suffer from multiple dental diseases, all of which could have been avoided if they had had access to preventive care. Instead, they have serious dental issues that impact their overall health and quality of life.

That's a serious problem, and one that cannot be addressed by the number of dentists currently practicing in North Dakota. More high-priced providers for routine care won't make that care more affordable.

SB 2354 would help meet the demand for affordable, routine dental care by authorizing Advanced Practice Dental Hygienists to perform routine procedures under the supervision of a dentist. No doubt, some dentists are opposed to this important legislation because they claim hygienists aren't qualified to perform those procedures and the quality of care will suffer, but that simply is not the case.

Mid-level dental practitioners, similar to the Advanced Practice Dental Hygienists proposed in SB 2354, currently practice in 50 other developed countries and several other states. In fact, just last week, the Commission on Dental Accreditation, the entity responsible for accrediting dental and dental-related education programs in the United States, approved mid-level standards on Friday. If mid-level providers were unsafe, unqualified, or experimental in any way, the commission would not have accredited programs that train mid-level providers.

By acquiring the necessary additional education and clinical training, advanced practice dental hygienists will be able to provide routine dental care, increasing access for North Dakota's underserved populations and allowing dentists to focus on the more complex cases.

4.2

At this time, Chairman Lee and members of the committee, I'd like to review with you the sections of SB 2354 so it is clear what the bill does:

- Section 1: establishes definitions used in this bill including some of the procedures that could be included in the scope of practice as identified in the collaborative management agreement with the supervising dentist.

- Section 5: defines the practice limitations for APDH. In addition to being able to practice dental hygiene, this section emphasizes that an APDH may not practice independently.

- Section 12: specifies all the requirements that must be part of a collaborative management agreement between the supervising dentist and the APDH. This agreement must be submitted to the Board upon request.

- Section 13: makes it very clear that the APDH may not prescribe any drug. With authorization from the supervising dentist they may provide, dispense, and administer analgesics, anti-inflammatories, and antibiotics. The APDH cannot provide, dispense, or administer any narcotic drug.

- Section 14: reaffirms the sovereignty of tribes within North Dakota to use, and obtain federal reimbursement for services provided by, any licensed, certified, or otherwise sanctioned dental provider in the United States in Indian Country, if allowed by the tribes.

- Section 17: establishes an evaluation process and reporting requirements to legislative committees by the Board for evaluating the effectiveness of the APDH program. Items to be reported are listed in this section. Most of the data would be maintained by the Board, except for Medicaid data that could be secured from the Department of Human Services.

SB 2354 is a North Dakota solution that would significantly improve access to affordable, routine dental care, particularly for our state's underserved populations. The North Dakota Dental Hygienists Association fully supports this important legislation.

Attached is a section-by-section summary of SB 2354.

SB 2354 Summary

Section 1: establishes definitions used in this bill including some of the procedures that could be included in the scope of practice as identified in the collaborative management agreement with the supervising dentist.

Section 2: establishes the same application process for the advanced practice dental hygienist (APDH) and that of dental hygienists, and further defines the certification requirements (education, examination, clinical practice requirements, etc.) for the APDH.

Section 3: defines the certificate renewal process for the APDH which replicates the licensing process of dental hygienists.

Section 4: establishes the same board standards for certification for APDH as the standards for licensure of dental hygienists concerning conviction of any offenses.

Section 5: defines the practice limitations for APDH. In addition to being able to practice dental hygiene, this section emphasizes that an APDH may not practice independently.

Section 6: establishes the same rules for application denial and discipline for the APDH that currently exists for dental hygienists and the dental assistants.

Section 7: makes it illegal to practice as an APDH without a certificate as provided for dental hygienists and the dental assistants.

Section 8: provides the ND Board of Dental Examiners (Board) authority to enforce this chapter and make rules to regulate the practice of APDH, and the examination of the APDH, just as they do for dental hygienists and registered and qualified dental assistants.

Section 9: defines that the practice of APDH is supplemental and auxiliary to the practice of dentistry.

Section 10: clarifies that the APDH has the same responsibility as dental hygienists for notifying the Board of any address change within 30 days.

Section 11: defines that the APDH may administer block and infiltration anesthesia under the general supervision of a dentist, and that the procedure must be stipulated in the collaborative management agreement.

Section 12: specifies all the requirements that must be part of a collaborative management agreement between the supervising dentist and the APDH. This agreement must be submitted to the Board upon request.

Section 13: makes it very clear that the APDH may not prescribe any drug. With authorization from the supervising dentist they may provide, dispense, and administer analgesics, anti-inflammatories, and antibiotics. The APDH cannot provide, dispense, or administer any narcotic drug.

Section 14: reaffirms the sovereignty of tribes within North Dakota to use, and obtain federal reimbursement for services provided by, any licensed, certified, or otherwise sanctioned dental provider in the United States in Indian Country, if allowed by the tribes.

4.4

Section 15: reaffirms the same powers of the Board as currently exists for regulating dental hygienists.

Section 16: applies the same prohibitions under subsection 9 of 43-28-18 regarding sharing any professional fee with anyone or referral fees to a dentist that exist with dental hygienists.

Section 17: establishes an evaluation process and reporting requirements to legislative committees by the Board for evaluating the effectiveness of the APDH program. Items to be reported are listed in this section. Most of the data would be maintained by the Board, except for Medicaid data that could be secured from the Department of Human Services.

Attach #5
SB2354
02/10/15
23588

ND PUBLIC HEALTH ASSOCIATION

Access to Oral Health Care

Whereas, oral health is an important part of overall health and well-being throughout life and dental caries (tooth decay) is the single most common chronic childhood disease; and

Whereas, the US Surgeon General's Report on Oral Health, states that tooth decay, although preventable, is a chronic disease impacting children's ability to learn, speech development, eating habits, activities and self-esteem; and

Whereas, among adults, diet, nutrition, sleep, psychological status, social interaction and career achievement are affected by impaired oral health. Acute dental conditions contribute to a range of problems for employed adults, including restricted activity, sick days and work loss; and

Whereas, dental disease is not uniformly distributed in North Dakota:

- Minority children have more untreated tooth decay and urgent dental needs.
- Native American children experienced more dental caries (81% vs. 49%) than whites and also had more untreated dental decay (39% vs. 17%).
- Children in rural areas have more untreated tooth decay compared to children in urban areas (28% vs. 17%).
- Children in schools with high rates of poverty were more than twice as likely to have untreated tooth decay (32% vs. 15%) In 2011, only 28.6 percent of North Dakota children on Medicaid age 1-20 received preventive dental services and only 15.2 percent received any dental treatment services
- More than one-fourth (29%) of ND adults had not visited the dentist within the past year and nearly one-fifth (19%) of adults age 65 and older had lost their natural teeth due to tooth decay or gum disease and

Whereas, oral health care is not universally available for all populations in North Dakota and many individuals, including older adults, populations of lower socioeconomic status, racial, cultural or linguistic minorities, migrant workers, people with special health care needs, rural populations, homeless individuals and very young children; and

Whereas, numerous barriers exist that prevent access to oral health care, including:

- Lack of knowledge,
- Cultural values and beliefs,
- Inability to take time off from work,

5.2

- Lack of transportation and dental insurance
- Lack of available providers, providers that accept Medicaid insurance, public health programs and community health centers that provide dental services,
- Underutilization and underfunding of federal and state oral health programs, and
- A state dental practice act that restricts scope and practice for allied dental health professionals; and

Whereas, more than one-fourth of North Dakota Counties are designated as Dental Health Professional Shortage Areas (HPSAs); and

Whereas, all individuals should have access to needed oral health prevention and treatment services,

Therefore, be it resolved that the North Dakota Public Health Association supports policy efforts to:

- Build an effective health infrastructure that meets the oral health needs of all North Dakotans and integrates oral health effectively into overall health.
- Remove known barriers between people and oral health services
- Promote medical dental collaboration to improve oral health.
- 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.
- Adequately fund public programs to allow equitable access to services.

Signed: _____ Date: _____

References

Surgeon General's Report on Oral Health 2000. http://www.surgeongeneral.gov/library/reports/

North Dakota Oral Health Program, http://www.ndhealth.gov/oralhealth/

Oral Health in North Dakota Burden of Disease and Plan for the Future 2012 – 2017, http://www.ndhealth.gov/oralhealth/Publications/2012-2017_Oral_Health_State_Plan.pdf

ND Area Health Education Center http://www.ndahec.org/

Health Resources and Services Administration. State Health Professions Shortage Areas http://hpsafind.hrsa.gov/HPSASearch.aspx

Attach #6
SB 2354
02/10/2015
23588

Testimony in Support of SB 2354 by Leon A. Assael, DMD
Dean, University of Minnesota School of Dentistry
Senate Human Services Committee, Senator Judy Lee, Chairman
February 10, 2015

I am here to express my strong support for the effort in North Dakota to enact SB 2354. I am the Dean of the University of Minnesota School Of Dentistry. Since 2009, we have had the privilege of training and graduating 55 dental students from North Dakota. 55 North Dakota graduates, who are now dentists, who had the opportunity to return home after completing their education.

In addition to dentists, we also train a similar provider to the one you are considering today. Our graduates are already in practice under the supervision of dentists and providing needed dental care to underserved patients and communities in Minnesota. I know from seeing these providers firsthand that their patients are well-served and receive the highest quality of dental care in a variety of dental practices in our state.

I know there are questions about the appropriateness of this program from some in the dental community. Critics question that the quality of the services might be inferior. I can assure you that these arguments are not supported by facts, research, or our experiences of Minnesota, Alaska and over 50 countries where similar oral health practitioners are practicing today.

Let me be very clear about the education of the Advanced Practice Dental Hygienist you are considering today. It mirrors the education requirement of our providers in MN. The clinical hours required of these providers match those of dental students for the procedures for which they are licensed. **Both dental and midlevel provider students take the same integrated classes and undergo the same clinical rotations of the same length with the same passing and examining criteria for procedures that overlap between the two.**

Our graduates are well-trained, fully understand the limited but essential scope of services they are authorized to provide, and provide high quality dental services under the supervision of a dentist. Their devotion to a limited area of practice makes them very effective in that specific area.

I firmly believe that the type of provider you are considering today will soon be a well-accepted member of the dental team and will be embraced by dentists, the whole health care team and patients. It's already happening in Minnesota. It is critical our dental health care system change to address the devastating impacts of untreated dental disease—and SB 2354 goes a long way toward addressing them.

Dental caries, or decay, remains the number one untreated disease in children and destroys an essential organ system in adults. As in other parts of our health care system, our workforce must continue to evolve to embrace the concept of teams, with each team member working at

6.2

the level consistent with their education and training. It does not make sense for a dentist, with extensive and expensive training, to perform routine procedures that could be done as well—and less expensively—by the type of provider you're discussing today and integrated into the oral health care team. SB 2354 is an effective way to address the greatest unmet oral health care need, the treatment of dental caries.

Change is hard and will be resisted by some, but I urge you to stand for our patients and your constituents. I encourage you to support SB 2354. Advanced Practice Dental Hygienists will reduce costs of dental care and improve access for underserved communities. Our University of Minnesota graduates are living proof of that achievement. I look forward to receiving applications from folks in North Dakota and educating them alongside the dental students from North Dakota—strengthening the oral health team for your state so that more people have access to high quality care.

Attach #1
SB 2354
02/10/15

Testimony in Support of SB 2354 by Dr. Donald Warne, Director of the Masters of Public Health Program, NDSU 23588
Senate Human Services Committee, Senator Judy Lee, Chairman
February 10, 2015

Chairman Lee and members of the committee, thank you for the opportunity to testify today in support of SB 2354. My name is Dr. Don Warne and I'm the director of the Masters of Public Health program at North Dakota State University. I also spent several years serving patients as a general practice doctor.

You've been hearing a common theme today: North Dakota does not have enough access to affordable, routine dental care. It's a decades-old problem in our state that affects the general health and quality of life of thousands of North Dakota's residents.

Those most affected are rural residents and those who live on reservations. That's because two-thirds of North Dakota's dentists are located in Cass, Burleigh, Grand Forks and Ward counties. That leaves a lot of North Dakota struggling to access dental care.

On reservations specifically, a shortage of dentists translates to an average wait time of six months to see a dentist. That affects not only children, but adults and elders, too. Lack of dental access is more than just an oral health issue – as a general practice physician, I can tell you it's also general well-being issue. Poor oral health increases the risk of other diseases, including diabetes, which disproportionately affects Native Americans.

By improving access to affordable, routine dental care, we can improve both oral and general health on our state's reservations and rural communities.

SB 2354 will help provide that access by giving dentists the option to hire Advanced Practice Dental Hygienists who can travel to reservations and other rural areas to provide routine care to the most underserved populations in our state. I know you will hear testimony today that dentists are concerned about mid-level practitioners negatively affecting the quality of care their patients receive and the profitability of their practices, but the same things were said when nurse practitioners and physicians assistants were introduced. Now, it's hard to imagine having a medical system that does not use these professionals. As a physician myself, I appreciated the excellent work done by the mid-level practitioners because it allowed me to serve more patients and focus on more complex cases.

The same thing will happen if we authorize Advanced Practice Dental Hygienists. Increasing access to dental care will help improve overall health for all North Dakotans, not just those living in the urban parts of the state.

Attach #9
SB2354
02/10/15
23588

AARP Real Possibilities in

North Dakota

SB 2354 – SUPPORT
Tuesday, February 10, 2015
Senate Human Services Committee

Josh Askvig – AARP North Dakota
jaskvig@aarp.org or 701-989-0129

Chair Lee, members of the Senate Human Services Committee, I am Josh Askvig, Associate State Director of Advocacy for AARP North Dakota. We stand in support of SB 2354.

The oral health of older Americans is in a state of decay, and this is particularly true for citizens of North Dakota. Access to dental care is one of the greatest challenges facing older adults and their caretakers, and many of those near retirement are not aware that Medicare does not cover dental care.

According to a 2012 study funded by the Otto Bremer Foundation, the elderly, particularly those living in nursing homes in North Dakota, are at risk for not receiving oral health care because of their 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. The rural areas of the state are disproportionately elderly so geography also complicates access for many older people.[i]

One in three North Dakota seniors (32%) report having dental problems, more than any other group in the state. That's largely because there is a lack of access to affordable, routine dental care for those on Medicare, because Medicare does not cover routine dental care.

The lack of dental care opportunity is especially true of low-income and elderly individuals. While almost half of seniors purchase Medigap supplemental insurance, it does not cover dental.[ii] To further illustrate, 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. Among the lower-income, one in three had not visited a dental provider in five years.[iii] Additionally, nearly 70% of older Americans have no dental coverage.[iv] About 10,000 Americans retire daily, but only 9.8% of them do so with dental benefits.[v]

Further, poor oral health can lead to other problems including diabetes, cardiac disease, stroke and respiratory diseases, specifically pneumonia.[vi] Nationally, 23% of seniors have severe gum disease, one in three seniors have untreated cavities (50% for those over 75), and 30,000 people (mostly elderly) are diagnosed with oral and pharyngeal cancers yearly.[vii] In North Dakota, one-fifth of our seniors have lost their natural teeth. When that happens, their diets are negatively impacted because they cannot chew properly, and their ability to speak and interact socially is impaired.

North Dakota currently authorizes dental assistants, dental hygienists and dentists in the state, but not a mid-level dental provider like a dental therapist. These additional types of providers—similar to nurse practitioners or physician assistants on a medical team—can be educated to perform both preventive and routine restorative dental care, like filling cavities. They were recently authorized in Maine and already practice in Alaska and Minnesota. Because these providers are trained to do a much small number of procedures, dental practices can add them to the team and a practice can serve larger numbers of Medicaid patients in a financially viable way.[viii] Even for the uninsured, practices can use lower cost providers to provide care to more patients in a more affordable way.[ix]

Using general supervision and telehealth technology (allowing dentists to supervise staff from a different site) can allow these practitioners to bring care directly to patients in nursing homes, assisted living centers, and even patients' homes.

At AARP North Dakota, we know access to dental care for the elderly is a growing problem for members in our state because we hear from them. They are counting on us to do something, and that is why we urge this committee to give it a DO PASS RECOMMENDATION.

---

[i] Center for Health Workforce Studies. "Oral Health in North Dakota: Executive Summary." August 2012. Page 5.
[ii] Oral Health America, "A State of Decay: Are Older Americans Coming of Age Without Oral Healthcare?" 2014, Page 3. Accessible at http://b.3cdn.net/teeth/1a112ba122b6192a9d_1dm6bks67.pdf
[iii] Kaiser Commission on Healthcare and the Uninsured, "Oral Health in the US: Key Facts," The Henry J. Kaiser Family Foundation, June 2012. Accessible at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8324.pdf
[iv] Oral Health America, "A State of Decay: Are Older Americans Coming of Age Without Oral Healthcare?" 2014, Page 3. Accessible at http://b.3cdn.net/teeth/1a112ba122b6192a9d_1dm6bks67.pdf
[v] Oral Health America, "A State of Decay: Are Older Americans Coming of Age Without Oral Healthcare?" 2014, Page 1. Accessible at http://b.3cdn.net/teeth/1a112ba122b6192a9d_1dm6bks67.pdf
[vi] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
[vii] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
[viii] The Pew Charitable Trusts, *Expanding the Dental Team*, February 2014. Accessible at http://www.pewtrusts.org/en/research-and-analysis/reports/2014/02/12/expanding-the-dental-team
[ix] The Pew Charitable Trusts, Expanding the Dental Team, June 2014, Accessible at http://www.pewtrusts.org/en/research-and-analysis/reports/2014/06/30/expanding-the-dental-team

Attach #9
SB 2354
02/10/15
23588

Testimony on SB 2354
10 AM Tuesday, Feb 10, 2015
before the Senate Human Services Committee
>>

Chair Senator Lee and Members of the Committee -

My name is Mike Tomasko, a resident of District 13 West Fargo, and having retired year-ending 2007 after a 35 year career in health care administration and about 1 year as a dental business coordinator. I presently serve as a Volunteer for ND AARP, where I am also a member of their Executive Council.

A thank you to those who have sponsored this legislation and those who have spoken to all sides of this issue.

Hearing of this bill took me back some 25 or so years ago early in my health care CEO career. I received a 730AM Sunday call from one of our new internists, on call for our clinic and that department, saying he had received a 2AM call from an Internal Medicine patient who had recently had dental work done and was having pain. The Doctor asked if he had called his dentist and he replied, "I don't know the number or how to get a hold of him, so I called the hospital and they gave me you". Our Doctor advised the gentleman to (1) try to get a hold of his dentist, and if that failed (2) present to the Emergency Room where he would be seen by the ER Doc or the Internist.

The following Monday morning I checked with the Internist and he said the gentlemen was seen in the ER. I followed up with the hospital and we checked the ER billing which was quite substantial, the hospital administrator saying it was much more then if seen by his dentist. The hospital administrator advised this is not an uncommon situation, and I inquired how do we solve it. The hospital administrator said not likely in our life-times and welcome to the two A's --- that is access and affordability --- two A's he said that have plagued both the medical and dental field for some years.

You have heard the facts today from many speakers. I will simply relate in closing the debate that raged in our clinic some years ago when the topic of employing mid-level health care providers was the topic of discussion. I distinctly remember two physicians strongly opposed:

the first, a family practice physician who was strongly opposed presented to my office to tell me the walk-in clinic was overflowing and we needed help. I told him I could see if some NP's were available, but that he was opposed to having them work on his shift, and he replied get 1, get 2, get 3 – just get someone or we'll be here till midnight. We did get an NP to come in and help, and on Monday he presented to tell me the NP did a good job, asked appropriate questions and when he reviewed her charts gave appropriate care. As a surgeon told me Sunday at my grandsons concert when discussing this bill that had been in The Fargo Forum, he told me the key to making it work is: the correct level of advanced education, an appropriate scope of practice, and a good cooperative supervisory arrangement with a physician – in the case of this bill a dentist.

9.2

- the second a surgeon told me this ain't going to happen, I told him he was likely going to be outvoted and he reminded me that if his salary went down, he would have my job! Well less then a year later he was in my office telling me that he had been observing his colleagues use of mid-level health care providers, they had rotated with him when their surgeon was gone to conference or on vacation, and he said they do good work --- so get me one of them-there people.

And because my job appeared to be on the line, whether tongue-in-cheek or not, I kept close track of incomes and we found that salaries went up (the help allowed the physician to do more) and MOST IMPORTANTLY access improved which is the goal of SB2354 – an important need for our elderly population as you heard from Mr. Askvig and others.

Thank you for receiving my remarks today and I would be happy to answer any questions members of the committee might have.

Attach #10
02/10/15
SB 2354
23588

Testimony of Dr. David Gesko in Support of SB 2354
Senior Vice President and Dental Director
HealthPartners Dental, Bloomington, MN

Senate Human Services Committee, Senator Judy Lee, Chairman
February 10, 2015

Chair Lee and Members of the Committee, thank you for having me here today to discuss my experiences related to the exciting legislation you are considering. For your background, I am currently Dental Director at HealthPartners Dental in Minnesota—a consumer-governed, nonprofit, integrated health system. I started my career as a solo practice dentist in Bozeman, Montana, and also currently serve as president of the Minnesota dental board, though I'm not here to speak on the Board's behalf.

The bill in front of you today, SB 2354, represents visionary leadership. I hope my personal experiences with similar dental providers in Minnesota can give you the background you need as you consider this bill, and I'll try to be short in case you have questions.

As a dentist, the first thing I want to say has nothing to do with statistics on the number of people getting care, the cost of care, etc. It's simply that it's been fun and rewarding to be able to work with another type of provider on the dental team. What's been even more interesting in our practice is the reaction of other dentists.

When we started with one of these types of providers, some dentists weren't sure about the idea. Yet with experience integrating them into the dental team, interest grew and more dentists wanted to work with them. In fact, we now have three on staff working with our dentists. At the same time, for those that think an Advanced Practice Dental Hygienist is a bad idea, it's important to remember that they don't have to hire one. It's another tool in the toolbox, so to speak, that dentists and clinics can use if they choose.

Some of you may be hearing that the quality of care is not the same with the type of provider you're considering here today, but we have disproved that claim in Minnesota. We haven't seen any safety-related complaints, as mentioned in a study published in February 2014 by our state. These types of practitioners are providing great dentistry *within their limited, specific scope of practice*. Dentists who have them on staff are able to do more high level and complex procedures because they don't have to do routine fillings all day.

In that respect, the medical world is way ahead in educating different types of practitioners to handle routine duties and allowing physicians to practice at a much higher level. Of course, that did not come smoothly, but it has been a great thing for both physicians and patients while increasing access and decreasing the cost of care. The same is happening with dental care in Minnesota now. If we are going to get at "access to care" issues, we can't have a dental system that continues to focus on producing the highest priced provider for many routine procedures.

10.2

The other big issue often mentioned by opponents is whether it is financially viable for dental practices. I can tell you that in Minnesota, we have seen providers similar to the Advanced Practice Dental Hygienists in this bill in a variety of settings—nonprofit clinics, FQHCs, group private practices, and solo private practices. They're also in a variety of locations—rural areas, bigger cities, and suburbs.

This is happening despite the fact that Minnesota's Medicaid reimbursement rate is far lower than North Dakota's. I have to say that when I heard that your state reimburses at about 62 cents on the dollar, I felt jealous about what we could do with that same kind of support. Of course, this routine care helps keep people on Medicaid out of expensive emergency rooms.

With that, I want to close by saying that the sponsors of this bill should be applauded for their effort and willingness to advance this idea in your state. While a number of dentists may now be opposed, like they were in Minnesota initially, I know that will change as they get to experience working with Advanced Practice Dental Hygienists. We are seeing that every day in Minnesota and every dentist who starts working with these types of providers continues to do so. As I said earlier, this is another tool in the toolbox that the government should allow dentists to use to expand their practices and increase access to care.

Thank you again for the opportunity to testify, and I am happy to answer any questions.

Attach #11
SB 2354
02/10/15
23588

Testimony of Sarah Wovcha, Executive Director, Children's Dental Services
Senate Human Services Committee (February 2015)

- Chair Lee and members of the committee, I appreciate the opportunity to testify before you today. My name is Sarah Wovcha and I am the Executive Director of Children's Dental Services, a nonprofit organization located in Minnesota dedicated to improving the oral health of children from families with low incomes by providing accessible treatment and education to our diverse community. I am here today in support of SB 2354.

- CDS serves children from birth to age 21, regardless of family income, low-income pregnant women, and the un- or under-insured.

- 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.

- CDS accepts all forms of public and commercial insurance, and has a zero-based sliding scale for income eligible families. Families who are below 100% of the federal poverty level receive free care. No one is denied care based on inability to pay.

- In 2014 CDS treated nearly 34,000 patients. Of those patients, 99% had incomes below the Federal Poverty Guideline, 80% received Medical Assistance, 19% were uninsured and enrolled in sliding scale programs and fewer than 1% had private insurance.

- We are working with the Fargo Public School District to collaborate and provide more care to children in the school system, including on-site care within the schools. We would like to be able to use Advance Practice Dental Hygienists supervised by dentists in places like the Fargo public schools.

- In 2009, MN authorized advanced dental therapists—similar to the type of provider proposed in SB 2354. We saw this provider as an opportunity to expand the reach of our dental teams throughout the state in a financially sustainable way.

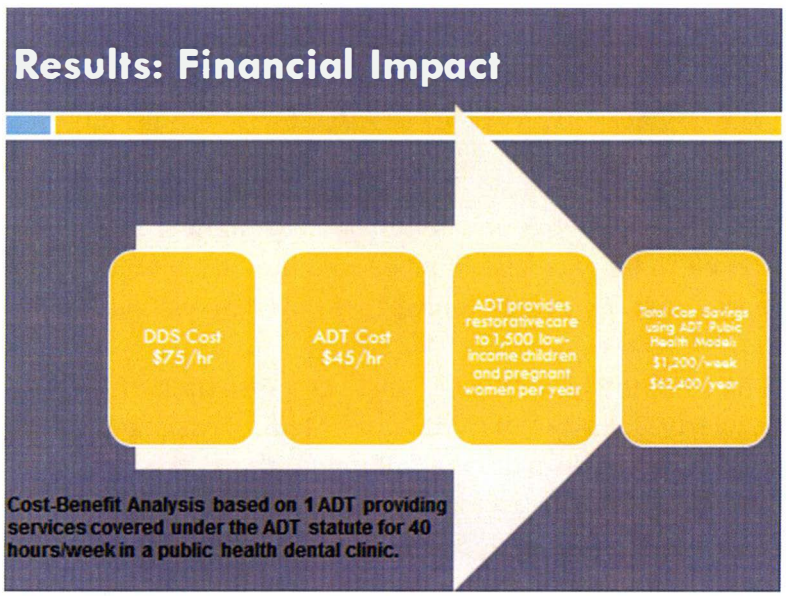
- CDS' mid-level providers are community-based and integrate preventive care and routine restorative care such as fillings into patient visits—freeing dentists to practice at the "top of their license" and focus on complex cases.

- CDS' mid-levels work in remote settings in rural Minnesota while their supervising dentists are often in Twin Cities metro area. Through use of digital x-rays and electronic charts, these providers are able to connect with their supervising dentist, regardless of location.

11.2

- Our mid-levels have increased access and savings for CDS—Production stats/Economic savings:

  - 2011: Average production of team is $280.72/hr
  - 2012: Average production of team is $298.09/hr ($292.13 adjusting for fee increase); Average production of ADT is $340.35/hr
  - 2013: Average production of team is $336.87 per hour ($326.76 adjusting for fee increase); Average production of ADT is $365.04/hr
  - ADTs are vital to the financial viability of CDS; other clinics, such as private practice dentist Dr. John Powers, are seeing similar productivity and financial impact



- Patient satisfaction and reception to these providers being part of the dental team is overwhelmingly positive.

- When the concept of this type of dental provider was introduced in 2007 in MN, it met great opposition from organized dentistry—similar to the arguments you will likely hear today.

- However, our experience is that this is a common sense idea that works and is gaining in popularity among dentists, including those in private practice. We have paid 100% of tuition costs for two of our Registered Dental Hygienists to become mid-levels because of the positive impact they have had on access and income for our organization.

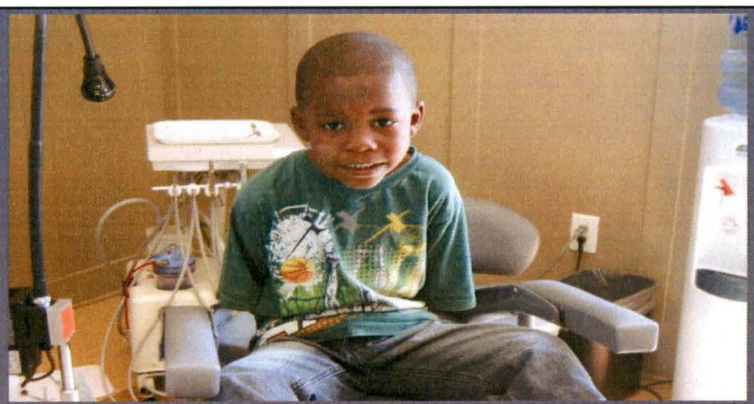
- I appreciate the opportunity to testify and am happy to answer any question you may have.

Attach #12 2/9/2015
SF2354
02/10/15
23588

Children's Dental Services

Dental Therapy in Minnesota: A Study of Quality and Efficiency Outcomes

Sarah Wovcha, JD, MPH, Executive Director
Emily Pietig, DDS, Dental Director



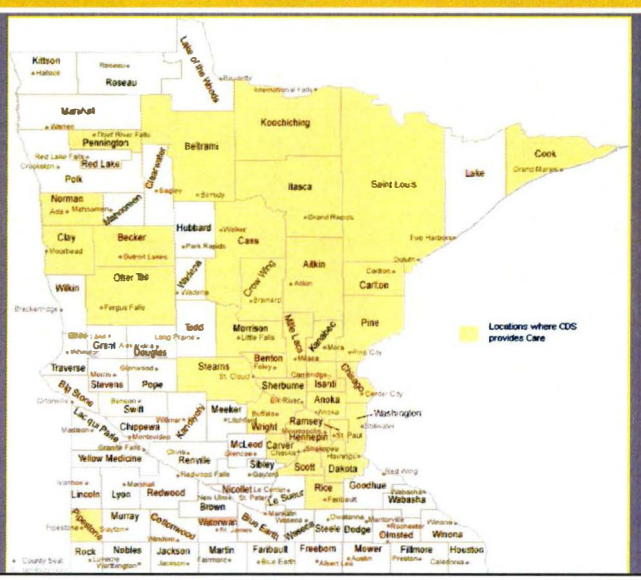
Since 1919 Children's Dental Services is dedicated to improving the oral health of children from families with low incomes by providing accessible treatment and education

Children's Dental Services

Children's Dental Service History

- Children's Dental Services was established in 1919 and received non-profit status in 1954
- Minnesota's primary provider of portable dental care to low-income children
- First provider in the nation of on-site dental care in Head Start setting
- Serves entire state

Map of CDS' Service Area

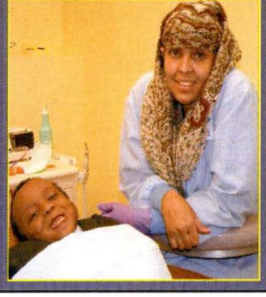


2014 Demographics

- In 2014 CDS treated 33,847 patients who were provided 73,518 procedures over the course of 45,980 visits.
- Somali/East African (25%), Latino (24%), African American(19%), Caucasian (17%), Hmong/Southeast Asian (9%), and American Indian (6%).
- 59% female, 41% male
- 80% receive Medical Assistance (MA), 19% are uninsured and enrolled in sliding scale programs (80% of whom receive free care), and less than 1% have private insurance.

Focus on culturally targeted dental care

- Language fluency: CDS' staff speak over 17 different languages and hail from more than 20 countries
- Representing cultures served: Understanding the cultural norms, religious needs and diets of target communities staff create culturally targeted and translated curriculum for care in school-based settings



Problems Preceding Advent of Dental Therapy

- **CDS background:**
- -previously housed in public health department
- -became independent entity struggling for funding
- -swelling patient population
- -difficulty hiring and retaining dentists (DDS)
- -sought alternatives: foreign trained dentists, mid-level providers

Why Advanced Dental Therapists (ADTs) are a solution

- Community-based
- More continuously present than scarce dentists
- Engage patients
- Naturally integrate preventive care and education into patient visit
- Gain expertise on limited scope of restorative procedures
- Free dentists to practice at "top of license" and focus on complex cases

Characteristics of ADTs

- All ADT services can be provided under General Supervision.
- General Supervision is defined in Minnesota Rule 3100.0100: "The supervision of tasks or procedures that do[es] not require the presence of the dentist in the office or on the premises at the time the tasks or procedures are being performed, but requires that the tasks be performed with the prior knowledge and consent of dentist".
- ADTs will therefore directly increase access to care by providing care in rural or low-income area where access is a huge problem.
- While ADTs are not required to undergo chart review by Dentists, CDS ADTs do consult and review cases in a collaborative manner.
  - Teledentisty and frequent communication enables these reviews for Dentists practicing in Minneapolis and St Paul and for ADTs practicing in Greater MN.
- CDS currently employs 1 Dental Therapist and 5 Advanced Dental Therapists

Procedures performed by ADTs

Oral Evaluation and Assessment	• OHI • X-Rays • Preliminary charting
Non Surgical Extractions of Primary and Permanent teeth	• Dressing changes • Administration of nitrous oxide • Suture removal
Restorations	• Placement of temporary restorations • Atraumatic restorative therapy • Administration of local anesthetic • Application of desensitizing medication or resin • Tissue conditioning and soft reline • Tooth re-implantation

Procedures performed by ADTs, cont'd.

Preventive	• Mechanical Polishing • Application of topical preventive or prophylactic agents, including fluoride varnishes and sealants
Endo	• Pulp vitality testing • Pulpotomies on primary teeth • Indirect and direct pulp capping on primary and permanent teeth
Mouthguards	• Fabrication of athletic mouth guards • Fabrication of soft occlusal guards

Practice Settings for Minnesota ADTs

Subd. 2.Limited practice settings:
An advanced 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.

https://www.revisor.mn.gov/statutes/?id=150a.105

Collaborative Management Agreements

- Collaborative Management Agreement (CMA): a formal agreement detailing roles and responsibilities for dental therapists and advanced dental therapist and supervising dentists
- Statute requires all advanced dental therapists to engage in a CMA
- No more than five DTs or ADTs can enter into a collaborative agreement with a single DDS
- CMAs must include:
  - Practice settings and populations to be served
  - Any limitations of services provided by the DT or ADT and level of supervision required
  - Age and procedure specific practice protocols
  - Dental record recording and maintaining procedures
  - Plan to manage medical emergencies
  - Quality assurance plan
  - Dispensing and administering medications protocol
  - Provision of care to patients with special medical conditions or complex medical histories protocol
  - Supervision criteria of dental assistants
  - Referral and reallocating clinical resources protocol
    - Collaborating DDS accepts responsibility for unauthorized care provided by DT/ADT

Issues of Quality and Risk

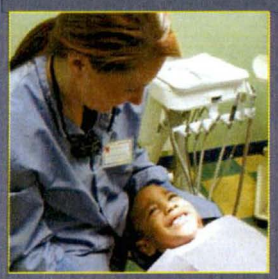
- ADTs and DDS undergo the same licensure exams for procedures they both provide.
- Marsh Insurance provides professional liability coverage for ADTs currently licensed as dental hygienists and members of ADHA. The cost is approximately $93/year.
- Professional malpractice insurance from various providers range in cost from $564 to $1,209 for CDS' dentists (average cost is $775/year)

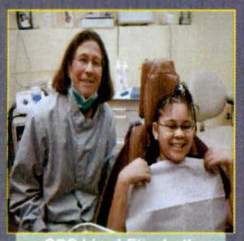
Hiring: the first ADTs In Minnesota

Christy Jo Fogarty, a graduate of Metropolitan State University, was the first ADT hired and credentialed in Minnesota.

Employed at CDS since December 2011.

Became Minnesota's first licensed ADT in January 2013.





CDS hired Elizabeth Branca, its third ADT from the Metropolitan State University Program, in June 2013.

CDS' most recent ADT hire is Jodi Becker who graduated from Metropolitan State University Program in June 2014

Effective Dental Teams

According to the PEW Center on the States a team approach to dentistry has been found to be the most effective and provide the most access to dental care:

"In solo private dental practices—where most dentists work—adding new types of providers and dental hygienists produced gains in productivity and increased earnings by a range of 17 to 54 percent. Dentists who operate a practice by themselves can increase their pre-tax profits by six or seven percent by accepting more Medicaid-enrolled children and hiring either a dental therapist or a hygienist-therapist".

Structure of New Dental Team

Traditional team: DDS, RDH and LDA.

Today: DDS, ADT, Collaborative Practice RDH, RDH, LDA, Unlicensed DA.

Integrating ADT:

- Scheduling own column of patients
- Similar to dental school: start, prep and final checks
- Program producing highly skilled and qualified clinicians

Quote of one CDS dentist about working with CDS ADT:
"She completes fillings better than I do."

Initial Questions about ADTs:

Dentists' biggest source of information about the field=local dental association

- Many questions arose about:
- -quality
- -ability to handle uncooperative patients
- -impact on patient care

Observations of ADTs

-strong clinical skills

-significant relevant experience:

U-MN dental students generally do 1 SSC, ADTs do an average of 50 SSCs;

U-MN in dental students receive no motivational interview training, ADTs receive training on an average of 10 motivational interviews

-good behavior management

-mature, experienced professionals

-motivated

Impact on the Dental Team

- Requires increased communication which has developed into cohesive team experience
- The ADTs' questions and desire to learn has spurred additional learning among DDS
- Opportunity to reflect on clinical decisions through teaching/supervising
- Frees DDS to focus on specialized restorative care (DDS appreciate opportunity to hone higher skill level & relief from routine care)
- Overall increase in quality of care
- Overall reduction in cost of care

CDS' data on Dental Therapy Care

- Since December of 2011, CDS' ADTs combined have provided care to over 6,000 patients.
- There have been 3 requests to see a dentist instead of a dental therapist.
- There have been no complaints or claims of poor quality.
- Over 90% of survey respondents state that they are satisfied or very satisfied with the quality of care received by an ADT.

Results: Production 2011

NOTE: based on billing in community clinic setting with lower than average fees

Production Summary August 2011

Provider Code	Total Production Charges	Total Hours Worked	Total Production
DR11 Endo Provider	10,040	24	$418.33
DR01	55,165	136.8	$403.25
DR20	4,178	11.5	$363.30
DR12	47,261	148.85	$317.51
DR24	36,518	120.16	$303.91
DR36	45,898	161.53	$284.15
DR38	37,646	144.96	$259.70
DR42	26,105	116.7	$223.69
DR04	878	4.65	$188.85
DR41	7,301	40.09	$182.12
DR43	8,739	51.45	$169.85
DR44	3,616	24.2	$149.42
DR30	7,678	51.83	$148.14

12.12

Results: Production 2012

Production Summary August 2012 (*CDS began tracking ADT productivity in March. ADT productivity has consistently risen since that time.)*

Provider Code	Total Production Charges	Total Hours Worked	Total Production
DR11 Endo Provider	6,420	16	401.25
DR01	66,696	130.39	511.51
DR04	2,132	4.35	490.08
DR20	4,974	12	414.50
ADT01	66,508	171	388.94
DR12	43,978	150.66	291.90
DR36	43,562	162.35	268.32
DR43	22,946	85.95	266.97
DR44	43,219	174.65	247.46
DR38	27,094	111	244.09
DR42	20,757	85.94	241.53
DR24	23,861	110.2	216.52
ADT02	9,390	52	180.58
DR41	3,017	23.55	133.79

Results: Production 2013

Production Summary August 2013

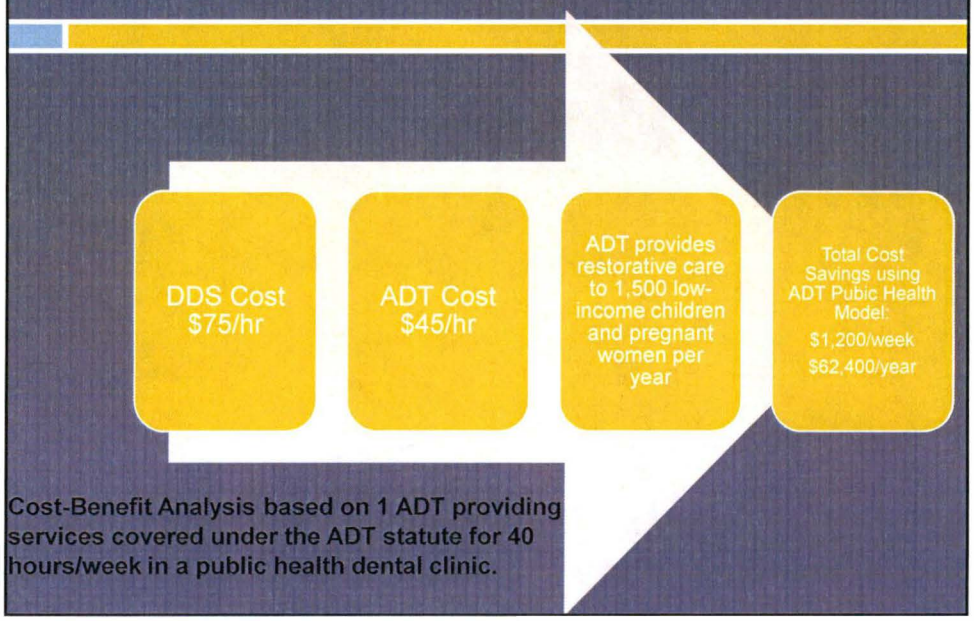
Provider Code	Total Production Charges	Total Hours Worked	Total Production
DR11 Endo Provider	8,516	16	$532.25
DR20	19,343	43.15	$448.27
DR44	53,555	138.05	$387.58
ADT01	46,755	123.5	$378.58
DR24	53,507	144.91	$361.45
DR36	42,304	140.05	$302.06
DR01	41,008	144.96	$299.66
DT01	4,277	16.3	$262.39
DR43	3,382	4.65	$207.48
DR12	57,856	171.87	$203.46
DR53	10,676	62.74	$170.16
DR04	487	3.05	$159.67

12.13

Summary of Dental team production results with integration of dental therapist

- 2011: Average production of team is $280.72/hr
- 2012: Average production of team is $298.09/hr ($292.13 adjusting for fee increase); Average production of ADT is $340.35/hr
- 2013: Average production of team is $336.87 per hour ($326.76 adjusting for fee increase); Average production of ADT is $365.04/hr
- ADTs are vital to the financial viability of CDS; other clinics, such as private practice dentist Dr. John Powers, are seeing similar productivity and financial impact

Results: Financial Impact



12.14

Lessons Learned/Suggestions

- Graduated ADTs are in high demand for employment
  - Ability to do preventive care in portable settings is useful.
  - Ability to practice under general supervision allows flexibility and frees clinic space for additional providers.
  - Supervising dentists find that quality of care is excellent with ADTs.
  - Entire dental team is more efficient with integration of ADTs.
  - There have been no patient complaints related to any dental therapy work.
  - Flexible and transferable model of care delivery.

References

http://www.pewcenteronthestates.org/report_detail.aspx?id=61678

http://www.pewcenteronthestates.org/report_detail.aspx?id=61678

http://www.normandale.mnscu.edu/academics/deans/pdf/ADEAPresentation1.pdf

https://www.revisor.mn.gov/statutes/?id=150a.105

http://www.dentalboard.state.mn.us/Portals/0/Licensing/Dental%20Therapist/DEPT_CMA%2012-410approved.pdf

https://www.revisor.mn.gov/statutes/?id=150a.105

12.15

THANK YOU

Questions?

Sarah Wovcha, JD, MPH
Executive Director
Children's Dental Services
612-636-1577

Attach #13
SB 2354
02/10/2015
23588

Written Testimony

Metropolitan State University

NORMANDALE COMMUNITY COLLEGE

February 10, 2015
Testimony for the Senate Human Services Committee

Chair Lee and members of the Senate Human Services committee, my name is Colleen M. Brickle, Dean of Health Sciences at Normandale Community College in Bloomington, MN. Thank you for allowing me this opportunity to provide testimony as you consider expanding the scope of practice for hygienists by establishing an advanced practice dental hygienist (APDH) in North Dakota. My testimony will highlight the education of similar practitioners in Minnesota as well as their impact so far.

Based on my reading of the legislation before this committee, North Dakota is currently considering something similar to the Advanced Dental Therapist in MN. During the 2008 and 2009 legislative sessions, I actively advocated for an ADT while simultaneously leading the curriculum development for the Minnesota State Colleges and Universities System (MnSCU). The MnSCU program is administered jointly by Normandale Community College in Bloomington, Minnesota and Metropolitan State University in St. Paul (Metropolitan State confers the degree).

The program educates and trains licensed dental hygienists with a baccalaureate degree to practice with the expanded scope an ADT. **In fact, we currently have a student from North Dakota going through our program. Should you decide to pass the legislation before you today, please know that interested dental hygienists who meet admissions requirements for the program are welcome to apply. The cost for the entire 16 month program is $36,000, which includes tuition, books, supplies and all lab fees. Our goal within the next four years is to provide the ability for students to attend our program in an area outside the Twin Cities. One area we are exploring is the Moorhead area.**

Students are taught specific routine restorative and surgical procedures within a defined scope of practice to the same competencies as a dental student, learning side by side with dental students and/or dental residents. In other words, the education and training to remove decay and prepare teeth for restorations are taught to the same standards and competencies as dental students learn across the country.

In addition to dental courses, our ADT students take coursework in pharmacology and medical emergencies, epidemiology, health policy and leadership, cultural awareness, and managing patients with special needs (an emphasis in geriatric and pediatric care). The clinical component of an ADT's education provides opportunities to serve all population groups. MnSCU students are provided extended campus rotations through Community Dental Care Clinic that serves patients from ethnicities all over the globe; Hennepin County Medical Center for special needs, pediatric and oral surgery experiences; Apple Tree Dental nursing homes for the geriatric and medically compromised patient care; and Children's Dental Services to serve children and pregnant mothers. These experiences allow students the opportunity to work directly with populations they will serve upon graduation.

Graduates are required to pass a *patient-based* clinical examination that is based on the examination dental students must also take for licensure, though focused on the more limited set of procedures they can provide compared to a dentist. This examination is conducted by the Central Regional Dental Testing Service. The exam evaluators are unaware as to which patients are treated by a dental student or a DT

13.2

student. This exam validates that *in their defined scope of practice*, ADTs are educated to the same level of a dentist.

It is not until after practice under indirect supervision of a dentist and passing a certification examination issued by the Minnesota Board of Dentistry that someone can be credentialed as an ADT. This allows ADTs to perform services under general supervision (dentist working at a different site) within the protocols established in a collaborative management agreement between a dentist and ADT.

ADTs improve access to quality care for rural and underserved populations and increase entry points for patients into the oral health care delivery system. **The ADT is not a replacement for a dentist but is intended to extend the reach of dentists.** Although dental disease is preventable, there are populations with rampant untreated decay and periodontal (gum) diseases. The ADT's ability to provide preventive care and disease treatment can be extended to outreach locations by collaborating with a dentist when providing care. If working offsite and within the protocols outlined in a collaborative management agreement with a dentist, patients are referred to a dentist when they need the services beyond the ADT's scope of practice. This allows ADTs the ability to work in schools, community centers, nursing homes, virtually any place where there are unmet. In opening access to dental care and delivering care directly to a patient who has challenges making it to a private office will result in a cost-saving expense on the public healthcare system. However, it also gives private dental offices, especially in rural areas, a way to serve more patients in their communities.

While Minnesota is the first to license this type of provider in the United States (2009), Maine authorized them last year. Additionally, Alaska and more than 50 other countries have educated and utilized these dental providers safely and effectively for decades. Preliminary data from the Minnesota Department of Health and Board of Dentistry found the following:

1. Clinics employing this type of provider see more patients and most are on public programs and underserved
2. They improve efficiency of clinics, allow dentists to handle more complex procedures
3. They have reduced wait times and travel distances for patients
4. They produce direct cost savings to dental clinics
5. Dental clinics use most savings from this type of provider to see more underserved patients
6. No quality or safety concerns

The acceptance level of ADTs is growing, even among the original, stronger opponents of this legislation, and the ADT is being integrating as a key new member of the dental team. **All of our program's graduates have been employed at this time.**

What can be learned from our experience? First, these providers can offer quality, safe, and cost-effective care to Minnesotans who struggle to find care. Second, in addition to a dentist, they provide another entry point for a patient to access the dental system. This type of provider can assess and treat dental pain without the patient first having to see a dentist by working under the collaborative management agreement. This enables a patient to get needed treatment quicker and more efficiently. Third, utilizing an already well-educated workforce of dental hygienists results in a practitioner with an expanded scope of care in a relatively short time. **ADT students incur less educational expense for the scope of practice they are authorized to perform than that of dental students.** Dental hygienists have proven to be a ready and willing untapped resource that can assist to open access to dental care not only in Minnesota but across the country.

Too many people struggle to enter the oral healthcare system and this type of provider can be that additional entry point, extending the arm of dentists and dentistry to assist those who desperately need care. In addition to opening access, ADTs provide safe, quality, effective dental care for those most in need. For years we have searched unsuccessfully for ways to improve access to dental care for the underserved. As with dental hygienists who are dentistry's valued and trusted "preventive specialists", health promotion and disease prevention remain the primary focus of ADTs. Yet, until we care for patients who are far beyond preventive services, we are losing ground each passing day. It's my hope that North Dakota passes this common sense legislation, SB 2354.

Thank you for your time and consideration. Please contact me if you have any further questions.

Sincerely,

Colleen M. Brickle

Colleen M. Brickle EdD, RDH, RF
Dean of Health Sciences
Normandale Community College
9700 France Ave S
Bloomington, MN 55431
952-358-8158 (Direct)
colleen.brickle@normandale.edu

SB 2354
Attach # 14
02/10/15

SB 2354 Testimony

February 10, 2015 23588

Senate Human Services Committee

Hon. Senator Judy Lee, Chairwoman

Chair Lee and Committee Members,

Thank you for the opportunity to present my testimony in opposition to SB 2354 today. My name is Brad Bekkedahl, Senator from District 1, representing the City of Williston. I am also a practicing Dentist, licensed in North Dakota and Minnesota for over 30 years. In full disclosure, I am currently in the sale process of my private practice in Williston, and after this Session, will return to assist Dr. Buntrock in his operation of the practice.

SB 2354 is a radical re-write of the ND Dental Practice Act and allows providers with less training than licensed Dentists to perform irreversible dental surgical procedures. There does not currently exist enough evidence for ND to be only the 4th state to experiment with this practice model since 2009. We also have an adequate supply of Dentists in North Dakota. In the last 5 years, the growth in the number of Dentists statewide has exceeded that of our significant population growth. Distribution is more of an issue than numbers, and one study shows with over 300 Dentists, any shortage could be alleviated with only 7 more Dentists, far fewer than the 30 new Dentists we have been currently licensing each year.

Another issue is that this dental therapist provider model was not deemed to be a practical solution in North Dakota for reducing barriers to care by the Pew Charitable Trusts/UND Center for Rural Health's "North Dakota Oral Health Report: Needs and Proposed Models 2014". The ND Legislature's Interim Health Services Committee determined that this proposed midlevel practitioner model needed more study, and no bill was produced out of committee for the 2015 Legislative Session.

There are many components responsible for barriers to care that exist today. Every State is different, and in North Dakota, collaborative solutions to reduce these barriers are already working. These include partnerships with safety-net clinics, fluoride and sealant preventive programs in schools this Committee has supported, highly effective loan repayment programs for Dentists in under-served areas, discussions to improve Native American facility credentialing, and several volunteer programs targeting special populations in need. There will be others here today to testify to more specifics on these programs.

While I have given several concerns and reasons as to why I do not support this bill, I need to close by asking you to consider quality of care as central to this issue. I have 35 years of involvement in the profession of Dentistry, including nearly 10 years at a Tribal Health Facility, almost 20 years with the US Army Dental Corps, and over 30 years in Private Practice. My career focus has always been serving patient needs and delivery of the highest possible quality of care. If this change is the model that I felt truly delivered better access to care at the highest possible standards, I would be among the first to embrace it. Absent that evidence in this current environment, I think the best public policy is to monitor results from other States in their implementation of the model and continue to work collaboratively with all aspects of the Dental professional team to improve access issues. To accomplish this, I request this Committee recommends a Do Not Pass on SB 2354 for consideration to the entire Senate.

Thank you for your attention and I would be happy to entertain any questions from the Committee.

Attach #15
SB 2354
02/10/15
23588

Senate Human Services Committee- SB 2354

North Dakota Dental Association

Brent L Holman DDS, Executive Director

Paul Tronsgard DDS, President

Chair Lee and members of the committee, my name is Dr Brent Holman and I am Executive Director of the North Dakota Dental Association. I along with Dr. Paul Tronsgard, President, will present testimony to oppose SB 2354. The bill would redefine the practice of dental hygiene to include irreversible procedures currently defined in the practice of dentistry and would create a new dental provider with an unprecedented reduction in supervision. We feel there is not enough evidence or urgency to justify a model that has had minimal history in practice. Solutions to reduce barriers to care should be collaborative and address the many factors that determine why patients do not go to the dentist. Workforce is only one of these factors (Exhibit A). According to the Pediatric Oral Health Research Center, AAPD, additional reasons children do not go to the dentist include the following:

".....child's temperament (e.g. resistance to tooth brushing); low

15.2

parental literacy and an inability to adequately understand current educational materials; lack of parental knowledge about optimal oral health, and uncertainty about prevention; financial difficulties which make it challenging to prioritize dental care; dental anxiety and phobias; perceived lack of access to affordable sources of care; home oral care activities perceived as time consuming and low-priority when compared to other responsibilities, lack of health and dental insurance; limited hours of dental office and clinic operations; and inability to schedule appointments that do not conflict with workplace demands and other parental responsibilities; lack of transportation and geographic distance to dental providers; having to miss school and/or taking time off of work for dental appointments; the complexity of navigating the health care system; and socioeconomic or cultural factors."

Data

We welcome the UND Center for Rural Health study "North Dakota Oral Health Report: Needs and Proposed Models 2014" that developed recommendations based on stakeholders input. The recommendations of the PEW/UND Study evolved from the 24 proposed oral health

models considered by the stakeholders participating in the study (http://ruralhealth.und.edu/projects/nd-oral-health-assessment/pdf/north-dakota-oral-health-report-exec-sum-2014.pdf). The group listed ten of these models as priority recommendations. The dental mid-level provider model was not included in this priority group. In fact the 5 highest-ranked priorities were all models that have been part of collaborative solutions that are already active in the state and supported by the North Dakota Dental Association and the Oral Health Coalition (http://www.ndohc.org).

These models mentioned above in the UND final report were also most mentioned by the interim Health Services Committee that after a year of study recommended 2 more years of study for midlevel providers and case management. It would seem important that after a year of study, the interim legislative committee failed to produce a bill. That committee, by their actions, decided that there is no urgency to propose legislation of the kind proposed by SB 2354.

While data presented in the UND study points out the barriers to care in the state, there are several important data points worth clarifying. How

15.4

is North Dakota really doing? We have an expanding and adequate supply of dentists that is increasing faster than the state population due primarily to North Dakota's economic prosperity (Exhibit B). 65 new dentists were licensed in the state in the past 2 years. When discussing workforce, Health Professions Shortage Area (HPSA) data is often cited to evaluate dentist distribution. As the attached HRSA table (Exhibit C) describes, there are 34 total HPSA designations, some of which are counties, American Indian reservations, and FQHC safety net clinics. What is important to point out is that according to this table, only 7 dentists are needed to remove designations. Also, please look at the HPSA map of the US (Exhibit D). Compare North Dakota to the other states with mid-level practitioners, Maine, Alaska, and Minnesota. The difference in the number of HPSA designations is striking.

Medicaid utilization and dentist participation are important factors affecting barriers to care. Medicaid participation by dentists is highly variable depending upon how you define it and where you obtain the numbers. The last ASTDD data provided by our state health department survey in 2012 showed 62% of ND dentists billed at least one paid claim and 37% of dentists were "billing" dentists with claims greater than

$10,000. While this is considered a valid survey, it is important to note that DHS tracks only "billing providers" which can include group practice dentists and that do not necessarily show up individually in participating dentist data. As this committee well knows, Medicaid reimbursement, along with minimizing administrative burdens and managing patient compliance, are consistent challenges for maintaining adequate dentist participation. The current discussion about data complexity emphasizes the importance of adequately defining problems and collaboratively developing solutions. We need to more accurately define unused dental capacity, develop statistically-valid dentist/population projections well into the future, and study the growth in Medicaid-eligibles and how that relates to workforce. See attached the CMS Toolkit summary description (Exhibit E) of strategies to improve Medicaid utilization. As you can see, program administration and enrollee/community factors must also be addressed in addition to provider participation. Data provides context but real patient options tell the story. All the larger cities in North Dakota have dentists who see Medicaid patients and are supported by safety-net clinics. Most of the smaller towns have a Medicaid provider. All of the 11 pediatric dental specialists in North Dakota see Medicaid patients.

15.6

Efforts must continue to challenge dentists to see Medicaid patients despite reimbursement below the cost of providing services. Dental visits by Medicaid patients to Hospital ER's has been mentioned as an indicator of access to care. At Sanford Health statewide, ER dental visits by Medicaid patients were down 18% from 2013 to 2014 (Personal Communication). Does this mean that there is no urgency to reduce barriers? Of course not. Our disagreements are not with the problems but whether the remedy in SB2354 has enough evidence to support it as a solution relevant to North Dakota. Once North Dakota makes the decision to redefine provider standards, it is unlikely there will be an option to reverse that decision. In sum, regardless of how you define the barriers, **solutions should be defined with just as much evidence as that which you require in defining the problems.**

It is clear that the most intense barriers to care exist in our Native American communities. From a provider standpoint, Indian Health Service dental lacks capacity and is perennially underfunded. The challenges to make that delivery system efficient are many, regardless of provider type. The credentialing barriers to allow non-IHS volunteerism or contracting with the local dental community are large

and real (Exhibit F). Immediate solutions focus on the 3 C's: 1) easing stringent IHS **credentialing** requirements to allow non-public health dentists, 2) **collaborating** with local dental communities to solve unique problems, 3) and providing assistance to tribes to help them use the "638" process to **contract** their dental IHS to effectively serve patients, as is being done at Three Affiliated Tribes in New Town. The dental program at Three Affiliated could serve as a model. The North Dakota Dental Association has an ongoing collaborative program that networks Tribal and dental leaders to identify barriers to care and develop solutions. Pediatric dental outreach projects treated some 600 children, many with severe treatment needs, at Spirit Lake and Standing Rock with 100 dental volunteers. Native American citizens deserve the same level of care as the rest of North Dakotans.

Finally, from a national data perspective, it is early to make any evidenced-based judgments about a new provider model with less training. There is lack of agreement regarding education and accreditation standards, the effects on applicant quality due low applicant numbers for existing programs, and the cost of resources to

15.8

effectively implement the unprecedented changes proposed. All deserve much more study. North Dakotans deserve no less.

Before turning to our solutions and summary, I would entertain any questions thus far about what I have presented.

Recognizing that action is what solves problems, Dr Tronsgard, President of the NDDA, will present here our list of 10 solutions to reduce barriers to care.

Chairperson Lee and members of the committee, my name is Dr. Paul Tronsgard and I am President of the North Dakota Dental Association. As Dr. Holman said, I will present our solutions to reduce barriers to care and summarize our presentation. Also attached is our North Dakota Action for Dental Health (Exhibit G), which describes in detail, current activities that are ongoing. The following is our list of solutions.

Ten Solutions

1. **Expand and simplify dental loan repayment programs** to target those starting practice in rural communities, serving Medicaid patients, or working in dental safety-net clinics (SB 2205).

2. **Expand the Seal! ND school sealant program** (SB 2197) through the State Department of Health to serve more low-income

children and add Medicaid-supported case management to direct high-risk patients into dental homes to save treatment costs.

3. **Expand the non-profit dental safety-net clinics** through public-private partnerships and innovative outreach to high-need areas and populations in the state.

4. Utilize the **North Dakota Dental Foundation** through grants to reduce barriers coinciding with the mission of the Foundation:
    - Reduce barriers to care
    - Prevention of dental disease
    - Improve education of the dental workforce

5. **Improve Dental Medicaid**
    - Use data analysis to target reasons for low utilization of recipients
    - Maintain adequate dentist participation through adequate reimbursement, reduction of program paperwork, and dentist recruitment programs
    - Develop Dental Medicaid Advisory Committee to improve Medicaid administration and provider relations

6. **Utilize dental hygienists and dental assistants** to their maximum level of education through outreach collaborative practice and training of expanded restorative functions.

7. **Engage tribal communities** to reform Indian Health Service, maximize prevention, reduce credentialing barriers and facilitate contracting with the local dental communities.

8. **Establish outreach programs in long-term care facilities** in partnership with the Oral Health Program, State Department of Health.

9. Support and strengthen the **Oral Health Coalition** (http://www.ndohc.org) to **collaboratively** identify problems and solutions to reduce barriers to care.

15.10

10. Coordinate and facilitate the development of **dental assisting training programs** in western North Dakota to address severe shortages of dental assistants in that part of the state.

Questions

Robert Merton in his 1936 paper listed possible causes of unanticipated consequences: "...error, overriding of long-term interest by immediate interest, and basic values that require or prohibit action". As you deliberate major changes in the way dentistry is delivered in North Dakota, we urge you to contemplate the consequences of your decisions well beyond the obvious intentions. Please consider the following:

1. Will lesser-trained providers foster the growth of large corporate dental operators with less service and no reduction in cost to patients?
2. Does the population in North Dakota really want this change in the way their care is delivered?
3. How is there any assurance that a new provider will have enough demand in rural areas to justify their investment? Would they need to be subsidized?

4. Are the estimated resources and costs necessary for the Board of Dental Examiners to implement this unprecedented change realistic?
5. What input would North Dakota have in training programs that currently have no accreditation standards and are not located in North Dakota?
6. How does a mid-level provider fit into a dental team? What are the effects on current workforce and workflow? What effect does this have on patients? Where will they find dental assistants given the current statewide shortage?
7. Are there ethical issues if mid-level providers with less training are limited to specified populations or sites?
8. How does the potential lack of examination by a dentist affect overall treatment plan decisions and oral health for patients?
9. What is the measurable effect on access to care in a state such as North Dakota given the resources and collaborative capital necessary to implement it? Is it worth it?

We feel that SB 2354 takes a one-size-fits-all solution, with little if any evidence base relevant to North Dakota, and attempts to prematurely

15.12

imprint it on our state with little thought to long-term consequences. We feel that the best alternative is to challenge the dental profession to produce results with collaborative solutions. In the end, you, as a legislator, have the same duty as providers: "first do no harm". Given the uniqueness of North Dakota, what is the urgency to be only the 4th state to try the mid-level provider experiment? Are you convinced that we should? We are not. We are on the same team and have the same goals. Help us to reduce barriers to care the North Dakota way…collaboratively. Thank you for your consideration.

Exhibit A

Access - Determinants

Exhibit B

Table 1: Supply of Dentists in the US by State - Dentists Working in Dentistry

Return to Table of Contents

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
North Dakota	315	325	330	332	329	318	306	300	305	315	315	316
Total US	155,087	157,228	158,641	160,388	160,781	163,291	164,664	166,383	163,345	165,597	167,499	169,731

Sources: American Dental Association, Health Policy Institute analysis of ADA masterfile (2001-2013), Distribution of Dentists Surveys (1993-2000).

2005	2006	2007	2008	2009	2010	2011	2012	2013	
312	311	322	333	344	361	370	383	394	**North Dakota**
171,556	172,603	176,087	178,331	181,341	183,165	186,025	188,820	191,348	**Total US**

Table 2: US Population by Table 2: US Population by State

Return to Table of Contents

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
North Dakota	641,216	644,804	647,832	650,382	649,716	647,532	644,259	642,200	639,062	638,168	638,817
Total US	259,918,588	263,125,821	266,278,393	269,394,284	272,646,925	275,854,104	279,040,168	281,421,906	284,968,955	287,625,193	290,107,933

Source: US Census Bureau, Population Estimates Program, https://www.census.gov/popest/index.html.

2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	
644,705	646,089	649,422	652,822	657,569	664,968	672,591	683,932	701,345	723,393	**North Dakota**
292,805,298	295,516,599	298,379,912	301,231,207	304,093,966	306,771,529	308,745,538	311,591,917	313,873,685	316,128,839	**Total US**

Exhibit C

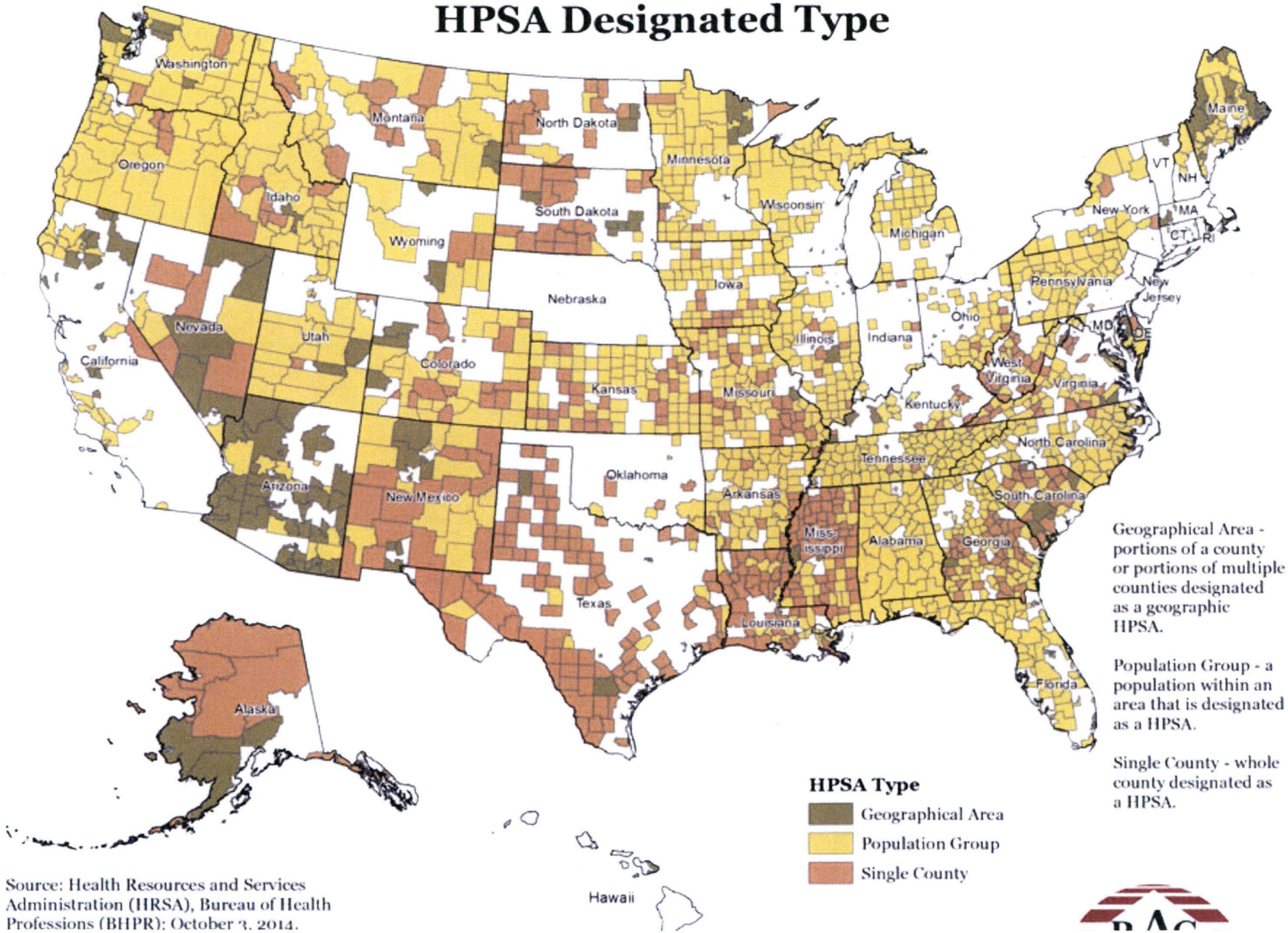
Designated Health Professional Shortage Areas (HPSA) Statistics

Dental Care	Total Designations[1]	Whole County	Service Area	Population Group	Facility	Total Population	Estimated Unserved Population (3000:1)	Practitioners Needed to: Remove Designation[2]	Practitioners Needed to: Achieve (3000:1)[3]
Region VI	**537**	**162**	**24**	**48**	**303**	**7,283,183**	**4,064,507**	**689**	**1,233**
New Mexico	72	13	9	11	39	693,670	498,562	104	152
Texas	230	96	15	8	111	4,193,895	2,260,695	366	692
Arkansas	42	9	0	11	22	201,280	138,112	30	34
Oklahoma	93	3	0	5	85	88,965	57,465	15	13
Louisiana	100	41	0	13	46	2,105,373	1,109,673	174	342
Region VII	**474**	**61**	**1**	**204**	**208**	**2,397,939**	**1,728,814**	**362**	**448**
Missouri	146	24	0	75	47	1,313,127	1,024,572	231	292
Kansas	136	26	0	69	41	677,491	463,378	89	102
Iowa	119	11	0	57	51	402,279	238,764	42	54
Nebraska	73	0	1	3	69	5,042	2,100	0	0
Region VIII	**307**	**59**	**14**	**75**	**159**	**1,560,022**	**1,071,015**	**217**	**288**
North Dakota	34	12	3	2	17	74,896	50,528	7	10
Montana	70	11	3	12	44	195,821	144,221	28	34
Colorado	78	16	2	27	33	533,019	385,694	78	109
Wyoming	23	2	2	8	11	71,782	36,982	7	7
South Dakota	54	16	3	5	30	125,036	105,236	24	23
Utah	48	2	1	21	24	559,468	348,354	73	105

1516

Exhibit B

Health Professional Shortage Areas (HPSA) - Dental Health
HPSA Designated Type



Geographical Area - portions of a county or portions of multiple counties designated as a geographic HPSA.

Population Group - a population within an area that is designated as a HPSA.

Single County - whole county designated as a HPSA.

Source: Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPR): October 3, 2014.

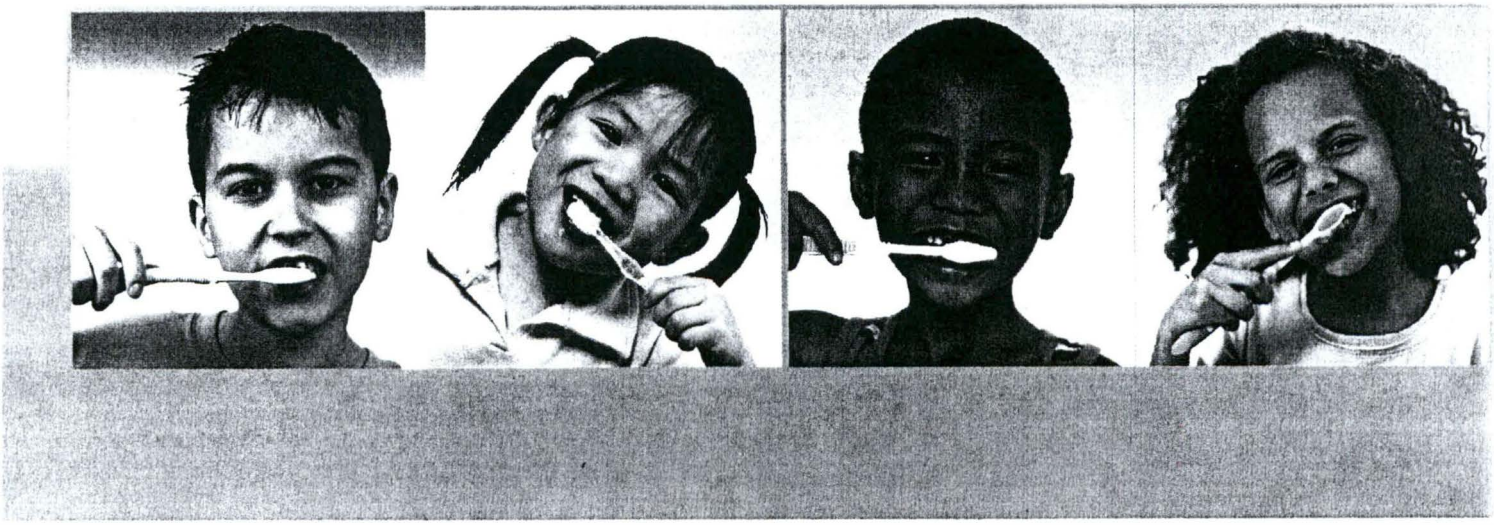
15.16

15.17
Exhibit E

Improving Oral Health Care Delivery in Medicaid and CHIP

A Toolkit for States

June 2014



Medicaid/CHIP
Health Care Quality Measures

Table 4A. Strategies to Address Provider Participation Barriers

Administrative	Provider-Focused	Enrollee-Focused	Collaborative
• Eliminate delays in provider reimbursements and ensure that clean claims are paid promptly. • Strategically increase provider payments based on gaps in access (including gaps in geographic, sociodemographic, and specialty care access). • Consider contracting out the administration of oral health benefits to a single "administrative services only" vendor with experience managing dental benefits and recruiting providers in the region. • Use clear, concise, accurate and up-to-date materials to recruit providers.	• Pursue efforts to change state practice acts to allow dental hygienists to evaluate children's oral health and provide preventive services without a dentist's prior exam, and to directly reimburse dental hygienists serving Medicaid/CHIP children. • Train primary care medical providers and their teams to conduct and bill for oral health risk assessments, furnish fluoride varnish applications, and make referrals for preventive and treatment dental services. • Sponsor trainings for general dentists in how to manage toddlers and young children in a clinical setting. • Through the state's dental association, cultivate local "champions" among Medicaid-participating dentists to engage in peer-to-peer recruiting and mentoring of new participating dental providers. • Offer targeted pay for performance incentives to dental plans and providers. • Encourage dental and dental hygiene students to pursue training opportunities in underserved areas (e.g., through placement in dental clinics within community health centers) and support creative efforts to increase student interest and willingness to practice in underserved communities. Collaborate with dental and dental hygiene schools and loan repayment programs.	• Deliver communications to families frequently, at a minimum at enrollment and renewal, about the importance of dental care to their child's overall health and how to access care. • Support providers in reducing no-shows by creating a centralized no-show reporting and follow-up system. • Embark on efforts to increase the oral health literacy of enrollees, including the importance of using good oral health practices at home.	• Partner with school-based health centers to integrate preventive dental services, including sealants, into school health programs. • Partner with state chapters of the American Academy of Pediatrics to work with their specially-trained Oral Health Advocates in securing more pediatrician participation in oral health prevention. • Partner with the state's primary care association and community clinics to develop and implement strategies to improve access such as outside-the-four-walls approaches to delivering dental care to children. • For States with significant Native American populations, partner with local Tribes and the Indian Health Service to identify and implement strategies for improving access to dental care for Native American children. • Collaborate with external partners to seek grant funding for efforts to increase access to dental care.

15.18

CREDENTIALS CHECKLIST (revised 09/08/2011) Exhibit F

NAME:

SERVICE UNIT:

15.19

CREDENTIALS FORM:	Credentialing Coordinator: YES	NO	DATE OBTAINED:	Clinical Director: YES	NO	Aberdeen OMCE: YES	NO	DATE OBTAINED:
1. National Provider Identification #:								
2. Photo Identifications – driver's licensure, employment ID – not just photograph (Verified with documented statement)								
3. AMA PROFILE, NATIONAL STUDENT CLEARING HOUSE, ETC. COMPLETED								
4. Completed Application/Re-application form (ALL blank areas filled in—use "NA" when applicable)								
5. DOCUMENTATION of any "yes" questions on liability, final judgments, settlements, or claims. (with complete explanations)								
6. Updated Curriculum Vitae – within past 6 months								
7. EMPLOYMENT GAPS > 2 months (ALL gaps to be explained)								
8. CLINICAL PRIVILEGES SPECIFIC TO FACILITY and specific to the applicant's abilities/competencies (ALL blank areas to be filled in – ALL discrepancies must be explained)								
9. COMPETENCE related to PI activities -- CD review sheet &/or reappointment review sheet								
10. PHYSICIAN PROFILING information (Info must be submitted with the file)								
11. CNACI status – Note evidence of clearance or have waiver in place								
12. CD & CEO signature approval on application, Clinical Privileges, & CNACI waiver								
13. Human Resource check for liability, investigative, etc. issues								
14. COPY OF CURRENT LICENSE(S) PRESENT:								
15. VERIFICATION OF ALL LICENSE(S) from primary source (MUST include all current & previous licensures) Active Current "In good standing" Without restrictions/disciplinary actions								Expires / Verified
16. DEA LICENSURE & STATE CDS certificates: Current & without restrictions; Expiration Date (Verification of both DEA & State CDS)								Exp Date
17. EDUCATION/TRAINING VERIFICATION from primary source with copies of diplomas								
18. LIABILITY INSURANCE current or TORT COVERAGE applicability (Verify last 10 years of professional coverage – review/document any cases)								Exp Date
19. HEALTH STATUS/STATEMENT of the applicant with provider attestation (this is Page 15 of the application form)								
20. TB STATUS within past 1 year (IMMUNIZATIONS RECORD to be placed in Employee Health file)								
21. CURRENT NPDB & HIPDB (within past 3 months)								
22. LETTERS OF REFERENCE – 2-3 within past 6 months (1 from medical supervisor & 1-2 from peers) – Verify reference letters								
23. CME current with BLS/ACLS/ATLS/PALS/NRP as applicable Listing of all CME over past 2 years								
24. Signed Bylaws Attestation statement								
25. TEMPORARY <120 DAYS APPT/CP's Date – Granted / Expires								

- VERIFICATION by phone call should be documented on the copy of (license/diploma/certification) within the file to note date & time called, person who gave you the information, & exactly what they verified.
- VERIFICATION by written form (letters requesting information & documentation letters returned) should be kept in the credentials file.

I have verified that the documents required for the credential process are within the credentials file.

Credentialing Coordinator's Signature _____ Date _____

Clinical Director's Signature _____ Date _____

OMCE Signature _____ Date _____

COMMENTS:

15.20

Exhibit G

North Dakota Action for Dental Health

Donated Dental Services Program (DDS)

http://dentallifeline.org/north-dakota/

The Donated Dental Services (DDS) program provides free, comprehensive dental treatment to our country's most vulnerable people with disabilities or who are elderly or medically fragile. These are people who cannot afford necessary treatment and cannot get public aid. The program operates through a volunteer network of more than 15,000 dentists and 3,600 dental labs across the United States. Since its inception in 1985, the DDS program has surpassed $250 million in donated dental therapies, transforming the lives of more than 120,000 people.

Since the DDS program began in North Dakota in 2001, 721 vulnerable individuals have received $2,297,839 in donated dental treatment from some of the 138 dentists and 13 dental laboratories that volunteer statewide! 43% of dentists in the state participate in DDS which is the 3rd highest rate in the nation.

ND Loan Repayment Programs

The North Dakota dental loan repayment programs are a combination of state and federally-financed programs with a variety of eligibility and benefits to encourage new dentists to practice in three areas of need:

15.21

serving low-income patients, working in safety-net non-profit clinics, and practicing in rural areas.

The NDDA was instrumental in starting these programs and modifying them over the years to make them effective in meeting the goals. As a result, North Dakota is a national leader in the number of new dentist licensees per year relative to its population. The net number of dentists in state has increased more than the growing population in the last 5 years.

Native American Collaboration

The North Dakota Dental Association has an ongoing collaborative program that networks Tribal and dental leaders to identify barriers to care and develop solutions. Efforts are ongoing to help improve the Indian Health Service dental system to effectively serve patients. Credentialing, to allow local dentists to contract or volunteer with tribal communities to reduce barriers to care, needs to be simplified. Resources are being directed to help tribes use the "638" process to separate their dental services component from IHS and use contracting to provide care. This collaboration requires trust and this trust must be earned. One of the frequent barriers expressed by Indian Health Service dental staff was the inability to get the kids with the most extensive treatment needs to pediatric dentists in nearby cities to complete treatment. In 2011 at Spirit Lake and in 2013 at Standing Rock, the dental community in North Dakota built a collaborative partnership that created a volunteer network of 20 pediatric dental specialists and some 75 dental team members to provide restorative treatment to the these high-need children. At these events, 600 children received treatment

with an estimated donated value of $260,000. 70 children were identified with acute, extensive dental disease and referred to pediatric dentists for treatment under general anesthesia in a hospital setting. 60 of those children had that treatment completed. The dental community also raised a total of $60,000 to provide the infrastructure and supplies to make these events possible. There was no government funding used for these projects.

Spirit Lake Pediatric Dental Days Video:

http://vimeo.com/30200365

Oral Health Coalition (http://www.ndohc.org/about-us.html)

Formed in 2005, the North Dakota Oral Health Coalition is a chartered, collaborative, statewide coalition comprised of a variety of public and private agencies, organizations and individuals focused on improving the oral health of North Dakotans. The North Dakota Dental Association has participated and collaborated with the Coalition since its inception. The Oral Health Coalition represents the best of dental collaboration, "the North Dakota way", solving problems through partnership, consensus, and sharing of resources. 45 organizations and many more individuals participate in building consensus-based solutions to reduce barriers to care. Current efforts of the OHC include introduction of a dental loan repayment bill that simplifies loan repayment programs to better target them to workforce needs. A bill that expands the Seal ND! Program that provides sealants in schools for high-risk children will add about 1800 low-income children to the

15.23

current program. The bill provides funds for case management to get high-risk kids into dental homes.

Expansion of Duties of Duties of Registered Dental Hygienists and Assistants

The NDDA supports expansion of duties of the current workforce and supported the recent rules changes passed by the North Dakota State Board of Dental Examiners which allows registered dental assistants and hygienists to do expanded restorative functions under the supervision of a dentist with additional training. With increased delegation of these duties, efficiency and productivity is increased which extends the reach of the dentist in providing access to care. The NDDA feels better utilizing our current dental professionals are the best route to improved efficiency for more patients.

Case Management Outreach Model

The Case Management Outreach model is currently being proposed by the NDDA that aims to create a sustainable model for dental assistants and hygienists to work with their collaborative dental offices in outreach community settings. These settings could include schools, preschools, medical settings, and long-term care facilities. Oral health assessments, fluoride varnish, sealants, and case management services would be provided with the goal of reaching high-risk dental patients and getting them into a dental home. A dental home is the most effective way to prevent oral disease and future costs of treatment. The key to developing this model is to achieve third party reimbursement

(Medicaid and dental insurance) for the 4 outreach services mentioned above to make the outreach a sustainable business model that will save these third parties money. A pilot for this model is being added to the school sealant expansion bill specified above.

Give Kids A Smile Program (GKAS)

Give Kids A Smile Day, will celebrated nationally on February 6, 2015. Dentists and dental teams participate in this program statewide and nationally to provide donated services and prevention to children through a variety of programs and venues. Many offices participate by providing free services on this date or on other dates throughout the year at their office, and by pre-scheduling children in need to receive screenings, cleanings, sealants and other needed treatments. For many children, this is an opportunity to find a dental home, and for dentists and dental team members, it is a great way to be involved in helping the local community. To sign up for GKAS or for more information about the program, visit the ADA's Give Kids A Smile webpage at www.ada.org/givekidsasmile.

Seal! ND Program through Oral Health Program, State Department of Health

The NDDA supports the Seal! ND program which is a result of legislation passed in 2009 that permits general supervision of licensed dental hygienists for procedures authorized in advance by a dentist. In 2011, four temporary public health hygienists employed by the Department of Health and supported through a Health Resources and Services Administration (HRSA) Workforce grant began applying fluoride

15.25

varnish and dental sealants to children pre-kindergarten through sixth grade in schools throughout the state. The NDDA supports legislation to fund expansion of this program to target more low-income children in public schools across the state that do not have a dental home. The State Oral Health Program currently is applying for a continuation grant through Dentaquest to establish dental care programs in long-term care facilities and assure links with dentists in their respective communities.

North Dakota Safety Net Public Health Dental Clinics

The NDDA has helped initiate and/or supports safety net non-profit dental clinics in North Dakota. There are currently 5 in the state:

- Bridging the Dental Gap in Bismarck
- Family HealthCare in Fargo
- Northland Community Health Center - Dental Clinic in Turtle Lake and Minot
- Valley Community Health Centers Dental Clinic in Grand Forks
- Red River Valley Dental Access Project in Moorhead, Minnesota (www.rrdentalaccess.com)

The NDDA supports expansion of these public health clinics particularly in the western part of the state where there are unique needs requiring specialized solutions to reduce barriers to care. There are opportunities utilizing these facilities to develop innovative ways to target high-risk patients to get them connected to dental homes and prevent costly treatment.

Ronald McDonald Care Mobile of North Dakota

The Ronald McDonald Care Mobile, a mobile dental clinic on wheels, delivers urgently needed dental care to underserved children ages 0 through 21 in their own neighborhoods in the western half of North Dakota. The Ronald McDonald Care Mobile of North Dakota is owned and operated by Ronald McDonald House Charities of Bismarck. Bridging the Dental Gap, Inc. of Bismarck, a non-profit dental clinic, is the clinical services manager for the the Ronald McDonald Care Mobile Program. The Ronald McDonald Care Mobile is a 40-foot long state of the art mobile dental clinic with its own dentist, dental hygienist and dental assistant. The mobile clinic staff delivers the dental care to underserved children in their own neighborhoods. The NDDA supports the Care Mobile. It is another model to fill in the gaps in our state where barriers to care exist, especially rural and Tribal communities. http://rmhcbismarck.org/caremobile/

North Dakota Dental Medicaid

Recognizing that most of the care in North Dakota for low-income patients is delivered by private practice dental offices, it is important to maintain adequate reimbursement for dental fees through Medicaid so that Medicaid-eligible patients have adequate access to dental care. North Dakota is one of the states that offer an adult Medicaid program. Currently dental Medicaid fees in North Dakota are below the cost of providing services. We must continue to advocate for adequate Medicaid funding as well as streamlining paperwork so that there continues to be an adequate network of dentist that will see Medicaid patients. Additional studies need to be done to make sure that areas of

15.27

low utilization in the Medicaid population are targeted for strategies for improvement. This takes collaboration between state agencies and dental organizations.

North Dakota Dental Foundation

Through the dissolution of the Dental Service Corporation administered by Blue Cross Blue Shield of North Dakota, a 6 million dollar endowment will be available beginning in 2015-16 through the North Dakota Dental Foundation. The endowment will support initiatives that reduce barriers to care, provide oral health prevention and education to the public, and support education of dental professionals.

Attach #16
23588
SB 2354
02/10/15

Senate Human Service Committee
SB 2354
February 10, 2014

Chairperson Lee and members of the committee,
My name is Brenda Schmid. I am submitting this written testimony to express my concerns and opposition to the SB 2354. We are proud parents of Hannah Schmid. Hannah is 17 years old and has disabilities and special health care needs. 1 in 5 households in the state of North Dakota are affected by disability and/or special health care needs. 10.5 of North Dakota residents have a disability. This number does not include those living with chronic health difficulties. In this testimony I represent myself as Hannah's mother and hope to help you understand the negative impact SB 2354 would have on the disability and special needs community. It is my understanding that SB 2354 intent is to help serve the underserved. Those with disabilities have been identified in this bill as underserved. Although this may be true this bill is not the answer.

Allowing Advanced Practice Dental Hygienist to practice under direct, indirect or general supervision of a dentist will only fragment the dental care of a patient. Those individuals with special health care needs rarely use the words "minor surgical" or "simple extraction". The Advanced Practice Dental Hygienist simply will not have the training or expertise to treat individuals with special health care needs. They will have a very narrow spectrum of knowledge.

One of my many concerns is that individuals like my daughter will be limited to tier 2 level of care (Advanced Practice Dental Hygienist) per medical assistance rules and regulations. That Dentist will be considered specialist which will require a visit to tier 2 level care first and then have to be referred to the Dentist. This causes a lot of wasted and critical time in getting medically necessary treatment. One stop does not fit all. Many with special health care needs will have to make 2 stops which will cost Medical Assistance 2 office visits instead of one.

16.2

In my opinion and 17 years of experience working with individuals with disability and/or special health care needs Advanced Practice Dental Hygienist is not the right fit for this population.

Another major concern I have is safety. The proof of the safety of Advanced Practice Dental Hygienist providing care for those with special health care needs does not exist to my knowledge. I feel this SB 2354 is premature with many unknowns. I ask for your support in opposing this Bill. Please protect those who are living with disability and/or special health care needs. Do not allow this population to be forced into tier 2 level care. Do not allow their Dental Care to become fragmented and substandard. All citizen's of North Dakota deserve quality, qualified and accountable Dental Care.

Thank you for your time and consideration. If you have any further questions I can be reached at 701-235-1781.

Regards,

Brenda Schmid
6024 27th St. S
Fargo, ND 58104

Attach #17
SB2354
02/10/15
2 3588

TESTIMONY IN OPPOSITION TO SB 2354

February 10, 2015

Robert Lauf, DDS

North Dakota State Board of Dental Examiners

Good morning Chairman Lee and members of the Committee, I am Rob Lauf, currently serving as President of the North Dakota State Board of Dental Examiners (NDSBDE).

The Board has an obligation to the public to assure that prescribed levels of knowledge and skill are achieved through a core of accredited education, training and experience. This, in addition to the assessment of competency, are the foundation for granting licensure privileges. Administrative rules put forward by the ND State Board of Dental Examiners to expand duties of the current workforce have followed a number of regulatory safeguards in place to assure public safety so that all parties affected by and with an interest in the changes have adequate notification and opportunity to provide input related to the shape and magnitude of the changes proposed. In contrast SB 2354 introduced only two weeks ago and containing major changes to the landscape of the dental workforce did not provide enough time to fully evaluate the legislation. As a result, the NDSBDE does not support the proposed change.

SB 2354 poses several logistical problems:

1) The Commission on Dental Accreditation (CODA) establishes guides for institutions that wish to create new programs or improve existing dental education programs. Goals related to the educational environment and the

17.2

corresponding standards are influenced by best practices in accreditation from other health professions. To date, CODA has yet to finalize standards for a new workforce involving dental therapists. The NDSBDE feels that the educational standards for any midlevel provider should be finalized before this additional workforce entity is permitted to work in North Dakota.

2) Expansion of duties of the current workforce: The Board began the process required for expansion of duties of dental assistants and dental hygienists in January/2013. Measures proposed in SB 2354 conflict with legislation currently being considered by the 2015 legislature. Administrative rules that are currently in progress include a measure to loosen the supervision and age requirements pertaining to administration of local anesthesia, restorative procedures for dental hygienists and dental assistants, language to include dental assistants in public health settings, expanded duties for dental hygienists and dental assistants within the oral surgery setting. These expanded functions in other states, Public Health Service, Indian Health Service and the U.S. Military have been shown to improve efficiencies in the delivery of dental care, while maintaining the quality and safety of dental care. Although increased efficiency can lead to increased access and lower costs, the primary concern of the North Dakota State Board of Dental Examiners with regard to the delivery of all dental care is for safety of the public.

3) A mandated study: The fiscal impact is estimated to be $145,000, creating a financial burden for licensees.

4) Section 14, Page 11. Tribal sovereignty: This proposed section in the dental practice act does not relate to any other language in the act. The Board has

never encountered licensing/disciplinary or regulatory conflicts with Native American tribes and is aware of tribal sovereignty and the challenges present within the Indian Health System related to dentistry. The purpose and intent of this reference to Tribal Sovereignty is unclear.

5) The organization of the language of the bill does not take into account the existing format which the Board has deliberately worked to organize. The organization of this bill is inconsistent with the dental hygiene, registered dental assistant and qualified dental assisting statute and rule.
6) Data sources admit that information currently available for work force models of this type is incomplete due to insufficient numbers of providers. Media has also presented conflicting information. For example, national proponents tout the success of dental therapists in New Zealand as an example. Yet after having dental therapists for 90 years, New Zealand reports radically different data as noted in the two articles submitted for your review.

Considering the magnitude of the introduction of a new workforce model, lack of data to assure public safety, misinformation regarding efficacy and understanding that other remedies utilizing the current workforce have a proven efficacy to address access to care, the NDSBDE urges you to oppose SB 2354.

In September of 2013, the University of Minnesota's Dean Dr. Leon Assael stated that gathering of data related to dental therapists in Minnesota has not provided a clear picture of efficacy due to the small numbers of practitioners (27) and the small data samples collected. Proponents of the workforce model state that what has happened in Alaska and MN is best for ND. The NDSBDE concludes that North

17.4 Dakota has ample competent dental workforce providers who can deliver comprehensive preventative, restorative, and public health care services in an increasing array of settings without placing the public at risk.

Conclusions about the impact of the mid-level provider are fundamentally flawed

Please vote "do not pass" on SB 2354.

Attachments: "The New Zealand Herald; NZ children's dental health still among worst" and "Revealed: state of our kids' teeth"

17.5

The New Zealand Herald

NZ children's dental health still among worst

By Abby Gillies
5:30 AM Sunday Mar 6, 2011

Jenni Graham with daughter Mikayla who already has three fillings and is only 5 years old. Photo / Janna Dixon

The dental health of young children continues to be among the worst in the developed world, figures reveal.

Forty-four per cent of 5-year-olds have at least one decayed, missing or filled tooth, a school dental services report has found.

The Government has spent $417 million on the problem since 2007 but the figures have shown little improvement.

In 2000, 48 per cent of 5-year-olds had cavities, and the figure has not dropped below 43 per cent since.

New Zealand rates are worse than the UK, US and Australia.

Auckland paediatric dentist Clarence Tam said it wasn't unusual to see children as young as 2 or 3 with huge holes in several teeth.

"It definitely seems to be on the rise for 5-year-olds and younger children. Cavities start to rip through their teeth like wildfire," he said.

The report, by the Ministry of Health, showed the worst hit areas were Counties Manukau, where 11,830 cavities were recorded, followed by Waikato, 9152, and Northland, 7810.

The study showed Maori and Pacific Island 5-year-olds had the worst oral hygiene, with 65 per cent and 73 per cent having one or more decayed, missing or filled teeth respectively.

Free dental care is available for children up to 18. Most public primary schools have a dental clinic and many regions operate mobile clinics.

Despite campaigns to improve access and enrolment, a number of factors led to poor oral hygiene, the ministry said.

Many parents didn't see oral health as a priority and only took their children to a dentist in an emergency, said New Zealand Dental Association spokeswoman Deepa Krishnan.

Tam agreed and said diet was also to blame, with people choosing unhealthy snacks that allowed acid to attack teeth.

"I've seen a baby bottle filled with Coca-Cola. People choose to eat cakes or potato chips as opposed to a slice of cheese, nuts or carrot sticks."

Parents needed to set a good example and get children to brush their teeth at least twice a day and floss, said Tam.

Losing baby teeth early could mean problems as they got older, including a lack of space for adult teeth.

In extreme cases, where most of the baby teeth had to be pulled out, children could be without teeth for several years, said Krishnan.

17.6

"Imagine a 2 to 3-year-old with no teeth. They cannot eat, can't bite or chew. They have problems with speaking and it affects their self esteem."

In the US, 28 per cent of children aged between 2 and 5 had one or more decayed, missing or filled teeth in 2004.

In 2005, the figure for 5-year-olds in England was 39 per cent and in Australia 43 per cent.

The Government has allocated $116m to refurbish and build dental clinics, and to buy mobile clinics in the next five years. Another $40m is available each year for community oral health services.

DAUGHTER'S DECAY CAME AS A SHOCK TO CAREFUL MOTHER

Former dental assistant Jenni Graham was shocked to discover her 4-year-old daughter Mikayla had several cavities.

One hole was so deep it reached the nerves inside the living pulp of her tooth.

"I was horrified and my first reaction was, what has caused this? Why her?"

Mikayla, now 5, is on the waiting list to go under general anaesthetic for two fillings.

The pulp of one tooth may need to be removed and a stainless steel crown fitted.

"We've got to wait six weeks to have the treatment done. In the meantime, she's in discomfort."

The Kumeu mother of four said she was in a better position than most to know about how to care for teeth but there had been no warnings of her daughter's tooth decay.

She brushed Mikayla's teeth twice a day and kept her away from sugary treats.

But as a baby, she often gave Mikayla a bottle of milk when she woke at night crying: "I knew in the back my mind it wasn't good".

However, Mikayla was scared of going to the dentist from a young age, which made check-ups difficult.

Graham said parents had to be educated about how to care for their children's teeth, to prevent the pain of early decay.

SIMPLE IS BEST WHEN IT COMES TO CARING FOR CHILDREN'S TEETH

A healthy balanced diet doesn't need to be expensive, according to Mission Nutrition nutritionist Claire Turnbull.

Her tips include eating fruit and vegetables that are in season, using lentils, chickpeas and beans to bulk out meat dishes and drinking tapwater rather than juice or soft drinks.

She says that healthy eating can save time in the long run because "you will feel better, work better, concentrate better and be able to be more efficient".

Foods with a high sugar content are bad news for teeth, and children who snack often are most at risk.

Decay is caused when bacteria in the mouth comes into contact with sugar, turning it into lactic acid, which slowly breaks down the tooth's surface.

Specialist paediatric dentist Nina Vasan recommends healthy snacks with little or no sugar and sipping water after snacking to dilute lactic acid build-up.

Juice and soft drinks should be avoided but if drunk, should be consumed through a straw so the liquid doesn't touch the teeth, says Vasan.

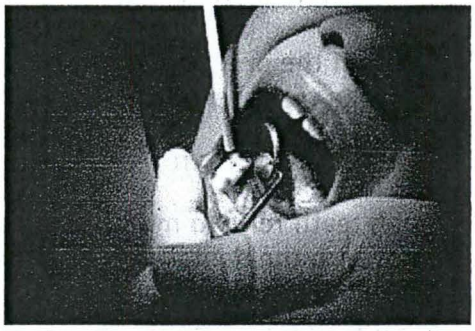
By Abby Gillies

The New Zealand Herald

12.7

Revealed: state of our kids' teeth

By Nikki Preston
5:00 AM Wednesday Sep 10, 2014


Ngapera Ronaki, 5, has her teeth checked at the mobile dental clinic at her school. Picture / Christine Cornege

More pre-schoolers are being hospitalised with dental disease including severe tooth decay than any other age group, and the rate of admissions in New Zealand for all age groups have grown significantly in the past 20 years.

Children aged 8 or under had the highest rate of admission to hospital for dental care with 3- and 4-year-olds requiring significantly more treatment than anyone else, according to a report published by the Ministry of Health reviewing admission to hospitals for dental care between 1990 and 2009.

Between 2005 and 2009, 20.7 in every thousand children aged 3 to 4 years old were hospitalised for dental treatment, up from 17.8 in every thousand between 2000 and 2004. The number of 5- to 8-year-olds also rose to 12.7 in every thousand from 8.9 in every thousand during the same period.

The figures have alarmed health experts who say better access to dental care, greater access to fluoridated water, better diets and cleaning regimes would all contribute to improve dental health in early childhood. In New Zealand basic dental care is provided free to children under the age of 18.

Hawkes Bay District Health Board clinical director oral health services, Dr Robin Whyman, one of the report's authors, said children were admitted to hospitals because often it was easier and safer for younger children to be put under general anaesthesia to treat severe decay.

Dr Whyman said children needed to be seen by a community dental service earlier than the traditional practice where they were not seen before 2 years old.

Waikato District Health Board community oral health manager Diane Pevreal said lower decile schools generally had a higher rate of decay and poor dental health was often shown in family patterns. Maori and Pacific children tended to have poorer oral health and the report showed these groups had a higher rate of hospitalisation.

Hamilton dental therapist Jo McCaffrey, who has been in the industry for 35 years, said she felt the problem of tooth decay among pre-schoolers had got worse and said sugary drinks were a major culprit.

Ministry of Health chief dental officer Robyn Haisman-Welsh said reinvestment by the government in oral health since 2008 to fund fixed and mobile dental clinics had the potential to slow or reverse the trend of more children having severe dental issues. The aim of the $116 million capital investment was to promote earlier enrolment.

Sugar gets the blame

When Toni Ronaki's sixth child was born, she thought she knew the answer to tooth decay.

17.8 The teacher aide at Insoll Avenue Primary School in Hamilton had learned about dental care the hard way when her 14-year-old son needed his front teeth removed after drinking juice so was determined not to go through it again with her younger children.

But she was shocked last year to learn 5-year-old Ngapera required fillings and a stainless steel crown.

A check-up at the mobile community dental clinic at Insoll School this week found she needed another tw crowns.

Ms Ronaki said she had taken Ngapera to the clinics for check-ups from 2.

She said Ngapera tried and "did her best to clean her teeth in the morning and at night".

Ms Ronaki the only way she could have improved Ngapera's dental health was by removing sugary foods and drinks from her diet altogether.

Keeping them clean

- Brush teeth for two minutes twice a day (after breakfast and dinner) with a fluoride toothpaste
- Enrol with the dental service at nine months of age and have regular check-ups
- Parents and health professionals "lift the lip" monthly and check children's teeth for any signs of decay
- Children eat teeth-friendly, healthy foods low in sugar
- Children drink water and milk rather than sugary acidic drinks

Source: Plunket

Dental treatment in children, 2005-2009

Age/ Hospital admissions per thousand children
0-2/ 2.2
3-4/ 20.7
5-8/ 12.7
9-12/ 2.3
Source: Admissions to New Zealand Public Hospitals for Dental Care: A 20-year review

By Nikki Preston

- NZ Herald

Attach #18
SB 2354
02/10/15
23588

Dear Chairman and Committee members for Senate Bill 2354:

My name is Dr. Carrie Orn, and I am urging you to vote NO on Bill 2354. I am a 5th generation Jamestown, ND resident and chose to come back to my hometown to practice dentistry. I own my own practice in Jamestown and was one of the recipients of the ND Loan Repayment Program in 2009. My practice is comprised of about 8% Medical Assistance (Medicaid) patients. I make annual nursing home visits and perform infant and early childhood dental exams/education/treatment for our local Head Start children twice a year.

My major concerns about this bill:

1) People are comparing the Advanced Practice Dental Hygienist (APDH) to a Nurse Practitioner; however, there are some key differences. APDHs would be performing irreversible procedures with less education than dentists. Some of the irreversible procedures this bill allows for are extractions of primary teeth and permanent teeth. Many people do not understand how extracting primary teeth ('baby teeth') can cause damage to permanent teeth and also can cause numerous irreversible problems in the mouth. It is amazing how many times a 'simple extraction' diagnosed on an X-ray (of either a primary or permanent tooth) ends up needing to be a more invasive surgical extraction. These procedures can be completed properly by a dentist with few risks. However, if they are performed by an individual with less training or education, these procedures can cause serious problems; ex. permanent numbness, sinus perforations, permanent sinus trauma, bone loss, etc.

2) If ND was to pass this Bill, we would only be the 4th state to do so. Currently, there are no clear regulations, education requirements, certification procedures, etc. for APDHs. I am concerned we would be conducting an 'experiment' on our citizens by trying to implement this Bill.

3) Supporters of this Bill have advocated that the APDHs would fill a gap in dental care that is needed in rural areas and on our State's reservations. However, the Bill, as written, does not provide any incentives for these new APDHs to work in those underserved areas. In addition, individuals in these areas are often high-risk patients with complex dental needs. Rather than introducing an individual with less training and education, the Legislature should focus on incentives and resources for trained dentists to care for these patients' oral health. As I mentioned earlier, I was a recipient of the ND loan repayment program, which required me to stay in ND for 4 years and treat a certain percentage of Medicaid patients. This program motivated me to return to ND to serve my hometown community, and some of my fellow dental school classmates also came back to rural ND because of this great incentive. I urge the Legislature to focus on programs such as these to encourage dentists to practice and serve our State, rather than creating a position that requires less training and education.

18.2

Unfortunately, this is a bill that sounds good in theory, but our citizens deserve quality dental care from people qualified to perform invasive, irreversible procedures. Please consider the negative impact of supporting this bill as changing the Practice Care Act may have serious consequences for the people of North Dakota.

Please vote No on Bill 2354.

Thank you for your consideration.

Sincerely,

Carrie Orn, D.D.S.
916 5th Ave. NE
Jamestown, ND 58401

Attach #19
SB 2354
02/10/15

23588

d St. Aubyn

From: Rod St. Aubyn <rodstaubyn@gmail.com>
Sent: Tuesday, February 10, 2015 6:11 AM
To: Judy Lee; Oley Larsen; Howard Anderson; Dick Dever; Tyler Axness; John Warner
Subject: CODA approves mid-level (dental therapy like Advanced Practice Dental Hygienists)

Senators,

CODA (Commission on Dental Accreditation, which is the academic body that accredits dental programs throughout the US) approved mid-level (dental therapy) standards on Friday, February 6, 2015. This is important because while dentists and others are saying no one but a dentist should do irreversible procedures, the Council on Dental Accreditation just approved standards allowing non-dentists to do irreversible procedures. It also speaks to the credibility of mid-levels such as the Advanced Practice Dental Hygienist. If they were not safe, not qualified, or experimental in any way—CODA would not have taken this step.

[redacted]opied the following from NDCC 43-28-01 which includes definitions under Chapter 43-28 [redacted]ling with Dentists:

1. "Accredited dental school" means a dental school, college, or university accredited by the commission on dental accreditation of the American dental association or its successor.

The following is taken from CODA's website:

CODA was established in 1975 and is nationally recognized by the United States Department of Education (USDE) as the sole agency to accredit dental and dental-related education programs conducted at the post-secondary level. CODA's mission is to serve the oral health care needs of the public through the development and administration of standards that foster continuous quality improvement of dental and dental related educational programs.

[redacted]

15.0848.01001
Title.

Prepared by the Legislative Council staff for
Senator Axness
February 16, 2015

SB2354
Attach #1
02/16/15
J#23930

PROPOSED AMENDMENTS TO SENATE BILL NO. 2354

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 43-28 of the North Dakota Century Code, relating to collaborative practice agreements with dentists and dental hygienists; and to provide for a legislative management study.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 43-28 of the North Dakota Century Code is created and enacted as follows:

Collaborative practice agreements.

1. As used in this section:

   a. "Collaborative practice agreement" means a written agreement between a dentist and a dental hygienist under which the dentist authorizes and accepts responsibility for the dental hygiene services performed by the dental hygienist and under which the authorized scope of practice is established.

   b. "Dental hygiene" has the same meaning as provided under section 43-20-03.

2. A dentist may enter a collaborative practice agreement with a dental hygienist to provide dental hygiene services in board-identified rural communities, underserved communities, and Indian reservations. Under a collaborative practice agreement:

   a. The dental hygienist may not provide dental hygiene services unless the patient is participating in a dental home with the collaborating dentist and the collaborating dentist has examined the patient within the previous twelve months.

   b. The dental hygienist may provide hygiene services without the collaborating dentist being present.

   c. The dental hygienist may provide dental hygiene services at a location other than the usual place of practice of the collaborative dentist or the dental hygienist.

   d. The dental hygienist may direct bill.

   e. The dental hygienist shall maintain professional liability insurance.

3. The scope of practice established in the collaborative practice agreement may be more restrictive than the scope of practice authorized under this section.

1.2

4. For a collaborative practice agreement to remain valid, the collaborating dentist and dental hygienist shall update the collaborative practice agreement every two years and shall amend the collaborative practice agreement when the scope of practice or any other term of the agreement is modified. The collaborative practice agreement or amendment to the agreement is effective when filed with the board.

5. The board may adopt rules under this section.

SECTION 2. MID-LEVEL DENTAL PRACTITIONERS - LEGISLATIVE MANAGEMENT STUDY. During the 2015-16 interim, the legislative management shall consider studying the feasibility and desirability of providing for mid-level practice by advanced practice dental hygienists in order to address unmet dental needs in this state. The legislative management shall report its findings and recommendation, together with any legislation required to implement the recommendation, to the sixty-fifth legislative assembly."

Renumber accordingly

SB2354
Attach #2
02/16/15
JH 23930

POTENTIAL AMENDMENTS TO SENATE BILL NO. 2354

AMENDMENT #1 – Pushing Back the Dental Board Report

from Dever

Page 12, line 12, remove "2015-16 and" and replace "interims" with "interim"

Page 12, line 15, remove "August 1, 2016, and"

Renumber accordingly

Explanation: As introduced, the bill requires the board of dental examiners to consult with the department of human services and report to legislative management in the two upcoming biennia the general impact and status of advance practice dental hygienists in North Dakota. This amendment would remove the reporting requirement for the 2015-16 biennium and require reporting only during the 2017-18 biennium. The amendment would also negate any fiscal impact to the board of dental examiners during this biennium. The requirement of the board of dental examiners to report during the 2015-16 biennium on implementation of the law to the administrative rules committee remains intact under this amendment.

From Dever

Attach #3
SB 2354
02/16/15
J# 23930

AMENDMENT #2 – Delayed Implementation of Act

Page 8, line 9, after "43-28-06." Insert "The board may, in its discretion, wait to develop rules necessary to implement and enforce this Act until August 1, 2016, if the board by majority vote determines that additional information necessary to protect the public interest will become available before such date."

***NOTE: Jennifer Clark is working with John Walstad to determine if there is a better way to draft this provision.*

Page 13, after line 13, insert:

"**SECTION 18. LEGISLATIVE INTENT – RULE-MAKING.** It is the intent of the sixty-fourth legislative assembly that the board of dental examiners work diligently to adopt rules necessary for the implementation and enforcement of this Act."

Renumber accordingly

Explanation: As introduced, this bill would become effective on the default date of August 1, 2015. Because of reservations on the efficacy of advance practice dental hygienists by the board of dental examiners and the dental association, an August 1, 2016, date to begin writing rules would give the board an additional year to consider any research or data that would assist in implementing the legislation. This amendment would not affect the requirement that the board regularly report to the administrative rules committee on the status of the board's implementation of the act.

Attach #4
SB 2354
02/16/15
J# 23930

AMENDMENT #3 – Limitation on Number of Advance Practice Dental Hygienists

Page 12, after line 3, insert:

"8. Limit the number of advance practice dental hygienists who may be supervised by a dentist, but may not limit a dentist from supervising up to three advance practice dental hygienists."

Renumber Accordingly

Explanation: As introduced the bill does not have a limitation on how many advance hygienists could be supervised by a dentist. This amendment would cap that number at three advance hygienists per dentist.

Attach # 5
SB 2354
02/16/15
J# 23930

AMENDMENT #~~5~~ 4 – Technical/Clean Up Amendments

Page 6, line 23, after the second "practice" insert "advance practice"

Page 9, line 29, after "the" insert "advance practice"

Renumber accordingly

Explanation:

The first amendment makes clear that an APDH cannot practice advance hygiene independently. As introduced, it prohibited an independent hygiene practice, not an independent *advance* hygiene practice.

The second amendment cleans up an incorrect reference to a dental hygienist in the section requiring a collaborative management agreement – the reference should be to advance practice dental hygienist.

SB2354
Attach #1
02/17/15
S#24000

Commission on Dental Accreditation (CODA)
Approved Educational Standards[i]

CODA-Approved Procedures	Irreversible?	Included in SB 2354?
a. identify oral and systemic conditions requiring evaluation and/or treatment by dentists, physicians or other healthcare providers, and manage referrals[ii]		Yes
b. comprehensive charting of the oral cavity		Yes
c. oral health instruction and disease prevention education, including nutritional counseling and dietary analysis		*Already part of ND hygienist scope*
d. exposing radiographic images		*Already part of ND hygienist scope*
e. dental prophylaxis including sub-gingival scaling and/or polishing procedures		*Already part of ND hygienist scope*
f. dispensing and administering non-narcotic analgesics, anti-inflammatory, and antibiotic medications		Yes[iii]
g. applying topical preventive or prophylactic agents (i.e. fluoride), including fluoride varnish, antimicrobial agents, and pit and fissure sealants		*Already part of ND hygienist scope*
h. pulp vitality testing		Yes
i. applying desensitizing medication or resin		Yes
j. fabricating athletic mouthguards		Yes
k. changing periodontal dressings		*Already part of ND hygienist scope*
l. administering local anesthetic	Yes	*Already part of ND hygienist scope for adults (SB 2066 would allow for kids)*
m. simple extraction of erupted primary teeth	Yes	Yes
n. emergency palliative treatment of dental pain limited to the procedures in this section	Yes	Yes[iv]
o. preparation and placement of direct restoration in primary[v] and permanent teeth	Yes	Yes
p. fabrication and placement of single-tooth temporary crowns		Yes
q. preparation and placement of preformed crowns on primary teeth	Yes	Yes
r. indirect and direct pulp capping on permanent teeth	Yes	Yes
s. indirect pulp capping on primary teeth	Yes	Yes[vi]
t. suture removal	Yes	*Already part of ND hygienist scope*
u. minor adjustments and repairs on removable prostheses		Yes
v. removal of space maintainers		*Already part of ND hygienist scope*

[i] CODA noted that states may decide to add additional procedures to a dental therapist's scope of practice other than what are listed in the CODA guidelines. In such cases, CODA requires that accredited institutions train students to perform these additional procedures. As in other states with similar dental providers, SB 2354 allows "Simple, nonsurgical extractions of periodontally diseased permanent teeth with tooth mobility of +3 to +4 as long as the teeth are not impacted, fractured, unerupted, or in need of sectioning for removal" (also allowed in AK, MN and being implemented in ME) as well as administration of nitrous oxide analgesia (allowed in MN and being implemented in ME).

[ii] SB 2354, Section 1 (I) includes a "brush biopsy" which would be part of this CODA section.

[iii] Addressed in Section 13 of SB 2354. In addition, an APDH is *prohibited* from *prescribing* drugs.

[iv] SB 2354 says "Emergency palliative treatment of dental pain and performing management of dental trauma, including a minor surgical care extraction and suturing."

[v] SB 2354 also specifies "e. Pulpotomy on primary teeth" which is often part of the "preparation" process.

[vi] SB 2354 also allows "direct" capping on primary teeth, as does MN.

Attach#2
SB2354
02/17/15 J#24000

From: Cheryl Rising <cdrising@earthlink.net>
Date: February 16, 2015 at 9:11:23 PM CST
To: Judy Lee <jlee@nd.gov>, <olarsen@nd.gov>, <hcanderson@nd.gov>, <ddever@nd.gov>, <taxness@nd.gov>, <jwarner@nd.gov>
Cc: Carey <crivinius2@yahoo.com>, Andrea Malucky FNP <amalucky@yahoo.com>, Cory Fong <cfong@odney.com>
Subject: regarding SB 2354
Reply-To: Cheryl Rising <cdrising@earthlink.net>

Senator Lee and Committee Members of the Senate Human Services:

I would like to inform you that the North Dakota Nurse Practitioner Association is in support of SB 2354, that will allow dental hygienists to seek and acquire additional education to become Advanced Practice Dental Hygienists and provide additional services under the general supervision of a dentist. We believe this will improve access for dental care to our ND residents. We have added our organization to the coalition that supports this bill.

If any questions please contact me at 701-527-2583, or email

Cheryl Rising, FNP Legislative Liaison NDNPA