**2019 HOUSE HUMAN SERVICES**

**HB 1426**

# 2019 HOUSE STANDING COMMITTEE MINUTES

**Human Services Committee**
Fort Union Room, State Capitol

HB 1426
1/21/2019
31138

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Elaine Stromme by Marjorie Conley

**Explanation or reason for introduction of bill/resolution: Relating to regulation of dental therapists and relating to dental therapist definition and unlawful practice of dental hygiene, dental therapy, and dentistry.**

**Minutes:** Testimony 1 - 18

**Chairman Weisz:** Opened Hearing on HB1426.

**Representative Devlin:** New member of a dental team is a dental therapist. Has to have completed at least 500 hours under a licensed dentist. (Testimony #1)

**Representative Westlind:** On page 3 it says a federally qualified health center or federally qualified health center look alike, not for profit governmental dental practice or ordination that serves primary low income and underserved individuals. Can you give me examples of those types of institutions?

**Representative Devlin**: The people behind me will present all that information.

**Representative Tveit:** You indicated that the dental therapist would be under the supervision of the dentist. At what distance, is the dentist on location or is he removed from the physical location?

**Representative Devlin:** That would be entirely up to the dentist and the dental therapist. If the dentist does not want to use a dental therapist in the state of North Dakota, he doesn't have to. Nothing in this bill would force them to do that. We think that it is time that option exists.

**Nathan Davis, a council representative for the Turtle Mountain Band of Chippewa Indians:** Supports HB1426. (Testimony #2)

**Representative Dobervich:** What options do people have on the Chippewa Reservation? What options do you have for dental care? How far do they have to travel?

**Nathan Davis:** Right now we have primarily are our local IHF facility. We have 3 dentists on staff and in our direct area of service, we have over 15,000 members receiving active treatment.

**Scott Davis, Executive Director of North Dakota Indian Affairs Commission:** I am in total support of HB1426.( Testimony # 3)

**Chairman Weisz:** Why does it seem that the dentists have a revolving door? Is there a federal program where they get their education paid so they put the time in and leave?

**Scott Davis:** Good question. They put their time in and off they go – private practice?

**Dr. Joanne Luger, DDS**: (Testimony #4) This bill will expand quality care to more patients. People in poverty will get quality care. In 2017 68% of children on Medicaid did not receive care. This bill doesn't require a dentist to hire one. It doesn't cost the state any money and the dental therapist will work in limited practice settings in clinic, not in private practice.

**Chairman Weisz:** What is a federally qualified center look alike look like?

**Dr. Joanne Luger, DDS**: I am not sure what that is. All I know is that it is a public health facility.

**Dr. Karl Self:** (Testimony #5)

**Representative Westlind:** How many students are enrolled in the program?

**Dr. Karl Self:** We have a target currently of eight students a year.

**Representative Westlind:** And you graduate eight students a year?

**Dr. Karl Self:** Yes.

**Vice Chairman Rohr:** Have you changed the curriculum? Have you added or deleted based on quality data?

**Dr. Karl Self:** We have made multiple modifications to our program. We are the first state in the nation to create an educational program for dental therapy. We have a dual degree in dental hygiene and dental therapy program. A dental therapist is not able to do a teeth cleaning in Minnesota.

**Chairman Weisz:** Any further questions from the committee?

**Dr. Karl Self:** I can respond to that question of F2HD. These clinics are federally designated clinics and they get federal dollars to support care to the uninsured as well as an increased difference reimbursement rate for those under care of a

government program. A look alike has the benefits and the advantages of getting the same enhanced reimbursement, but they don't get a separate grant to support the care of the uninsured. They have to follow the same rules and regulations.

**Representative Porter:** In the dual training, how many are working in a dual capacity?

**Dr. Karl Self:** There aren't recent statistics that break all of that down. We do know where people work and how much they are working in dental therapy component, so that the vast majority are focusing on the dental therapy skill set.

**Chairman Weisz:** Further testimony in support.

**Jim Nelson, Legislative Director of the North Dakota Veterans Legislative council:** (Testimony # 6) (32:54-35:25) The VA does not provide oral health care for everyone. There are a limited few that are eligible for oral health care.

**Sheri Solseng Trif:** I am currently an advanced dental therapist practicing in MN. (Testimony # 7)

**Emily Mallory, President of North Dakota Dental Hygienists' Association:** (Testimony # 8) (38:54 – 41:21) We believe that bringing dental therapy to North Dakota would achieve the goal of providing the public's overall dental health.

**Dr. Monica Meyer**: My Testimony is in terms of need. On the reservation we have only one dentist. We do have our oil resource. The federal budget for Fort Berthold is $700,000.00. It is not enough. We need basic care for our children and our elders.

**Dr. Todd Thierer:** (Testimony # 9) Dental therapists are a great help to a dentist. Medicare does not cover dental care. It is the dentists license that the therapist works under. The dentist decides what the dental therapist can and cannot do within the statutory scope of practice of dental therapists.

**Vice Chairman Rohr:** They do this under the general supervision of a dentist versus direct? Can you expound on this?

**Todd Thierer:** Indirect supervision, the dentist is right there. General supervision is the dentist is not there but accessible by phone or online. The don't have to be right there.

**Josh Askvig, AARP in North Dakota:** (Testimony #10)We support the bill for a couple of basic reasons. Once you reach Medicare, not all your medical expenses are taken care of, secondly Medicare generally does not cover dental care unless it is medically related.

**Dr. Donald Warne, Director of the Master of Public Health Program at the University of North Dakota School of Medicine and Health Sciences:** (Testimony #11)(54:28-57:57)

**Chairman Weisz:** Opposition to HB1426?

**Dr. William Sherwin, Executive Director of the North Dakota Dental Association**: (59:04 –1:29:56) (Testimony # 12) Several North Dakota dentists are opposed to dental therapists. We are here to advocate for our clinics. We are here to advocate for access to our dentists.

**Dr. William Sherwin** also submitted testimony for the Spirit Lake Reservation in Fort Totten. No voice testimony. (Included in Testimony #12)

**Representative Westlind:** How many patients do you see on the reservations?

**Dr. William Sherwin:** 1 to 2 per day up to 50 per day.

**Dr. Steven Deisz:** (Testimony #13 (1:30:44-1:42:43)

**Dr. Sarah Mertz:** (Testimony #14 (1:42:56-1:53:09)

**Dr. Bradley King:** (Testimony # 15) (1:53:35-2:04:14)

**Representative Schneider:** Would you favor a MN bill?

**Dr. Bradley King:** They need more training.

**Representative Skroch:** If this is written correctly, do you see in this profession being a way hiring a professional at a lower salary and then being able to cover patients with less funds being taken out of Medicare?

**Dr. Bradley King:** We feel that we have a responsibility to take care of Medicaid patients. We do it because it is the right thing to do. We all work together because we see the problems out there and understand them. I have been doing this for 37 years, some of my first patients were Medicaid patients.

**Representative Damschen:** How many dentists would allow this?

**Dr. Bradley King:** Aspen Dental charges less, they don't support Medicaid.

**Senator Brad Bekkedahl:** (Testimony # 16) (2:10:12-2:14:08)

**John Olsen, Representing the North Dakota Dental Association:** I Have a testimony from a dentist in MN (Testimony # 17).

**Chairman Weisz:** Closed the hearing on HB1426.

Testimony in opposition without voice from **Rita Sommers, Executive director of the Board of Dental Examiners**. (Testimony # 18).

# 2019 HOUSE STANDING COMMITTEE MINUTES

**Human Service Committee**
Fort Union Room, State Capitol

HB 1426
2/5/2019
32209

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Nicole Klaman by Donna Whetham

**Explanation or reason for introduction of bill/resolution:**

**Explanation or reason for introduction of bill/resolution:**
Relating to regulation of dental therapists and relating to dental therapist definition and unlawful practice of dental hygiene, dental therapy, and dentistry.

**Minutes:** Attachment 1

Chairman Weisz: Opened meeting on HB 1426. Handed out the proposed amendments.

**Representative M. Ruby:** Explained the amendment. I will not move it.(See Attachment 1).

**Chairman Weisz:** The amendment states a dentist would have to be on site now by eliminating the subsection on page 5. Line 5 says it has to be under indirect supervision if authorized by rules. Any discussion or questions?
Representative Porter: One of the arguments to pass the bill is to increase access and by doing your amendment it really doesn't do anything for access across rural North Dakota. It actually changes it and makes it worse for the possibility of access.

**Representative M. Ruby**: I can't argue that, I just have issues with sending a lower level technician out into the rural areas without having a dentist on site. This just addresses one of my issues.

**Representative Devlin**: I will move the amendment to HB 1426.

**Representative D. Anderson**: Seconded.

**Chairman Weisz:** Any further discussion? Seeing none.

**Voice Vote taken:** Motion carries to amend HB 1426.

**Chairman Weisz:** Any further discussion? Seeing none. What is the committees wishes?

**Representative D. Anderson**: I move a Do Pass as amended on HB 1426.

**Representative Devlin**: Seconded.

**Chairman Weisz:** Any further discussion? Obviously this was a contentious hearing.

**Representative Devlin:** I started down this journey a number of years ago based on a trip to Alaska when I saw what dental therapists could do for Native Americans and other people. When I got back I saw where people from the tribes had their first trip for dental issues was an emergency room at 7 or 8 years old. These children are not being served. The only ones opposing us in testimony is from the dentists. To me it more of a matter of competition than it is anything else. We need to reach the Medicaid population. They are not being reached now. We need to have this. It has worked well in other states. I would urge a do pass.

**Representative Westlind:**I talked to a dentist in Devils Lake that goes to Fort Totten every Friday and there are 3-4 dentists and two hygienists on staff there. They see only 3-4 patients a day. The dental hygienists have a 60% rate of no show of scheduled appointments. They are providing a great service there. They are contracted by the tribe so at Fort Totten there is plenty of coverage down there. At the Chippewa nation in Belcourt, they have 4 dentists on staff and several assistants on staff. With that many dentists on staff the problem is not to have another hygienist on staff. The problem is getting people educated on dental hygiene care. All of these dentist that I talked takes Medicaid patients. The dentist that goes down to Fort Totten if they have an extraction it is usually one that is not a simple procedure. Generally, the patient is in pain with massive decay and it basically will be a surgical procedure. It is not something a dental therapist could do. Even if the therapists were there it would be out of their scope of practice. The health department should be at these reservations and in the schools handing out toothbrushes and toothpaste. If we want to do something we need to pass bills that educate our young people on proper dental hygiene.
I really don't think this bill will do what it is supposed to do and I will vote no on HB 1426.

**Representative Devlin:** If you look at the population of those two reservations, 4-5 dentists couldn't begin to cover it. The other thing that is an absolute fact is both of those reservations and tribal governments, every Native American Tribe in North Dakota came in to support this because they see the need. I don't think I would want to speak for the tribes, they spoke for themselves. They said they need dental therapy in North Dakota and I think we have an obligation to support what the sovereign tribes of North Dakota said they needed and asked us to do. I will vote for this bill.

**Chairman Weisz:** Any further discussion? Seeing none. The clerk will call the roll for a Do Pass as amended on HB 1426.

**Roll call vote:** Yes 8 No 5 Absent 1. Motion passes.

**Representative Devlin:** Will carry the bill.

Hearing closed.

DA 2/5/19

19.0603.03001
Title.04000

Adopted by the Human Services Committee

February 5, 2019

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1426

Page 5, line 2, remove "1."

Page 5, line 4, after "under" insert "indirect supervision, or under"

Page 5, line 5, after "supervision" insert "if authorized by rules adopted by the board,"

Page 5, line 9, replace "a." with "1."

Page 5, line 13, replace "b." with "2."

Page 5, line 16, replace "c." with "3."

Page 5, line 18, replace "d." with "4."

Page 5, remove lines 19 through 24

Renumber accordingly

Date: 2-5-2019
Roll Call Vote #: 1

**2019 HOUSE STANDING COMMITTEE**
**ROLL CALL VOTES**
**BILL/RESOLUTION NO. HB 1426**

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 19.0603.03001

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

Other Actions: ☐ Reconsider ☐ _____

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

| Representatives | Yes | No | Representatives | Yes | No |
|---|---|---|---|---|---|
| Robin Weisz - Chairman | | | Gretchen Dobervich | | |
| Karen M. Rohr – Vice Chairman | | | Mary Schneider | | |
| Dick Anderson | | | | | |
| Chuck Damschen | | | | | |
| Bill Devlin | | | | | |
| Clayton Fegley | | | | | |
| Dwight Kiefert | | | | | |
| Todd Porter | | | | | |
| Matthew Ruby | | | | | |
| Bill Tveit | | | | | |
| Greg Westlind | | | | | |
| Kathy Skroch | | | | | |
| | | | | | |
| | | | | | |

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

**Voice Vote: Motion carries.**

Date: 2-5-2019
Roll Call Vote #: 2

**2019 HOUSE STANDING COMMITTEE**
**ROLL CALL VOTES**
**BILL/RESOLUTION NO. HB 1426**

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

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

Other Actions: ☐ Reconsider ☐ _____

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

| Representatives | Yes | No | Representatives | Yes | No |
|---|---|---|---|---|---|
| Robin Weisz - Chairman | X | | Gretchen Dobervich | X | |
| Karen M. Rohr – Vice Chairman | X | | Mary Schneider | X | |
| Dick Anderson | X | | | | |
| Chuck Damschen | | X | | | |
| Bill Devlin | X | | | | |
| Clayton Fegley | X | | | | |
| Dwight Kiefert | A | | | | |
| Todd Porter | | X | | | |
| Matthew Ruby | X | | | | |
| Bill Tveit | | X | | | |
| Greg Westlind | | X | | | |
| Kathy Skroch | | X | | | |
| | | | | | |
| | | | | | |

Total (Yes) 8 No 5

Absent 1

Floor Assignment Rep. Devlin

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

Motion carries.

## REPORT OF STANDING COMMITTEE

**HB 1426: Human Services Committee (Rep. Weisz, Chairman)** recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (8 YEAS, 5 NAYS, 1 ABSENT AND NOT VOTING). HB 1426 was placed on the Sixth order on the calendar.

Page 5, line 2, remove "1."

Page 5, line 4, after "under" insert "indirect supervision, or under"

Page 5, line 5, after "supervision" insert "if authorized by rules adopted by the board,"

Page 5, line 9, replace "a." with "1."

Page 5, line 13, replace "b." with "2."

Page 5, line 16, replace "c." with "3."

Page 5, line 18, replace "d." with "4."

Page 5, remove lines 19 through 24

Renumber accordingly

**2019 TESTIMONY**

**HB 1426**

**Rep. Bill Devlin Testimony – House Human Services Committee – HB1426**

Good afternoon, Chairman Weisz and esteemed members of the House Human Services Committee. For the record, I am Rep. Bill Devlin District 23. Our district is a rural legislative district in eastern North Dakota.

I am proud to introduce HB 1426 for your consideration.

North Dakota currently suffers from a significant shortage of dentists. Even though the number of dentists practicing in North Dakota has gradually increased during recent years, thousands of North Dakotans are unable to receive affordable, routine dental care every year.

House Bill 1426 would look to authorize a new dental provider called a dental therapist, like physician assistants, dental therapists are midlevel providers who are trained to offer routine and commonly needed preventive and restorative care, such as filling cavities.

Let me please run though what this bill would do – it would allow a new member of the dental team, called a dental therapist, to limited practice settings such as:

Federally Qualified Health Centers (FQHCs) and FQHC Look-Alike clinics, Tribal facilities, programs run through the Indian Health Service. Non-profit or government-run dental clinics, programs that provide dental care to the low income and underserved, including those that work in community settings like schools or nursing homes.

The Dental Therapist must:

- graduate from a board of dental examiners-approved dental therapy program or one that is accredited by the Commission on Dental Accreditation (CODA);

Pass board-approved exams in clinical competency and jurisprudence

- complete 500 hours of clinical practice under a dentist's direct or indirect supervision

The dentist is still the leader of the team. The goal is to use this provider to provide more of the routine care to free the dentist to practice at the top of his or her scope. It is important to emphasize that a dental therapist may only practice under the supervision of a dentist and under the terms of a written collaborative management agreement (CMA).

And within the Collaborative management agreements between the dentist and dental therapist they can address together any limitations on services and/or supervision of services, treatment settings, practice protocols, recordkeeping, managing medical emergencies, quality assurance, administering and dispensing medications, and supervision of dental assistants.

North Dakota is a leader in occupational licensing reform – let's keep that going by knocking down rules that prevent more people from getting quality dental care – rules that evidence shows are not necessary to guard the public from unsafe care. Rules that are keeping dental costs high by preventing practices from operating more efficiently with lower-cost providers. Doctors opposed nurse practitioners many years ago and now many offices could not operate without a mid-level in their office.

Twenty-four North Dakota groups support this legislation as an effective, common-sense solution to increase access to dental care and improve the oral health of our residents. Over 50 countries, and several states including Alaska and neighbor Minnesota, utilize these highly trained and skilled dental professionals to enhance treatment opportunities and provide more access to dental services.

Committee members, former Rep. Bette Grande, of The Heartland Institute couldn't be here today but wanted me to provide copies of her testimony supporting HB1426. I have provided them to the committee. Grover Norquist of the Americans for Tax Reform has provided written support of this bill to all of you through e-mail. If any of you did not receive it, I would be happy to provide copies of his testimony.

As I mentioned earlier in my testimony, the North Dakotans for Dental Access which is a statewide coalition of 24 organizations committed to increasing access to affordable, routine dental care in North Dakota are supporting this bill. You will hear from some of them and other supporters today.

Committee members, now is time to make this happen! I urge your support of HB 1426. I can certainly try to answer any questions you might have but prefer to let you hear from the experts that will follow me to the podium.

Thank you, Mr. Chairman and members of the committee.

HB 1426
#1
1/21/19
page 4

THE HEARTLAND INSTITUTE
FREEDOM RISING

**Testimony before the North Dakota House Human Services Committee**
**Bette Grande, Research Fellow**
**The Heartland Institute**
**January 21, 2019**

Chairman Weisz and members of the Committee, thank you for taking the time today to discuss the issue of dental therapy. The Heartland Institute is a 34-year-old independent, national, nonprofit organization whose mission is to discover, develop, and promote free-market solutions to social and economic problems. Heartland is headquartered in Illinois and focuses on providing national, state, and local elected officials with reliable and timely research and analyses on important policy issues.

I am Bette Grande, a research fellow at the Heartland Institute and coauthor of *The Case for Licensing Dental Therapists in North Dakota.*

HB 1426 is before you to allow dental therapists into the labor market. At a time when North Dakota is facing workforce issues in so many areas the State should be open to expanding opportunities for all types of employment to better serve the new and incoming population.

Authorizing dental therapy in North Dakota would expand oral care access for underserved patients. A growing number of states and tribal communities are allowing dentists to employ dental therapists to help meet the growing need for routine dental care. These midlevel providers function similarly to physician assistants with doctors, dentists use dental therapists to extend quality care to more patients, deliver treatment to underserved populations and increase their practices.

Dental therapists are trained to perform up to 94 services and procedures, compared to fewer than 40 services by dental hygienists and about 30 by dental assistants. Dental therapists would practice exclusively under the supervising dentists who employ them and deliver high-quality care. Dental therapists provide preventive and routine care, such as filling cavities, placing temporary crowns on teeth, and extracting severely diseased or loose teeth.

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

Thank you for your consideration.

Bette Grande

HB1426
#1
1/21/19
Pages

Research Fellow
The Heartland Institute

This Policy Brief keeps the liberty question front-and-center in the dental therapy debate.https://www.heartland.org/publications-resources/publications/the-state-lawmakers-case-for-legalizing-dental-therapy

A nonprofit foundation has launched a website designed to provide information about dental therapy for consumers, health care professionals, and policymakers. The website includes an extensive library of articles, infographics, and videos explaining how dental therapy, which involves the provision of general dental procedures by qualified professionals, improves access to quality dental care and lowers the cost of dental procedures.https://www.heartland.org/news-opinion/news/online-dental-therapy-resource-launched

The Kellogg Foundation's 460-page review of the benefits of dental therapy as demonstrated in more than 50 countries. https://www.heartland.org /publications-resources/publications/a-review-of-the-global-literature-on-dental-therapists

HB1426
#2
1/21/19
page1

House Human Service Committee

State Capitol

600 East Boulevard

Bismarck ND, 58505-0360

RE: House Bill 1426

66th Assembly (2019)

Dear Chairman and Committee members,

The Turtle Mountain Band of Chippewa Indians support House Bill 1426 and have drafted this letter for future reference of our support. My name is Nathan Davis and I'm a Councilman for the Turtle Mountain Band of Chippewa Indians. I will speak plainly, our overall access to dental care, on and off our Reservation is abysmal in North Dakota. Allowing a mid-level professional to perform restorative work as well as routine preventative work, will be a huge step towards solving this problem. House Bill 1426 would allow a dental therapist to work underneath the supervision of a dentist in the safety net areas. Like federally qualified healthcare centers, non-profit organizations, tribal entities, and IHS facilities. This bill mimics the legislation recently signed into law in Arizona and Michigan. This bill would greatly impact the people of North Dakota, by improving their access to oral healthcare. Our current oral healthcare system has proven inadequate to meet the demands our state is facing. I ask that you support this legislation, thank you for your consideration.

Sincerely,

Nathan A. Davis

Council Representative

Turtle Mountain Band of Chippewa Indians

HB1426
#3
1/21/19
page 1

**Testimony of Scott Davis, Executive Director of North Dakota Indian Affairs**
**House Human Services Committee**
**In Support of HB1426 – to authorize dental therapists in specific settings in the state**
**Monday, January 21, 2019**

Chairman Weisz and fellow members of the committee thank you for the opportunity to testify today. My name is Scott Davis and I am Executive Director of North Dakota Indian Affairs. In this role, I serve as a go between for North Dakota's state and tribal governments, to address issues ranging from education, economic development, social services, transportation and healthcare issues.

For this reason, I implore you to pass HB1426 – it is legislation that would allow for the creation of an additional member of the dental team – called a dental therapist. Sadly, dental decay in North Dakota among our children on and off the Reservation is atrocious.

Dental therapists would dramatically alleviate a growing dentist shortage that plague communities across the United States. According to the U.S. Department of Health and Human Services, 56.7 million Americans, roughly 17 percent of the population, live in areas designated as dental care health professional shortage areas.

Native Americans suffer from poor oral health in part because of a lack of available dentists: In 2014, more than 2.4 million Native Americans lived in counties with dental care shortage areas, and half of all Native American children lived in a shortage area.[1] **And what is most alarming, half of Native American 3rd graders in North Dakota have had untreated tooth decay**.[2]

Dental therapists can practice under the supervision of a dentist and can treat patients in remote settings where dentists are not available to treat them. This could include - nursing homes, federally qualified healthcare centers, Veterans' nursing homes, sliding-fee-clinics and tribal clinics. This new member of the dental team could provide a variety of preventive care and basic services – and that is the goal of HB1426.

If private practice dental settings won't take Medicaid patients and those families that fall in between the cracks, then let's allow a new provider to do so.

It is worth noting that while North Dakota has one of the highest dental Medicaid reimbursements rates in the United States at 63% … as of 2015, North Dakota ranked third from the lowest at preventive visits billed by dentists for children enrolled in North Dakota Medicaid.

---

[1] Center for Native American Youth at the Aspen Institute, "Oral Health and Native American Youth" (September 2014), http://www.aspeninstitute.org/sites/default/files/content/docs/cnay/Oral-Health-and-Native-American-Youth.pdf.

**In closing, I would submit, 24 different groups across the state support this bill including –**
**The United Tribes of North Dakota;**
**Spirit Lake Tribe;**
**Standing Rock Sioux Tribe;**
**Three Affiliated Tribes of Mandan, Hidatsa, and Arikara Nation and the**
**Turtle Mountain Band of Chippewa Indians**

I urge you to pass this common-sense solution – as this bill mirrors the dental therapy legislation recently signed into law in Arizona and Michigan. Thank you for your consideration.

HB1426
#4
1/21/19
page 1

**North Dakota House of Representatives**
**Human Services Committee**

**Testimony of Dr. Joanne Luger**
**In Support of HB1426 – to authorize dental therapists in specific settings in the state**
**Monday, January 21, 2019**

Chairman Weisz and Members of the committee, thank you for allowing me the opportunity to testify in favor of HB 1426 today.

My name is Dr. Joanne Luger, I'm a practicing dentist at Bridging the Dental Gap, a sliding fee clinic, located here in Bismarck.

I come before you today to urge your support of dental therapy. Similar to physician assistants, dental therapists are midlevel providers who are trained to offer routine and commonly needed preventive and restorative services, such as filling cavities. Dentists hire and supervise dental therapists to expand quality care to more patients, and provide treatment to underserved at-risk populations in community settings, such as schools or nursing homes**. Eight states have authorized dental therapists in some capacity: Arizona, Maine, Michigan, Minnesota, Vermont, and tribal communities in Alaska, Oregon, and Washington.**

- This bill HB1426 would authorize the use of DTs in limited practice settings. Federally Qualified Health Centers (FQHCs) and FQHC Look-Alike clinics
- Tribal facilities, programs or organizations including Urban Indian Health Centers, Tribal operated (638) health facilities, and those operated through the Indian Health Service
- Non-profit or government-run dental clinics, programs, or organizations that provide dental care to low income and underserved individuals, including those that provide services in community settings like schools or nursing homes.

I'm among the small number of dentists in this country who grew up in poverty. I am a member of the First Nation's tribe and lived with my family in Canada's Yukon Territory in a home with no running water. I know what it's like to grow up with no dental care – to live for days with a toothache and no way to relieve it. I imagine that many of the 97,000 people in our state who live in dentist shortage areas may have experienced what I did as a child. It doesn't have to be this way.

I can also tell you firsthand the gratitude that people from isolated communities experience when dental care comes to them. I know this because I started my career as a dental therapist in Canada, travelling by plane to remote towns in Northern Canada and caring for people using mobile equipment. I can tell you from experience what you may have read from the research – that dental therapists provide the same quality of care as dentists for the procedures they have in common. I know this as a former dental therapist and I know this from my experience as a dentist.

Our state has too many people living in areas with no or few dentists. Dental decay is a serious condition – left untreated it can cause abscesses and infections that in extreme cases can lead to death. Yet dentists are the only provider in North Dakota who can treat cavities. We need more providers who can treat decay and provide other basic dental care. Dental therapists can do this at a lower cost than dentists, so practices can afford to send them to underserved areas, to schools, to nursing homes, and

to other locations where people are in need. This is not second-tier care – it's quality care that can be accessible to so many more North Dakotans.

North Dakota also has the notorious reputation of being worst in the nation in getting dental care to children on Medicaid**. In 2017, 68% of Medicaid children in our state went without care. We have this ranking with one of the most generous Medicaid reimbursement rates in the country**. Dental therapists can make it more financially feasible for dentists to treat Medicaid patients, and they can help our safety net clinics stretch their dollars by using savings in labor costs to serve more Medicaid and uninsured patients. This is happening in Minnesota and it can happen here.

There is no ONE strategy for solving our state's dental care access problem. But it's clear that allowing practices to expand their teams with dental therapists can help. They can do this at a lower cost, at no risk to patient safety. I've seen it work firsthand and I can see no reason why North Dakotan' dentists shouldn't have the option to use this type of provider. This bill doesn't require a dentist to hire one, it doesn't cost the state any money and the dental therapist would work in limited practice settings like my clinic, NOT in private practice.

I ask for your support of HB1426. Thank you. I will take any questions.

Sincerely, Dr. Joanne Luger, DDS – Bridging the Dental Gap, Bismarck, ND

HB1426
#5
1/21/19
page 1

**Karl Self, DDS, MBA**

Testimony before the North Dakota House Human Services Committee (HB 1426)
January 21, 2019

Thank you, Mr. Chairman and members of the committee. My name is Dr. Karl Self and I have been a dentist for 35 years. While I have had the opportunity to work in a variety of practice settings, I have spent most of my practicing career in a community clinic setting. I have been on faculty at the University of Minnesota School of Dentistry since 2006, and I was appointed the Director of the Division of Dental Therapy at the School in 2010. I also have an MBA which I found to be very helpful when I was the Executive Director of a FQHC clinic in Minneapolis.

I appreciate the opportunity to speak with you today about Minnesota's experience utilizing dental therapists and our School of Dentistry's educational program. In Minnesota, everyone agrees that many different factors cause and affect the access to care issue and that workforce factors are an important component of this issue.

In 2015, estimates made by the Health Resources and Services Administration (HRSA)[1] showed that the Minnesota dentist workforce was inadequate and though there were 3,455 practicing dentists in the state, it would have required the addition of 88 dentists to eliminate all of our state's Dental Health Professional Shortage Areas in 2012. That need was projected to grow to 252 additional dentists by 2025. This problem is not unique to Minnesota. I've been told that in North Dakota, nearly half of the counties have either no dentists or just one. In fact, that same HRSA analysis projected that by 2025, North Dakota would need an additional 34 dentists to eliminate all of your state's Dental Health Professional Shortage Areas. That is roughly 10% more dentists than were practicing here in 2012.

Thus, while there is no single solution to correct this problem, in Minnesota we are finding that the addition of dental therapists to the oral health care team is one workforce solution that is making a difference. As of November 2018, there were 89 dental therapists licensed to practice

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025. Rockville, Maryland, 2015. https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/nationalstatelevelprojectionsdentists.pdf

in Minnesota. At that time, 94% of all licensed dental therapists were employed and they worked in a variety of settings, including private practices, nonprofit clinics, FQHCs, and large group practices. About 60% worked in underserved areas in and around the Twin Cities, and the other 40% worked in rural and remote corners of our state. A map and employment fact sheet are attached to my testimony.

Although the concept of dental therapy in Minnesota is still evolving, dental therapists have established themselves as permanent members of the oral health care team. Some dental therapist are not in the workforce by choice, but for those interested in employment, there are more employers looking to hire a dental therapist than there are available dental therapists to hire. A 2016 Minnesota Department of Health Dental Therapy Workforce report[2] noted that 87% of dental therapists were working full time. Yet, despite the challenges of initiating a new profession, that same report found that job satisfaction among dental therapists was high with 90% of dental therapists reporting that they were either "satisfied" or "very satisfied," with their career. These levels are similar to those of other Minnesota health care professionals for which data exists. Although, there may be some dentist who have explored adding a dental therapist to their dental team and found that the concept did not fit into their practice, I continue to hear from dentists about their high level of satisfaction with their dental therapists. This anecdotal evidence is supported by the fact that roughly 40% of dentists and clinics which currently employ a dental therapist have chosen to employ additional dental therapists in their practice or clinic.

Nationally, people want to know about the impact of dental therapy in Minnesota. Some have stated that dental therapy is not working in Minnesota because the percentage of kids covered by medical assistance statewide, who have seen a dentist, has not gone up. The reality is, with dental therapists comprising less than one-half of one percent of our oral health workforce that is not an appropriate measure of success. The value of adding a dental therapist to a clinic should be looked at in the context of how it impacts that specific clinic and the community it serves. In 2014, the Minnesota Department of Health in conjunction with the Minnesota Board

[2] Minnesota Department of Health. Minnesota's Dental Therapist Workforce 2016. Minnesota Department of Health. 2016
http://www.health.state.mn.us/divs/orhpc/workforce/oral/2016dtb.pdf

of Dentistry submitted to the state legislature a report titled Early Impact of Dental Therapy in Minnesota[3].

This report noted that:

- On average, 84 percent of the new patients seen by a dental therapist were enrolled in public programs.
- Nearly one-third of all patients surveyed experienced a reduction in wait times for an appointment since the dental therapist was employed.
- Some patients saw a reduction in travel time for their appointment with the dental therapist compared to their last appointment, this was most notable in rural areas.
- Other reported impacts included personnel cost savings, increased dental team productivity, and improved patient satisfaction.

It is instructive to note that the cost savings to clinics allowed the clinics to expand capacity in order to serve more underserved and public program patients.

Since 2014, there have been six case studies published documenting the experiences of various clinics employing dental therapists in Minnesota.[4,5,6,7,8,9] Four of those clinics are located in a rural area of the state, additionally, three were non-profit clinics with one being an FQHC. While each case study provides a unique look into the impacts of incorporating dental therapists into an existing clinic, I'd like to highlight three findings that are seen across the board and build on the results from the Early Impact Report.

1) Clinics that hire a dental therapist see increase numbers of uninsured and public insurance patients. In one rural clinic Medicaid patient visits increased by 50% in the dental therapists first year. A second rural clinic increased Medicaid patient visits from 3% to 20% in the first 3 months of hiring a dental therapist.

---

[3] Minnesota Department of Health. Early Impacts of Dental Therapists in Minnesota. Minnesota Department of Health. 2014
http://www.health.state.mn.us/divs/orhpc/workforce/oral/dtlegisrpt.pdf
[4] PEW Charitable Trust. "Expanding the Dental Team: Studies of two private practices" (February 2014)
[5] PEW Charitable Trust. "Expanding the Dental Team: Increasing Access to Care in Public Settings " (June 2014)
[6] Wilder Research. "Midwest Dental: Dental Therapist Case Study" (May 2017)
[7] Wilder Research. "Grand Marais Family Dentistry: Dental Therapist Case Study" Grand Marais, MN (May 2017)
[8] Apple Tree Dental. "An Advanced Dental Therapist in Rural Minnesota" (February 2018)
[9] Apple Tree Dental. "An Advanced Dental Therapist in Long-Term Care" (February 2018)

2) All clinics noted cost savings by hiring a dental therapist with many of the case studies documenting the increased clinic net revenue. In the case of the FQHC clinic, they chose to use those funds to hire a second dental therapist to address further unmet needs.
3) All clinics documented a change in their provider's practice patterns. With the support of a dental therapist focusing on fillings, the dentist could focus on providing care that only the dentist can provide. In one rural clinic, the dentist was able to increase the amount of extractions they performed by 75%. In a different clinic, the dentist was able to increase the amount of orthodontic care and care to treat gum disease by 86%.

These are real example of how dental therapist are improving access to oral health care for Minnesota residents.

Finally, there are others who have expressed concern about the quality of care provided by the dental therapists. To date, there has been no disciplinary actions taken by the Minnesota Board of Dentistry against a dental therapist. On the topic of quality, it is important to understand that although one case study found that the dental therapist could provide 71-79% of the care that was performed by the dental team in a long-term care facility, dental therapists are actually educated in a small subset of procedures that a dentist can perform. The Commission of Dental Accreditation, or CODA, is the educational accrediting body for the dental profession. They set the educational standards for dental, dental hygiene, dental assisting and now dental therapy educational programs. As all dental therapy programs in the country are in the process of pursuing approval through CODA, I have the privilege of sitting on the review committee that created and maintains the dental therapy standards. I can attest to the fact that the rigor of dental therapy educational program reviews will be the same as the rigor of dental student educational program reviews.

At the University of Minnesota, we have been educating dental therapists since our state authorized these providers in 2009. Dental therapists in Minnesota are trained in a defined scope of practice that includes both preventive and routine restorative procedures. At the University of Minnesota, we have a dual degree Bachelor of Science in Dental Hygiene/Master of Dental Therapy educational program. Our dental therapy students are educated alongside our dental and our dental hygiene students. As an example, where the scope of practice of a

dental therapy student overlaps with that of a dental student, like drilling and filling a cavity, both student groups take the same courses, have the same clinical requirements, and must pass the same examinations. Upon graduation from our educational program, and prior to licensure, dental therapy graduates are required to pass a patient-based clinical examination that is the same as a portion of the examination that dental graduates have to pass. Both groups take the exam at the same time and exam evaluators are unaware as to which individuals are testing to become a licensed dentist and which will become a licensed dental therapist. This blind evaluation ensures that dental therapists have the same skills and abilities as dentists for the procedures both providers are licensed to perform. Thus, from a quality of care standpoint, our dental therapy graduates are educated to the same standards as dentists for the limited scope of practice they are licensed to perform.

As you can see, there is evidence that dental therapy is an effective tool for closing gaps in access to care. I am proud to be a part of this effort and the University of Minnesota dental therapy program stands ready to educate North Dakota residents to become dental therapists in order to help address North Dakota's access to care issues. Thank you for the opportunity to speak here today. I am happy to answer any questions you may have.

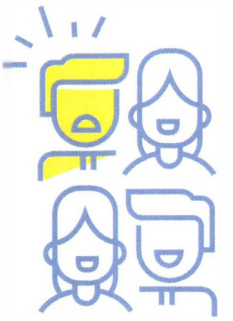
HB1426
#5
1/21/19
page 6

# Dental Therapists

## *Good for North Dakotans' Health and Good for North Dakota*

### *North Dakotans need dental therapists.*

- Dental therapists will help give access to dental care to elderly people, children, those in poverty, Native Americans, and those without insurance.
- Nearly 97,000 North Dakotans live in areas with a shortage of dentists.[i]
- Thousands of North Dakotans do not receive regular, routine dental care.[ii]
- More than 1 in 4 North Dakota 3rd graders have untreated tooth decay.[iii]
- North Dakota is the worst in the nation for providing dental care to Medicaid-enrolled children. 68% did not see a dentist in 2017.[iv]
- More than 1 in 5 adults have untreated decay.[v]
- Half of Native American 3rd graders have had untreated tooth decay.[vi]
- Among nursing home residents with teeth, 1/3 need early or urgent care.[vii]



More than 1 in 4 North Dakota 3rd graders have untreated tooth decay.

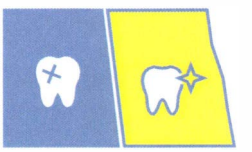
### *What is a dental therapist?*

- Similar to physician assistants, dental therapists are midlevel providers who are trained to offer routine and commonly needed preventive and restorative services, such as filling cavities.
- Dentists hire and supervise dental therapists to expand quality care to more patients, and provide treatment to underserved at-risk populations in community settings, such as schools or nursing homes.
- Eight states have authorized dental therapists in some capacity: Arizona, Maine, Michigan, Minnesota, Vermont, and tribal communities in Alaska, Oregon, and Washington.

A dental therapist is similar to a physician assistant on the medical team

### *North Dakota does not have enough dentists to provide routine care for the state's growing population.*

- Nearly half of North Dakota counties have no dentists or just one (17 have none, 8 have one).[viii]
- According to the American Dental Association, North Dakota dentists are the busiest in the nation.[ix]
- Allowing dentists to hire dental therapists would increase access to care for North Dakotans in rural and urban communities.[x]



Nearly half of North Dakota counties have no dentists or just one.

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

- 1,100 studies and assessments show dental therapists provide high quality care.[xi]
- A dentist will supervise each licensed dental therapist, affirm their abilities, and set their scope of practice through a written management agreement.
- To become licensed, dental therapists will need to go through the North Dakota Board of Dental Examiners process similar to dentists and other dental providers.
- The national accrediting commission for schools educating dentists and other dental providers has approved standards for dental therapy.[xii]
- The Journal of the American Dental Association published a study in 2011 stating that dental therapists provided high quality care comparable to dentists for procedures both can do.[xiii]

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

HB 1426
#5
1/21/19
Page 7

## *North Dakotans for Dental Access Coalition Members*

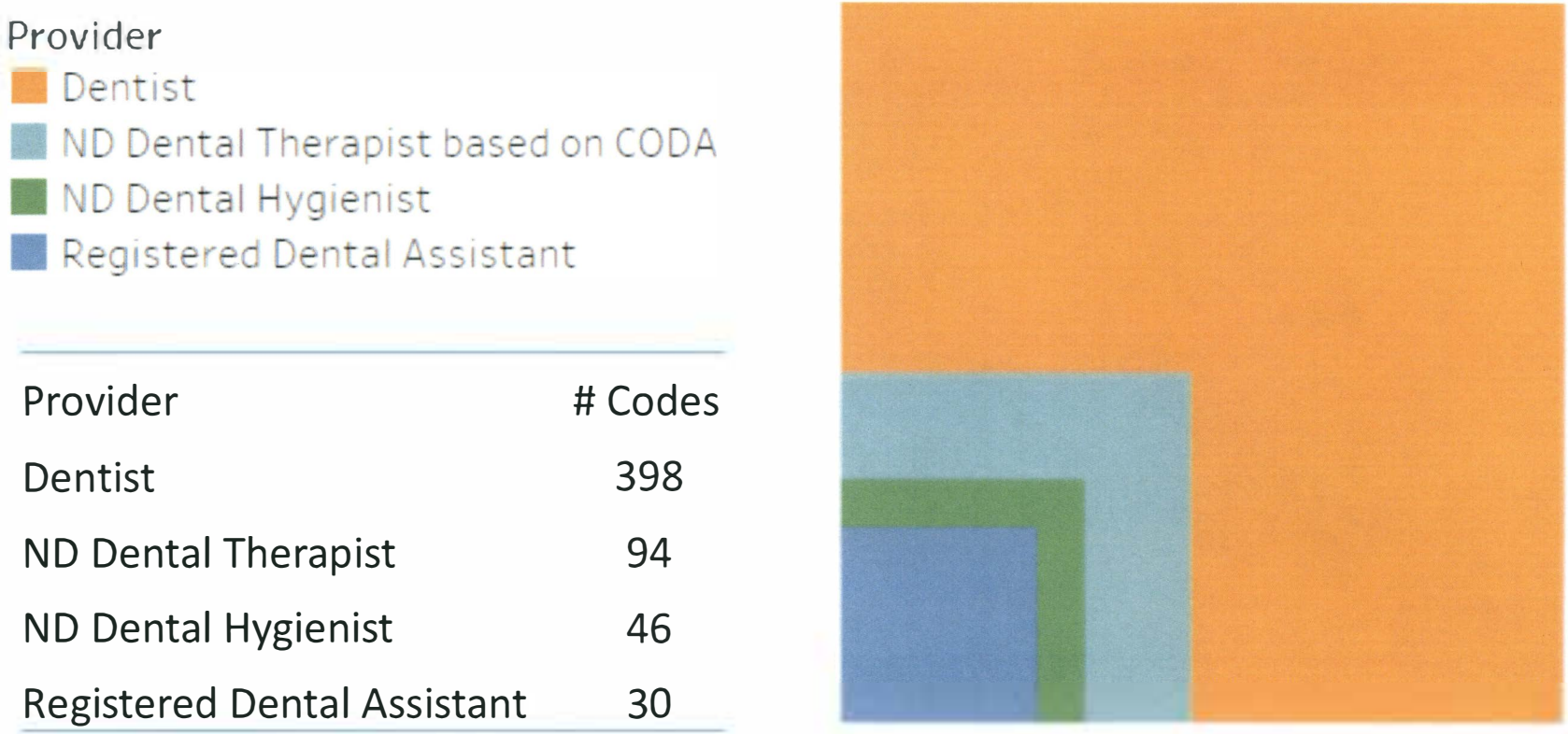
AARP North Dakota
Alliance for Health Care Access (Grand Forks)
Community Action Partnership of ND
Family Voices of ND
Fargo-Moorhead Coalition for Homeless Persons
North Dakota Chapter of the American Academy of Pediatrics
North Dakota Dental Hygienists' Association
North Dakota Nurses Association
North Dakota Nurse Practitioners Association
North Dakota Protection and Advocacy Project
North Dakota Public Health Association
North Dakota Rural Health Association
North Dakota State Association of City and County Health Officers
North Dakota Women's Network
Northland Health Centers
Third Street Clinic (Grand Forks)
Americans for Prosperity
Americans for Tax Reform
The Pew Charitable Trusts
United Tribes of North
Spirit Lake Tribe
Standing Rock Sioux Tribe
Three Affiliated Tribes of Mandan, Hidatsa, and Arikara Nation
Turtle Mountain Band of Chippewa Indians

---

i Health Resources and Services Administration, "Designated Health Professional Shortage Areas," Sept. 2018. ii Centers for Disease Control and Prevention, ND Oral Health Data, Adults (2016), Children (2014), accessed Jan. 2019. iii Nijau G. and Yineman K., "Findings and Lessons from the 2014-2015 North Dakota Oral Health Third Grade Basic Screening Survey," ND Department of Health (Presented at the Dakota Conference on Rural and Public Health, 2016). iv The Pew Charitable Trusts, analysis using Centers for Medicare and Medicaid Services, Annual Early and Periodic Screening, Diagnostic and Treatment Participation Report, Form CMS-416, 2017. v North Dakota Department of Health, Basic Screening Survey for Adults (2012). vi Nijau and Yineman (2016). vii Schroeder, S., UND Center for Rural Health, "Oral Health among North Dakota Elderly," Oct. 2016. viii Schroder, S., UND CRH, "Dental Workforce in Rural and Urban North Dakota," June 2016. ix Vujicic, M., "Rethinking dentist shortages," Journal of the American Dental Association 146(5), May 2015. x S. Schroder et al., UND CRH, "North Dakota Oral Health Report: Needs and Proposed Models, 2014," 2014. xi D. Nash et al., "A Review of Global Literature on Dental Therapists," W.K. Kellogg Foundation, April 2012. xii American Dental Association, Commission on Dental Accreditation, Accreditation Standards for Dental Therapy Programs, Feb. 2015. xiii J. Bader et al., "Clinical technical performance of dental therapists in Alaska," Journal of the American Dental Association 142(3), March 2011.

# Scope Comparison of ND Providers

- Colors represent the provider type, and size of each colored box represents the number of codes practiced by that provider




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

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

HB1426
#5
1/21/19
page 8

HB1426
#5
4/21/19
Page 9

# LICENSING DENTAL THERAPISTS in NORTH DAKOTA – HB 1426

## FOR IT:

AARP North Dakota
Alliance for Health Care Access (Grand Forks)
Community Action Partnership of ND
Family Voices of ND
Fargo-Moorhead Coalition for Homeless Persons
North Dakota Chapter of the American Academy of Pediatrics
North Dakota Dental Hygienists' Association
North Dakota Nurses Association
North Dakota Nurse Practitioners Association
North Dakota Protection and Advocacy Project
North Dakota Public Health Association
North Dakota Rural Health Association
North Dakota State Association of City and County Health Officers
North Dakota Women's Network
Northland Health Centers
Third Street Clinic (Grand Forks)
Americans for Prosperity
Americans for Tax Reform
The Pew Charitable Trusts
United Tribes of North Dakota
Spirit Lake Tribe
Standing Rock Sioux Tribe
Three Affiliated Tribes of Mandan, Hidatsa, and Arikara Nation
Turtle Mountain Band of Chippewa Indians

## AGAINST IT:

North Dakota Dental Assistants Association
North Dakota Dental Association *

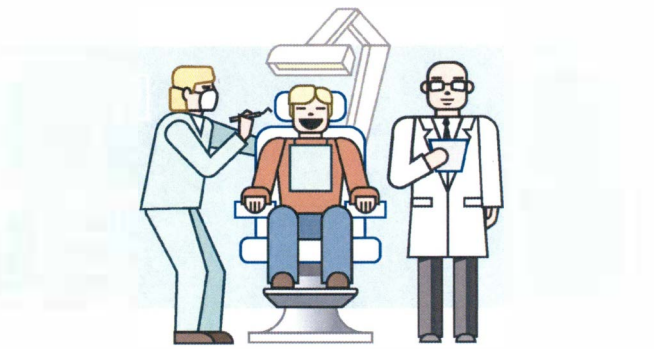
* *1 in 4 rural dentists, and 1 in 6 dentists statewide, are interested in hiring dental therapists – according to the Bismarck Tribune article on Jan. 19, 2017 and preliminary survey results from UND Center for Rural Health.*

# HB 1426: SUPERVISION OF DENTAL THERAPISTS

**Under HB 1426 as amended, supervision of dental therapists by dentists would be limited to direct and indirect supervision...**

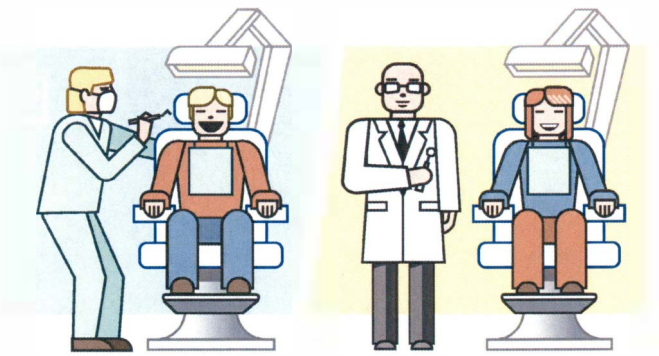
## Direct Supervision

As currently defined by the ND Board of Dental Examiners, direct supervision "means the dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the dental hygienist or dental assistant, and before dismissal of the patient, evaluates the performance of the dental hygienist or dental assistant."



## Indirect Supervision

As currently defined by the Board, indirect supervision "means that a dentist is in the dental office or treatment facility, has personally diagnosed the condition to be treated, authorizes the procedures, and remains in the dental office or treatment facility while the procedures are being performed by the dental hygienist or dental assistant."

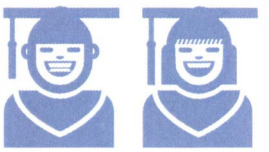


**...unless the Board were to develop rules to allow for the use of "general supervision," similar to rules already in place for supervising dental hygienists in North Dakota. According to the Board, general supervision "means the dentist has authorized the procedures and they are carried out in accordance with the dentist's treatment plan and with the dentist's diagnosis, if necessary. The dentist is not required to be in the treatment facility."**

*Source: North Dakota Administrative Code § 20-01-02-01.*

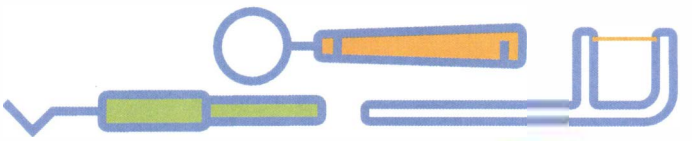
# NORTH DAKOTANS FOR DENTAL ACCESS
# HB 1426: Educating Dental Therapists

## CODA Accreditation



### NATIONAL ADA/CODA ACCREDITED PROGRAMS

In August 2015, the Commission on Dental Accreditation (CODA), the ACCREDITING BODY housed within the AMERICAN DENTAL ASSOCIATION for DENTAL EDUCATION PROGRAMS, implemented standards for dental therapy education programs. CODA accreditation means a program has achieved a NATIONALLY ACCEPTED LEVEL OF SAFETY AND QUALITY. HB 1426 requires students to graduate from a CODA accredited program or one of the existing master's level programs currently accredited by the Minnesota dental board which are currently working toward CODA accreditation (University of Minnesota School of Dentistry and Metropolitan State University/Normandale Community College).



### USING BEST PRACTICES

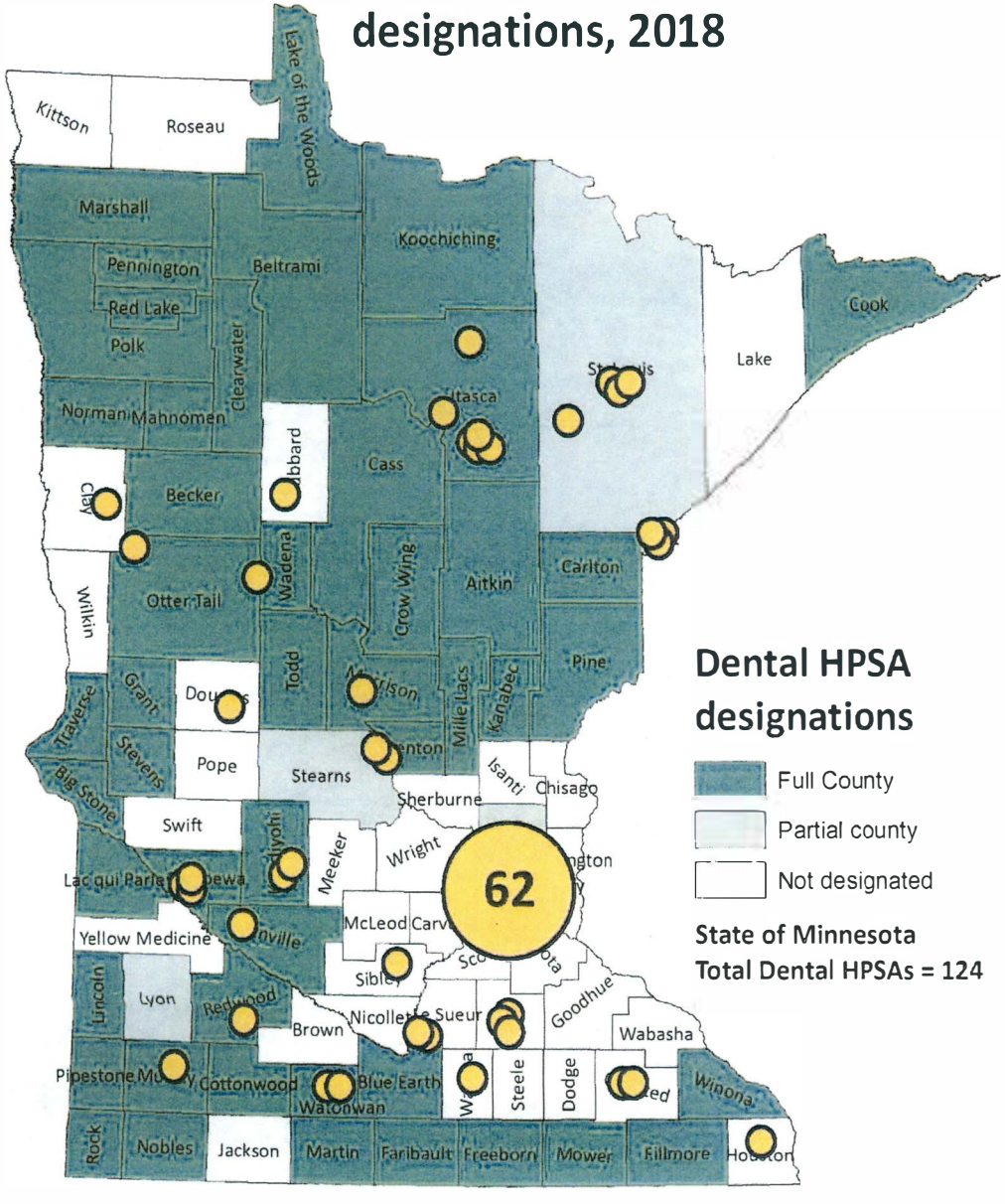
Dental therapy students are held to the SAME STANDARDS as those studying to become dentists. They take the same classes as dental students and must DEMONSTRATE THE SAME COMPETENCIES on the procedures they are trained to provide.

HB 1426 requires that dental therapists pass an exam approved by the NORTH DAKOTA BOARD OF DENTAL EXAMINERS in order to be licensed.

**Q. Can mid level providers "drill and fill" directly out of high school?** **A. NO.**

The skills needed to be a dental therapist in North Dakota would REQUIRE GRADUATION from a CODA ACCREDITED college or university—three academic years minimum—or one of the existing master's level Minnesota programs which are accredited through the Minnesota dental board, PLUS passing a ND-state licensing exam. Under HB 1426 dental therapists would be required to complete 500 clinical practice hours under the direct or indirect supervision of a dentist.

## Dental Health Professional Shortage Area (HPSA) designations, 2018




**This map provided by the University of MN School of Dentistry**

# Dental Therapy Employment Sites* by County

Metro Area – 60%

Greater MN – 40%

* Fixed clinic sites only.
Does not included mobile, school based or other community-based locations.



HB4128 #5 1/11/18 Page 12

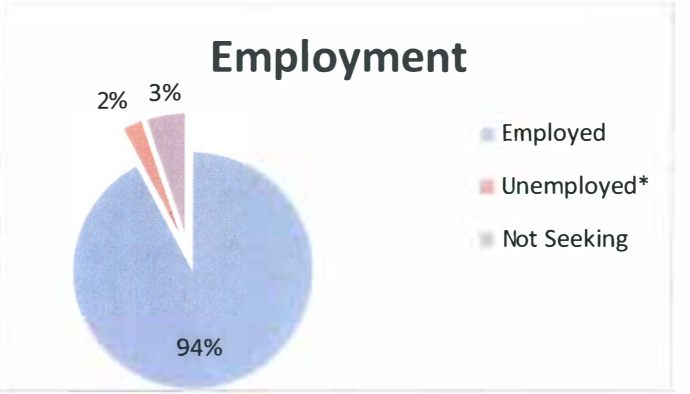
November 2018

# Dental Therapy Employment Information
2018

Currently there are 89 licensed dental therapists (DTs) licensed to practice in Minnesota, 59 of which are certified advanced dental therapists (ADTs). This information is a snapshot of the employment environment as it continues to evolve.

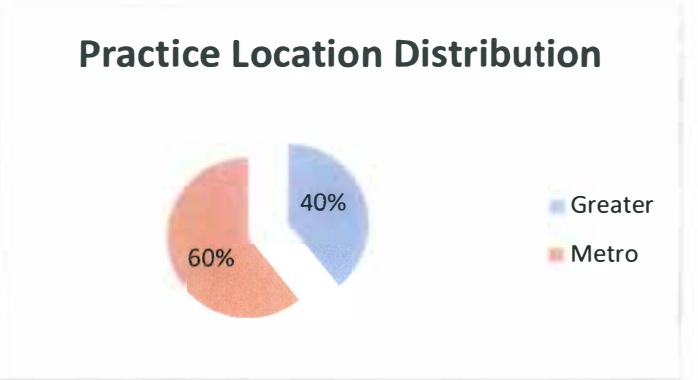
## Status

- 84 are employed
- 3 not seeking employment



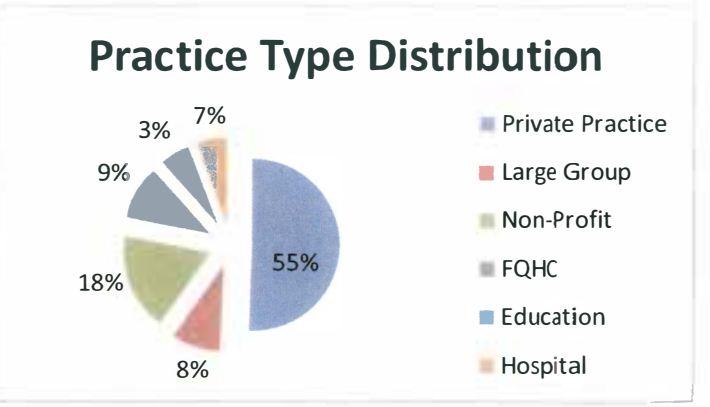

## Location

- 62 practice in the 7-county metro area
- 41 practice in Greater Minnesota




## Clinic Type

- 57 in Private Practices
- 19 in Non-Profit Clinics
- 9 in FQHCs
- 8 in Large Group Clinics
- 3 in Educational Institutions
- 7 in Hospitals




*All DTs regardless of clinic type are providing care to underserved patients. The number of clinic locations and types differ for the number of employed DTs due to the fact that many graduates work in multiple settings and some clinics employ more than one dental therapist.

HB1426—allow for dental therapists

The Veterans who are enrolled with VA Health system, especially here in North Dakota, receive relatively good health care. The VA gives us hearing aids, glasses and access to specialists such as dermatologists, heart and lung, etc. However, the VA does not provide oral Health care for everyone. The VA by law is authorized to provide extensive dental care, to a well define group of Veterans and in some cases, treatment may be limited. In order to receive dental care, you must meet the qualifications in 1 of 4 categories. Full dental coverage is only offered to Veterans who have service related compensable dental conditions, were prisoners of war, or are considered 100% disabled according to VA criteria. Veterans who do not fall into these categories are eligible for limited services I have provided a fact sheet discussing who fits where. The TRICARE Retiree Dental Program is a voluntary plan for members of the Uniformed Services and National Guard/Reserve who are receiving retired pay.

There is a well-established access problem for service members in the United States. Historically, dental readiness was the most problematic Department of Defense individual medical readiness requirement according to the Chief of TRICARE dental section. He states "Over the decade the Military Health System has enacted new services and programs that reduced the proportion of unfit DoD Selected Reserve troops due to dental problems from 40% to 10%.

Good oral health is important for overall and wellbeing. One study followed male veterans, aged 28-70, for 32 years, and found that tooth loss and gum disease were related to cognitive decline. Another study showed that chronic gum disease is associated with coronary heart disease among men under 60 in the Veteran community.

In 2017, North Dakota has approximately 51,000 Veterans. Of those about 27500 of them are enrolled in the VA health system, with only about 19000 receiving any medical services. Veterans comprised around 9% of the adult population in ND compare to 6.6% nationally. 40% of Veterans in North Dakota are at least 65 years of age. Research shows that 1 in 3 ND seniors report having dental problems and they are far more likely that any other groups to do so.

The North Dakota Veterans Legislative Council supports this bill and we feel it will allow dentists to extend much needed care to those North Dakotans currently underserved along with many of the States Veterans. We can see the possibilities of a dental therapist in the Veteran Home in Lisbon along with perhaps with the the many Veterans clinics though-out the state.

VA
U.S. Department of Veterans Affairs
Veterans Health Administration
Chief Business Office
Health Eligibility Center

IB 10-442
February 2014

HB 1426
#6
1/21/19
Page 3

# Dental Benefits for Veterans

Dental benefits are provided by the Department of Veterans Affairs (VA) according to law. In some instances, VA is authorized to provide extensive dental care, while in other cases treatment may be limited. This Fact Sheet describes dental eligibility criteria and contains information to assist Veterans in understanding their eligibility for VA dental care.

## Outpatient Dental Program

The eligibility for outpatient dental care is not the same as for most other VA medical benefits and

| If you: | You are eligible for: | Through |
|---|---|---|
| Have a service-connected compensable dental disability or condition. | Any needed dental care | Class I |
| Are a former prisoner of war. | Any needed dental care. | Class IIC |
| Have service-connected disabilities rated 100% disabling, or are unemployable and paid at the 100% rate due to service-connected conditions. | Any needed dental care. [Please note: Veterans paid at the 100% rate based on a temporary rating, such as extended hospitalization for a service-connected disability, convalescence or pre-stabilization are not eligible for comprehensive outpatient dental services based on this temporary rating]. | Class IV |
| Apply for dental care within 180 days of discharge or release (under conditions other than dishonorable) from a period of active duty of 90 days or more during the Persian Gulf War era. | One-time dental care if your DD214 certificate of discharge does not indicate that a complete dental examination and all appropriate dental treatment had been rendered prior to discharge.* | Class II |

| If you: | You are eligible for: | Through |
|---|---|---|
| Have a service-connected noncompensable dental condition or disability resulting from combat wounds or service trauma. | Any dental care necessary to provide and maintain a functioning dentition. A Dental Trauma Rating (VA Form 10-564-D) or VA Regional Office Rating Decision letter (VA Form 10-7131) identifies the tooth/teeth/condition(s) that are trauma rated. | Class IIA |
| Have a dental condition clinically determined by VA to be associated with and aggravating a service-connected medical condition. | Dental care to treat the oral conditions that are determined by a VA dental professional to have a direct and material detrimental effect to your service connected medical condition. | Class III |
| Are actively engaged in a 38 USC Chapter 31 vocational rehabilitation program. | Dental care to the extent necessary as determined by a VA dental professional to:<br>• Make possible your entrance into a rehabilitation program<br>• Achieve the goals of your vocational rehabilitation program<br>• Prevent interruption of your rehabilitation program<br>• Hasten the return to a rehabilitation program if you are in interrupted or leave status<br>• Hasten the return to a rehabilitation program of a Veteran placed in discontinued status because of illness, injury or a dental condition, or<br>• Secure and adjust to employment during the period of employment assistance, or enable you to achieve maximum independence in daily living. | Class V |
| Are receiving VA care or are scheduled for inpatient care and require dental care for a condition complicating a medical condition currently under treatment. | Dental care to treat the oral conditions that are determined by a VA dental professional to complicate your medical condition currently under treatment. | Class VI |
| Are an enrolled Veteran who may be homeless and receiving care under VHA Directive 2007-039. | A one-time course of dental care that is determined medically necessary to relieve pain, assist you to gain employment, or treat moderate, severe, or complicated and severe gingival and periodontal conditions. | Class IIB |

** Note: Public Law 83 enacted June 16, 1955, amended Veterans' eligibility for outpatient dental services. As a result, any Veteran who received a dental award letter from VBA dated before 1955 in which VBA determined the dental conditions to be noncompensable are no longer eligible for Class II outpatient dental treatment.*

HB1426
#7
1/21/19
page 1

**House Human Services Committee**
**Monday, January 21, 2019**
**Sheri Solseng Trif, Advanced Dental Therapist**
**Please support HB 1426 – authorize dental therapy in North Dakota**

Mr. Chairman and Members of the committee, thank you for allowing me the opportunity to testify in favor of HB1426 today.

My name is Sheri Solseng Trif, and I'm originally from Larimore, North Dakota. I'm currently an advance dental therapist practicing in Minnesota.

**I'm proud to be a native of the Peace Garden State** and yet I wish I could provide care to dental patients in North Dakota in the same way as I do in Minnesota.

As an advanced dental therapist (ADT) – I'm kind of like a nurse practitioner, but on the dental team. I can not only provide preventive care, like cleanings, but I can also provide routine restorative care like filling cavities. North Dakota ranks at the bottom in terms of access to oral healthcare, I read from the ND Dept. of Human Services screening survey - more than 1 in 4 North Dakota 3rd graders have untreated tooth decay**. That's awful.**

As an ADT, I can provide dental care to kids, adults and seniors - in different settings - I can go to the patients in a community healthcare clinic, a senior living center, a veterans nursing home, or a school-based clinic.

As an advanced dental therapist, I can practice in Minnesota, but not in North Dakota because the state practice act doesn't include licensing of dental therapists. Adding another clinician to the dental team extends the reach of helping folks who need it the most! It's working in Minnesota and I am proof. **Please support this legislation. North Dakota needs it!**

I'm happy to answer any questions you may have. Thank you for your consideration and time.
Sheri Solseng Trif

HB1426
#8
1/21/19
page1

**North Dakota Dental Hygienists' Association**

Emily Mallory, RDH, President
3865 13th Avenue South
Grand Forks, ND 58201

21 January 2019

RE: NDDHA supports dental therapy and HB 1426

Members of the Legislative Assembly of North Dakota
Human Services Committee

Chairman Weisz and Members of the Committee:

Hello, my name is Emily Mallory. I am a dental hygienist practicing in a community health center and the current president of the North Dakota Dental Hygienists' Association. The Hygienists' Association strongly supports HB 1426 to authorize dental therapy in North Dakota. Dental hygienists, who are the prevention experts, are committed to improving the public's oral and overall health, and we believe bringing dental therapy to North Dakota would help achieve this goal.

As has been stated repeatedly today, thousands of North Dakotans do not have access to affordable, routine dental career. In my own career, I have regularly seen patients drive hundreds of miles for care. Furthermore, many patients have extensive dental needs that cannot be completed in a timely manner due to provider shortages. Evidence has shown that dental therapists improve access to care for underserved patients; decrease wait times for patients; and increase the volume of patient seen in clinical settings. Too many of our residents suffer from dental diseases that are preventable with routine care, but the dental system has shut them out. This serious problem 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.

Dental Therapists are highly skilled individuals, who earn bachelor or masters level degrees alongside fellow dental hygiene and dental students. Academic and clinical standards have been approved by the American Dental Association's (ADA) Commission of Dental Accreditation (CODA) in 2015. If dental therapists were unsafe, unqualified, or experimental in any way, the Commission would never have approved these standards. The scope of practice for DT, outlined in HB 1426, insures that all dental therapists in North Dakota would be in a written collaboration management agreement with a supervising dentist. HB 1426 would help meet the demand for affordable, routine dental care by authorizing dental therapists to be licensed by the North Dakota Board of Dental Examiners to perform routine procedures under the supervision of a dentist. This, in turn, would allow the dentists who hire them to focus on more complex dental cases.

Dental therapist would serve as members of the dental care team. The DT would work alongside dentists, dental hygienists, and dental assistants in federally qualified health care centers

(FQHCs), FQHC "look alike" clinics, non-profit or governmental dental practices, and Indian health services clinics. Dental therapists currently practice as part of the dental team in more than 50 other countries and other states, and over 1,100 studies have shown they provide quality care.

If North Dakota is going to bring forth change in access to oral health care, we must consider the best opportunities for doing so. Dental therapy is not only an opportunity for dental hygienists to expand their knowledge, skills and careers; but also, a realistic addition to the dental team to improve access to care in North Dakota. It is going to be up to every member of the dental team to work collaboratively in order to make real improvements in access to care. Dental hygienists want to work together, with the dentists and the dental assistants, as dental therapists in order to accomplish this goal. Again, the North Dakota Hygienists' Association strongly supports this bill as this is one instrumental way to improve access to dental care for those most in need in North Dakota.

Sincerely,

Emily N. Mallory

Emily N. Mallory, RDH
President, NDDHA

---

Dental Therapy in Minnesota (2018).
http://www.dentisty.umn.edu/sites/dentisty.umn.edu/files/dental_therapy_in-minnesota.pdf

HB1426
#9
1/21/19
page 1

**Testimony – HB 1426**
**Dr. Todd Thierer, DDS, MPH, HealthPartners**
**House Human Services Committee**
**Monday, January 21, 2019**

Chairman Weisz and members of the committee, thank you for the opportunity to testify today in support of House Bill 1426 bipartisan legislation that would authorize midlevel dental providers known as dental therapists to practice in specific settings.

My name is Todd Thierer and I am currently the Associate Dental Director for Primary and Pediatric Dental Care at HealthPartners. Prior to my joining HealthPartners I was the Associate Dean for Clinical Affairs at the University of Minnesota School of Dentistry for seven years.

During my time at the School of Dentistry, I was responsible for the clinical functioning of the school, which included dental, dental therapy and dental hygiene students. I worked closely with all of these students and have a good appreciation for the training that dental therapists receive as well as how their clinical competence is assessed. In my time at HealthPartners, I have worked with dental therapists in a non-educational setting. I have been able to see, first hand, the quality of the work that dental therapists do, as well as the appreciation that patients have for the care they are receiving. In Minnesota, dental therapists have been a force multiplier in terms of the numbers of underserved patients that can be seen in a dental practice. As is the case with midlevel providers in medicine, dental therapists are well trained and can provide high quality care to people at a lower cost per patient and per procedure. Public funds that are utilized for providing oral health care to underserved populations can go further while providing the same level of care.

Dental therapists work under what is called a collaborative management agreement with the dentist. It is the dentist's license that the therapist is working under. The dentist decides what the dental therapist can and cannot do within the statutorily defined scope of practice for a dental therapist. In Minnesota, dental therapist primarily does fillings, although they can provide a limited number of additional emergency services, for example, a denture repair, recementing crowns, extracting baby teeth, and providing palliative treatment for dental pain. They do this under the general supervision of a dentist.

Many patients who have only had intermittent access to care have significant oral health needs. Frequently they have extensive decay with some teeth that need to be extracted and many teeth that need fillings. The dental therapists that I work with are extremely skilled and efficient in restoring the teeth that can be restored. That allows me to do the extractions and provide other treatment, like making dentures, that I am trained to do.

As I previously mentioned, I have extensive experience with the education of dental therapists. At the University of Minnesota, they are trained in exactly the same way, in exactly the same clinical environments as dental students are, for their scope of practice. They are also assessed in the same way for the same procedures that the dental students do. Additionally, for licensure, they take the same clinical dental boards that dental students do (except for the Periodontal portion which is out their scope of practice). In fact, their identity as a dental therapist is hidden from the board examiners. The 500 hours of supervised clinical practice that HB 1426 requires, is an additional safeguard to ensure quality of care provided by dental therapists.

I don't presume to understand the landscape of oral health needs of the citizens of North Dakota. I am aware, however, that there is a significant access to oral care issue in this state. Allowing Dental Therapists to join the oral health care team has been a powerful tool in providing high quality, lower cost care for underserved populations in Minnesota and I'm confident that it can also be utilized successfully in North Dakota.

This concludes my testimony. I would be happy to answer any questions you may have. Thank you.

HB1426
#10
1/21/19
page 1

Real Possibilities in

# North Dakota

HB 1426 – SUPPORT
January 21, 2019
House Human Services Committee
AARP North Dakota
jaskvig@aarp.org or 701-989-0129
mchaussee@aarp.org or 701-390-0161

Chairman Weisz, members of the House Human Services Committee,

AARP is a non-profit, membership organization with more than 88,000 members in North Dakota. Today, we are here in support of House Bill 1426 and increasing access to dental care for more North Dakotans.

Dental access is a challenge for older North Dakotans, especially those living in rural areas.

As research begins to emerge from other states that have accepted the practice of dental therapy we can't help but be excited about some of the findings. A study from the Minnesota Department of Health and Board of Dentistry http://www.health.state.mn.us/divs/orhpc/workforce/oral/dtlegisrpt.pdf shows patients travel less distance, wait less time and go to the ER less often now that they have provided access to dental therapists.

According to a study funded by the Otto Bremer Foundation, older North Dakotans, particularly those living in nursing homes, 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.

Recent demographic statistics provided by North Dakota Compass shows eight counties in North Dakota have an average age of 50 or older. Another 20 have an average age of 40-plus, most of those ranging in the high 40s. That's a relevant statistic because these are rural counties where health care access can be a challenge, including access to dental care. Adding another level of dental providers who can provide much needed routine care to older North Dakotans.

Another issue tied to dental care for older North Dakotans is cost. That's largely because there is a lack of access to affordable, routine dental care for those on Medicare, because basic Medicare does not cover routine dental care like cleanings, fillings, extractions or dentures https://medicare.com/coverage/medicare-dental-coverage-for-seniors/ .Providing services that could come at a reduced cost would benefit financially vulnerable older people.

Please accept our support for House Bill 1426.

Josh Askvig
AARP North Dakota

Mike Chaussee
AARP North Dakota

HB1426
#11
1/21/19
page 1

**Testimony of Dr. Donald Warne, Director of the Master of Public Health Program at the University of North Dakota School of Medicine & Health Sciences (SMHS) North Dakota House Human Services Committee, Monday, January 21, 2019**

Chairman Weisz and members of the committee, thank you for the opportunity to testify today regarding House Bill 1426 – that would authorize dental therapists to practice in specific settings.

My name is Dr. Donald Warne and I'm Director of the Master of Public Health Program at the University of North Dakota School of Medicine & Health Sciences. I also spent several years serving patients as a family practice physician.

Two years ago, I offered similar testimony to the Senate Human Services Committee and spoke of the struggles our residents face. We did not then, and still do not today, have enough access to affordable, routine dental care. Dental disease is preventable and without enough practitioners our high volume of dental decay will persist.

Our urban residents, rural residents and especially those North Dakotans living on reservations are no closer and no better off than before. According to our Board of Dental Examiners in 2016, 405 dentists practiced in the state -- along with 644 dental hygienists and 590 dental assistants. And of these professionals, 61 percent of dentists and 68 percent of dental assistants practiced in just four counties; Cass, Burleigh, Grand Forks, and Ward. Even in those counties, many kids on Medicaid aren't getting the care they need. We are leaving too many North Dakota residents behind. North Dakota has one of the higher Medicaid reimbursement rates in the country and we are still have nearly 70% of these children not seeing a dentist.

We need to address this healthcare crisis that exists in our state. This bill would allow dental therapists to practice in sliding-fee healthcare centers, federally qualified healthcare centers, tribal clinics and a school-based health care setting. This position would practice under the supervision of a dentist, and it would allow dentists to practice at the top of their scope, and allow the dental therapist to drill and fill cavities.

Right now, it also takes up to six months to see a dentist for those living on reservations, affecting children, adults, and seniors. Half of American Indian third graders today in North Dakota have untreated tooth decay, and 90% have experienced decay at some point in their short lives. I cannot stress enough; lack of preventive oral health care is directly related to overall health.

Additionally, here are some key data:

- BRFSS Data 2016: 43% of American Indian/Alaska Natives reported a dental clinic visits (for any reason) compared to 69% of white non-Hispanic residents (66% of the overall state population; 66% is the national average as well) – more concerning is this is the dental clinic visit rate – not the rate of preventive visits. It could be that these "visits" are treatment based or emergent.

- Cost of care is a significant concern: Income is correlated with percentage of population with all teeth extracted. Example, 30% of adults ages 65+ with a household income of less than $15,000 have had all their natural teeth extracted compared to only 6% of those with a household income of $50,000 + (BRFSS data, 2016)
- 64% of those who did not visit a dentist in 2015 in North Dakota reported they did not visit the dentist more often because of "cost" – 28% indicated the primary reason for forgoing a dental visit in the last 12 months was because of "Inconvenient location or time" [ADA Health Policy Institute survey data, 2015: [https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/OralHealthWell-Being-StateFacts/North-Dakota-Oral-Health-Well-Being.pdf]
- The Recent data from the state's Basic Screening Survey of third grade students isn't yet publically available, so drawing on data from the last cycle (2015 data) we know that: In 2015, roughly 73% of all third grade students in North Dakota had experienced decay, though only 28% had untreated decay. The rate of untreated decay was significantly* higher for American Indian (51%), and other minority children (41%) than for their Caucasian peers (24%). Compared to non-Hispanic White children, American Indian, and other minority third graders have:
    - Significantly lower rates of dental sealants.
    - Significantly higher prevalence of rampant decay.
    - Significantly higher need for early or urgent care.
- Likewise, children attending lower income schools (>50% of children eligible for National School Lunch Program (NSLP) have significantly higher rates of untreated decay, prevalence of rampant decay, and need for early or urgent dental care than students attending higher income schools. [Figures are available here: https://ruralhealth.und.edu/assets/2507-9202/north-dakota-pediatric-oral-health-disparities.pdf]
- In 2015, the North Dakota Department of Health's screening survey identified roughly 93% of all third grade students in North Dakota had a toothbrush at home. While 96% of all non Hispanic White third grade students have a toothbrush, the same is true for only 49% of their American Indian peers. As a result, only 32% of American Indian youth had brushed their teeth on the day of assessment compared to 66% of non-Hispanic White adolescents.
- The State has 23 Dental HPSAs and an additional 18 designated facility dental HPSAs

In Alaska, the Dental therapist program is working. A new study was released by the University of Washington. Led by Donald Chi, D.D.S., Ph.D., and funded by The Pew Charitable Trusts, the Rasmuson Foundation, and the W.K. Kellogg Foundation, the study presents an analysis of patients in the Yukon-Kuskokwim Health Corporation (YKHC) from 2006 to 2015. The YKHC, which is a part of the Alaska Tribal Health System, serves 25,000 Alaska Natives representing 58 federally recognized tribes.

Dental therapists, akin to physician assistants in medicine, work under the supervision of a dentist and offer routine restorative and preventive services, including preparing and placing fillings and performing simple tooth extractions. While U.S. studies to date of dental therapists have examined care quality and patient access, this is the first known study to look at long-term outcomes of communities served by these practitioners.

The study uses patient electronic health records and Medicaid claims data to uncover the key findings. Researchers counted the total number of dental therapist treatment days provided in each community. They then compared communities with no dental therapist treatment days to those with the highest number of treatment days and found the following:

For children under age 3, high exposure to dental therapists was associated with fewer extractions of the front four teeth.

For children under age 18, high exposure to dental therapists was associated with receiving more preventive care (defined as an exam, cleaning, fluoride treatment, or a combined cleaning and fluoride treatment).

Adults in communities with the highest dental therapist visit days also had fewer extractions and more preventive care visits.

Dental therapists were first employed in Alaska in 2004 to serve native communities. They have been authorized in Maine, Minnesota, and Vermont, and are also being used to care for Native American tribes in Washington and Oregon. In June 2017, the Alaska Native Tribal Health Consortium, which trains dental therapists, graduated its first student to begin practicing under pilot authority on Native American tribal lands in Oregon. Several other states—including Arizona, Kansas, Maryland, Massachusetts, Michigan, New Mexico, North Dakota, and Ohio—are exploring the potential for authorizing dental therapy to expand access for the underserved.

In summary, there is clearly a need for increased access to services among our American Indian population, Medicaid recipients, and rural and underserved communities. There are great programs like the Mission of Mercy – but I always explain that every person who lines up for care at Mission of Mercy – people who stand in line for hours to receive dental treatment are a perfect example of where we have failed in providing accessible dental care.

Thank you.

Journal of Public Health Dentistry . ISSN 0022-4006

# Dental therapists linked to improved dental outcomes for Alaska Native communities in the Yukon-Kuskokwim Delta

Donald L. Chi, DDS, PhD[1]; Dane Lenaker, DMD, MPH[2]; Lloyd Mancl, PhD[1]; Matthew Dunbar, PhD[3]; Michael Babb, MA[3]

1 School of Dentistry, University of Washington, Seattle, WA, USA
2 Southeast Alaska Regional Health Consortium, Sitka, AK, USA
3 Center for Studies in Demography and Ecology, University of Washington, Seattle, WA, USA

**Keywords**
Dental Health Aide Therapists; Alaska Native oral health disparities; dental utilization; access to dental care; dental workforce.

**Correspondence**
Donald L. Chi, School of Dentistry, University of Washington, Seattle, WA 98195-7475, USA. Tel.: 206 616-4332; Fax: 206 685-4258; e-mail: dchi@uw.edu. Dane Lenaker is with the Southeast Alaska Regional Health Consortium. Lloyd Mancl is with the School of Dentistry, University of Washington. Matthew Dunbar and Michael Babb are with the Center for Studies in Demography and Ecology, University of Washington.

Received: 10/15/2017; accepted: 12/15/2017.

doi: 10.1111/jphd.12263

Journal of Public Health Dentistry **00** (2018) 00–00

## Abstract

**Objectives:** Dental Health Aide Therapists (DHATs) have been part of the dental workforce in Alaska's Yukon-Kuskokwim (YK) Delta since 2006. They are trained to provide preventive and restorative care such as filling and extractions. In this study, we evaluated community-level dental outcomes associated with DHATs.
**Methods:** This was a secondary data analysis of Alaska Medicaid and electronic health record data for individuals in Alaska's YK Delta (2006-2015). The independent variable was the number of DHAT treatment days in each community. Child outcomes were preventive care, extractions, and general anesthesia. Adult outcomes were preventive care and extractions. We estimated Spearman partial correlation coefficients to test our hypotheses that increased DHAT treatment days would be associated with larger proportions utilizing preventive care and smaller proportions receiving extractions at the community-level.
**Results:** DHAT treatment days were positively associated with preventive care utilization and negatively associated with extractions for children and adults ($P < 0.0001$). DHAT treatment days were not associated with increased dental treatment under general anesthesia for children.
**Conclusions:** Dental therapists are associated with more preventive care and fewer extractions. State-level policies should consider dental therapists as part of a comprehensive solution to meet the dental care needs of individuals in underserved communities and help achieve health equity and social justice.

## Introduction

Poor oral health is common in Alaska Native communities (1-3). Untreated tooth decay leads to pain, difficulties eating and sleeping, systemic diseases, hospitalization, and, in rare cases, death (4,5). Other consequences include school absences, poor grades, low self-esteem, and employment problems (6-8). There are persisting oral health inequalities in Alaska Native communities (9,10).

Tooth decay is a multifactorial disease linked to a high sugar diet, inadequate fluoride, and poor access to dental care (11). Sugar-sweetened beverages comprise a large portion of modern Alaska Native diets and have fueled the tooth decay epidemic (12,13). In addition, piped-in water is not universal in Alaska Native communities, making water fluoridation costly (14). Further complicating local fluoride acceptance is the only documented death linked to water fluoridation in Hooper Bay, Alaska (15). Finally, Alaska Native communities are remote, making it difficult to provide a regular, local source of dental care. Seeking care involves traveling long distances, usually by airplane. As a result, most individuals are unable to receive preventive care or needed restorative treatment.

To begin addressing dentist shortages, the Alaska Native Tribal Health Consortium trained Dental Health Aide Therapists (DHATs) for deployment in areas like Alaska's Yukon-Kuskokwim (YK) Delta. The DHAT program is based on a model in place for decades in New Zealand and more than 50 other countries (16,17). The first DHATs began providing dental care in the YK Delta in 2006. DHATs are recruited

from local communities and are trained to provide preventive care as well as restorative care for primary teeth (e.g., fillings, crowns, pulp therapy, extractions) and permanent teeth (e.g., simple fillings and extractions) under general supervision in local communities by dentists located in the hub city of Bethel (18). Dental therapists currently provide care in Alaska, Minnesota, and parts of Washington state and Oregon (19). Vermont and Maine have authorized the practice of dental therapy, and other states are considering similar legislation (19).

Studies have documented initial outcomes associated with the DHAT program in the YK Delta. DHATs provide care that is similar to care provided by dentists in terms of clinical quality (20,21). Residents of YK Delta communities served by DHATs have reported shorter wait times for dental appointments and satisfaction with the care provided by DHATs (22). No studies to date have documented longer-term outcomes associated with this innovative workforce program.

Persisting oral health inequalities in underserved communities underscore the importance of research aimed at advancing social justice (23). Dental therapists are part of an upstream approach that could help to address oral health inequalities by diversifying the dental workforce, removing barriers to care, and closing the health gap between individuals in resource-rich and resource-poor communities.

The goal of this study was to evaluate YK Delta's DHAT program. The main research question was whether DHATs are associated with improved oral health outcomes since 2006. We hypothesized that a larger number of DHAT treatment days would be associated with dental utilization patterns consistent with improved oral health over time (e.g., more preventive care, fewer extractions, less general anesthesia). This is based on two premises: 1) indigenous communities have low rates of preventive care utilization and high rates of extractions and treatment under general anesthesia; and 2) dental therapists have the potential to influence these trends. The long-term goals of this research are to provide policymakers with information on existing dental therapy programs and to develop strategies to optimize the DHAT program.

## Methods

### Study location

This study focused on communities served by the Yukon-Kuskokwim Health Corporation (YKHC). Prior to 2006, patients traveled from remote communities to Bethel to obtain dental care. Dentists traveled to communities on an annual basis. DHATs work in decentralized Sub-Regional Clinics and travel to remote communities to provide care.

### Study design and data sources

This was a retrospective observational study (calendar years 2006–2015), corresponding to the 10-year period in which DHATs started providing care under general supervision in the YK Delta to when the most recent data were available. The study was approved by the YKHC Human Studies Committee and the University of Washington Institutional Review Board.

There were two data sources. The first was Medicaid data provided by the Alaska Department of Health and Human Services. These consisted of data on 1) monthly enrollment (e.g., name, age, sex, address) and 2) dental claims, indicating all procedures for which a claim was submitted by a dental provider and corresponding dates of services. The second was electronic health record (EHR) data provided by the YKHC dental clinic. These data consist of diagnosis and treatment data for all YKHC patients who received any dental care during the study period.

### Classifying individuals into communities

We classified individuals into a mutually exclusive YK Delta community for each study month. Of the 322,578 individuals in the Medicaid dataset, 22,645 lived in the YK Delta at some point during the 10-year study period. We used monthly address data to geocode these individuals using the Google Maps Geocoding API. There were 22,353 individuals with a geocodable address. Our geocoding algorithm accounted for individuals who moved within the YK Delta and YK Delta residents who lived outside of the YK Delta for at least 1 month during the study period. We reconciled address data for 1,034 individuals with overlapping dates of residence (e.g., an individual listed as living in a community May 1, 2007 to September 9, 2009 and July 1, 2008 to October 31, 2010). Twenty-seven individuals were excluded because of missing or invalid dates of residence.

The resulting Medicaid dataset contained 22,326 unique individuals who lived in the YK Delta for at least 1 month during the study period. The resulting EHR dataset contained 28,821 unique individuals who utilized dental care through a YKHC dental clinic at least once during the study period, all of whom were geocoded into a YK Delta community.

### Predictor variable

The main community-level predictor variable was the total number of days in which a community had $\geq$1 DHATs providing care (DHAT treatment days). This continuous variable was created from the EHR data. We identified all dental claims in the EHR dataset with a valid Current Dental Terminology (CDT) code submitted by a DHAT during the study period. For each day on which a DHAT provided dental care, the location of service (as indicated in the EHR) was noted and counted as one DHAT treatment day.

### Outcome variables

There were three child and two adult outcomes, each measured at the community-level using both the Medicaid and EHR data.

#### Child outcomes

a) Proportion of children <18 years utilizing preventive care, defined as an exam (D0120/D0145/D0150), cleaning (D1110/D1120), fluoride (D1203/D1204/D1206/D1208), or cleaning and fluoride (D1201/D1205). b) Proportion of children <3 years who had their four front teeth (D-E-F-G) extracted (D7111/D7140). c) Proportion of children <6 years who received ≥5 stainless steel crowns on a single day, a proxy measure of general anesthesia (D2930).

#### Adult outcomes

d) Proportion of adults ≥18 years utilizing preventive care, defined as an exam (D0120/D0150), cleaning (D1110), fluoride (D1204/D1206), or cleaning and fluoride (D1205). e) Proportion of adults ≥18 years with any tooth extraction (D7111/D7140).

The two datasets had different denominators. For the Medicaid data, the yearly denominators consisted of individuals classified into a community and enrolled in Medicaid for ≥1 month during the calendar year. For the EHR data, the yearly denominators consisted of individuals who were classified into a community and had at least one dental claim in the calendar year.

### Confounders

We identified two potential confounders. The first was dentist treatment days, which is the total number of days in which communities had one or more dentists providing treatment. We identified all EHR dental claims submitted by a dentist and estimated the total number of treatment days provided by a dentist in each community. The second was baseline poverty, which accounted for potential differences in resources and social conditions. Because there was no standardized community-level poverty measure, we adopted a proxy measure from the US Census Bureau indicating the proportion of all individuals living below poverty in 1999 in each community (potential range: 0 to 100).

### Analyses

The analyses were restricted to dental services provided within YK Delta communities. Location of service was unavailable in the Medicaid data. Therefore, we used the EHR data to determine the location of service for each Medicaid dental service. We matched on name, sex, and date of birth. After excluding claims without a match, there were 13,810 unique individuals in the final analytic population for the Medicaid data. The EHR claims data included information on location of service. After removing claims associated with locations of service outside of the YK Delta, there were 28,191 unique individuals in the final analytic population for the EHR data.

We used Spearman partial correlation coefficients for the confounder analyses (24). Spearman partial correlation coefficients were used to evaluate our study hypotheses ($\alpha = 0.05$), adjusting for dentist treatment days and baseline poverty. We adjusted for dentist treatment days to control for background differences in dental care due to dentists and as a surrogate measure for other potential secular trends in the availability of dental care. The analyses were aggregated by year for each community (48 communities × 10 years, $n = 480$), and generalized estimating equations were used to account for clustering within village due to multiple observation years (25). Observations from different villages were assumed to be independent. Three communities with small populations were excluded. We used SAS version 9.4 for the statistical analyses (SAS Institute, Inc., Cary, NC, USA).

## Results

### Study communities

There were 48 study communities. Sixteen communities had no dental services provided by a DHAT. The mean proportion of individuals at the community-level in 1999 that were below poverty was 28 percent (range: 10.7 to 64.5 percent).

### Predictor variable

The predictor variable was the number of DHAT treatment days. In 2006, there were two practicing DHATs in the YK Delta. The number of DHATs increased to 10 by 2015. In the 10-year period, there were a total of 9,012 DHAT treatment days.

### Child outcomes

Mean preventive utilization for children was 15.4 percent in the Medicaid data and 31.8 percent in the EHR data (Table 1). Over the 10 years, the proportion of children who received preventive care increased fivefold in the Medicaid data (7.4 to 35.6 percent) and doubled in the EHR data (30.5 to 57.8 percent). The mean proportion of D-E-F-G extractions for children was 3.1 percent in the Medicaid data and 14 percent in the EHR data. The proportion of D-E-F-G extractions increased in Medicaid data (1.9 to 16.3 percent) and decreased in the EHR data (19.2 to 12.1 percent). The mean proportion of children utilizing dental care under general anesthesia was 5.4 percent in the Medicaid data and 5.7 percent in the EHR data. The proportion of children undergoing

**Table 1** Dental Utilization for Individuals in Alaska's Yukon-Kuskokwim Delta by Year (2006 to 2015)

| | Year (%) | | | | | | | | | | All |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | years (%) |
| Child preventive dental care, Medicaid data | 7.4 | 9.0 | 10.7 | 8.7 | 13.4 | 13.3 | 17.7 | 21.1 | 30.4 | 35.6 | 15.4 |
| Child preventive dental care, EHR data | 30.5 | 24.2 | 30.4 | 29.5 | 35.4 | 27.4 | 35.4 | 42.2 | 52.7 | 57.8 | 31.8 |
| Child D-E-G-F extraction, Medicaid data* | 1.9 | 3.2 | 2.3 | 2.7 | 2.9 | 3.4 | 3.4 | 5.4 | 8.0 | 16.3 | 3.1 |
| Child D-E-G-F extraction, EHR data | 19.2 | 20.1 | 20.6 | 26.4 | 13.1 | 9.7 | 9.1 | 12.5 | 14.4 | 12.1 | 14.0 |
| Child general anesthesia, Medicaid data† | 1.6 | 2.4 | 2.1 | 2.0 | 4.0 | 5.5 | 6.4 | 7.4 | 13.7 | 15.8 | 5.4 |
| Child general anesthesia, EHR data | 7.3 | 7.8 | 7.6 | 7.7 | 8.1 | 5.9 | 5.6 | 5.9 | 6.3 | 4.8 | 5.7 |
| Adult preventive dental care, Medicaid data | 1.1 | 2.6 | 2.6 | 2.5 | 3.0 | 4.3 | 4.3 | 5.6 | 8.5 | 6.4 | 3.8 |
| Adult preventive dental care, EHR data | 24.0 | 19.8 | 15.7 | 16.7 | 24.4 | 22.8 | 20.7 | 28.9 | 36.9 | 35.3 | 18.7 |
| Adult extraction, Medicaid data | 6.6 | 8.9 | 7.3 | 6.6 | 8.1 | 6.9 | 7.8 | 7.6 | 10.7 | 10.3 | 7.8 |
| Adult extraction, EHR data | 34.5 | 32.7 | 33.2 | 33.7 | 31.9 | 29.2 | 27.5 | 29.1 | 31.0 | 30.9 | 32.9 |

*There were no tooth numbers available in the Medicaid data. Therefore, this measure was defined as four extractions on the same day.
†There were no tooth numbers available in the Medicaid data. Therefore, this measure was defined as five or more stainless steel crowns on the same day.

general anesthesia increased in the Medicaid data (1.6 to 15.8 percent) and decreased in the EHR data (7.3 to 4.8 percent).

## Adult outcomes

Mean preventive dental care utilization for adults was 3.8 percent in the Medicaid data and 18.7 percent in the EHR data (Table 1). Adult preventive care utilization in the Medicaid data started at 1.1 percent (2006), peaked to 8.5 percent (2014), and decreased to 6.4 percent (2015). For the EHR data, preventive utilization fluctuated during the 10-year study period, starting at 24 percent (2006) and ending at 35.3 percent (2015). The mean proportion of adults with extractions was 7.8 percent in the Medicaid data and 32.9 percent in the EHR data. Adult extractions fluctuated in both datasets, increasing from 6.6 to 10.3 percent in the Medicaid data and decreasing from 34.5 to 30.9 percent in the EHR data.

## Confounder analyses

Dentist treatment days were positively associated with the predictor ($\rho = 0.31$; $P < 0.0001$) and significantly associated with most outcomes (Table 2). Baseline poverty was not associated with the predictor ($\rho = -0.12$; $P = 0.53$) but significantly associated with most outcomes (Table 2).

## Main statistical analyses

Across the 10-year study period in both EHR and Medicaid datasets, increased DHAT treatment days were positively associated with child and adult preventive care, and negatively associated with extractions for children and adults (Table 3). From the EHR data, DHAT treatment days were negatively associated with treatment under general anesthesia for children, but this association was not statistically significant in the Medicaid data.

# Discussion

This is first known study to evaluate long-term outcomes associated with DHATs. The main finding is that increased DHAT treatment days were positively associated with preventive care utilization and negatively associated with extractions. These trends suggest that dental outcomes have improved in Alaska's YK Delta with the introduction of

**Table 2** Spearman Correlation Coefficients for Model Confounders

| | Spearman correlation coefficients<br>*P*-values | | | | |
|---|---|---|---|---|---|
| | Child preventive dental care | Child D-E-F-G extraction | Child general anesthesia | Adult preventive dental care | Adult extraction |
| Dentist treatment days | 0.33 | 0.21 | 0.16 | 0.31 | 0.02 |
| (Medicaid data) | <0.0001 | <0.001 | 0.01 | <0.001 | 0.78 |
| Dentist treatment days | 0.25 | 0.13 | 0.17 | 0.26 | −0.22 |
| (EHR data) | <0.001 | 0.09 | 0.03 | <0.001 | <0.01 |
| Baseline poverty | −0.12 | −0.16 | −0.18 | −0.10 | −0.001 |
| (Medicaid data) | <0.001 | <0.01 | <0.0001 | 0.01 | 0.53 |
| Baseline poverty | −0.15 | −0.18 | −0.16 | −0.20 | 0.001 |
| (EHR data) | <0.001 | <0.01 | <0.01 | <0.001 | 0.91 |

proportions of individuals utilizing preventive care and lower proportions utilizing invasive dental treatment (Table 4). Differences were similar in the EHR data although the magnitudes were larger. These findings suggest that clinically meaningful improvements in dental use can be achieved by incorporating DHATs into the care delivery system. Potential challenges to maintaining a cadre of active DHATs include difficulties with recruitment, preventing provider burn out, and managing provider preferences for communities that may not be the areas of greatest need – all of which are similar difficulties in retaining dentists in underserved areas (27-29). These issues should be explored through research involving current and former DHATs so that recruitment and retention strategies can be improved.

DHATs appear to have an impact on the dental care delivery system. Over the 10-year period, 13 DHATs provided 9,012 treatment days in the YK Delta, compared to 23,368 days of treatment provided by 41 full-time dentists and 14 per diem dentists. The mean number of treatment days provided by each DHAT was slightly higher than dentists, but the number of patients treated and the complexity of care are likely to be different.

One goal of the DHAT program is to address pent up demand for emergency and routine dental care needs, which should level off over time. As this happens, one would expect DHATs to spend more of their time on prevention efforts that go beyond the clinic setting. This could come in the form of community- and home-based behavioral and social interventions aimed at reducing sugared sweetened beverages and improving toothbrushing with fluoridated toothpastes. Evidence-based preventive efforts could be incorporated into the scope of dental therapy practice, which might be particularly effective in indigenous communities because of cultural concordance between DHATs and community members.

Future research should assess how community-level dental care needs change as dental therapists are integrated into the local delivery care system, and characterize the proper balance for DHATs between restorative and preventive activities based on changing community needs. The ultimate goal is to ensure that dental therapy programs do not simply replicate the existing dental care delivery system that focuses primarily on clinic-based treatment and that dental therapists and dentist are providing care that optimizes health outcomes at the lowest cost possible.

Policymakers considering dental therapy legislation are increasingly interested in outcomes data. One example is cost effectiveness. A recent simulation study from the United Kingdom found that mid-level dental providers working in a public dental care delivery system can be a dominant strategy over dentists (i.e., improved outcomes at a lower cost) (30). These findings may be applicable to the YK communities. Additional cost-effectiveness analyses would help to provide answers applicable to the US context.

Our study findings support dental therapists as part of an upstream approach to help address oral health inequalities and achieve social justice (23). Dental therapists in the YK Delta have diversified the dental workforce, created opportunities for community members to serve as healers, and removed cultural barriers to care – important steps in achieving health equity and social justice within indigenous communities.

The main study strength is that we had two longitudinal data sources. However, there are at least six limitations. First, this was an observational study. All findings are associations. Causal inferences can only be drawn from randomized clinical trials, but such trials are unlikely because of cost. In addition, there are ethical considerations in withholding care that has been shown to be safe and effective. Second, there is the potential for selection bias. We attempted to address this problem by adjusting for confounders. However, baseline poverty in 1999 may not accurately measure differences in resources across communities, particularly because the study period began in 2006. Future work should continue to refine the models by identifying and operationalizing additional covariates.

Third, there were differences between the two datasets. Utilization trends were consistent, but Medicaid proportions were generally lower than EHR proportions (Table 1). One reason is that the annual Medicaid denominators included all enrollees regardless of utilization. When we restricted the Medicaid analyses to those who utilized care, the proportions between the two datasets converged. For instance, Medicaid preventive care use in 2015 increased to 65.5 percent for children and 35.6 percent for adults.

Fourth, there was a relatively low match for location of service in the Medicaid data, which raises potential concerns regarding generalizability. We compared demographic and utilization differences between the 13,810 retained and 8,516 excluded Medicaid enrollees. There were no differences in sex or age distribution between retained and excluded enrollees. Proportions of retained children and adults who utilized preventive care utilization were higher, whereas there were no consistent differences in D-E-F-G extractions, dental treatment under general anesthesia, or adult extractions. These findings make it difficult to draw definitive conclusions regarding the degree of systematic bias represented in the retained Medicaid enrollees. Future studies should develop methods to increase the proportion of matches between individuals in Medicaid and EHR data as well as ways to impute location of service for Medicaid enrollees when matching is not possible.

Fifth, our study focused on utilization. We did not assess other outcomes like unmet dental care needs, disease prevented, or quality-of-life. Future studies should be conducted to evaluate ways dental therapists can help improve patient-centered outcomes. In addition, qualitative work within communities of varying degrees of DHAT treatment days could

**Table 3** Spearman Partial Correlation Coefficients Between DHAT Treatment Days (Continuous Variable) and Each Outcome During 10-Year Study Period Based on Medicaid and EHR Data

| | Spearman partial correlation coefficients* *P*-values | | | | |
|---|---|---|---|---|---|
| DHAT treatment days | Child preventive dental care | Child D-E-F-G extraction | Child general anesthesia | Adult preventive dental care | Adult extraction |
| Medicaid data | 0.23 | −0.17 | 0.05 | 0.20 | −0.16 |
| | <0.0001 | 0.03 | 0.45 | <0.001 | 0.02 |
| EHR data | 0.26 | −0.28 | −0.27 | 0.30 | −0.46 |
| | <0.0001 | <0.0001 | <0.0001 | <0.0001 | <0.0001 |

*Adjusted for dentist treatment days and baseline poverty.

dental therapists. These results are consistent with a study reporting positive associations between pediatric dentist density and preventive dental care use for children in Medicaid (26).

There are a number of potential explanations. The most plausible mechanism underlying increased preventive care utilization is improved local access to providers, which may have also increased patient demand for care. This is consistent with previous work indicating reduced patient-reported wait times for dental appointments in YK communities (22). Fewer extractions could indicate improvements in oral health behaviors and beliefs, as well as earlier restorative intervention before the need for extractions. These mechanisms could be assessed in the future by further examining restorative claims data and conducting interviews in communities, and comparing oral health behaviors and beliefs across communities that vary on DHAT treatment days. Similar interviews could be conducted with DHATs and dentists to measure provider perceptions of how patient attitudes, beliefs, and behaviors regarding oral health have changed over time.

We had inconsistent findings regarding general anesthesia for children. DHAT treatment days were negatively associated with general anesthesia in the EHR data but not significant in the Medicaid data. There are two possible explanations for this discrepancy. First, population characteristics differed across the two datasets. The EHR data consisted of individuals who utilized dental care, whereas the Medicaid data included all enrollees regardless of utilization of dental care. Second, the Medicaid-based outcome could be misspecified due to lack of tooth-level data. There was a near doubling in the proportion of children in the Medicaid data receiving dental care under general anesthesia between 2013 and 2014, which was not observed in the EHR data. A conservative conclusion is that increased DHAT treatment days were not associated with increased proportions of children receiving dental care under general anesthesia. Future research should continue to examine the associations between DHAT treatment days and child general anesthesia.

Improvements in dental utilization were particularly noticeable in communities where DHATs had the greatest presence. In post-hoc subgroup analyses, we identified communities in which DHATs did not provide any dental treatment ($N = 16$) and communities in which the DHAT treatment day to population ratio was >75th percentile ($N = 7$). Across both datasets, communities with the highest DHAT treatment days exhibited consistently greater

**Table 4** Percentage Point Differences in Outcomes Between Communities with No DHAT Treatment Days and the Highest Number of DHAT Treatment Days

| | No DHAT treatment day communities $N = 16$ (%) | Highest DHAT treatment day communities $N = 7$ (%) | Percentage point difference between highest and no DHAT treatment day communities (%) |
|---|---|---|---|
| Medicaid data | | | |
| Child preventive dental care | 15.5 | 24.8 | 9.3 |
| Child D-E-F-G extraction | 7.3 | 1.9 | −5.4 |
| Child general anesthesia | 7.9 | 5.5 | −2.4 |
| Adult preventive dental care | 3.2 | 5.6 | 2.4 |
| Adult extraction | 9.6 | 7.1 | −2.5 |
| EHR data | | | |
| Child preventive dental care | 30.5 | 46.9 | 16.4 |
| Child D-E-F-G extraction | 22.6 | 7.4 | −15.2 |
| Child general anesthesia | 8.5 | 5.4 | −3.1 |
| Adult preventive dental care | 15.3 | 27.1 | 11.8 |
| Adult extraction | 40.5 | 27.0 | −13.5 |

reveal other important differences associated with care provided by DHATs.

Sixth, dental care is not a panacea. Preventive care utilization was generally low even in recent years. This underscores the importance of targeting behaviors relevant in oral health such as limiting sugar intake and optimizing fluoride exposure. Future work should examine how preventive behaviors and norms within Alaska Native communities are influenced by the presence of DHATs. There is a need for evidence-based strategies that can be incorporated into the Alaska Native dental care delivery system to help providers like DHATs promote patient-level behavior change. This is especially relevant in the YK Delta in which DHATs maintain familial ties, share a common history, and understand the strengths and challenges as experienced by local populations. The eventual goal would be to harness the dental care delivery system as a way to improve oral health behaviors among individuals and norms within families and communities.

## Conclusions

Our results provide evidence of positive benefits associated with dental therapists within underserved communities. These promising findings are relevant to policymakers in states with active or pending dental therapy legislation, which is a step toward meeting the dental care needs of vulnerable populations and achieving oral health equity and social justice.

## Acknowledgments

Thank you to the individuals and communities in the Yukon Kuskokwim Delta represented in this study for making this study possible. We also thank the Yukon Kuskokwim Health Corporation and the Alaska Department of Health and Human Services for providing data. This study was funded in part by the Pew Charitable Trusts, the W.K. Kellogg Foundation, the Rasmuson Foundation, the U.S. National Institute of Dental and Craniofacial Research Grant No. K08DE020856, the William T. Grant Foundation Scholars Program, and the Center for Advanced Study in the Behavioral Sciences (CASBS) at Stanford University.

### References

1. Lewis CW, Riedy CA, Grossman DC, Domoto PK, Roberts MC. Oral health of young Alaska Native children and their caregivers in Southwestern Alaska. *Alaska Med.* 2002;**44**(4): 83-7.
2. American Academy of Pediatrics, Committee on Native American Child Health, Canadian Paediatric Society, First Nations, Inuit and Métis Committee. Early childhood caries in indigenous communities. *Pediatrics.* 2011;**127**(6): 1190-8.
3. Chi DL. Reducing Alaska Native paediatric oral health disparities: a systematic review of oral health interventions and a case study on multilevel strategies to reduce sugar-sweetened beverage intake. *Int J Circumpolar Health.* 2013; **72**(1):21066.
4. Casamassimo PS, Thikkurissy S, Edelstein BL, Maiorini E. Beyond the dmft: the human and economic cost of early childhood caries. *J Am Dent Assoc.* 2009;**140**(6):650-7.
5. Holmberg P, Hellmich T, Homme J. Pediatric sepsis secondary to an occult dental abscess: a case report. *J Emerg Med.* 2017;**52**(5):744-8.
6. Jackson SL, Vann WF Jr, Kotch JB, Pahel BT, Lee JY. Impact of poor oral health on children's school attendance and performance. *Am J Public Health.* 2011; **101**(10):1900-6.
7. Guarnizo-Herreño CC, Wehby GL. Children's dental health, school performance, and psychosocial well-being. *J Pediatr.* 2012;**161**(6):1153-9.
8. Glied S, Neidell M. The economic value of teeth. *J Hum Resour.* 2010;**45**(2):468-96.
9. Centers for Disease Control and Prevention (CDC). Dental caries in rural Alaska Native children–Alaska, 2008. *MMWR Morb Mortal Wkly Rep.* 2011;**60**(37): 1275-8.
10. Chi DL, Hopkins S, O'Brien D, Mancl L, Orr E, Lenaker D. Association between added sugar intake and dental caries in Yup'ik children using a novel hair biomarker. *BMC Oral Health.* 2015;**15**(1):121.
11. Fisher-Owens SA, Gansky SA, Platt LJ, Weintraub JA, Soobader M-J, Bramlett MD, Newacheck PW. Influences on children's oral health: a conceptual model. *Pediatrics.* 2007; **120**(3):510-20.
12. Price WA. Eskimo and Indian field studies in Alaska and Canada. *J Am Dent Assoc.* 1936;**23**(3):417-37.
13. Kolahdooz F, Simeon D, Ferguson G, Sharma S, Smith B. Development of a quantitative food frequency questionnaire for use among the Yup'ik people of Western Alaska. *PLoS One.* 2014;**9**(6):100412.
14. Atkins CY, Thomas TK, Lenaker D, Day GM, Hennessy TW, Meltzer MI. Cost-effectiveness of preventing dental caries and full mouth dental reconstructions among Alaska Native children in the Yukon-Kuskokwim delta region of Alaska. *J Public Health Dent.* 2016;**76**(3): 228-40.
15. Gessner BD, Beller M, Middaugh JP, Whitford GM. Acute fluoride poisoning from a public water system. *N Engl J Med.* 1994;**330**(2):95-9.
16. Batliner TS. American Indian and Alaska Native access to oral health care: a potential solution. *J Health Care Poor Underserved.* 2016;**27**(1):1-10.
17. Nash DA, Friedman JW, Kardos TB, Kardos RL, Schwarz E, Satur J, Berg DG. Dental therapists: a global perspective. *Int Dent J.* 2008;**58**(2):61-70.

18. Pew Charitable Trusts. Expanding the dental team: increasing access to care in public settings [Internet]. c2014 [cited 2017 June 6]. Available from: http://www.pewtrusts.org/~/media/assets/2014/06/27/expanding_dental_case_studies_report.pdf
19. Koppelman J, Singer-Cohen R. A workforce strategy for reducing oral health disparities: dental therapists. *Am J Public Health.* 2017;**107**(S1):S13-7.
20. Bolin KA. Assessment of treatment provided by dental health aide therapists in Alaska: a pilot study. *J Am Dent Assoc.* 2008;**139**(11):1530-5; discussion 1536-9.
21. Bader JD, Lee JY, Shugars DA, Burrus BB, Wetterhall S. Clinical technical performance of dental therapists in Alaska. *J Am Dent Assoc.* 2011;**142**(3):322-6.
22. Wetterhall S, Burrus B, Shugars D, Bader J. Cultural context in the effort to improve oral health among Alaska Native people: the dental health aide therapist model. *Am J Public Health.* 2011;**101**(10):1836-40.
23. Treadwell HM, Northridge ME. Oral health is the measure of a just society. *J Health Care Poor Underserved.* 2007;**18**(1):12-20.
24. Sheskin DJ. *Handbook of parametric and nonparametric statistical procedures.* 2nd ed. New York: Chapman & Hall/CRC; 2000.
25. Hardin J, Hilbe J. *Generalized estimating equations.* London: Chapman and Hall/CRC; 2003.
26. Heidenreich JF, Kim AS, Scott JM, Chi DL. Pediatric dentist density and preventive care utilization for Medicaid children. *Pediatr Dent.* 2015;**37**(**4**):371-5.
27. Osborne PB, Haubenreich JE. Underserved region recruitment and return to practice: a thirty-year analysis. *J Dent Educ.* 2003;**67**(5):505-8.
28. Silva M, Phung K, Huynh W, Wong H, Lu J, Aijaz A, Hopcraft M. Factors influencing recent dental graduates' location and sector of employment in Victoria. *Aust Dent J.* 2006;**51**(1):46-51.
29. Hayashi AS, Selia E, McDonnell K. Stress and provider retention in underserved communities. *J Health Care Poor Underserved.* 2009;**20**(3):597-604.
30. Hill H, Macey R, Brocklehurst P. A Markov model assessing the impact on primary care practice revenues and patient's health when using mid-level providers, lesson learned from the United Kingdom. *J Public Health Dent.* 2017;**77**(4):334-43.

**Testimony on HB 1426**
**House Human Services Committee**
**The North Dakota Dental Association**
**William Sherwin, Executive Director**
**January 21, 2019**

Good Afternoon Chairman Weisz and members of the House Human Services Committee, my name is William Sherwin and I am the Executive Director of the North Dakota Dental Association (NDDA). I am here today to present testimony in opposition to HB 1426. As the NDDA, we represent over 400 dentists across the state of North Dakota, of which, 97% oppose the dental therapy model and its implementation in North Dakota. With your permission Chairman Weisz, following my testimony, I would like to invite Dr. Steven Deisz to present his testimony on behalf of the NDDA from a clinical expert perspective.

Dental therapists, with considerably less training than a dentist, have been proposed as a solution to reduce barriers to care in North Dakota. With limited experience from only one state, Minnesota, there is minimal evidence that it improves quality of care, improves access to care, or reduces costs, particularly in a rural state like North Dakota. We need to affirm that all North Dakotans, regardless of socio-economic status, deserve quality dental care from the highest-trained professionals. Further, though well-intentioned, dental therapy's proposed focus on low-income and underserved patients incentivizes discrimination and puts the neediest, most complex cases, a step further from a dentist. The North Dakota Senate in 2015 and the North Dakota House in 2017, again affirmed our position that the dental therapy model is not the right solution for North Dakota for the following reasons:

1. **Young Dentists and New Graduates are Choosing North Dakota More Than Any Other State**

North Dakota leads the country in the net in-migration of dentists. When compared to our neighboring states, our dental workforce is growing at two to three times the rate of our neighbor's dental workforce. This leading growth in our dental workforce even accounts for our drastic population growth over this time. Further, this in-migration of dentists is populated by younger dentists who are quickly locating and replacing our aging dental workforce faster than they are retiring. The dental workforce market in our state is robust, adequate and arguably over-saturated. The free market is working and licensing an additional midlevel provider is not needed, particularly given the lack of evidence how this new provider would benefit North Dakota patients.

Please see attached demographic and migration information.

**2. North Dakota Collaborative Partners and North Dakota Solutions**

The NDDA continuously partners with organizations, state health officials, and North Dakota's dental community to provide education, prevention, collaboration, and outreach in North Dakota. These collaborative partnerships drive the real change through a variety of avenues in our state. The partnerships and applications vary from outreach and education to prevention and clinical care.

The NDDA advocated for the "Smiles for Life" curriculum to be recognized and implemented in North Dakota. This curriculum provides dental education and allows doctors, advanced practice RNs, physician assistants, RNs and licensed practical nurses to apply fluoride varnish. Since its's inception, the "Smiles for Life" curriculum has been taught in 54 clinics and to 256 health professionals treating patients in Local Public Health Units, Long Term Care Facilities, and medical clinics across the state. Another collaborative program showing dramatic results is the Seal!ND Program. This program provides low-income students with dental screening, sealant placements and fluoride varnish applications by hygienists. There are 112 North Dakota schools currently participating in the program, of which 49 are served by private practice dentists.

North Dakota dentists continuously volunteer to give back in their communities. Through Donated Dental Services, 875 North Dakota Patients have received more than $3 million in donated services from 126 dentists and 11 dental labs in North Dakota. In 2018 on "Give Kids a Smile" day alone, dental hygiene/assistant students and pediatric dentist volunteers at the North Dakota State College of Sciences (NDSCS) donated $17,000 of services to North Dakota children. Even though Medicaid reimbursement fees are less than the cost of care, 75 North Dakota dentists pledged to take more dental Medicaid patients. Most amazingly, on September 28-29 of 2018, the NDDA organized our first ND Mission of Mercy in Bismarck. At this free dental care event, 110 dentists, 48 hygienists, 105 dental assistants and 4 lab techs provided an estimated $564,964 of dental care for 916 individuals.

The NDDA supports and partners with our five public health safety net clinics to provide dental homes for the underserved. These clinics also partner with their local hospitals on ER Diversion programs for next-day care. Public loan repayment programs help recruit dentists to these clinics, rural and other underserved areas. The Ronald McDonald Care Mobile provided $572,868 worth of dental care to over 1000 children in western North Dakota with their state-of-the-art mobile dental clinic.

The North Dakota Dental Foundation (NDDF) was boosted with a $6.3 million dollar endowment in 2015. These funds are used to remove barriers to dental care, provide prevention and education in our state. Grants have been awarded to provide outreach in North Dakota schools and on North Dakota

tribal lands. The NDDF has also worked on education programs and oral health career advocacy to ensure a robust dental team workforce in our state.

This education, prevention, collaboration, and outreach in North Dakota is the true solution to solving North Dakota's oral health problems. We welcome the help and support of the North Dakota legislature with these continued programs and partnerships to maintain and accelerate the changes we all wish to see in oral health outcomes. Our solutions must be based in just as much evidence as which we require in defining our problems. Only through these evidence-based proven solutions will we find the measurable results we all desire to produce.

Please see attached North Dakota Oral Health Programs and Partners.

**3. Oral Health In North Dakota: The North Dakota Barriers and Solutions**

Over the course of many years working toward providing quality care, the NDDA has identified barriers to care unique to North Dakota. Addressing these barriers while promoting disease prevention is an ongoing effort that requires a collaborative approach among the dental community, state government, public health entities and patients. North Dakota-specific solutions should prioritize **patient outreach and case management.**

One solution to barriers to care is expanding and supporting our nonprofit clinics and other outreach programs. The NDDA collaborates with our 5 existing nonprofit clinics and our state Oral Health Program on many of their programs across the state. Community Dental Health Coordinators are currently practicing in North Dakota and more are undergoing training to expand our reach into underserved areas.

A second solution is to improve dental Medicaid. In order for the state to expand outreach, we should adopt existing teledentistry and case management codes for reimbursement. We need to recruit Medicaid dentists through innovative marketing programs and streamline administrative process to maintain dentist retention. And most importantly, we must work to close the gap in dental Medicaid reimbursement to encourage continued dentist participation.

A third solution is to maximize our existing dental team workforce. Dental loan repayment programs, created in part by the NDDA, help recruit new dentists and encourage them to practice in underserved areas of our state. A collaborative effort among the NDDA, NDDF, and NDSCS is focused on recruiting and training in-demand dental assistants. These assistants and dental hygienists would benefit

from an Expanded Restorative Functions Course to expand the functions they could provide and increase the productivity of their accompanying dentists.

Our final solution is to improve access to care for our tribal communities. The NDDA led a national effort with US Senator John Hoeven to address the IHS credentialing process to standardize its protocol. We continue to partner with the tribes and provide support to tribes electing to go "638" status. Specifically, when the Spirit Lake Clinic lost its IHS dental provider in the summer of 2016, the NDDA recruited four dentists to assist until a new full-time dentist was hired. Finally, we must continue to connect our tribes with local dentists and other dental services to not only augment their dental workforce but also improve their efficiency to identify additional dental resources.

By tackling these barriers through many of the proposed solutions, we as a collaborative team, can continue to make the changes we all wish to see for oral health in North Dakota. This is an ongoing effort and we must continue to focus our time and resources on solutions that work and not the distraction that is dental therapy. Our focus should be on a broader discussion of North Dakota-specific solutions which should prioritize patient outreach and case management.

Please see attached North Dakota Oral Health Barriers and Solutions.

**4. Dental Therapy: A Costly and Unproven Approach in Minnesota and Around the World**

There is minimal evidence that dental therapy improves quality of care, improves access to care, or reduces costs, particularly in a rural state like North Dakota. Not only is dental therapy not the solution for North Dakota, but it has also turned out to be a costly and failed experiment in both Minnesota and around the world. The North Dakota legislators agreed in 2015 and 2017 that dental therapy is not the right solution for North Dakota.

In Minnesota, after 8 years only about 5-15 dental therapists practice in designated rural areas of the state with most of them practicing in the Twin Cities Metro. Since Minnesota has enacted its dental therapy legislation their Medicaid children have not benefited from any increase in access to dental services. In fact, Minnesota is doing so poorly in providing dental care to their children that the federal government put the state on notice that they are at risk of having federal Medicaid money withheld. When looking at the data it is quite clear that while the Pew Foundation and its allies declare Minnesota's dental therapist experiment a spectacular success, it really is nothing more than negligible evidence not backed by true clinical statistical data.

Dental therapy in Canada failed without government subsidies and many of the existing programs in the U.S. rely on support through state subsidies or special interests to survive. The Vermont law allowing dental therapists has received hundreds of thousands of dollars from the WK Kellogg Foundation to develop a plan in the state... a plan that is still not functional three years later. Similar to the failed Canadian program, Minnesota dental therapists are abandoning underserved rural communities to seek higher wages in urban areas. Simply put, these programs do not work and have shown the need for government or grant subsidies to be viable. In Minnesota, implementation of dental therapy has cost the state over $215,000 in unanticipated costs (Minnesota Board of Dentistry minutes 2010 – 2014). This process would reduce governmental efficiency by regulating a scope of practice that duplicates procedures already allowed for dentists with no results or cost savings for patients. We cannot afford to waste the time and state funds for a midlevel provider model that is unproven and will not increase oral health outcomes for North Dakotans.

Please see attached independent third-party studies of Minnesota and Canadian Programs.

**5. Dental Therapy Pilot Projects on Oregon Tribes FAIL Site Visits**

SB 738, approved in the 2011 in Oregon, permits the Oregon Health Authority (OHA) to approve pilot projects to explore new roles in Oregon's oral health workforce, allowing individuals to practice dentistry or dental hygiene within the restrictions of an approved pilot project without a license or outside of the scope of their license. Pilot Project #100: allows Dental Health Aide Therapists (DHAT), a new mid-level provider, to practice in tribal dental clinics. There remain many concerns about the project's overall integrity and ability to produce empirical evidence and measurable outcomes. There also remain significant patient safety and technical concerns. The project failed a site visit at its Native American Rehabilitation Association (NARA) clinic with a range of serious issues from lack of patient informed consent to DHATs performing extractions outside of their approved scope of practice. While there was acknowledgement from both parties that the site visit documented sufficient reasons to end the Project, a legal stipulated agreement was signed with defined parameters that must be met moving forward.

Please see attached public OHA failed site visit documents.

**6. Dental Therapy Level of Training Not Comparable or Adequate for Irreversible Procedures**

Dental therapists with three years of training are not prepared at the level of their dental peers and should not be providing irreversible procedures with an unprecedented reduction in supervision. In

depth discussion and differentiation to show the clearly inadequate level of training for the procedures to be provided by dental therapists will be discussed by our clinical representative Dr. Steven Deisz who will be following my testimony. He will cover the distinctions of dental therapy and dental curriculum. Further, he will also clarify the differences between midlevel providers within the medical and dental worlds. Finally, he will explain the dire ramifications of placing the neediest patients with the most complex medical, behavioral and dental needs in front of the least trained professional for dental care. Through his testimony it will be readily evident that dental therapists should not be providing care to any North Dakotans, especially the underserved.

Please hold questions for Dr. Steven Deisz as our clinical representative.

**7. Cost of Care is NOT Reduced for Patients or the State**

Dental therapists are frequently cited as making dental care more affordable for patients. This is false. Insurers, patients and the state pay set fees for dental procedures, regardless of who performs them. There is zero cost savings under the dental therapy model to either the patient or the state. Patients and public assistance programs will be paying the same price for procedures that will be performed by lesser trained professionals. Is this something that we as a state want to incentivize for treatment to our underserved and tribal communities? We at the NDDA believe that all patients deserve and need to be treated by a dentist. Especially our underserved and tribal communities who are dealing with complex medical, behavioral and dental issues.

**8. Dental Therapy Legislation is Inconsistent in Definitions, Scope, Education and Oversight**

The definition of a dental therapist varies wildly depending on where you are. The inconsistencies in definition, scope, education and oversight make it difficult to make accurate predictions of the potential success or failure of a new state program. HB 1426 defines a "Federally qualified health center look-alike." What are these facilities and what does this mean? Is this really something we want to define within North Dakota Century Code? The bill requires the NDBODE to recognize CODA (Council on Dental Accreditation) accredited programs when in fact, **the only two training programs that exist national are in Minnesota and NEITHER are accredited.** The fall back clause requires the board to recognize education programs "approved by a regulatory board of another jurisdiction." What does that mean? What dental therapists are we talking about? Are we comfortable approving any "midlevel provider" that has drastically different training from any jurisdiction?

The scope of practice accounts for a list of procedures plus "other related services and functions that are authorized by the supervising dentist within the dental therapist's scope of practice and for which the dental therapist is trained." What does this mean? Are we to include any and all "services and functions" from any educational program recognized by the regulatory body of another jurisdiction? Do we know the extent of potential programs and procedures taught in these wildly varying programs? Are we now forced in North Dakota to recognize these procedures?

Further, under HB 1426 these recognized providers from any jurisdiction would only be required to practice 500 hours (3 months) under clinical supervision of a dentist before practicing under general supervision. What does this mean? As the bill states on page five, "a dental therapist may... perform dental services in a practice setting at which the supervising dentist is not onsite and has not previously examined or diagnosed the patient. The supervising dentist must be available for consultation by telephone or other means of electronic communication." **So, we are now allowing dental therapists to provide any procedure they have been trained for, through drastically different educational programs, in any foreign jurisdiction, and after 500 hours we deem them capable of practicing remotely anywhere within our state, while the dentist could be anywhere in the world so long as they are accessible by electronic means?** We are confident this is not the solution for North Dakota and it definitely is not one that the NDDA or North Dakota patients will support for the delivery of dental care in our state. The answer from the NDDA and our over 400 member dentists is a resounding **NO.**

Please see attached highlighted HB 1426.

**9. Oppose HB 1426 and give it a Do Not Pass Recommendation**

Dental therapy is an unproven one-size-fits-all model that is failing in other states. There is minimal evidence that dental therapy reduces costs or improves quality or access to care, particularly in a rural state like North Dakota. North Dakotans, regardless of socio-economic status, deserve quality dental care from the highest trained professionals. HB 1426 with its focus on low-income and underserved patients incentivizes discrimination and puts the neediest, most complex cases, a step further from a dentist. We must continue to partner and focus on education, prevention, collaboration, and outreach specific to our state which are strategies that are currently showing positive results. For these reasons, **I would ask the committee to please oppose HB 1426** and reaffirm the decisions made by the 2015 North Dakota Senate and the 2017 North Dakota House of Representatives.

Over the past two years, we have had the opportunity to provide dental services at Spirit Lake Reservation in Fort Totten, North Dakota. This has been a rewarding experience working with great people, both co-workers and patients. To say that there is a need for oral health care would be an understatement. Dental care and oral hygiene instruction (education) is much needed. Unfortunately, it is very common to have rampant decay in pre-school aged children and also having to extract permanent teeth in six year-olds.

At Spirit Lake, we are fortunate to have a more than adequate number of dentists to provide dental care. There are currently two full-time dentists and six part-time dentists. Access to care is NOT an issue. The lack of education and utilization of dental services available is prevalent and unfortunately wide-spread. Lack of transportation services is also an issue.

Having no registered and certified dental assistants is a large barrier to efficiency and quality and quantity of dental care provided. Frequently, dentists are either providing dental care without an assistant or a dentist is assisting another dentist who is providing care. Shortage of dental assistants, in our opinion, is the greatest barrier in providing dental care other than the population not utilizing the services provided. Oral healthcare in this setting is reactionary rather than preventative in nature. Care is obtained only when pain and infection is present. A lack of dental hygienists is also a barrier. The importance of which is lacking in this setting as well, as it has been proven oral health care is paramount in the over-all health of an individual.

Our experience at Spirit Lake has been very rewarding. The population is being well served with the care and expertise provided. Our frustrations are the under utilization of the dental services being provided, the credentialing process, and the less than efficient delivery of care.

Respectfully submitted;

Robert C. Lauf, Jr, DDS

Kristin Kenner, DDS

Raymond Evans, DDS

Amy Holtan Ellingson, DDS

Dale Brewster, DDS

Chris Schmaltz, DDS

William Johnson, DDS

Dr. Lauf is a private practice dentist in Mayville, ND. He is past-president of the North Dakota Dental Association and the North Dakota Board of Dental Examiners. He is president-elect of the Western Regional Examining Board (WREB). He is a dental board examiner for two testing agencies in the United States.

Dr. Kenner is a private practice dentist in Devils Lake, ND. She is past-president of the North Dakota Dental Association.

Dr. Evans is the Chief of Dental Service at Spirit Lake Health Center. He practices full time at Spirit Lake Dental Center.

Dr. Ellingson is a private practice dentist in New Rockford, ND.

Dr. Brewster is retired from private practice in Stanley, ND. He is past-president of the North Dakota Board of Dental Examiners. Dr Brewster is a dental board examiner for all five testing agencies in the United States.

Dr. Schmaltz is a private practice dentist in Fargo, ND.

Dr. Johnson is a private practice dentist in Moorhead, MN.

HB1426
#12
1/21/19
page 10

North Dakota
DENTAL ASSOCIATION

# Position Statement
# Dental Therapy 2019

Dental therapists, with considerably less training than a dentist, have been proposed as a solution to reduce barriers to care in North Dakota. With limited experience from only one state, Minnesota, there is minimal evidence that it improves quality of care, improves access to care, or reduces costs, particularly in a rural state like North Dakota. We need to affirm that all North Dakotans, regardless of socio-economic status, deserve quality dental care from the highest-trained professionals. Further, though well-intentioned, dental therapy's proposed focus on low-income and underserved patients incentivizes discrimination and puts the neediest, most complex cases, a step further from a dentist. The North Dakota Senate in 2015 and the North Dakota House in 2017, again affirmed our position that the dental therapy model is not the right solution for North Dakota. We must continue to partner and focus on education, prevention, collaboration, and outreach specific to our state which are strategies that are currently showing positive results.

# Dental Therapy Model in ND Survey - FQHC/Community Clinics (Dec 2018)

**Q1. There is currently a proposal in North Dakota that would create a new type of licensed dental provider called a Dental Therapist (Mid-level provider) who would provide dental care to people who are going without care. A licensed Dental Therapist would be allowed to provide the following services – preventive services, local anesthesia administration, preparing teeth, removing caries, placing restorations, and extractions. Based on this description, how would you feel about this proposal:**

| | |
|---|---|
| Strongly Favor: | 1 |
| Favor: | 0 |
| Oppose: | 1 |
| Strongly Oppose: | 8 |

Comments:

- The minimal training that the therapists receive is not up to the quality standard that their patient's need/deserve
- This has been tried in Manitoba and then cancelled a few years later. Could they have the ability to write prescriptions without a thorough pharmacology course of study?
- I don't feel that someone without dental school experience should be doing irreversible treatment to teeth. People with the greatest need for dental care also have the most complex cases which would need a dentist to treat.
- Not necessary; if individuals want to provide dental services to the general public they need to go to dental school and get licensed. No reason to have a dental therapist in ND; besides supporting UMN.
- Bottom line a dental therapist is under-trained and unable to provide SAFE care even if they are seeing patients that would not be able to be seen otherwise.

A survey of North Dakota Dental Association Members conducted in October, 2018 reports 97% of the membership oppose Dental Therapy in ND; only 3% are in favor. This affirms our continued stance as reported through surveys in 2014 and 2016 which opposed this unproven model that is not backed by evidence or data.

# Dental Therapy Model in ND Survey - IHS Clinics (Dec 2018)

**Q1. There is currently a proposal in North Dakota that would create a new type of licensed dental provider called a Dental Therapist (Mid-level provider) who would provide dental care to people who are going without care. A licensed Dental Therapist would be allowed to provide the following services – preventive services, local anesthesia administration, preparing teeth, removing caries, placing restorations, and extractions. Based on this description, how would you feel about this proposal:**

| | |
|---|---|
| Strongly Favor: | 0 |
| Favor: | 0 |
| Oppose: | 1 |
| Strongly Oppose: | 5 |

Comments:

- The services listed here are the bread and butter of a typical dental practice, and dentists spend 8 years in training to them. How long do dental therapists train?
- Dentists need all the education they can get.

A survey of North Dakota Dental Association Members conducted in October, 2018 reports 97% of the membership oppose Dental Therapy in ND; only 3% are in favor. This affirms our continued stance as reported through surveys in 2014 and 2016 which opposed this unproven model that is not backed by evidence or data.

HB 1426
#12
1/21/19
page 13

1A

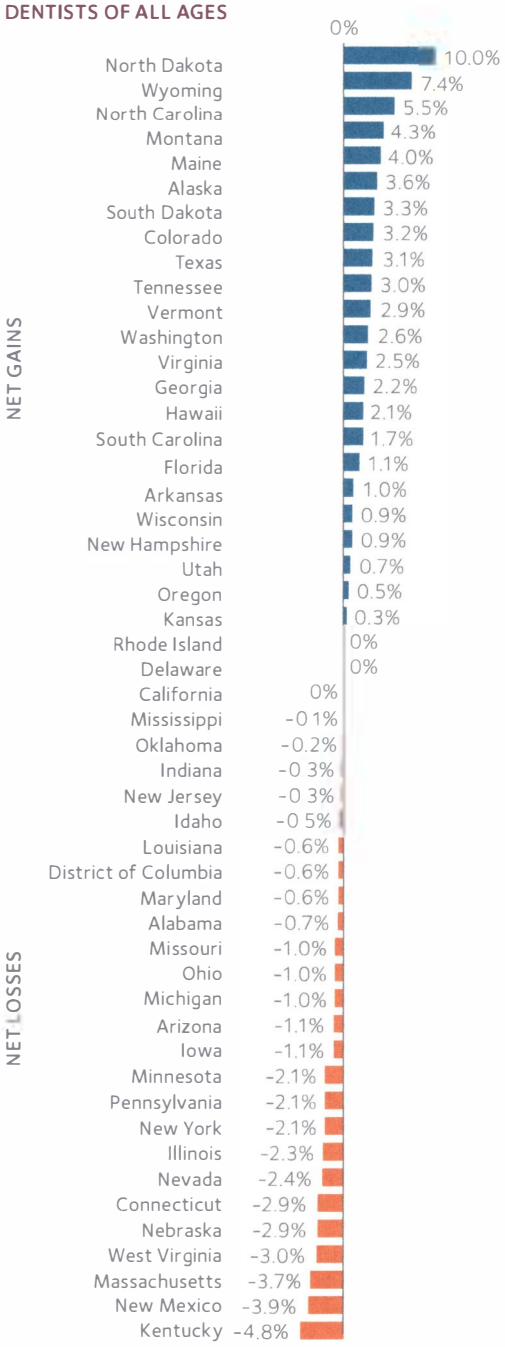
HPI Health Policy Institute

ADA American Dental Association®

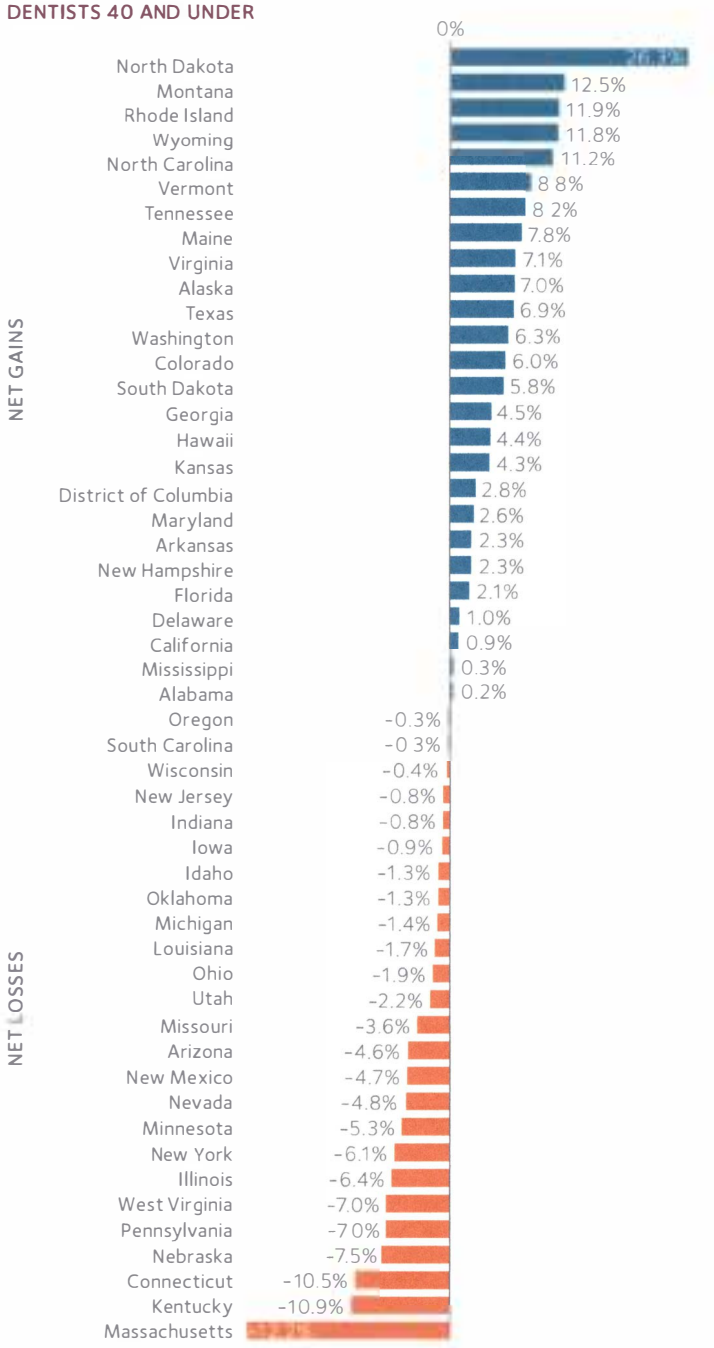
# Dentist Migration Across State Lines

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

## DENTISTS OF ALL AGES




## DENTISTS 40 AND UNDER




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

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

# Supply of Dentists in the US: 2001-2017
## ADA Health Policy Institute, Jan 2018

| 2010-2017 | % Increase in Population | % Increase in Dentists |
|---|---|---|
| Minnesota | 5% | 3% |
| South Dakota | 7% | 11% |
| Montana | 6% | 8% |
| North Dakota | 12% | 23% |
| USA | 5% | 8% |

HB1426
#12
1/21/19
page 1 of 3

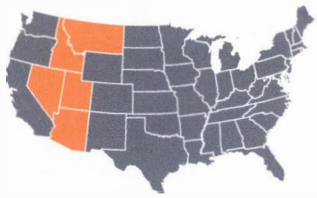
18

HPI Health Policy Institute

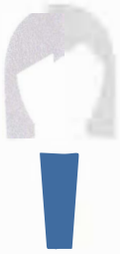
ADA American Dental Association®

# U.S. Dentist Workforce by Age Group

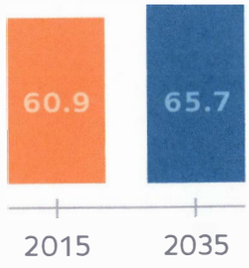
| | AGE<35 | AGE 35-49 | AGE 50-64 | AGE 65+ |
|---|---|---|---|---|
| Idaho | 13.3% | 50.7% | 25.6% | 10.4% |
| Nevada | 19.9% | 43.6% | 25.9% | 10.6% |
| Utah | 11.0% | 51.0% | 27.7% | 10.2% |
| Arizona | 16.3% | 42.8% | 29.1% | 11.7% |
| Montana | 18.3% | 39.7% | 28.6% | 13.4% |
| Texas | 20.9% | 36.9% | 30.2% | 12.1% |
| Washington | 16.2% | 41.3% | 29.5% | 13.0% |
| Oregon | 16.1% | 41.0% | 29.6% | 13.4% |
| Colorado | 17.0% | 39.2% | 31.3% | 12.5% |
| North Dakota | 18.2% | 37.7% | 31.7% | 12.2% |
| Wyoming | 21.1% | 34.7% | 29.7% | 14.5% |
| Alaska | 20.9% | 34.7% | 28.6% | 15.7% |
| South Carolina | 20.9% | 34.1% | 30.5% | 14.6% |
| North Carolina | 18.8% | 37.3% | 31.4% | 14.5% |
| Virginia | 16.7% | 36.3% | 32.8% | 14.1% |
| South Dakota | 20.7% | 32.4% | 34.1% | 12.8% |
| Massachusetts | 19.9% | 32.9% | 33.2% | 14.1% |
| Georgia | 14.2% | 38.1% | 32.9% | 14.8% |
| New Mexico | 22.5% | 29.3% | 31.8% | 16.3% |
| Nebraska | 22.9% | 28.7% | 32.7% | 15.7% |
| Oklahoma | 20.1% | 31.4% | 34.4% | 14.0% |
| Iowa | 20.8% | 30.4% | 37.7% | 11.1% |
| Mississippi | 17.0% | 33.9% | 35.8% | 13.3% |
| Minnesota | 18.5% | 32.2% | 37.3% | 11.9% |
| Louisiana | 19.5% | 31.2% | 32.8% | 16.5% |
| Kentucky | 16.9% | 33.2% | 35.5% | 14.4% |
| Florida | 16.0% | 33.9% | 35.3% | 14.8% |
| Delaware | 14.6% | 33.8% | 30.9% | 19.5% |
| U.S. | 15.9% | 33.4% | 35.7% | 15.0% |
| California | 12.7% | 36.6% | 36.7% | 14.0% |
| West Virginia | 19.6% | 29.2% | 35.5% | 15.7% |
| Indiana | 17.0% | 31.6% | 37.6% | 14.3% |
| Alabama | 15.6% | 32.2% | 35.0% | 17.2% |
| Kansas | 16.8% | 30.7% | 37.7% | 14.8% |
| Arkansas | 16.9% | 31.5% | 38.3% | 14.3% |
| Maryland | 15.3% | 31.4% | 36.3% | 17.0% |
| Tennessee | 16.9% | 29.5% | 36.2% | 17.5% |
| Missouri | 18.9% | 25.9% | 36.2% | 19.0% |
| New Hampshire | 13.3% | 31.4% | 39.5% | 15.9% |
| Wisconsin | 17.1% | 27.2% | 41.5% | 14.2% |
| Michigan | 15.8% | 28.5% | 40.2% | 15.6% |
| Connecticut | 13.4% | 30.1% | 37.3% | 19.2% |
| New Jersey | 12.0% | 31.2% | 40.1% | 16.6% |
| New York | 13.2% | 29.8% | 39.0% | 18.0% |
| Ohio | 15.0% | 27.8% | 39.2% | 17.9% |
| Washington, D.C. | 19.2% | 23.5% | 35.1% | 22.2% |
| Illinois | 16.1% | 26.3% | 42.9% | 14.7% |
| Maine | 16.0% | 25.9% | 38.3% | 19.7% |
| Pennsylvania | 14.7% | 26.3% | 40.5% | 18.3% |
| Rhode Island | 11.7% | 29.4% | 40.6% | 18.4% |
| Hawaii | 12.3% | 28.7% | 45.9% | 15.1% |
| Vermont | 11.8% | 26.8% | 38.9% | 22.5% |



**THE FIVE STATES** with the highest shares of dentists younger than 50 are on or west of the Rockies (Idaho, Nevada, Utah, Arizona, Montana)



**DENTISTS' AVERAGE RETIREMENT AGE WAS 69 IN 2015***




**WE PROJECT THE SUPPLY OF DENTISTS** per 100,000 population to increase from 60.9 (2015) to 65.7 (2035)*

**Source:** ADA Health Policy Institute analysis of ADA masterfile, end-of-year 2015

*Munson B., Vujicic M. Number of practicing dentists per capita in the United States will grow steadily. *Health Policy Institute Research Brief.* American Dental Association. June 2016 (Revised).

North Dakota Dental Association Member Dentists Age as of December, 2018

| Age of DDS in ND | Number of Member Licensed Dentists 404<br>Number of Licensed Dentists in ND 476 |
|---|---|
| 25-29 | 22 |
| 30-34 | 42 |
| 35-39 | 73 |
| 40-44 | 35 |
| 45-49 | 17 |
| 50-54 | 14 |
| 55-59 | 27 |
| 60-64 | 44 |
| 65-69 | 43 |
| 70-74 | 29 |
| 75-79 | 22 |
| 80-84 | 16 |
| 85-89 | 15 |
| 90-94 | 1 |
| 95-99 | 2 |
| 100+ | 2 |
| Non-reporting | 20 |

| | |
|---|---|
| NDDA Board of Directors Average Age: | 42 |
| NDDA District Leadership Average Age: | 34 |
| Combined Leadership Average Age: | 38 |

HB1426
#12
1/21/19
page 17

2A

North Dakota
DENTAL ASSOCIATION

# Dental Education, Prevention, Collaboration and Outreach in North Dakota

The North Dakota Dental Association firmly believes that all North Dakotans – regardless of their socioeconomic status – deserve quality dental care from the highest-trained professionals. With that driving determination, NDDA continuously partners with organizations, state health officials and North Dakota's dental community to provide education, preventive care and dental treatment to reach as many in need as possible.

## Programs and partnerships currently in place include:

**256**
ND HEALTH PROVIDERS PARTICIPATED

**Smiles for Life** – 256 North Dakota health providers and 54 clinics have participated since 2014. Smiles for Life provides dental education and allows doctors, advanced practice RNs, physician assistants, RNs and licensed practical nurses who complete North Dakota dental board-approved curriculum to apply fluoride varnish.

**112**
ND SCHOOLS

**Seal!ND** – 112 North Dakota schools currently participate – 49 served by private dental offices. Implemented by the North Dakota Dept. of Health Oral Health Program, Seal!ND provides low-income students with dental screening, sealant placements and fluoride varnish applications in their schools. The program was established in part due to HB 1176 in 2009, which allows dental hygienists to perform procedures in outreach settings authorized in advance by a dentist.

**875**
PATIENTS

**Donated Dental Services (DDS)** – 875 patients have received more than $3 million in donated services from 126 dentists and 11 dental labs in North Dakota since 2011. Nearly 40% of North Dakota dentists volunteer. DDS provides free, comprehensive treatment to people with disabilities, the elderly or the medically fragile as part of the national Dental Lifeline Network.

**$17K**
IN DONATED SERVICES

**Give Kids a Smile** – Dental hygiene/assistant students and pediatric dentist volunteers provided more than $17,000 worth of services to North Dakota children in 2018. North Dakota State College of Science (NDSCS), through its Allied Dental Education program, participates each year in this national program that provides screenings, cleanings, sealants and other dental treatments to in-need children.

**73%**
OF PATIENTS HAD NO INSURANCE

**Mission of Mercy (MOM)** – 110 dentists, 48 hygienists, 105 dental assistants and 4 lab techs provided an estimated $564,964 of dental care for 916 individuals. 73% of patients served reported having no dental insurance. A program to provide free dental care to anyone in need, North Dakota's first MOM was held Sept. 28-29, 2018, in Bismarck. Treatments included extractions, replacement front teeth, root canals, fillings, cleanings and sealants.

HB1426
#12
1/21/19
page 18

**5** NON-PROFIT CLINICS SERVING THOUSANDS

**Nonprofit Public Health Dental Clinics** – 5 clinics, in Bismarck, Minot, Grand Forks and Fargo, serve thousands of patients each year. Clinics include Bridging the Dental Gap, Family HealthCare, Northland Community Health Center Dental Clinic, Valley Community Health Centers Dental Clinic and the Red River Valley Dental Access Project. These clinics and private practice dentists partner with the North Dakota Dept. of Health Oral Health Program to help provide dental care to older adults at long-term care facilities across North Dakota.

**ER Diversion** – Patients presenting for dental issues at Sanford Health emergency rooms in Fargo and Bismarck are referred to non-profit clinics for next-day care. Clinics are staffed in part by volunteer community dentists and oral surgeons, and backed up by local dentists.

**1,001** CHILDREN IN WESTERN ND RECEIVED CARE

**Ronald McDonald Care Mobile** – 1,001 children in western North Dakota received $572,868 worth of dental care in 2017. The state-of-the-art mobile dental clinic is owned and operated by the Ronald McDonald House Charities of Bismarck. Nonprofit clinic Bridging the Dental Gap is the clinical manager. A school-based sealant program served an additional 930 children in 2017. Priority service areas include low-income students, Head Start programs, American Indian reservations and community health centers without dental clinics.

**Take Five More** – 75 North Dakota dentists agreed to increase the number of Medicaid-eligible patients through the Take Five More initiative in 2015, although Medicaid reimbursement fees for dentists are less than the cost of providing care.

**$250K** AVERAGE DENTIST STUDENT LOAN DEBT

**Loan Repayment** – North Dakota licenses 20-30 new dentists each year and leads the nation in dentist in-migration, due in part to its loan repayment programs. Most dental school graduates have an average of $250,000 in debt. By providing state and federally financed repayment programs, North Dakota is successfully incentivizing young dentists to serve low-income patients, work in nonprofit clinics and practice in rural or underserved areas.

**Collaboration with Tribal Communities** – The North Dakota Dental Association networks with local dentists to boost IHS dental workforce and address the arduous credentialing process. Outreach events coordinated by NDDA and local dentists provide care for in-need children.

**$6.3M** ENDOWMENT IN 2015

**Continuous Overall Outreach** – The North Dakota Dental Foundation was boosted with a $6.3 million endowment in 2015 with remainder funds from the dissolution of Dental Services Corporation. NDDF works with partners across North Dakota to remove barriers to dental care, provide prevention and education and ensure an adequate supply of dental staff are available.

**Maximizing Current Workforce** – Rules passed in 2014 allow registered dental hygienists and assistants with additional training to perform expanded duties under a dentist's supervision. These duties include filling cavities after a dentist prepares them. Allowing and incentivizing hygienists to perform duties without a dentist present, and facilitating reimbursement for case management, expands outreach to rural settings, schools and long-term care facilities.

HB1426
#12
1/21/19
page 19

# Oral Health Programs in North Dakota
# December 2018

## Smiles For Life Fluoride Varnish Program

During the 2007 legislative session, HB 1293 was passed, which gave physicians, advanced practice registered nurses, physician assistants, registered nurses and licensed practical nurses the ability to apply fluoride varnish upon the completion of a fluoride varnish curriculum approved by the North Dakota Board of Dental Examiners. The North Dakota Board of Dental Examiners approved the Smiles for Life, Course 6, Caries Risk Assessment Fluoride Varnish & Counseling. The North Dakota Department of Health, Oral Health Program utilizes and continues to promote this course for health professionals in various locations like: Local Public Health Units, Long Term Care Facilities and medical clinics across the state. Since 2008, many local public health units and Head Start entities have applied fluoride varnish to children's teeth. Since 2014, outreach and training have been provided to medical clinics; as a result, 54 clinics and 256 health professionals have been trained in the application of fluoride varnish.

## School-based Fluoride Varnish and Seal!ND (Sealant) Program

In 2009, HB 1176 was passed, which allowed licensed dental hygienists to perform procedures authorized in advance by a dentist. As a result of this legislation, the **North Dakota Department of Health, Oral Health Program**, implemented a school-based fluoride varnish and sealant program (Seal!ND). Services include an initial screening, sealant placement and fluoride varnish application. Schools with 40 percent or greater of their students on the free and reduced-fee school lunch program are given priority for the program. This criterion helps to reach underserved children who may otherwise be unable to receive dental screening and dental sealants to help prevent tooth decay. Since 2011, public health hygienists funded by the department have served about 5,500 students through this program. During the 2017-18 school year, the program provided services in 29 schools throughout the state. 899 students were screened, and 331 students received sealants. Funding for the Seal!ND Program is provided by Health Resources and Services Administration (HRSA) Grants to States to Support Oral Health Workforce Activities, the Centers for Disease Control and Prevention (CDC) Cooperative Agreement, North Dakota Dental Foundation grant funds, Otto Bremer, Delta Dental grant, and reimbursement from North Dakota Medicaid for services provided by the public health hygienists. **Efforts to make school-based sealant programs sustainable have been very successful in that 112 schools now have sealant programs with 49 of them provided by private practice dental offices, 17 provided by FQHC non-profits clinics, and 17 provided by the Ronald McDonald Care Mobile.**

**Donated Dental Services Program**

Supported through state general funding and the **State Department of Health ($50,000 per biennium)**, the Donated Dental Services (DDS) program, a national project of the Dental Lifeline Network, provides free, comprehensive dental treatment to the most vulnerable people—those with disabilities or those who are elderly or medically fragile. Donated Dental Services, operates through a volunteer network of more than 15,000 dentists and 3,600 dental labs across the country. Since its inception in 1985, the DDS program has surpassed $250 million in donated dental treatment, transforming the lives of more than 120,000 people.

Since the North Dakota DDS program began in 2001, 875 vulnerable individuals have received $3,177,088 in donated dental treatment from some of the 126 dentists and 11 dental laboratories that volunteer statewide! Almost $15 of care is donated for every $1 spent. 38% of the dentists in North Dakota participate in DDS, which is the well above the 17% national average.

**Give Kids A Smile Program**

Dentists nationwide participate annually in the Give Kids A Smile Day(GKAS) event held in February. Dentists and dental teams provide donated screenings, cleanings, sealants, and other needed treatments to needy children through a variety of programs and venues. For many children, this is an opportunity to find a dental home. And for dentists, dental team members, and other volunteers, it's a great way to help the local community. Visit the American Dental Association's Give Kids A Smile website for more information about the program, or to donate to help needy children receive care.

North Dakota State School of Science in Wahpeton has participated in the GKAS program for many years. Services provided include basic restorative procedures, simple extractions and patient exams. NDSCS Allied Dental students perform cleanings, radiographs, sealants, fluoride applications and oral health education. Volunteer pediatric dentists perform needed treatment. More than $17,000 worth of donated services was provided to local children in 2018.

**Mission of Mercy Events**

The North Dakota Dental Association partnered with the Minnesota Dental Association in a "Dental Mission of Mercy" held July 22-23, 2016 at Concordia College in Moorhead, MN. A 100-chair portable clinic was set up and 600 dental professionals volunteered their services to patients that faced barriers to care. 1173 patients were seen and $997,785 of free dentistry was provided by 841

total volunteers. 40% of the patients were from North Dakota and 75 of the 150 volunteer dentists were from North Dakota. Only 9.5% of the patients were eligible for government assistance.

North Dakota's first "solo" Mission of Mercy (NDMOM) was held on September 28-29, 2018 at the Bismarck Event Center, Bismarck, ND, with a goal of providing donated dental care to 600 patients in need. 50 dental chairs were set up in the Bismarck Event Center. The North Dakota Dental Association and the North Dakota Dental Foundation organized the event, recruited the workforce, and raised funds to make the event a success. Over 120 individuals, organizations, and businesses provided cash and in-kind contributions to support the event.

916 patients received care, with 35 of them able to return for a second visit for additional treatment. 14% of the patients were 17 years old and under, 23% were 18-29 years old, and 62% were 30 or older. 38% of the patients had visited a dentist in the last 2 years, however nearly 4% had never been to a dentist.

110 dentists, 48 hygienists, 105 dental assistants, and 4 lab techs provided urgently needed dental care. Dental Assisting and Dental Hygiene students from Minnesota State - Moorhead and North Dakota State College of Science (NDSCS) in Wahpeton rotated through the various departments of the clinic. A total of 570 volunteers registered for the event. The majority of volunteers were lay people who escorted patients, served meals and snacks to volunteers, registered patients, helped set-up and tear-down the clinic, and provided language translation, among other duties.

Treatment provided included 961 extractions, 358 composite fillings, 72 amalgam fillings, 48 root canals, 203 cleanings, 56 sealants, and almost 60 appliances to replace missing front teeth. The estimated dollar value of the donated treatment provided was $564,964.

The patients came from 33 different counties in North Dakota. Only 6 patients were from our neighboring states. 67% of patients traveled less than 30 minutes to receive care at the event.

About 43% of the patients stated they had dental pain and 20% reported they had sought dental care in the past at an emergency room/emergency clinic. Interestingly, 73% of the patients reported they had no insurance to pay for their dental care, but 32% said they had a place to go for dental care after the event. Of note, only 7% of the patients indicated they were eligible for government assistance/Medicaid. 14% said they were covered by dental insurance and 0.5% listed Indian Health Service as an option for dental coverage. Cost was mentioned most frequently as a reason the patient had not received needed dental care, with fear/anxiety of seeing a dentist a distant second. 71% of the

patients were Caucasian/White, 9% were Native American/Alaska Native, 6% were Hispanic/Latino, 5% were Black/African American, and 1% were Asian.

While the Mission of Mercy is not a long-term solution to reduce barriers to care in North Dakota, it made a difference in the lives of 916 patients. The event also provided needed oral health education and raised awareness of the importance of oral health in the community and for policymakers. It was a true statewide community event that energized the dental community to continue to look for collaborative solutions to reduce barriers to care. Thank you to the amazing volunteers and contributor partners that made this event a success!

**Expansion of Duties for Registered Dental Hygienists and Assistants**

Rules changes were passed by the North Dakota State Board of Dental Examiners in 2014, which allow registered dental assistants and dental hygienists with additional training to do expanded, reversible, restorative functions under a dentist's supervision. These functions include filling cavities after a dentist prepares them. When we expand the services these trained professionals can provide, it increases efficiency and productivity. It also extends dentists' capacity and, by extension, increases access to care. Maximizing the capacity of the existing dental team is the best route to providing more care to more patients.

The Oral Health Coalition led a Task Force of interested professionals and **affirmed** collaborative practice by hygienists under the general supervision (dentist not on-site) in outreach settings. These collaborative practice rules were established by the State Board of Dental Examiners in 2009. The outreach settings would include schools and long-term care facilities. Efforts must continue to expand this practice and to make case management a part of the process.

**Safety Net Public Health Dental Clinics**

We're proud to support safety net nonprofit dental clinics in North Dakota. These clinics help provide the necessary dental care to many North Dakota residents who too often go without. There are currently six:

- Bridging the Dental Gap (Bismarck)
- Family HealthCare (FQHC)(Fargo) Additionally provides follow-up care for dental patients that are referred from Sanford Health ER.
- Northland Community Health Center - Dental Clinic (FQHC) (Turtle Lake, Rolette, and Minot)
- Valley Community Health Centers Dental Clinic (FQHC) (Grand Forks)
- Red River Valley Dental Access Project (RRVDAP)(Fargo, ND-Moorhead, Minn.) Since 2002, 45 dentists have provided walk-in humanitarian relief of pain at Family Health Care Center on Tuesday evenings on a rotating basis. About 10,000 patients without a dental home have received treatment since the clinic's inception. Local dentists led the development

of the RRVDAP and the walk-in clinic.
We want to expand these public health clinics, where there are unique needs requiring specialized solutions to reduce barriers to care. These facilities can develop innovative ways to target high-risk patients and connect them to dental homes, where regular preventive treatment can prevent painful and costly disease. North Dakota's dental loan repayment program is especially critical for these programs to maintain their workforce.

**Hospital Emergency Room Dental Diversion Programs**

Currently, dental patients that show up in the Sanford ER's in Fargo for dental pain are seen the next day at the Family Health Care Dental Clinic (non-profit FQHC) for definitive dental treatment, and if the patients cannot be seen there for any reason they are referred to the Red River Valley Dental Urgent Care Clinic on Tuesday nights. This clinic is staffed on a rotating basis by 50 volunteer Fargo-Moorhead community dentists and oral surgeons.

A similar ER diversion program is operational in Bismarck utilizing the non-profit clinic, Bridging the Dental Gap(BDG). BDG staff see dental referrals from the Bismarck ER's and is backed up on a rotating schedule by a network of 10-15 local dental practices.

**Ronald McDonald Care Mobile of North Dakota & RMHC School-Based Sealant Program**

The Ronald McDonald Care Mobile (RMCM) is a 40-foot-long, state-of-the-art mobile dental clinic staffed by a dentist, dental hygienist, and dental assistant. It delivers urgently needed care to underserved children through age 21 in their own neighborhoods in western North Dakota. The priority areas for service include schools with 40 percent or greater of their student population on the free and reduced-fee school lunch program, Head Start and Early Head Start, American Indian Reservation areas, and community health centers without dental services. The RMCM began operation in 2012 and serves the western half of ND. In 2017, the Care Mobile served 1,001 children with 1,994 patient appointments, providing 7,521 dental services for a total value of $572,868. In the 3rd year of our RMHC School-Based Sealant Program, we treated an additional 930 children with 2,003 services and a value of $73,592.This brings the total number of children served in 2017 to 1,931. The Care Mobile is currently booking into 2019. The Ronald McDonald Care Mobile is owned and operated by Ronald McDonald House Charities of Bismarck. Bridging the Dental Gap, Inc. of Bismarck, a nonprofit dental clinic, is the clinical manager of the Ronald
McDonald Care Mobile Program.

**Older Adult Programs**

The State Department of Health, Oral Health Program, partners with Bridging the Dental Gap (BDG), a safety-net dental clinic in Bismarck, to provide services to older adults living in long-term care facilities. The Mission of BDG is "To Provide Access to Dental Care for Underserved Populations in North Dakota." BDG provides services in several long-term care centers in the Bismarck/Mandan area. Funding for this program is provided through the HRSA Oral Health Workforce Grant.

Northland Community Health Center implemented an older adult program in June 2014 at three facilities: Benedictine Living Center in Garrison; the Garrison Memorial Hospital (swing bed facility with long term beds available); and the Community Memorial Hospital in Turtle Lake (swing bed facility with long term beds available). Grant funding provides support for these programs.

**North Dakota Dental Medicaid**

Recognizing that private practice dental offices deliver most of the care in North Dakota for low-income patients, it's imperative to maintain adequate funding for dental care for Medicaid-eligible patients. Currently, the fees that Medicaid pays dentists are *less than the cost of providing care,* but North Dakota dentists continue to look for ways to reduce barriers to care.
We must continue to advocate for adequate Medicaid funding and streamlined administration so that there continues to be an adequate network of dentists to care for Medicaid patients. Through the "Take Five More" initiative, 75 North Dakota dentists agreed to increase the number of patients eligible for Medicaid that they see in their practices.

**North Dakota Dental Loan Repayment Programs**

Most new graduates of dental schools now have an average of $250,000 in education debt. The North Dakota dental loan repayment programs provide state and federally financed programs with a variety of eligibilities and benefits to encourage new dentists to practice in three areas of need: serving low-income patients, working in safety-net nonprofit clinics, and practicing in rural or underserved areas. Our safety-net non-profit clinics absolutely depend on these programs to help recruit their dentists. The North Dakota Dental Association and the State Department of Health, Oral Health Department, were instrumental in starting these programs and modifying them over the years to make them effective in meeting the goals. Since inception, most of the recipients have completed their commitment to stay in their community for the length of their contract and about half have remained in those communities beyond that commitment ("ND Health Professionals Assistance Programs" 2016, ND State Dept of Health"). Currently, North Dakota is licensing between 20 and 30 new dentists a year, and the growth in new dentist numbers is greater than the population increase. Loan repayment programs also are a great way to market North Dakota to new dentists. The NDDA supported legislation that was passed

in the 2015 session, which greatly simplified the dental loan repayment programs in North Dakota and potentially made them available to more new dentists in the state. Loan repayment programs have contributed greatly to why North Dakota led the nation in in-migration of dentists since 2010.

**Native American Collaboration**

Our Native American citizens have higher rates of dental disease and more barriers to care. One of the frequent barriers expressed by Indian Health Service dental staff is 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. It is important to continue to find ways to engage Native American communities with local dentists so immediate community resources can augment IHS dental staff.

In the summer of 2016, the NDDA helped recruit 5 dentists on a temporary basis to help provide care at Spirit Lake Reservation in Ft Totten while they searched and secured a permanent workforce. Since 2017, Spirit Lake has hired a new full-time dentist and several of the temporary dentists have continued on a part-time basis.

Maintaining an adequate workforce within Indian Health Service clinics has always been a barrier to care. The arduous credentialing requirements of Indian Health Service dental professionals has been identified as a barrier for not only IHS dentists that are assigned to the Great Plains Area, but also to local dentists that wish to volunteer or contract their services with a tribe. Engagement with the local dental community continues to be critical to provide adequate dental care in our tribal communities.

The NDDA, in coordination with North Dakota's congressional delegation in Washington, had input into federal legislation known as the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act, which addressed funding, accountability, credentialing, and employee recruitment and retention within the Great Plains region of the IHS.

**North Dakota Foundation**

The North Dakota Dental Foundation, a North Dakota charity for almost 30 years, was boosted in 2015 with an endowment of $6.3 million of remainder funds from dissolution of Dental Services Corporation, a nonprofit dental plan for North Dakota residents that was also founded by North Dakota dentists.

The Foundation receives management services from Dakota Medical Foundation so that its leaders can focus on a North Dakota where dental care to all citizens is second to none, rather than managing paperwork. DMF also provides guidance to the Dental Foundation for reaching its vision. DMF has a long history of guiding this type of strategic funding, with $80 million-plus invested in programs improving health since its modern history of grant-making and leading initiatives began in 1996.

North Dakota Dental Foundation exists, in the broadest sense, to remove barriers to dental care for North Dakotans, provide prevention and education, and to assure an adequate supply of skilled, well-trained dentists, hygienists & assistants so people across the state can receive dental care that allows them to be healthy and lead better lives.

HB 1426
#12
1/21/19
Page 27

# North Dakota Collaborative Partners

ND Dental Foundation

ND Long Term Care Association

ND Indian Affairs Commission

ND Board of Pharmacy

ND Head Start Association

ND Medical Association

ND Hospital Association

US Senator John Hoeven (IHS Credentialing Issues)

Smiles For Life

Seal!ND Program (School-Based Sealant Program)

Donated Dental Services-Dental Lifeline Network

Oral Health Program, ND State Department of Health

Depart of Health Primary Care Office

Human Services Dental Medicaid

ND Women, Infants, Children (WIC) Offices

ND State College of Science

Minnesota State Community and Technical College-Moorhead, MN

Northwest Technical College-Bemidji, MN

Bridging the Dental Gap-Bismarck

Family HealthCare Centers

Valley Community Health Centers

Northland Community Health Center

Ronald McDonald House / Caremobile

Red River Valley Dental Access Project

Sanford Health (Emergency Department Referral Program)

Tobacco Free North Dakota

Minnesota Dental Association

South Dakota Association

Montana Dental Association

American Dental Association

Mandan, Hidatsa, & Arikara Nation (Three Affiliated Tribes)

Spirit Lake Nation

Standing Rock Sioux Tribe

Turtle Mountain Band of Chippewa Indians

Sisseton-Wahpeton Oyate Nation

Trenton Indian Service Area

2B

HB1426
#12
1/21/19
Page 2

North Dakota
DENTAL ASSOCIATION

# Oral Health in North Dakota: Barriers and Solutions

Over the course of many years working toward providing quality care, the North Dakota Dental Association (NDDA) has identified barriers to care unique to North Dakota. Addressing these barriers while promoting disease prevention is an ongoing effort that requires a collaborative approach among the dental community, state government, public health entities and patients.

**North Dakota-specific solutions should prioritize patient outreach and case management.**

## Areas of focus include:

### 1 Expand and support nonprofit clinics, outreach programs.

NDDA collaborates with 5 existing nonprofit clinics to recruit staff and provide low-cost dental care to patients throughout North Dakota.

NDDA collaborates with North Dakota's Oral Health Program for ongoing implementation of the school-based sealant program, Seal!ND, and long-term care facility outreach programs.

NDDA organized North Dakota's first "Mission of Mercy" in Sept. 2018. 110 dentists and 200 hygienists and assistants provided care for 916 patients over two days. Numerous other low/no-cost care programs are coordinated each year by NDDA and supported by ND dentists.

Grant funds could increase the number of ND Community Dental Health Coordinators, who connect patients to dental homes through case management.

### 2 Improve dental Medicaid.

To expand outreach, adopt existing teledentistry and case management codes for reimbursement in North Dakota.

Collaborative efforts needed to improve current MMIS claims system.

Recruit dental Medicaid providers through innovative marketing programs.

NDDA participates in ongoing quarterly meetings with Department of Human Services Medicaid officials to improve program administration.

Close gaps in cost of service versus adequate Medicaid fee reimbursement to encourage continued dentist participation.

### 3 Maximize existing dental team workforce.

An Expanded Restorative Functions Course would allow dental hygienists and assistants to perform expanded functions.

Dental loan repayment programs, created in part by NDDA, help recruit new dentists and encourage them to practice in underserved areas of the state.

A collaborative effort among NDDA, the North Dakota Dental Foundation and NDSCS is focused on recruiting and training in-demand dental assistants.

Teledentistry will allow dental hygienists in outreach settings to perform preventative care and connect high-risk patients to a dental home. A pilot program is underway.

### 4 Access to care for tribal communities.

NDDA led a national effort to simplify Indian Health Service credentialing, resulting in legislation to standardize credentialing protocol.

NDDA provides support for tribes electing "638" status to contract directly for dental workforce.

Ongoing collaboration with tribal communities connects them with local dentists and volunteer services.

## For more information, visit

www.smilenorthdakota.org

3

North Dakota
DENTAL ASSOCIATION

**December 5, 2018**

## How can we collaborate to reduce barriers to care in North Dakota?

### Defining the problem

There are many reasons why patients do not visit the dentist:

- Fear
- Cost
- Transportation
- Low knowledge of value for oral health
- Not experiencing pain
- Cultural factors
- Language barriers
- Lack of available workforce

Dental Medicaid is the primary program that provides state support for low-income patients to access dental care. For patients eligible for Medicaid that do seek treatment, there are other potential barriers that limit access to the system. In North Dakota, the percentage of dentists enrolled in Medicaid, along with the Medicaid fee reimbursement, are above national averages (ADA HPI, 2015), however there are still other measures of utilization of services that are below national averages (ADA HPI-CMS).

National research has identified three reasons that dentists limit participation in Medicaid: 1) fee reimbursement below the cost of providing the service (in ND around 50% of usual fees); 2) claims administration complexity and delayed payment; and 3) failed appointments at a 30-50% rate. North Dakota experiences all of these barriers. The Department of Human Services MMIS Medicaid transition in October, 2015 required many hours of office administrative time to adapt to the new system. Despite these inherent barriers, the four urban centers in North Dakota, where one-half of Medicaid recipients reside (DHS Medicaid Access Monitoring Plan 2016), all have public health dental clinics that are currently fully-staffed and supported by statewide oral health programs as well as private practice Medicaid providers.

Sorting out the reasons that Medicaid recipients visit a dentist less frequently than the rest of the population is less important than finding ways to reduce barriers. Keep in mind effective solutions address the reasons patients do not visit the dentist. Workforce, although it receives a lot of attention, is only one of many important factors. Education, prevention, and outreach to high-risk patients are equally as important.

**What are the solutions (blue) and current actions (red)?**

1. **Improve dental Medicaid** with adequate funding, reduce administrative burden, and vigorous dentist recruitment.

- Studies from several states show that fee reimbursement closer to market-based rates will significantly improve dentist participation (NASHP 2009).
- The North Dakota Dental Association (NDDA) will work with the Governor and DHS to improve the current MMIS claims system and partner in considering a risk-based managed care organization (MCO) to facilitate administration and build in prevention and value incentives. Currently 18 states utilize dental MCO's (ADA 2016). ACTION: The NDDA provided technical assistance to the interim Legislative Health Care Reform Committee regarding Medicaid managed care options. Any managed care changes to the dental Medicaid system in the state will benefit patients and costs more effectively if practicing dental providers are part of any changes.
- The NDDA will continue to work with dental offices to minimize Medicaid administrative barriers and continue vigorous recruitment efforts such as the "Take Five More" program started in 2015 which resulted in 75 dentists taking a pledge to see more Medicaid patients.
- Continue the quarterly Medicaid Advisory Committee meetings with DHS Medicaid officials to improve administration.

2. **Maximize the current dental hygiene and assistant workforce** through expanded training programs, community outreach, and case management to connect more high-risk patients to a dental home.

- The ND State Board of Dental Examiners passed rules in January, 2016 that allow dental hygienists and assistants, with training, to do expanded restorative functions to include placing fillings and finishing them under supervision. This will leverage the productivity of dental practices while assuring standards of care. ACTION: Discussions are continuing to develop an **Expanded Restorative Functions Course** through a collaboration with an out-of-state online course with the clinical component completed on-site in North Dakota.
- Community outreach is key in North Dakota given its rural population and the impracticality of starting high-cost dental practices with limited patient demand. North Dakota is expanding the number of low-income children who receive screenings and sealants in school-based outreach programs, such as those sponsored by the State Department of Health (Seal!ND). In the 2017-2018 school year, 899 children were screened in the Seal!ND Program and 331 students received sealants in 29 North Dakota schools. Many more children received sealants in Federally-Qualified Health Centers (FQHC's), the Ronald McDonald Care Mobile School-Based Sealant Program, and in private

offices. The total number of schools that were served by school-based sealant programs increased from 18 in the 2014-2015 school year to 112 in the 2017-2018 school year. 49 of these schools were served by private practice dentists (Program Evaluation:ND Department of Health Seal!ND 2017-2018, NDSU Center for Social Research, Nov 2018). ACTION: Continue to support the Seal!ND Program and encourage business models that expand sustainable, private-practice, school-based sealant programs.

- The North Dakota Dental Foundation (NDDF), in collaboration with a dedicated $6.3 million endowment at Dakota Medical Foundation, will be a significant contributor to future access programs, including outreach and expanded education. Collaborative efforts should continue to find the most effective solutions. ACTION: The NDDF has committed funds to expand the dental assistant workforce through on-site training and DANB certification, career marketing strategies, and alternative pathways to the RDA designation statewide. The NDDF also supported the recent dental Mission of Mercy in Bismarck that provided donated care to 916 patients.
- Case management should be integrated in all dental public health programs to reach the 25% of the population that has 80% of the dental disease to get them into a dental home (Healthy People 2000, Oral Health Review, CDC). This navigation is now recognized nationally by the establishment of reimbursement codes that will eventually allow a mechanism for reimbursement by Medicaid. **Medicaid reimbursement for case management needs to be established in North Dakota**. Three North Dakota dental assistants have completed certification through the online Community Dental Health Coordinator (CDHC) program through Rio Salado College (http://www.riosalado.edu/programs/Documents/DC_FL_DentalHealthCoord_0715-R9.pdf). This program provides evidenced-based case management training. These case management experts show great promise in working in Native American communities and public health outreach. These opportunities should be expanded through grant funding. ACTION: Currently, discussions are on-going to utilize grant funds to train more CDHC's in FQHC non-profit clinics and private practices to connect patients to dental homes through CDHC case management.
- There are currently "ER Diversion" programs operating in Fargo and Bismarck whereby patients without a dental home that present at the hospital emergency rooms for dental problems are referred to the local public health clinic with additional support being provided by volunteer local dentists.
- Teledentistry, whereby dental hygienists work in outreach settings providing preventive care and communicate exam data electronically to a supervising dentist, shows efficacy for North Dakota. The North Dakota Dental Foundation is currently piloting a program with grant funding to develop best practices and a viable private practice business model. Teledentistry equipment has been purchased for the project. All rules and regs are in place in North Dakota to allow teledentistry. ACTION: The NDDA advocates for establishing Medicaid reimbursement in ND for teledentistry and case management is to establish more outreach.

- The Ronald McDonald Care Mobile provides mobile dental care for rural and Native American schools in western North Dakota. This project should be supported and expanded where needed.
- Continue to support the many volunteer safety net programs including Mission of Mercy events, Donated Dental Services, etc. ACTION: The NDDA organized a "Dental Mission of Mercy" that was held at the Bismarck Civic Center on September 28-29, 2018 that provided over $560,000 of donated care for 916 patients. The effort was supported by 110 North Dakota volunteer dentists, 200 dental hygienists and assistants, and 260 lay volunteers.
- Given the severe shortage of dental assistants across the state, efforts continue to expand the dental assisting workforce. ACTION: An NDDA-led Work Group that included NDSCS, western colleges, and other stakeholders, studied options that included a distance-learning expansion of the current accredited NDSCS program. A grant proposal to expand the dental assistant workforce through on-site training and DANB certification, career marketing strategies, and alternative pathways to the RDA designation statewide was approved by the ND Dental Foundation and is currently in action. The goal is to increase the number of registered dental assistants statewide over the next 5 years.

3. **Expand and support non-profit safety-net clinics** through public-private grant partnerships, student internships, and dentist loan repayment programs.

- Collaboration should continue with the six non-profit dental public health clinics to support their workforce through recruitment activities, grant support for outreach, and volunteer dentist support. ACTION: The NDDA collaborated with the State Oral Health Program, State Department of Health, on grant applications to fund the on-going state school-based sealant program, the long-term care outreach program to connect nursing home residents to dental care, student internships, and a case management pilot program. Grants were awarded in September.
- The NDDA maintains a semi-annual survey of North Dakota dentists to match dentists interested in volunteering or contracting with non-profit or Indian Health Service clinics.
- Continue to advocate for and publicize the state loan repayment programs and WICHE Professional Student Exchange Program, which provide incentives for dentists to start practicing in the state with a focus on non-profit clinics, Medicaid, and rural areas. These programs have been successful in recruiting dentists to the state and have been a big reason that North Dakota leads the nation in the net in-migration of dentists (ADA HPI, 2016). These programs are most important to provide an adequate workforce for non-profit clinics. ACTION: The NDDA markets these loan repayment programs to dentists and graduating dentists on an on-going

basis. The NDDA also helped facilitate a recent grant from the NDDF to Valley Community Health Dental Clinic (FQHC community clinic) to support a September internship of 2 University of Minnesota 4th year dental students. The students treated 162 patients, which included 105 Medical Assistance patients. These internships help recruit new dentists to North Dakota and connect them to oral public health.

4. **Engage with tribal communities** to improve Indian Health Service dentistry, maximize prevention, reduce credentialing barriers, and facilitate contracting with the local dental community.

- Continue to provide support from the local dental communities for Indian Health Service clinics that have chronic workforce shortages. After the Spirit Lake Clinic lost its Indian Health Service (IHS) dental provider in summer 2016, the NDDA recruited four dentists to assist until a new full-time dentist was hired. There are currently 6 part-time dentists working there along with the new full-time dental director that was hired January 2017. ACTION: Visits were made in 2018 to the 5 Native American IHS/contracted dental clinics to learn where help is most needed. A site visit at Spirit Lake was made in March 2018 with dental staff, Cankdeska Cikana Community College staff, and Spirit Lake Medical Administration to develop a plan to establish a local CDHC training program to assure an adequate workforce and improve community outreach.
- Continue to facilitate outreach on reservations through the state school-based sealant preventive programs and the Ronald McDonald CareMobile.
- Provide support for tribes that elect "638" status to contract directly for their dentist workforce and establishment of third-party billing systems.
- Continue working with our Congressional delegation to require IHS to simplify credentialing throughout the system to allow better recruiting of contracted and volunteer dental professionals. Credentialing has been a major barrier to engaging the local dental community to help with IHS workforce needs. ACTION: The NDDA led a national effort in 2017-2018 to simplify IHS credentialing in coordination with the American Dental Association and the ND congressional delegation. This resulted in legislation to standardize credentialing protocol at the national IHS level.

For more information, contact the North Dakota Dental Association at 701-223-8870 or wsherwin@smilenorthdakota.org.

HB 1426
#12
1/21/19
Page 34

North Dakota
DENTAL ASSOCIATION

# Dental Therapy: A Costly and Unproven Approach

Our position is that the dental therapy model does not fit North Dakota and that we should continue to focus on education, prevention, collaboration and outreach specific to our state – strategies that are showing results.

**There is minimal evidence that dental therapy reduces cost or improves quality or access to care, particularly in a rural state like North Dakota.**

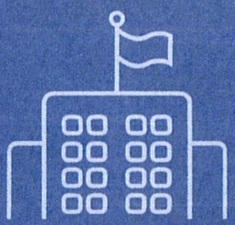
- After 8 years, only 9 dental therapists practice in rural areas of Minnesota – most practice in the Twin Cities metro.
- The dental therapy strategy treats only symptoms of dental disease, not the disease itself.

**North Dakotans – regardless of socioeconomic status – deserve quality dental care from the highest-trained professionals.**

- Dental therapy's focus on low-income and underserved patients incentivizes discrimination and puts the neediest, most complex cases a step further from a dentist.
- With limited training, dental therapists can perform irreversible surgery – impacting patients for life.
- Nurse practitioners and physician assistants have more intense training requirements and are still not allowed to perform irreversible surgery with limited or no supervision.

**Dental therapy programs are a cost burden to states and do not decrease patient costs.**

- Dental therapy in Canada failed without government subsidies. Existing programs in the U.S. rely on support through state subsidies or special interests to survive.
- Dental therapists are not independent – they work as employees of dental practices and charge the same fees for services as dentists.
- Establishing a dental therapy licensure would require a financial investment by North Dakota and would reduce governmental efficiency by regulating a scope of practice that duplicates procedures already allowed for dentists.



**North Dakota legislators agreed in 2015 and again in 2017 that dental therapy is not the right solution for North Dakota.**

**For more information, visit**
www.smilenorthdakota.org

4A

HB 1426
#12
1/21/19
page 35

# Nine Years Later: Minnesota's Dental Therapist Access to Care Solution

***False Promises and Delayed Care; Solutions Needed Now***

In 2009, proponents in Minnesota positioned midlevel dental practitioners as the solution to the state's oral health crisis. Nine years later, Minnesotans continue to experience the same barriers to obtaining good dental health.

---

**THE PROMISE:** "Minnesota has a chance to truly lead the nation in its desire to improve access and to address some of the root causes that plague the oral health crisis in Minnesota and in this country." *—Then-Senator Ann Lynch, Dental Therapist legislation sponsor, and now lobbyist for its trade association ADH, Minnesota Senate testimony, 3-11-09*

**THE REALITY: Nine years later Minnesota is near the bottom of states in the payment rate for adult dental Medicaid services. Dental therapists work predominantly in clinics or offices overseen by dentists and receive the same public reimbursement rates as dentists. This system fails to reduce costs passed on to patients or incurred by the state.**

**THE PROMISE:** "… Our innovative academic program [that] will prepare oral health practitioners to help address the chronic disparities in access to oral healthcare in Minnesota." *—Dr. Linda Baer, Fmr. Senior Vice Chancellor, Minnesota State Colleges and Universities, Minnesota Senate testimony, 3-11-09*

**THE REALITY: Nine years later, according to the Minnesota Dental Board Licensure Verification, there are 79 licensed dental therapists in Minnesota. The same data reveal only 10 are working in Census-designated rural areas.**

**THE PROMISE:** "We are very pleased to propose a model that will substantially improve healthcare without requiring additional state investment." *—Dr. Sue Hammersmith, Fmr. President, Metropolitan State University, Minnesota Senate testimony, 3-11-09*

**THE REALITY: Taxpayer funds were spent on a program that was promised to meet, yet has failed to adequately serve the needs of underserved rural communities. While the program is funded by special interests, its startup cost was underestimated, leaving the state with unanticipated costs.[1] Furthermore, patients are still seeking dental treatment in emergency rooms at significant cost to taxpayers and community hospitals.**

**THE PROMISE:** "Public health advocates in Minnesota campaigned successfully for a law to increase children's access to dental care. The new law is likely to ensure that dental care will reach many kids who are underserved." *—Pew Foundation 'The Minnesota Story'*

**THE REALITY: Just over one third of Minnesota kids on the state's public health insurance received preventive oral health care in 2015. So low that the program is at risk of losing federal funding. Minnesota's failed experiment has left kids without the oral health care they need.** *– Star Tribune, 5-1-2017*

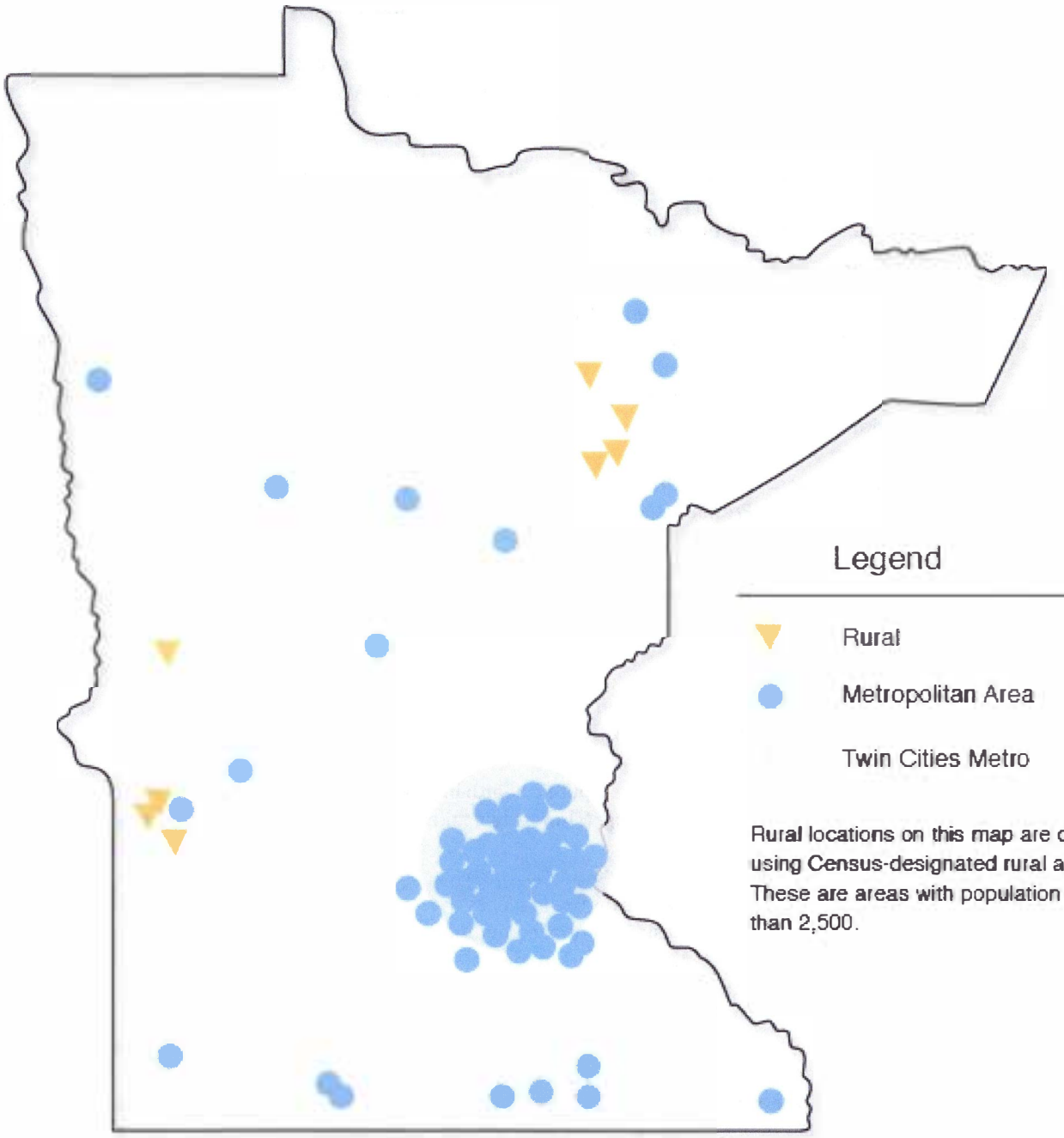
**THE PROMISE:** According to federal statistics, 63 million Americans live in places that the federal government has designated as dentist shortage areas. More than half of this population resides in rural communities. Minnesota policymakers focused on this gap in access in 2009 when they moved to become the first state to authorize dental therapists to practice statewide. – *Dental Therapists Can Provide Cost-Efficient Care in Rural Areas, Pew Foundation, 3-12-18*

**THE REALITY: Nine years later, there are only seven actively licensed dental therapists practicing in rural dentist shortage areas in Minnesota[2] Similar to a failed Canadian program, licensed dental therapists are abandoning underserved rural communities to seek higher wages in urban areas. In fact, they are in metropolitan areas at a higher rate than the general population and other practitioners.**

---

[1] Minutes of the Minnesota Board of Dentistry 2010-2014
[2] Minnesota Board of Dentistry

# 2018 Practice Locations of Licensed Dental Therapists in Minnesota




Source: Active licensees as of 3/9/2018, from the Minnesota Board of Dentistry

The North Dakota BRFSS data shows that adults in the state are more likely to have visited a dentist in the last 12 months, than have visited a physician for routine checkup. Below you'll find a link to the data.

| Year | DDS Visit in the last 12 Months | MD Visit in the last 12 Months |
|---|---|---|
| 2012 | 67.2% (95% CI: 65.4 - 69.0) | 62.5% (95% CI: 60.5 - 64.5) |
| 2014 | 65.5% (95% CI: 63.7 - 67.3) | 64.3% (95% CI: 62.5 - 66.1) |
| 2016 | 66.1% (95% CI: 64.5 - 67.7) | 62.0% (95% CI: 60.2 - 63.8) |

http://ndhealth.gov/brfss/data/

HB 1426
#12
1/21/19
Page 38

SAINT LOUIS UNIVERSITY

Department of Health Management & Policy
College of Public Health and Social Justice
3545 Lafayette Avenue
Salus Center, Suite 300
St. Louis, MO 63104
Phone: (314) 977-8264
Fax: (314) 977-1674

# Review of the Oral Health Workforce

Jeremy Craig Green, Ph.D.
Assistant Professor
Saint Louis University
Department of Health Management & Policy
College of Public Health and Social Justice

February 22nd, 2017

4B

*The author wishes to note that while this report was commissioned by the American Dental Association, the charge was to evaluate critically the documents covered in this report from a neutral standpoint. Thus, the findings are not intended to reflect the views of the American Dental Association or any other organization or individual.*

In their *Health Affairs* paper, Koppelman, Vitzthum, and Simon (KVS) make the claim that dental therapists provide "cost-efficient" care. Unfortunately, there is little or no research contained in the KVS paper that might support this and similar claims made by KVS throughout their paper. Indeed, KVS do not include reports of original research, but instead summarize the research of others. Per KVS, "a growing body of research has found that dental therapists provide high-quality, cost-effective care and improve access to care for underserved populations," as the authors write in the abstract. However, the narrative of the KVS paper is based on a noticeably small number of research studies conducted by other authors and published in other outlets. In their section describing research to date, KVS cite only six studies to support the bold claims made throughout their paper. Only two of these six studies were published in peer-reviewed journals (Nash et al. 2014; Wright et al. 2013), and the remaining four studies are government materials and related grey literature. One of the references is simply a set of PowerPoint slides that contains little if any detail on the methodology behind the research (Wovcha & Pietig 2016). The lack of peer review, lack of methodological detail, and sparsity of references cast doubt on the main conclusions of KVS.

**Key Findings**

- Koppelman, Vitzthum and Simon's *Health Affairs* paper lacks the necessary research backing and peer review to fully support claims made in their conclusions. The primary claim of the paper is that "a growing body of research has found that dental therapists provide high-quality, cost-effective care and improve access to care for underserved patients." However, the authors provide no original research to support this claim and much of the data presented by others either lacks peer review or has a high risk of bias.
    - In other words, the "growing body of research" claimed by the authors does not appear to exist.
- The claim that dental therapists provide cost-effective care is not supported by the research, as the studies assess cost and quality separately as opposed to a combined cost-effectiveness analysis.
- The dental therapist model needs to show value if it is to be viable, and this value has not been documented in research to date. More research is needed to determine if the dental therapist model is effective or cost-effective.

HB 1426
#12
1/21/19
Page 40

SAINT LOUIS UNIVERSITY

Department of Health Management & Policy
College of Public Health and Social Justice
3545 Lafayette Avenue
Salus Center, Suite 300
St. Louis, MO 63104
Phone: (314) 977-8264
Fax: (314) 977-1674

# Review of the 2018 Minnesota Dental Therapy Issue Brief

Jeremy C. Green, Ph.D.
Assistant Professor
Saint Louis University
Department of Health Management & Policy
College for Public Health and Social Justice

September 7th, 2018

*The author wishes to note that while this report was commissioned by the American Dental Association, the charge was to evaluate critically the documents covered in this report from a neutral standpoint. Thus, the findings are not intended to reflect the views of the American Dental Association or any other organization or individual.*

The 2018 Minnesota Dental Therapy Issue Brief, released by the Minnesota Department of Public Health and the Minnesota Board of Dentistry, seeks to provide an overview of the oral health workforce as it relates to dental therapists. The 2018 Minnesota Dental Therapy Issue Brief can be divided into two main sections according to its substantive contents. The first section of the 2018 Minnesota Dental Therapy Issue Brief describes the oral health workforce as it relates to dental therapists. This section of the report is largely descriptive, reporting and summarizing basic information and facts about dental therapists. Information on this section of the report includes, for example, an overview of legislation relating to the educational requirements for dental therapists and the licensure of dental therapists. The section of the 2018 Minnesota Dental Therapy Issue Brief is not as straightforward, and at points may even be described as misleading. This section of the report intends to summarize information from earlier, more technical reports. These earlier, more technical reports are more specifically concerned with research questions on access to care and financial viability that relate to dental therapists, as compared to dentists. Unfortunately, the information reported in the 2018 Minnesota Dental Therapy Issue Brief suffers from a series of methodological and technical limitations and problems that undermine its efforts to accurately describe what, if anything may or may not be known about access to care and financial viability as it relates to dental therapists. There are many limitations of the underlying research methods, and the misrepresentation of the underlying research in the issue brief exacerbates this problem.

**Key Findings**

- The data on access and quality contained in the 2018 Minnesota Dental Therapy Issue Brief is based on a surprisingly small number of outdated studies. Much of the information comes from an outdated 2014 report to the Minnesota state legislature. Other information comes from a handful of case studies by Pew and Wilder.

- Research data drawn from the outdated report to the Minnesota state legislature suffers from methodological problems including small, idiosyncratic survey samples, survey nonresponse and sample selection bias, and recall bias. Additional statistical analysis, heretofore unreported, is consistent with a finding of recall bias.

- Research findings drawn from the Pew and Wilder case studies are misrepresented in the 2018 Minnesota Dental Therapy Issue Brief which could mislead policymakers. The 2018 Minnesota Dental Therapy Issue Brief confused oral health services volume and outcomes, confused revenues with financial viability, and neglected to follow best standards in economic evaluation and cost-effectiveness analysis.

HB1426
#12
1/21/19
page 1/2

SAINT LOUIS UNIVERSITY

Department of Health Management & Policy
College of Public Health and Social Justice
3545 Lafayette Avenue
Salus Center, Suite 300
St. Louis, MO 63104
Phone: (314) 977-8264
Fax: (314) 977-1674

# Review of the Minnesota Dental Therapist Workforce

Jeremy Craig Green, Ph.D.
Assistant Professor
Saint Louis University
Department of Health Management & Policy
College of Public Health and Social Justice

February 22nd, 2017

*The author wishes to note that while this report was commissioned by the American Dental Association, the charge was to evaluate critically the documents covered in this report from a neutral standpoint. Thus, the findings are not intended to reflect the views of the American Dental Association or any other organization or individual.*

Minnesota's Dental Therapist Workforce (MDTW), 2015 report, Highlights from the 2015 Dental Therapist Workforce Survey was published in August 2016 by the Minnesota Department of Health's Office of Rural Health and Primary Care. The MDTW reports the results of a survey fielded in November and December of 2015 by the Minnesota Department of Health and the Minnesota Board of Dentistry. The purpose of the survey and report are to describe the employment, demographics, education, career plans, and job satisfaction of dental therapists in Minnesota. The MDTW report can be misleading for several reasons. The MDTW description of dental therapist employment is inconsistent between the narrative of the report and the data collected in the survey. Consequently, the MDTW employment narrative overestimates the number of hours worked by dental therapists in Minnesota.

The MDTW report on employment of dental therapists also suffers from missing data problems which can further exacerbate the overestimates of the number of hours worked by dental therapists. Discrepancies between the narrative of the report and the data from the survey, and problems of missing data, are detrimental both for the MDTW analysis of dental therapist employment and for the MDTW analyses of dental therapist demographics, education, career plans, and job satisfaction. Fundamental parameters of research design, including survey sample size, survey response rates, and even the year of the survey, are mathematically incorrect and otherwise inconsistent throughout the MDTW. These discrepancies raise further concerns about the validity of the MDTW data and the conclusions of its narrative.

**Key Findings**

- The report contains numerous inconsistencies regarding dental therapist employment in Minnesota, including fundamental research parameters that are mathematically incorrect. Several of the narratives in the report are directly contradicted by the actual data from the survey results.
- The MDTW narrative describes increasing dental therapist employment rates, but in contrast, the actual data of the report shows dental therapist employment rates decreased from 2014 to 2015.
- It also says 95 percent of dental therapists "considered their schedule full-time," yet data from the survey results reports only 57 percent of dental therapists work 36 or more hours per week.
- The report claims that dental therapists worked more hours in 2015 compared to 2014, but the data in the report shows dental therapists worked fewer hours in 2015.
- The MDTW narrative describes a shift toward increased dental therapist employment in rural areas, but a large number of missing survey responses could result in a greater proportion of dental therapists employed in the urban Minneapolis-Saint Paul region.
- The analysis overestimates the number of 2016 dental therapy graduates, and counts of dental therapy graduates in 2015 were lower than any other year for which data was reported.
- With missing data taken into account, only 26 percent of dental therapists (14 of 53) reported being very satisfied with their career in the last 12 months.

HB1426
#12
1/21/19
Page 44

CENTER FOR PREVENTION AND HEALTH PROMOTION
Oral Health Program
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon St, Ste 825
Portland, Oregon 97232-2186
Office: 971-673-1563
Cell: 509-413-9318
Fax: 971-673-0231
www.healthoregon.org/dpp

**DATE:** April 9, 2018

**TO:** Joe Finkbonner
Northwest Portland Area Indian Health Board

**FROM:** Bruce Austin, Statewide Dental Director
Oregon Health Authority

**RE:** Status of February 26, 2018 Site Visit
Findings & Further Clarification Needed on Dental Pilot Project #100

---

## SITE VISIT

On February 26, 2018, the Oregon Health Authority (OHA) conducted the second required site visit for Dental Pilot Project #100, "Oregon Tribes Dental Health Aide Therapist Pilot Project."

The OHA Dental Pilot Projects Program is responsible for monitoring approved pilot projects. The primary role of the Oregon Health Authority is monitoring for patient safety. Secondarily, program staff shall evaluate approved projects and the evaluation shall include, but is not limited to, reviewing progress reports and conducting site visits. OHA is responsible for ascertaining the progress of the project in meeting its stated objectives and in complying with program statutes and regulations.

Per Oregon Administrative Rule (OAR) 333-010-0455, a report of findings and an indication of pass or fail for site visits shall be provided to the project director in written format within 60 calendar days following a site visit. The Oregon Health Authority has determined that Dental Pilot Project #100 is in non-compliance with the requirements set forth in OARs 333-010-0400 through 333-010-0470, and therefore has **failed** the site visit.

As outlined in OARs 333-010-0400 – 333-010-0470, dental pilot projects are required to operate according to their approved applications and modifications. Projects that operate outside of the approved provisions in their application or modifications are in violation of the OARs. A pilot project may be suspended or terminated during the term of approval for violation of 2011 Oregon Laws, chapter 716 or any of the OARs 333-010-0400 through 333-010-0470.

## STIPULATED AGREEMENT

On April 3, 2018, the Northwest Portland Area Indian Health Board (NPAIHB) entered into a signed Stipulated Agreement which states that the NPAIHB and OHA agree that OHA has

5

adequate grounds to issue a Notice of Proposed Suspension to NPAIHB. In lieu of OHA issuing a Notice of Suspension to the project, NPAIHB agreed to the terms outlined in the agreement. NPAIHB agrees that if they violate the terms of the agreement, OHA may suspend its approval of the project until such time as it can come into compliance with its approved plan and OARs 333-010-0400 to 333-010-0470.

**SITE VISIT FINDINGS & ITEMS NEEDING FURTHER CLARIFICATION**

As part of the site visit, there are several items that need to be addressed or require further clarification from NPAIHB:

1. **Failure to Follow OHA Directives**: On November 27, 2018, OHA issued a notice to NPAIHB requiring the project to cease providing planned extractions by dental health aide therapist (DHAT) trainees since it is outside of the scope of practice requirements as outlined in the approved application. NPAIHB failed to inform the project sites of the directives issued by OHA. DHAT trainees at the pilot project sites continued to perform planned extractions outside of the requirements that they be a medical emergency. Medical emergencies are defined under ORS 682.025 and OAR 141-120-0000.

   Corrective Action: On February 28, 2018, OHA informed both the NPAIHB and clinic sites verbally of the concerns discovered in the oral interviews with the Native American Rehabilitation Association (NARA) clinicians. A commitment to cease procedures that are not allowed under the approved application was obtained from both the NPAIHB and pilot sites. On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will agree to follow clinical parameter criteria for extractions outlined in the agreement.

2. **Nitrous Oxide**: DHAT trainees at the pilot sites provided services to patients who were under the use of nitrous oxide. Nitrous oxide was administered by the supervising dentist under direct supervision.

   In an addendum to their approved application, NPAIHB states "The DHATs are not trained to use it; they will not be using Nitrous Oxide." At subsequent Advisory Committee meetings, the NPAIHB was questioned as to the methodology and logic of excluding DHAT trainees from receiving training on nitrous oxide when it is used at each pilot site.

   On October 31, 2017, the NPAIHB stated that "Nitrous is used at both NARA and CTCLUSI, but for the purposes of this pilot, we have decided at this point not to modify our application to include additional training in Oregon on Nitrous Oxide for DHATs. DHATs are able to provide treatment to a patient that is placed under Nitrous Oxide or other analgesics."

   On November 21, 2017, OHA informed the NPAIHB in writing of the following requirements:

   I. If DHAT trainees are providing treatment to patients under "nitrous oxide or other analgesics," then OHA requires that the trainees participating in the approved pilot project follow the Oregon Board of Dentistry administrative rules for

Anesthesia OARs 818-026-0000 through 818-026-0120.

II. The project must provide clarification on the intention of using nitrous oxide by DHATs in the pilot project, as well as the training received and competency if operating as an Anesthesia Monitor, etc.

III. If it is the intention of the project trainees to utilize nitrous oxide or work on patients under nitrous oxide, then the project must apply for a modification to their application.

A copy of the administrative rules for nitrous oxide OARs 818-026-0000 through 818-026-0130 was supplied to the NPAIHB.

On November 30, 2017, OHA received a memo from NPAIHB stating: "After further review of the Oregon Dental Practices Act, we agree that our DHATs are not, and will not be authorized to administer Nitrous Oxide, or work on patients that have received Nitrous Oxide from someone who has a valid Nitrous Oxide permit."

NPAIHB failed to inform the project sites of the directives issued by OHA. The DHAT trainees at both pilot sites provided services to patients who were under the use of nitrous oxide.

Corrective Action: On February 28, 2018, OHA informed both the NPAIHB and clinic sites verbally of the concerns discovered in the oral interviews with the NARA clinicians. A commitment to cease procedures that are not allowed under the approved application was obtained from both the NPAIHB and the pilot site. On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will prohibit DHAT trainees from treating patients who are receiving nitrous oxide.

Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

3. **Practicing Outside the Scope of Approved Practice**: Review of the chart records indicate that on three separate occasions the trainee completed extractions or attempted to complete extractions, which are outside of the trainees approved scope of practice as outlined in the Community Health Aide Programs Board (CHAP) Standards and approved application:

   As stated in the approved application under CHAP Standard 2.30.610, in addition to the requirement that extractions must be completed by DHAT trainees in the event of a medical emergency, DHAT trainees are authorized to complete uncomplicated extractions with prior evaluation of the x-ray and consultation when appropriate for proximity to the mandibular canal; proximity to the maxillary sinus, root fractures or dilacerations; multiple roots; a well-defined periodontal ligament space; and enough

clinical crown to luxate the tooth.

Project trainees are only authorized to complete simple uncomplicated extractions. In two of these instances, the procedure became surgical in nature in order to complete the procedure.

A. In the first instance, the trainee attempted to extract tooth #20 with no clinical crown above the gingival level. Radiographs demonstrate that the tooth had no clinical crown. Chart notes state that the trainee was unable to extract the tooth and required intervention by the supervising dentist. The dentist was required to cut a flap in order to extract the tooth.

B. In the second instance, the trainee extracted teeth #15 and #16. Chart notes state that after the teeth were extracted by the DHAT trainee, buccal bone was attached to the extracted teeth. The supervising dentist was required to take over the procedure and used a bone file to reshape the bone in the extraction site and suture the area.

C. In the third instance, the trainee extracted teeth #18 and #19. Tooth #18 had no clinical crown. The two remaining roots of #18 were embedded in the soft tissue. Both radiographs and intra-oral images demonstrate that the tooth had no clinical crown. Chart notes state that the trainee was successfully able to extract the teeth.

OHA is concerned that the DHAT trainee was authorized to complete procedures that fell outside of their scope of practice according to the approved project application. DHAT trainees do not have the scope of practice to cut soft tissue or resolve extractions that become surgical in nature. The NPAIHB has stated on several occasions that the DHAT trainees are taught the limitations of their scope of practice and are aware of those limitations. Of particular concern is that the DHAT trainee at the NARA site has been practicing for over 8 years.

There is considerable concern that the project's intention is to have the DHAT trainee complete extraction procedures under general supervision. Had the DHAT trainee been authorized to complete these procedures under general supervision, with no dentist on-site, the DHAT trainee would have lacked the necessary skills to complete the procedure. This would have resulted in undo pain for the patient and would have necessitated a referral to a dentist to complete the procedure.

Corrective Action: On April 2, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB must only allow a DHAT trainee to perform extractions under the following conditions:

1. All extractions must be performed under the indirect supervision of the DHAT trainee's supervising dentist. Indirect supervision is defined under ORS 679.010 as supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

2. For primary and permanent tooth extractions, the DHAT trainee will first receive and document authorization from the supervising dentist.

3. For primary teeth, the trainee may perform non-surgical extractions on teeth that exhibit some degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gum line, or needs to be sectioned for removal.

4. For permanent teeth, the trainee may perform non-surgical extractions of periodontally diseased teeth with evidence of bone loss and +2 degree of mobility. The trainee will not extract a tooth if it is unerupted, impacted, fractured or decayed to the gum line, or needs to be sectioned for removal.

5. Document all information related to extractions as specified above along with the criteria required for the project evaluation which include a recent radiograph of the tooth to be extracted, a pre-operative intra-oral image of the tooth to be extracted, and a post-operative image of the extracted tooth.

Required Next Steps: The project is required to clarify the scope of practice concerns around intra-oral suturing. The DHAT trainee indicated in their interview during the site visit that they are specifically taught that intra-oral suturing is outside of their scope of authorized practice. This was confirmed in statements by the supervising dentist. Each stated that DHAT's are not taught suturing in the training program and are prohibited from suturing. This is of concern as NPAIHB contradicts the statements of both the trainee and supervising dentist. NPAIHB provided information to OHA stating that DHAT's are in fact authorized to perform suturing and are taught this as part of their training. Clarification as to the contradicting statements is required.

NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

4. **Informed Consent**: The project failed to obtain written informed consent for services by the trainee on the date of service, as required in OAR 333-010-0440 and OAR 123-456-7890, on multiple occasions in charts provided for review – including treatment of 3 minors. On four occasions, the signed consent to be treated by a trainee was obtained after the initial date of service. On two occasions, the printed patient name is not listed on the signed informed consent form. On one occasion, informed consent to be treated by the trainee was absent entirely. Overall, only 74% of the 23 charts reviewed in the randomized sample had a signed form consenting to treatment by the DHAT trainee on the initial date of service.

Additionally, an approved oral surgery consent form is required for all extractions. Of the 9 charts reviewed for which an oral surgery consent form is required, only 1 chart had a signed oral surgery consent form that matches the form approved for the pilot project. For the remaining charts, 7 charts included a different oral surgery consent form. Written consent for oral surgery is missing entirely for one chart.

Corrective Action: On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB must ensure that all required consent forms are completed and placed in charts prior to services being performed.

Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

5. **Non-Adherence to Approved Evaluation & Monitoring Plan**: Based on review of the 23 submitted charts, the project is not in compliance with Appendix C intra-oral image and radiographic collection requirements of the approved Evaluation and Monitoring Plan.

   In the 23 charts submitted, there were 42 unique procedures identified that required a pre- and post-operative intraoral image. Of these, 12 procedures (29%) were missing a pre-operative and/or post-operative intraoral image. Additionally, restoration procedures require an intraoral image of the tooth prep, which was missing in 5 of the 31 identified procedures requiring a prep image. Adequate patient safety and procedure quality cannot be determined without proper image documentation.

   Corrective Action: On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will adhere to their approved Evaluation and Monitoring Plan.

   Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

6. **Failure to Submit Required Information to OHA as Required**: As part of the site visit, the project was required to submit a randomized sample of charts to OHA by February 27, 2018 based upon quarterly data submitted in the Detailed Data Report. Upon review, it was determined that a significant portion of these charts were incomplete and were missing significant components required for review and assessment of quality. These include pre-operative intra-oral images, prep intra-oral images, post-operative intra-oral images, pre-operative radiographs and informed consent forms.

   Reviewers were unable to adequately assess several of these charts as required for evaluation of patient safety. Of the 24 charts requested, 63% were missing one or more element. OHA further requested the missing components of the charts and received most of the required materials on March 16, 2018. Project managers indicated on that

date that one chart number had been included in the Detailed Data Report in error, and was not a patient seen by the trainee.

Corrective Action: On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will adhere to their approved Evaluation and Monitoring Plan.

Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

7. **Detailed Data**: The project is required to submit a full and complete detailed data report (DDR) to OHA quarterly. Upon review of the DDR and comparison of the chart records, numerous procedures were omitted on the detailed data report. Instructions for submission of the DDR indicate that every service provided by the trainee must be included as a separate entry. Stratified random samples are selected from the information contained in the DDR, so accuracy of the DDR is critical to the required evaluation by OHA.

   Based upon the submitted DDR, there were an expected 41 unique procedures (defined by ADA CDT codes) completed by the trainee on 23 unique patients. After review, there were 102 unique procedures identified as being completed by the trainee. Of the 23 charts reviewed, only 35% were accurately represented in the DDR. The procedures omitted in the DDR include one completed extraction, as well as many preventive and restorative services. This is an indication of severe data validity issues in the detailed data reports as submitted. Without a complete data set in the DDR, conclusions cannot be drawn as to the representative nature of the charts submitted. It is unknown how many other procedures have been completed by the trainee that were not included on the DDR for charts not selected in the randomized sample.

   Corrective Action: On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will adhere to their approved Evaluation and Monitoring Plan.

   Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

   The next detailed data report is due to OHA by April 30, 2018 and must include every procedure completed by the trainee.

8. **Failure to Document**: The pilot site has failed to maintain accurate patient records in accordance with OAR 818-012-0070. Examples include incorrectly recording treatment

rendered, incorrectly coding for one procedure when a different procedure was performed, and not recording patient weight when administering analgesics to minors.

Additionally, in one instance, the trainee completed an extraction that was coded as D7210, which falls outside the scope of DHAT practice. D7210 is defined as surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Project managers indicated that this was coded in error, which indicates a failure to accurately document patient treatment.

Required Next Steps: NPAIHB will develop written standing operating procedures (SOPs) and reference resources for use by each pilot project site. OHA will require the project to conduct training sessions at each pilot project site for compliance with required SOP and associated materials. Training sessions must be completed at each pilot site by August 1, 2018. Dates and attendees of the training sessions must be supplied to OHA.

9. **Advisory Committee**: The project failed to meet with their own advisory committee in the two years since approval of the dental pilot project. The approved application includes details of the project assembling an Advisory Committee of their own and meeting regularly. The project has not met once in two years since the approval of the project in February 2016.

   Corrective Action: OHA will require the project adhere to their approved application. OHA will require that the NPAIHB conduct quarterly meetings with their own Advisory Committee. The NPAIHB will submit dates and attendees of these meetings in their quarterly progress report to OHA.

10. **Project Management:** There is considerable concern that the NPAIHB is failing to adequately communicate clinical concerns with the project sites. Supervising dentists at each pilot site have indicated frustration with a lack of communication on issues which are highly relevant and time sensitive. Concerns remain that the NPAIHB does not have a clinical dental subject matter expertise in the project manager role. There remains ambiguity and inconsistencies regarding clinical questions and concerns raised by both OHA and the Advisory Committee around extractions, nitrous and suturing. Several statements received by OHA from the project have contradicted each other and have caused concern regarding patient safety and the provision of quality care.

    Corrective Action: On April 3, 2018, NPAIHB entered into a signed Stipulated Agreement agreeing that in lieu of OHA issuing a Notice of Suspension to the project, the NPAIHB will hire or contract for an Oregon-licensed dentist actively practicing in the State of Oregon, to provide clinical technical expertise and project oversight by **June 21, 2018**.

**RESPONSE REQUIRED**

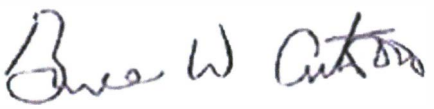
The project will respond to all concerns outlined above that are not addressed in the Stipulated Agreement. OHA will conduct a follow-up site visit to the NARA pilot site within

the next 6 months to assure that the corrective actions outlined above have been performed.

The Northwest Portland Area Indian Health Board must respond to any findings or requests for clarification by **Wednesday, May 16, 2018**.

A full report of findings will be issued by OHA by August 1, 2018.

Sincerely,



Bruce Austin, DMD
Statewide Dental Director

CC: Dental Pilot Project Advisory Committee #100

HB 1426
#12
1/21/19
page 53

19.0603.03000

Sixty-sixth
Legislative Assembly
of North Dakota

# HOUSE BILL NO. 1426

Introduced by

Representatives Devlin, D. Anderson, Dobervich, Johnston, Rohr, Schneider

Senators Dever, Heckaman, O. Larsen, J. Lee, Schaible

A BILL for an Act to create and enact four new sections to chapter 43-20 of the North Dakota Century Code, relating to regulation of dental therapists; and to amend and reenact sections 43-20-01.1 and 43-20-08 of the North Dakota Century Code, relating to dental therapist definition and unlawful practice of dental hygiene, dental therapy, and dentistry.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1. AMENDMENT.** Section 43-20-01.1 of the North Dakota Century Code is amended and reenacted as follows:

**43-20-01.1. Definitions.**

As used in this chapter and chapter 43-28, unless the context otherwise requires:

1. "Dental assistant" means an individual who provides dental assistance under the supervision of a dentist and within the scope of practice established by rule and section 43-20-13.
2. "Dental hygienist" means an individual licensed to practice dental hygiene.
3. "Dental therapist" means an individual licensed to practice dental therapy.
4. "Federally qualified health center look-alike" means a community-based health care provider that meets the requirements of the federal health resources and services administration health center program but does not receive health center program funding.
5. "Qualified dental assistant" means an individual registered as a qualified dental assistant to provide dental assistance as established by rule.

~~4.~~6. "Registered dental assistant" means an individual registered as a registered dental assistant to provide dental assistance as established by rule.

**SECTION 2. AMENDMENT.** Section 43-20-08 of the North Dakota Century Code is amended and reenacted as follows:

HB 1426
#12
1/21/19
Page 5#

**43-20-08. Unlawful to practice without license or registration.**

A person may not practice dental therapy or dental hygiene or practice as a registered or qualified dental assistant in the state, without first obtaining from the board a license or registration. A person may not practice as a dental assistant outside the scope of practice established by the board by rule and section 43-20-13.

**SECTION 3.** A new section to chapter 43-20 of the North Dakota Century Code is created and enacted as follows:

**Dental therapist licensing.**

1. Except as otherwise specified in this chapter, an individual seeking to practice dental therapy in this state shall apply to the executive director of the board on forms and in the manner prescribed by the board and using the processes for licensing of dentists and dental hygienists. The board shall grant a license to practice dental therapy to an applicant who has met the following requirements:
   a. The applicant is a graduate of a board-approved dental therapy education program.
      (1) In determining whether to approve an education program, the board shall consider whether the program is accredited by the American dental association's commission on dental accreditation.
      (2) If, after a review under paragraph 1 the board does not approve a dental therapy education program, and the applicant graduated from or is enrolled in a dental therapy education program before January 1, 2020, the board shall consider whether the education program is approved by a regulatory board of another jurisdiction and whether the program's education is comparable to an accredited program, including any postgraduation education the applicant may have obtained to achieve a comparable education.
   b. The applicant passed a board-approved examination to demonstrate competency in dental therapy.
   c. Within one year of submitting the application, the applicant passed a written examination on the laws and rules governing the practice of dentistry in this state.

d. The applicant completed five hundred hours of dental therapist clinical practice under the direct or indirect supervision of a dentist which may be completed during or after the applicant's education program or a combination of both. Supervised clinical practice under this subdivision for the purpose of qualifying for licensure is not a violation of section 43-20-08.

e. Grounds for denial of the application under section 43-20-05 do not exist.

f. The applicant has met any requirement for licensure established by the board by rule.

2. Except as otherwise provided in this chapter, sections 43-20-01.3, 43-20-01.4, 43-20-02.1, 43-20-05, 43-20-06, 43-20-10, 43-20-11, 43-20-12.2, and 43-28-06 also apply to dental therapist licensing.

**SECTION 4.** A new section to chapter 43-20 of the North Dakota Century Code is created and enacted as follows:

**Dental therapists - Limitations on practice.**

1. A dental therapist may not practice dental therapy unless the dental therapist is an employee or contracted provider of:

a. A federally qualified health center or a federally qualified health center look-alike.

b. A not-for-profit or governmental dental practice or organization that serves primarily low-income and underserved individuals.

c. An organization providing services on behalf of or under the authorization of Indian health services, a tribal entity providing health care under the federal Indian Self-Determination and Education Assistance Act of 1975 [Pub. L. No. 93-638; 88 Stat. 2203; 25 U.S.C. 5301 et seq.], or other organization providing services to members of a federally recognized Indian tribe in this state.

2. To the extent authorized by the organization and the supervising dentist, a dental therapist employed by or under contract with an organization described in subsection 1 may provide services in a community setting, including a school, nursing home, veterans' facility, or dental clinic.

**SECTION 5.** A new section to chapter 43-20 of the North Dakota Century Code is created and enacted as follows:

**Dental therapists - Scope of practice.**

1. Unless restricted or prohibited by the supervising dentist in the written collaborative management agreement, a dental therapist may perform the following services under the supervision of a supervising dentist:
   a. The dental therapy services listed in the American dental association's commission on dental accreditation's accreditation standards for dental therapy education programs;
   b. Processing radiographic images;
   c. Fabricating soft occlusal guards;
   d. Administration of nitrous oxide analgesics;
   e. Nonsurgical extractions of periodontally diseased permanent teeth that exhibit plus three or grade 3 mobility and that are not impacted, fractured, unerupted, or in need of sectioning for removal;
   f. Pulpotomy on primary teeth;
   g. Recement permanent crown;
   h. Intraoral suturing;
   i. Placement of space maintainers;
   j. All functions of a dental assistant;
   k. Other related services and functions that are authorized by the supervising dentist within the dental therapist's scope of practice and for which the dental therapist is trained; and
   l. Other services of a dental therapist authorized by the board by rule.
2. A dental therapist may not prescribe any drug. Within the parameters of the written collaborative management agreement, within the practice of dental therapy, and with the authorization of the supervising dentist, a dental therapist may provide, dispense, and administer the following drugs: analgesics, anti-inflammatories, and antibiotics. A dental therapist may not provide, dispense, or administer a narcotic drug.

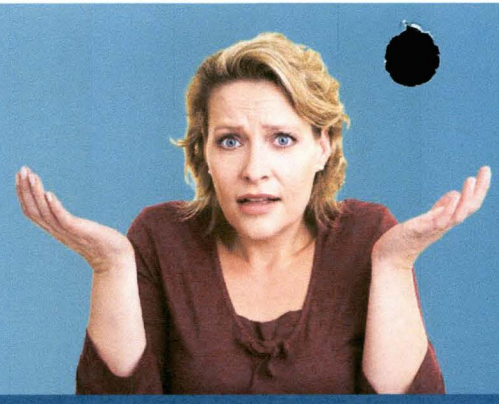
**SECTION 6.** A new section to chapter 43-20 of the North Dakota Century Code is created and enacted as follows:

**Dental therapist supervision.**

1. Except under the supervision of a dentist and pursuant to a written collaborative management agreement with the supervising dentist, a dental therapist may not practice dental therapy. A dental therapist may perform dental therapy services under general supervision to the extent authorized by the supervising dentist and consistent with protocols, conditions, and limitations contained in the collaborative management agreement. The written collaborative management agreement entered between a dentist and a dental therapist must:
   a. Address any limitation on services established by the supervising dentist, the level of supervision required for various services or treatment settings, practice protocols, recordkeeping, managing medical emergencies, quality assurance, administering and dispensing medications, and supervision of dental assistants;
   b. Include specific written protocols to govern situations in which the dental therapist encounters a patient requiring treatment that exceeds the authorized scope of practice of the dental therapist;
   c. Be signed and maintained by the supervising dentist and the dental therapist; and
   d. Be submitted to the board upon request of the board.
2. To the extent authorized by the supervising dentist in the written collaborative management agreement, a dental therapist may evaluate and assess oral health conditions, plan treatment, and perform dental therapy services in a practice setting at which the supervising dentist is not onsite and has not previously examined or diagnosed the patient. The supervising dentist must be available for consultation by telephone or other means of electronic communication.

# What is a DENTAL THERAPIST?

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



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

1. New Zealand Dental Council, Health Practitioners Competence Assurance Act 2003, Prescribed Qualifications for Dental Therapists, 2016
2. Accreditation Canada, National School of Dental Therapy (NSDT), February 2011
3. Alaska Native Tribal Health Consortium, DHAT Curriculum & Application Certification, 2016
4. Minnesota House of Representatives, Loan Forgiveness for Dental Therapy: Dental Therapy Fact Sheet, January 2015
5. Minnesota Dental Association, Dental Therapy in Minnesota Issue Brief, July 2013
6. State of Maine, Maine H.P. 870 – L.D. 1230, April 2014
7. Vermont State Legislature, S. 20, 2016
8. New Zealand Dental Council, Health Practitioners Competence Assurance Act 2003, Scope of practice for dental therapy, 2016
9. College of Dental Surgeons of British Columbia, Dental Therapists Scope of Practice
10. Alaska Native Tribal Health Consortium, DHAT Certification & Scope of Practice, 2016
11. Minnesota Office of the Revisor of Statutes, 2015 Minnesota Statutes, 2015
12. Minnesota Board of Dentistry, 2009 Session Laws: Dental Therapist Scope Of Practice, 2009
13. The American Dental Education Association, ADEA State Update, May 2014
14. Journal of Dental Education, Influence of Private Practice Employment of Dental Therapists in Saskatchewan on the Future Supply of Dental Therapists in Canada, August 2012
15. New Zealand Ministry of Health, 2009 New Zealand Oral Health Survey, December 2010
16. Canadian Ministry of Health, Summary Report On The Findings Of The Oral Health Component of the Canadian Health Measures Survey 2007-2009, April 2010
17. American Journal of Public Health, Improving the Oral Health of Alaska Natives, May 2005
18. Alaska Department of Health and Social Services, Division of Public Health, Alaska Oral Health Reports,
19. Minnesota Department of Health Oral Health Program, The Status of Oral Health in Minnesota, September 2013
20. Dental Council Of New Zealand, 2010 Annual Report, March 2010
21. Journal of Dental Education, Influence of Private Practice Employment of Dental Therapists in Saskatchewan on the Future Supply of Dental Therapists in Canada, August 2012
22. Alaska Native Tribal Health Consortium, Support the DHAT Educational Program, 2016
23. Alaska Business Monthly, Alaska Native Tribal Health Consortium to Receive $3 million in Appropriations from Federal Government, December 2009
24. Minutes of the Minnesota Board of Dentistry 2010-2014
25. Minnesota Dental Board, Licensure Verification, March 2017
26. Vermont Legislative Joint Fiscal Office, S. 20 Fiscal Note, 2016
27. Untreated Decay: New Zealand Ministry of Health, 2009 New Zealand Oral Health Survey, December 2010
28. Minnesota Department of Health, Minnesota Oral Health Plan, January 2013
29. Maine Office of the Governor, Supplement No. 9: Governor Paul LePage Veto, April 2016
30. American Dental Association Health Policy Institute, State-by State Analysis Vermont's Oral Health Care System, December 2015
31. American Dental Association Health Policy Institute, State-by-State Analysis Vermont's Oral Health and Well-Being, June 2016
32. Dental Therapy Technical Advisory Group, Recruitment and Practice of Dental Therapists, June 2004

HB 1426
#12
1/21/19
Page 60

# NDDA Key Points-Dental Therapy

**All North Dakotans – regardless of socioeconomic status – deserve quality dental care from the highest-trained professionals. Though well-intentioned, dental therapy's proposed focus on low-income and underserved patients incentivizes discrimination and puts the neediest, most complex cases a step further from a dentist.**

- Poor children and adults shouldn't be stopped from seeing a dentist by a system that redirects them to providers with less training than dentists.
- Dental therapists would essentially be allowed to perform irreversible surgery with less training than a dentist. Nurse practitioners in the U.S. have more training and are still not allowed to perform major irreversible surgery.

**Available funding for improving public oral health is scarce. The most effective way to make real improvements is through prevention and education, not adding another provider to the mix whose focus will be drilling and pulling teeth.**

- Dental therapy programs are heavily subsidized by and cannot stand up on their own without government assistance or support from special interests.
- Dental therapy reflects a strategy of treating the symptoms of dental disease, rather than treating the disease itself.

**Dental therapy programs are a cost burden to states in which they operate—too expensive to survive without subsidies. The Canadian program failed once government subsidies ended.**

- Dental therapy fails to reduce costs for the patient or the state – the cost of a procedure is the same no matter who provides it. Taxpayers, insurance companies and patients paying out of pocket save no money when they are seen by a dental therapist.
- Existing dental therapist models in the U.S. are either subsidized by sponsoring agencies (in Alaska) or charge the very same amount to taxpayers as dentists (in Minnesota).
- The dental therapist movement reflects a strategy of treating the symptoms of dental disease, rather than its causes. Under this program, resources are diverted from prevention, education, and connecting populations with dentists – all of which are critical to improving patient health.

**Dental therapy fails as a "free market" solution to reduce healthcare costs because it adds a new layer of state licensure, and they do not provide competition for dentists.**

- Creating dental therapy makes it harder for states attempting to reduce licensure requirements and regulations, because it creates more government. By definition their scopes of practice are redundant to procedures already allowed for dentists, creating a new layer of bureaucracy without delivering any new service or savings to patients.

- A successful free-market approach to improve patient oral health would involve direct competition between new dental practice models, resulting in better care and lowers costs. That is not what dental therapy offers or delivers. Dental therapists work within existing dental practices as employees and charge the same amount for their services as dentists.

- Dental therapists in Minnesota are also now being offered loan forgiveness to encourage them to practice in rural areas. This additional unanticipated cost to taxpayers shows how these redundant programs require significant government subsidies and are not working as promised.

**Creating a new dental provider in North Dakota is not a viable solution to reduce barriers to care in rural areas. Dental therapists can only do limited procedures and do not have the broader diagnostic education necessary to work without a dentist on-site. After 8 years, only 9 dental therapists practice in rural areas of Minnesota; most practice in the Twin Cities area.**

**North Dakota solutions are needed to reduce barriers to care:**

- **Improve dental Medicaid** with adequate funding, reduced administrative burden, and vigorous dentist recruitment
- **Maximize the current dental hygiene and assistant workforce** through expanded training programs, community outreach, and case management to connect more high-risk patients to a dental home
- **Expand and support non-profit safety-net clinics** through public-private grant partnerships and dentist loan repayment programs
- **Engage with tribal communities** to improve Indian Health Service dentistry, maximize prevention, reduce credentialing barriers, and facilitate contracting with the local dental community.

**HB 1426**

**Dr Steven Deisz**

**North Dakota Dental Association**

**January 21, 2019**

Chairman Weisz and members of the House Human Services Committee, my name is Dr. Steven Deisz. I am here today representing the North Dakota Dental Association (NDDA), our board of trustees, and our over 400 member dentists across the state of North Dakota.

I was born and raised in Bismarck and returned home after receiving my dental degree from Midwestern University in 2014, where I have practiced for almost five years and currently serve as the President of the Missouri Slope Dental Society.

I am here today to testify in opposition to House Bill 1426 on behalf of the North Dakota Dental Association. The benefits of dental therapy have been continually oversold; all while there is still no evidence to show it will work as promised in North Dakota. As Mr. Sherwin has mentioned, the North Dakota Senate in 2015 and the North Dakota House in 2017 again affirmed our position that the dental therapy model is not the right solution for North Dakota.

I'd like to discuss the dental therapy bill concerns from a clinician's standpoint:

1. **Dental School Training**

   I am proud to say that I made it through four incredibly difficult, fast paced years of dental school. From the day I started until the day I graduated, I was learning and perfecting my skills as a dentist. We were put through two years of preclinical training before even moving to clinic. That's two years of practicing on plastic teeth, literally thousands of preparations and fillings. On top of all the preclinical dental education we were received, we learned about the human body at the same level as our medical student counterparts. I am in no way trying to claim that I also have a medical degree, but I did spend time studying the same things medical doctors start their programs with. There is a reason dental schools teach this, we are working on people, sometimes with multiple systemic issues, and not just their teeth. Part one of our dental boards involves

general concepts of tooth anatomy and occlusion as well as Anatomic Sciences, Microbiology/Pathology, Biochemistry/Physiology, and Ethics and Patient Management. Once in clinic, we learned why the first two years were so difficult. Our patients had complex dental needs, complex medical histories, medication lists that filled multiple sheets of paper. Dental school is four years for a reason; there was not a day I was not pushed to my limits because that is what it takes to prepare someone to handle the needs of each and every dental patient.

To compare curriculums briefly, in my first two years of dental school at Midwestern University in Glendale 120 credit hours were required. That was before I had a chance to ever work on a single patient. Dental therapists in the 3-year program have 118 credit hours. Even more alarming is that only 44 of those credit hours are dedicated to the dental therapy curriculum. At that point, they would be out practicing "simple dentistry" under the supervision of a dentist (whether it be general or direct supervision). They'd be able to do pulpotomies (baby tooth root canals) and place stainless steel crowns on baby teeth. I'm sure my pediatric dentist friends probably were just having fun while they endured 10 years of school to be able to treat their patients with the highest quality of care.

It is also unfair to compare dental therapists to Physician's Assistants and Nurse Practitioners. To become a Physician Assistant, one must earn a bachelor's degree, which takes roughly four years, and complete a physician assistant training program, which takes another two years. To become a Nurse Practitioner, a student must complete a 4-year Bachelor's of Science in Nursing (BSN). After earning your BSN, you'll need to complete a master's degree program that trains nurse practitioners. NP degrees can take 2 to 4 years. Despite the fact that PAs and NPs have more than 2 times the training, they are still not performing irreversible procedures. The comparison is a poor one as the scope that dental therapy is asking to perform includes irreversible procedures.

2. **Bridging the Dental Gap**

After graduation, I was lucky to have had the opportunity to work at Bridging the Dental

Gap for a few months. In my time at Bridging the Dental Gap, I learned a tremendous amount about the dental community, its diversity, and its needs. I saw Medicaid patients, patients that needed help with pain, help with function, and help with their confidence. I was amazed at the impact I could have on someone's life when providing treatment that they desperately needed. I also learned that sometimes, people did not put enough value on their dental needs. Patients with a broken tooth who would miss three appointments but would then call 2 months later and demand to be seen immediately because they were in so much pain. I had to learn that sometimes, educating a patient to address needs before they were emergencies was essential because not everyone knew the consequences of neglecting their dental care.

I was also lucky enough to volunteer on the Ronald McDonald Care Mobile as well. My time on the Care Mobile was wonderful. I realized that not only could I help fix the cavities that a 5 year old had, but I could talk with his/her mother or father about why the cavities formed. Not only did that hopefully prevent the 5 year old from getting additional cavities, but the 3 year old, 2 year old, and 6 month old siblings also benefitted from the education of their parents. While it was often incredibly difficult dentistry, I feel the greatest impact I was able to make was in education, which then becomes prevention.

In September, I was lucky enough to participate in North Dakota's first Mission of Mercy event. You have heard or seen all the numbers, you know the impact that 110 dentists, 48 hygienists, 105 dental assistants and 4 lab techs had as they provided an estimated $564,964 of dental care for 916 individuals. I did triage of dental needs and extracted teeth at this event. I took out close to 40 teeth in one day, not one was a simple extraction. While screening patients, their chief complaints were never simple dental needs. The patients who were seen at the MOM event needed to be seen by dentists. I did not see a single patient at the event that I would have sent to a dental therapist if they were readily available at the event. I have also had patients in my office that needed a single simple extraction and removed the tooth in under 30 seconds solely because it was that loose. Then the unexpected happens, the patient bites on gauze and you see no clotting, they just bleed. I have to go in pack the extraction site with a

resorbable sponge, suture, have the patient bite on gauze or a teabag all to get a "simple extraction" to stop bleeding. I've had simple extractions turn into surgical extractions, dentistry is not simple, and each patient is different.

**3. Medicaid and IHS patients**

Providing access to **ALL** North Dakotans, is something that is important to me and all of my fellow North Dakota Dental Association counterparts. With HB 1426, the idea is to provide better access to care. However, the bill may actually make it more difficult for these patients to see appropriately trained clinicians. The majority of my Medicaid patients that I saw in my time at Bridging the Dental Gap, or that I still see daily in private practice, come in with incredibly complex medical histories. Patients come in with uncontrolled diabetes, high blood pressure, anxiety, depression, psychiatric disorders, fibromyalgia, etc. In an effort to provide proper care to a patient, it is imperative that dental providers are able to properly comprehend medical histories or the contraindications to administration of anesthetics, contraindications to treatments, and when to refer to an appropriate medical professional. I have great concern for patients' well-being when someone who doesn't receive enough training on the complications that might occur due to health history or medications that these patients are taking. I'd argue that the most complicated health histories or medication lists are on the patients that this bill is attempting to put in the hands of dental therapists. Each and every North Dakotan deserves access to someone that is properly trained to comprehend whole health. I'd like to share a prime example of the difference my training can make and would ask you to consider the outcomes had I been a layperson who elected to seek care from a dental therapist. I found a lump in my neck. Everything I was taught said it was not good. It was hard and painless which I wanted to tell myself meant it was no big deal, but I knew from my training in dental school that it was concerning. I was in the best shape of my life, I felt great, my wife and I were expecting our first child, I was in the dental practice I knew was my future, I was on top of the world. It would have been really easy to sweep this finding under the rug and say it's probably nothing. Every step along the way I was able to tell my GP doctor "I think this is Hodgkin's Lymphoma." To tell the radiologist who took the biopsy, "how long does it take the pathologist to let me know if he sees any Reed-Sternberg cells?" To ask my

oncologist, "So since it is Stage 4 Hodgkin's Lymphoma, I will need to undergo 6 months of ABVD, correct?" Those are the things I learned in dental school. I'm not arguing dental professionals should be making these diagnoses. I am arguing they should understand them.

**4. NDDA Actions**

The North Dakota Dental Association is taking many steps to improve access to care.

1. We are working to improve dental Medicaid with adequate funding, reducing administrative burdens, and continued dentist recruitment.

2. Maximize the current dental hygiene and assistant workforce through expanded training programs, community outreach, and case management to connect more high-risk patients to a dental home. The Seal!ND program is a prime example of the utilization of our current workforce to make a huge difference. We have also worked to set up ER diversion programs in Fargo and Bismarck so patients without a dental home can be seen the next day by local non-profit clinics with support from private practice dentists in the event that the non-profit clinics cannot see them quickly enough.

3. Expand and support non-profit safety-net clinics through public-private grant partnerships, student internships, and dentist loan repayment programs.

4. Engage with tribal communities to improve Indian Health Service dentistry, maximize prevention, reduce credentialing barriers, and facilitate contracting with the local dental community.

I welcome and encourage those on this committee, along with the rest of the North Dakota State Legislature, to join us in discussion of an approach that is based on proven solutions rather than continuing to revisit a program that has been rejected multiple times by this body and that is showing no signs of success in other states. We owe it to all North Dakotans to find a way to solve the access to care issue with proven solutions, not experiments. This body said dental

therapy wasn't a good fit the first time, said it wasn't a good fit the second time, and here we are a third time. I think an analogy that will make sense to everyone needs to be made here. My two-year-old son was trying to get a square block to go through a round hole. He tried and it didn't work. He tried a second time and it still didn't work. I showed him that he just needed to find the round block and that would solve his problem. Dental therapy is a square block and North Dakota access to care is a round hole. You can try 100 times, but it still won't fit. If we use strategies that are working and proven, we've found our round block and we can make a difference in the access to care issue.

# COMPARING PROVIDER CREDENTIALS

## MEDICAL SURGEON

**EDUCATION** — POST-HS: 11–18 YEARS

- High school diploma
- Four-year undergraduate degree
- Four-year medical school degree
- 3–10 years of residency
- Fellowship training

- Can perform major irreversible surgical procedures

HB1426 #13 1/21/19 Page 7

## DENTIST

**EDUCATION** — POST-HS: 8–15 YEARS

- High school diploma
- Four-year undergraduate degree
- Four-year dental program
- 1–5 years additional training for specialty or state requirements

- Can perform major irreversible surgical procedures
- Evaluates, diagnoses, prevents and treats oral conditions

## NURSE PRACTITIONER

**EDUCATION** — POST-HS: 7–9 YEARS

- High school diploma
- Four-year undergraduate degree
- 2–3 year master's degree
- 1–2 years' registered nursing practice

- Cannot perform major irreversible surgical procedures
- Can perform diagnostic tests and minimally invasive procedures

## ADVANCED DENTAL THERAPIST

(MINNESOTA)

**EDUCATION** — POST-HS: 6–7 YEARS

- High school diploma
- Bachelor's degree in dental therapy
- Master's-level advanced dental therapy program
- 2,000 hours supervised clinical practice *(typically 1 year)*

- Can perform irreversible surgical procedures

## DENTAL THERAPIST

(VERMONT)

**EDUCATION** — POST-HS: 4.5+ YEARS

- High school diploma
- Three year dental hygienist program; requires licensure
- CODA-accredited dental therapy program
- 1,000 hours supervised clinical practice *(typically 6.5 months)*

- Can perform irreversible surgical procedures

HB1426
#13
1/21/19
Page 8

# Dual Degree Curriculum Overview
## 2018-2021

### DH3/DT3

***Term 1: Fall***

| | | |
|---|---|---|
| DH 2121 | The Dental Hygiene Care Process: Clinical Application I | 5 cr. |
| DH 2132 | Head and Neck Anatomy | 2 cr. |
| DH 2225 | Microbiology | 3 cr. |
| DH 4315 | Foundations of Interpersonal Communication and Collaboration | 1 cr. |
| DT 5429 | Intro to Psychomotor Skills | 1 cr. (DDS 6433) |
| DT 5430 | Oral Anatomy Lecture | 2 cr. (DDS 6431) |
| DT 5431 | Oral Anatomy Lab | 3 cr. (DDS 6432) |

***Term 2: Spring (DH clinics begin)***

| | | |
|---|---|---|
| DH 2212 | Communications for Oral Health Providers | 2 cr. |
| DH 2221W | Periodontology | 3 cr. |
| DH 2222 | The Dental Hygiene Care Process: Clinical Application II | 4 cr. |
| DH 3125 | General and Oral Pathology | 2 cr. |
| DH 3151 | Oral and Maxillofacial Radiology | 2 cr. (DDS 6233) |
| DT 5130 | Preclinical Pediatric Dentistry | 1 cr. (DDS 6131) |
| DT 5432 | Operative I Lecture | 1 cr. (DDS 6434) |
| DT 5433 | Operative I Lab | 1 cr. (DDS 6435) |
| DT 5410 | Biomaterials | 1 cr. (DDS 6411) |

***Term 3: Summer***

| | | |
|---|---|---|
| DH 3121 | Local Anesthesia and Pain Management | 2 cr. |
| DH 3123 | Dental Hygiene Care Process: Clinical Application III | 4 cr. |
| DH 3133 | Pharmacology | 2 cr. |
| DT 5130 | Preclinical Pediatric Dentistry | 1 cr. (DDS 6131) |
| DT 5410 | Biomaterials | 1 cr. (DDS 6411) |
| DT 5471 | Pros. Topics | 2 cr. |
| DT 5434 | Operative II Lecture | 1 cr. (DDS 6436) |
| DT 5435 | Operative II Lab | 1 cr. (DDS 6437) |

### DH4/DT4

***Term 4: Fall***

| | | |
|---|---|---|
| DH 2231 | Cariology and Applied Nutrition in Dental Hygiene Care | 3 cr. |
| DH 3224W | Dental Hygiene Care Process: Clinic Application IV | 6 cr. |
| DH 3234 | Oral and Maxillofacial Radiology: Theory, Principles and Radiographic Analysis | 1 cr. (DDS 6234) |
| DH 3238 | Dental Public Health and Academic Service Learning | 3 cr. |
| DH 3228 | Ethics and Jurisprudence | 1 cr. |
| DT 5140 | Preventive Pediatric Dentistry Clinic | 1 cr. |

Revised 6/29/18

***Term 5: Spring (DT Clinics begin, DH Outreach rotations begin)***

| | | |
|---|---|---|
| DH 4125W | Dental Hygiene Care Process: Clinical Application V | 6 cr. |
| DH 4105 | Dental Professional Development | 1 cr. |
| DH 4136 | Periodontology III | 1 cr. |
| DH 4139 | Dental Public Health and Academic Service Learning II | 2 cr. |
| DH 4135W | Research Methods in Health Sciences | 3 cr. |
| DT 4460 | Essentials of Clinical Care | 3 cr. (DDS 6921) |
| DT 5321 | Treatment Planning for the ADT | 1 cr. (DDS 6314) |

***Term 6: Summer***

| | | |
|---|---|---|
| DH 4226 | DH Process of Care: Case Presentation | 6 cr. |
| DH 4234 | Leadership and Professional Development | 2 cr. |
| DT 4960 | Essentials of Clinical Care | 4 cr. (DDS 6921) |

***DH CDCA Clinical Board Examination in Summer***
***BSDH Awarded***

***Master Program Only - MDT***

***Term 7: Fall (DT Outreach rotations begin)***

| | | |
|---|---|---|
| DT 5162 | Oral and Maxillofacial Surgery | 1 cr (DDS 6152) |
| DT 5460 | Essentials of Clinical Care | 10 cr. (DDS 6921) |
| DT 5360 | Outreach Experiences I | 1 cr. (DDS 6361) |

***DT CDCA Manikin Board Examination in Spring***

***Term 8: Spring***

| | | |
|---|---|---|
| DT 5141 | Clinical Pediatric Dentistry | 2 cr. (DDS 6141) |
| DT 5320 | Comprehensive Care Clinic | 4 cr. (DDS 6313) |
| DT 5361 | Outreach Experiences II | 2 cr. (DDS 6361) |
| DT 5443 | Operative Clinic | 4 cr. (DDS 6441) |
| DT 5000 | Capstone | 1 cr. |

***DT CDCA Clinical Board Examination in Spring***
***MDT Awarded***

**TOTAL CREDITS IN CURRICULUM: BSDH: 74 MDT: 44**

# Midwestern University Curriculum
## College of Dental Medicine-Arizona

### First Year Total: 54.5

**Fall Quarter Total**

| | | |
|---|---|---|
| BASIG 1501 | Basic Science Integrated Sequence I | 4 |
| BASIG 1502 | Basic Science Integrated Sequence II | 4 |
| BASIG 1503 | Basic Science Integrated Sequence III | 4.5 |
| COREG 1560I | Interprofessional Healthcare/One Health | 0.5 |
| DENTG 1510 | Preventive Dental Medicine I | 1 |
| DENTG 1512 | Oral Health Sciences I | 3 |
| DENTG 1512L | Oral Health Sciences I Lab | 2 |
| DENTG 1514 | Healthcare Ethics I | 0.5 |
| DENTG 1515 | Personal Finance | 0.5 |
| Total | | 20 |

**Winter Quarter**

| | | |
|---|---|---|
| BASIG 1504 | Basic Science Integrated Sequence IV | 2.5 |
| BASIG 1505 | Basic Science Integrated Sequence V | 4.5 |
| BASIG 1506 | Basic Science Integrated Sequence VI | 4.5 |
| COREG 1570I | Interprofessional Healthcare/One Health | 0.5 |
| DENTG 1520 | Preventive Dental Medicine II | 1 |
| DENTG 1522 | Oral Health Sciences II | 2.5 |
| DENTG 1522L | Oral Health Sciences II Lab | 2 |
| DENTG 1523 | Healthcare Ethics II | 0.5 |
| Total | | 18 |

**Spring Quarter**

| | | |
|---|---|---|
| BASIG 1507 | Basic Science Integrated Systems VII | 3.5 |
| BASIG 1508 | Basic Science Integrated Systems VIII | 2.5 |
| BASIG 1509 | Basic Science Integrated Systems IX | 4 |
| COREG 1580I | Interprofessional Healthcare/One Health | 0.5 |
| DENTG 1534 | Healthcare Ethics III | 0.5 |
| DENTG 1533 | Oral Health Sciences III | 2.5 |
| DENTG 1533L | Oral Health Sciences III Lab | 2 |
| DENTG 1535 | Introduction to Human Behavior I | 1 |
| Total | | 16.5 |

### Second Year Total: 65.5

**Fall Quarter**

| | | |
|---|---|---|
| PHARG 1601 | General Pharmacology I | 2 |

| | | |
|---|---|---|
| DENTG 1612 | Dental Community Service I | 0.5 |
| DENTG 1614 | Oral Health Sciences IV | 10.5 |
| DENTG 1614L | Oral Health Sciences IV Lab | 7 |
| DENTG 1615 | Dental Ethics and Professionalism I | 0.5 |
| DENTG 1617 | Clinical Case Studies I | 1 |
| Total | | 21.5 |
| | **Winter Quarter** | |
| PHARG 1621 | General Pharmacology II | 3 |
| DENTG 1622 | Dental Ethics and Professionalism II | 0.5 |
| DENTG 1623 | Dental Community Service II | 0.5 |
| DENTG 1625 | Oral Health Sciences V | 10.5 |
| DENTG 1625L | Oral Health Sciences V Lab | 7 |
| DENTG 1627 | Clinical Case Studies II | 1 |
| Total | | 22.5 |
| | **Spring Quarter** | |
| DENTG 1633 | Dental Ethics and Professionalism III | 0.5 |
| DENTG 1634 | Dental Community Service III | 0.5 |
| DENTG 1636 | Oral Health Sciences VI | 9.5 |
| DENTG 1636L | Oral Health Sciences VI Lab | 8 |
| DENTG 1637 | Anesthesia I | 1 |
| DENTG 1638 | Medical Emergencies | 1 |
| DENTG 1639 | Clinical Case Studies III | 1 |
| Total | | 21.5 |

## Third Year Total: 69

| | | |
|---|---|---|
| | **Summer Quarter** | |
| DENTG 1721 | Anesthesia II | 1 |
| DENTG 1724 | Surgical Periodontics General Practice | 1 |
| DENTG 1726 | Special Needs | 0.5 |
| DENTG 1728 | Advanced Imaging | 1 |

| | | |
|---|---|---|
| DENTG 2000 | Introduction to Dental Clinic | 12 |
| DENTG 2010 | Intro Clinical Professionalism | 1.5 |
| DENTG 2020 | Clinical Conference I | 0.5 |
| Total | | 17.5 |
| | **Fall Quarter** | |
| DENTG 1730 | Introduction to Human Behavior II | 1 |
| DENTG 1733 | Clinical Reviews | 2 |
| DENTG 1734 | Dental Ethics Grand Rounds I | 0.5 |
| DENTG 2001 | Patient Care I | 12 |
| DENTG 2011 | Clinical Professionalism I | 1.5 |
| DENTG 2021 | Clinical Conference II | 0.5 |
| Total | | 17.5 |
| | **Winter Quarter** | |
| DENTG 1740 | Implantology | 1 |
| DENTG 1742 | Clinical Pharmacology I | 1 |
| DENTG 1745 | Practice Management I | 0.5 |
| DENTG 1749 | Clinical Topics I | 1 |
| DENTG 2002 | Patient Care II | 12 |
| DENTG 2012 | Clinical Professionalism II | 1.5 |
| Total | | 17 |
| | **Spring Quarter** | |
| DENTG 1750 | Practice Management II | 2 |
| DENTG 1759 | Clinical Topics II | 1 |
| DENTG 2003 | Patient Care III | 12 |
| DENTG 2013 | Clinical Professionalism III | 1.5 |
| DENTG 2022 | Clinical Conference III | 0.5 |
| Total | | 17 |

## Fourth Year Total: 62

| | | |
|---|---|---|
| | **Summer Quarter** | |
| DENTG 1822 | Clinical Grand Rounds | 1 |
| DENTG 1823 | Practice Management III | 1 |
| DENTG 1824 | Clinical Service Learning I | 1 |
| DENTG 2004 | Patient Care IV | 11 |
| DENTG 2014 | Clinical Professionalism IV | 1.5 |
| Total | | 15.5 |
| | **Fall Quarter** | |
| DENTG 1832 | Dental Ethics Grand Rounds II | 0.5 |

| | | |
|---|---|---|
| DENTG 1834 | Clinical Service Learning II | 1 |
| DENTG 1836 | Advanced Topics I | 1 |
| DENTG 1837 | Practice Management Selectives | 0.5 |
| DENTG 1838 | Clinical Pharmacology II | 1 |
| DENTG 2005 | Patient Care V | 11 |
| DENTG 2015 | Clinical Professionalism V | 1.5 |
| DENTG 2023 | Clinical Conference IV | 0.5 |
| Total | | 17 |
| | **Winter Quarter** | |
| DENTG 1842 | Dental Ethics Capstone | 0.5 |
| DENTG 1843 | Clinical Service Learning III | 1 |
| DENTG 1845 | Advanced Topics II | 1 |
| DENTG 1847 | Occlusion Capstone | 1 |
| DENTG 2006 | Patient Care VI | 11 |
| DENTG 2016 | Clinical Professionalism VI | 1.5 |
| Total | | 16 |
| | **Spring Quarter** | |
| DENTG 1852 | Clinical Service Learning IV | 1 |
| DENTG 2007 | Patient Care VII | 11 |
| DENTG 2017 | Clinical Professionalism VII | 1.5 |
| Total | | 13.5 |

UNIVERSITY OF MINNESOTA
**Driven to Discover®**
Crookston Duluth Morris Rochester Twin Cities

# DT Class of 2021 Projected Cost of Attendance*

| | | 2018-2019 (DT3) - Year 1 | 2019-2020 (DT4) - Year 2 | 2020-2021 (MDT) - Year 3 |
|---|---|---|---|---|
| Tuition | **Resident w/ 13 Credits or More** (Terms 1-6 at the Under Grad rate, terms 7-8 at the Grad rate) | $19,587.00 | $19,587.00 | $17,064.00 |
| | **New Non-Resident w/ 13 Credits or More** (Terms 1-6 at the Under Grad rate, terms 7-8 at the Grad rate) | $43,104.00 | $43,104.00 | $26,402.00 |
| Education | **Student Service Fee** | $1,329.00 | $1,329.00 | $1,329.00 |
| | **Collegiate Equipment & Technology Fee** | $621.00 | $621.00 | $621.00 |
| | **Instrument Fee** | $2,239.00 | $2,239.00 | $2,239.00 |
| | **Health Insurance Fee** (If No Insurance Coverage) | $2,844.00 | $2,844.00 | $2,844.00 |
| | **Textbooks/Manuals** (Estimated Costs) | $1,303.00 | $242.00 | $0.00 |
| | **Clinic Attire** (Safety Glasses, Scrubs & Shoes) | $110.00 | | |
| | **Dental Hygiene National Board Exam** | | $635.00 | |
| | **CDCA Dental Hygiene Regional Board Exam** | | $975.00 | |
| | **CDCA Dental Therapy Regional Board Exam** | | | $1,750.00 |
| | **Total: Total Annual Program Cost - Resident** | **$28,033.00** | **$28,472.00** | **$25,847.00** |
| | **Total: Annual Program Cost - Non-Resident** | **$51,550.00** | **$51,989.00** | **$35,185.00** |

* **Projections estimate a 3.5% increase annually. Tuition and fees are subject to change without notice. Living and other incidental expenses not included.** As a public institution, tuition levels are significantly affected by both federal and state funding. The amounts provided are good faith estimates for planning purposes. **The School of Dentistry's academic calendar (summer/fall/spring) varies from the University's financial aid calendar (fall/spring/summer).**

**Health Insurance:** Students are required to purchase health insurance. The cost of health insurance is included in this estimate. Students may submit a Cost of Attendance Appeal to include the cost of health insurance in their financial aid assessment. Students may elect to purchase the University's Student Health Benefit Plan (SHBP) or private insurance. The 2018-2019 rate for SHBP single student coverage is $1116 each for Fall and Spring semesters. The SHBP rate for Summer semester is $612.

**Living Expenses:** For estimates, please go to https://onestop.umn.edu/finances/cost-attendance. You are not required to accept the full amount of the loan offered to you. It is recommended that you borrow only what is needed for your unique situation, in consideration of any other funding sources and variations in individual living expenses. If students accept too much aid, it is possible to return aid by contacting Liz Holm or One Stop.

HIB 1420
#13
1/21/19
page 14

HB1426

Dr. Sarah Mertz

Dentist

January 21st, 2019

Chairman Weisz and members of the House Human Services committee, my name is Dr. Sarah Mertz. I was raised in rural North Dakota on a farm and ranch, am a first-generation college student, was the first in my family to obtain a Doctorate degree and I am a 2013 graduate of the University of Colorado School of Dental Medicine. During my time in Colorado, I had various experiences in public health clinics which ultimately led me to employment upon graduation at Bridging the Dental Gap, a nonprofit clinic here in Bismarck, where I have been practicing dentistry full time for over 5½ years. I have received funds from the ND loan repayment program and am proof that programs such as this attract competent and well-trained professionals to serve our underserved populations. I am proud of the work I am doing for underserved populations in this great state of North Dakota.

I am here today for the safety of my patients to testify in opposition to HB 1426. I believe that patients in public health, nonprofit and IHS clinic are some of the most at risk and vulnerable patients with complex and extensive dental disease as well as complex medical issues and need a highly trained and skilled dental provider.

I am here because introducing a new level of provider that can perform irreversible and invasive procedures on my patients would be compromising the standard and quality of care. My patients deserve to see a dentist and have the same level of care as anyone else, regardless of socioeconomic status. Introducing an undertrained provider will not solve issues with our underserved populations and frankly I am afraid of the damage it could cause for the patients I

see every day. If people were just teeth it would be seemingly easy to treat teeth. My patients are not just a set of teeth, they are people; people with complex medical issues, mental health issues, anxiety, behavioral issues and, many times, undiagnosed and untreated conditions.

I obtained 8 years of extensive education to become a dentist, four of those years focusing on medical and dental issues. I find it alarming that we could potentially be comfortable with someone practicing very similar procedures as a dentist with only 3 years of total education, two of which are dental hygiene education. Surely, their educational curriculum is not the same as a dentist, but they are allowed to perform many of the same duties, including surgery, with much less understanding and knowledge. This worries me for the standard of care that many of the patients I serve will be subject to and that they won't even know that they aren't seeing a highly trained and skilled professional, something that almost all of my patients deserve and need.

Many of my patients are seeing me more than they see their primary care physician and many times I am counseling and referring based on medical history review, blood pressure screening, reported symptoms, etc. because I have the education and understanding to recognize other health issues besides their dental disease. A dental therapist does not have enough education to be able to do this vital part of patient care because their educational background simply does not provide them the tools.

I have been to the University of Minnesota's lecture on Dental Therapy. I went with an open mind as I wanted to learn what they had to present and explain the model. I was the only North Dakota dentist in the room. They painted a picture of the dental therapist solving so many issues that we face in dentistry; access to care by placing them in rural areas, being able to treat patients from the emergency room, treating many low income children, counseling patients and providing preventative care. I found contradictions in many of these proposals which are

particularly key in this year's HB 1426. As written, therapists will be in public health, nonprofit and IHS clinics. Many of these clinics are in major cities across North Dakota so we aren't providing geographic access to the rural patients. The therapist cannot take care of a swollen patient or toothache from the ER; they cannot start a root canal nor can they remove an adult tooth that is not class 3 mobility or greater. They are allowed to treat low income children, including difficult procedures such as a pulpotomy. Often when children have extensive dental issues, they need a pediatric dentist who has obtained 10 years of education. The dental therapist does not have the educational background to educate patients like a dentist can and the preventative care they can provide is already something provided by my dental hygienist.

I recently was speaking with one of my patients about the proposed dental therapist model. She happens to have a complex dental case, medical issues, and North Dakota Medicaid for her dental coverage. She would fall into the category of patients that would most likely encounter a dental therapist as a provider. She was shocked and did not want this type of provider for her care. Simply, she stated "I need a dentist and I don't want someone with minimal training working on me." She went on to comment that something similar happened when the 2-year RN was introduced; quality of care and competency of provider decreased. Do we want this for our patients? Do we want this for dentistry?

I see many other solutions to the problems we face with our underserved population. Using existing workforce and expanding their knowledge through expanded function dental assistants, educating the public by deployment of community dental health coordinators to provide community-centered, culturally appropriate dental health education, and aiding in navigation to connect patients with dental care, are just a few ways to increase dental visits of underserved populations. Public awareness about the available resources such as the nonprofit clinic here in town is vital as I often hear of people saying they have never heard of the Bridging the Dental

Gap. Continuing the North Dakota loan repayment program is critical and perhaps even a few modifications to that program could make it even more attractive to dentists.

In summary, I am concerned about what introducing a dental therapist with minimal training will do to the quality of care that underserved populations would receive. Other solutions exist to use our existing skilled workforce to reach our target populations and to educate them on the importance of a dental home and preventive dental care. I often ask this question when practicing dentistry; would I want this for my mother or grandmother? With that, do we want this for our underserved population? Is inadequate care better? I encourage you to vote NO on HB 1426 for my patients who deserve highly trained and skilled dental professionals for their oral health.

HB1426
#14
1/21/19
Pages

The following is a list of dentists affiliated with Bridging the Dental Gap who are in support of Dr. Sarah Mertz's testimony being presented in opposition of HB 1426.

Dr. Alexa Carlson, Dentist in Bismarck, ND

Dr. Bethany Schuetzle, Dentist in Bismarck, ND

Dr. Heidi Nichols-Johnson, Dentist in Bismarck, ND

Dr. Christy Peterson, Dentist in Bismarck, ND

Dr. Leslie Hollevoet, Dentist in Bismarck, ND

Dr. Breanna Schuster, Dentist in Bismarck, ND

Dr. William Quinn, Dentist in Bismarck, ND

Dr. Murray Greer, Dentist in Minot, ND

Dr. Elizabeth Greer, Retired Dentist, Minot, ND

Dr. Steve Deisz, Dentist in Bismarck, ND

Dr. Brent Holman, Retired Pediatric Dentist, Fargo, ND

Greetings,
I am Dr. Bradley King, founder of Prairie Rose Dentists in Bismarck. We are the largest dental practice in the state. For 37 years I have treated Medicaid patients. All of the 14 doctors in my practice treat Medicaid patients, including our 2 pediatric dentists. For 37 years I have supported the states Medicaid program and I know the business of dentistry. I hope that that gives me a little more credibility than ONE, out of state, liberal, political entity seeking to sway your votes.

Can I ask who actually wrote this bill? Whose ideas were used?

This is a very poorly written bill. I have with me the Minnesota statues concerning Dental therapy. The bill you have before is much, much more liberal than the Minnesota statutes.

Though the other side says that this bill will only allow organizations such as Bridging the Dental Gap to hire Dental therapists doing a limited number of procedures, the truth is that the way it is written any dentist could hire Dental therapists and place them in any office and have them treat patients doing any procedure a dentist can do, while he sits beside his swimming pool in Arizona and he will never see any of the patients.
If you will indulge me I will go through the bill and show you how this is possible.

First there is nothing in this bill that requires Dental therapists to treat Medicaid patients. Why would they, You lose money on every Medicaid patient you see. Even Minnesota statues require that half of a therapists patients be Medicaid but under this bill they can just see full fee patients. Please look at the Star Tribune article I gave to you. If this is the solution for getting Medicaid patients seen, why is Minnesota is under threat of losing Medicaid funding as their Medicaid children are not being seen. North Dakota, without Therapists, working with the North Dakota Dental Association does a much better job of taking care of Medicaid patients.

Please look at Section 3 1 d. It addresses the amount of clinical training a Dental therapist must have to treat patients. It says they need 500 hours. 500 hours is just 3 months of hands on training 3 MONTHS and that under INDIRECT supervision. Indirect supervision means that no one checks the treatment during or after it is done. A dental assistant is required to have 650 clinical hours before they are allowed to take an x ray much less treat a

patient. The writers of this bill assume that dentistry is easy to learn. It is not. It is hard, precise and difficult. There is a reason so many dentists burn out and commit suicide each year.

Section 4 1 b..... says that a not for profit organization may hire therapists and section 4 2 says that they can contract them out to a dental clinic. Under this law any dentist could form their own not for profit, decide the definition of what they consider being low income and underserved is, and contract them back to their own dental clinic.

4 c..... addresses the Indian health service. It is my understanding that the State of North Dakota has no licensure authority over the tribes. They could have hired therapists long ago, they just would not be reimbursed for seeing Medicaid patients. Therapists could see non Medicaid patients freeing up the dentists to see the Medicaid patients. They may not even need this bill, they may just have to be smart on how they do this.

Please go to Section 5 1 k..... It is wide open to interpretation. It indicates that anything the supervising dentist feels the therapist has been trained in he can let the therapist do. Dental personnel receive a lot of their training after dental school. Send the therapist to an orthodontic course and he can do braces. Have the dentist train him to do root canals and he can.

Lastly lets read section 6 part 2... please take a minute to read it. This is the most dangerous part. Even Minnesota does not allow this. The supervising dentist would never need to see the patients, review the medical history, make a diagnosis, or even be on site. He could be a thousand miles away in Arizona sitting by his pool and as long as someone can reach him by phone, text, or email. He is not available if there is an emergency.

Is this what you believe is best for the most venerable. Should someone with 3 months of clinical training be treating fragile seniors in nursing homes with multiple medical problems with really no supervision? Very few of Medicaid patients are just poor. They are disabled, they are fragile diabetics, they are at risk of uncontrolled bleeding emergencies, they are your parents and someday you. I should know who they are, because I treat them

I really do not think whoever wrote this bill understands dentistry and the issues involved. I respectfully ask you to vote no on this bill.

HB1426
#15
1/21/19
Page 3

# Feds warn Minnesota: Improve kids' dental care in Medicaid

By Glenn Howatt Star Tribune

Minnesota has been warned that its main government health insurance program risks losing federal funding if it doesn't provide more preventive dental care to children.

The problem is familiar to many families on Medical Assistance: Many dentists don't accept new patients covered by the program because Minnesota pays some of the lowest dental reimbursement rates in the country.

Just 37 percent of children on Medical Assistance in MInnesota got preventive dental care in 2015, and 62 percent of the participants reported having been told that a dentist was not taking new patients covered by the program. Nationally, 46 percent of children on Medicaid got preventative dental care, according to the Centers for Medicare and Medicaid (CMS).

Noting that such figures could place Minnesota out of compliance with federal rules, CMS regulators informed Minnesota officials that they must devise an improvement plan within 90 days.

"CMS has us on notice saying we have to take some kind of action," said Nathan Moracco, assistant commissioner for health at the Minnesota Department of Human Services, which runs Medical Assistance, Minnesota's version of Medicaid.

Gov. Mark Dayton's budget submission for the coming biennium proposed a 54 percent increase in dental reimbursement rates, but the nature of any solution hinges on what happens at the Legislature, where a conference committee is working on a compromise between health and human services funding bills from both chambers.

The Senate bill contains a 25 percent rate increase, while the House has no new money for dental reimbursement.

"It doesn't look too good," said Carmelo Cinqueonce, executive director of the Minnesota Dental Association, which supports Dayton's plan.

"At the bottom of this issue is ultimately appropriate funding for a program that has been woefully underfunded for far too long." Under current state payment rates, dentists get about 25 percent of their typical fees.

At Northern Dental Access Center in Bemidji, a nonprofit provider that serves 20 counties in northwestern Minnesota, about 62 percent of the 5,000 children they see annually have tooth decay.

"Access is a big problem in Minnesota and especially up here," said Executive Director Jeanne Edevold Larson. With 200 new patients each month, the clinic has to triage appointments to take care of those with the greatest need.

Access is not the only problem, Larson said. Many of the center's patients have complex needs, such as transportation problems and chronic medical conditions.

Federal officials have raised concerns about the issue before, but this is the first time they have warned that Minnesota could be out of compliance with federal regulations.

"The federal government is sending a clear message that they want to see dollars directed to providers," said Moracco.

It's not clear what CMS will do if Minnesota does not deliver on a plan, but the federal government has leverage because it provides a large share of funding for Medical Assistance.

"Certainly it can be up to and including the withdrawal of federal funds," Moracco said.

**Glenn Howatt** has been with the Star Tribune since 1990. In addition to covering health care, he served as the newspaper's data editor for several years

House Human Services Committee
Honorable Representative Robin Weisz, Chairman

January 21, 2019

HB 1426 Testimony by Senator Brad Bekkedahl

Chairman Weisz and Committee,

For the record, I am Brad Bekkedahl, Senator from District 1, city of Williston. I stand before you today to present testimony in opposition to House Bill 1426. To give some background, I have been a licensed Dentist in North Dakota and Minnesota for 35 years. In June of 2015, I sold my practice to a ND native that had been practicing in a clinic in Minnesota. With this sale, I retired from full time patient care, and assist the office part time as requested. I primarily treat Medicaid patients, as I have throughout my career.

Today you have heard testimony about successful North Dakota solutions to our dental health delivery system. Testimony you have been given shows we have responded to partner with the State and others to make improvements to access and treatment issues. We have witnessed a Great Migration of dental practitioners into our State. The statistics of the increase in dentists and the young age of this immigrating workforce show market conditions helping solve issues of access to care statewide. The dental loan repayment program has incentivized new dentists to locate in our smaller rural communities, work in community clinic settings, and treat more Medicaid patients. As a profession, we are engaged. This message of how North Dakota citizen Dentists have cooperated to bring locally generated solutions to the access to care issue stands in stark contrast to the out of state interests you have seen today and their attempts to force a delivery model upon our citizens as "what's best for you" to promote their own national agenda. I have two questions to ponder on this issue. As Legislators, why do we even consider accepting this recommendation from those outside our state when our practicing Dentists ask us not to? Why is the voice of those that don't even live here better received than those that invest their lives and profession with us as neighbors and constituents?

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

I hope the testimonies presented today about local North Dakota solutions lead you to oppose House Bill 1426. I hope you support the recommendation to focus on quality of patient care, and not the promotion of out of state agendas for a national campaign. I hope you want the best level of care for all our residents and do not support creating differences in treatment for some citizens. I ask you also to support the 97% of practicing Dentists in our North Dakota communities that oppose this bill today. We can be deliberative and diligent, as we usually are in North Dakota, and implement the right changes when it is best for our citizens and patients, such as when we are all on the same page, and not when out of state interests tell us to do something.

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

# Questioning Dental Therapy in Minnesota

My name is Dr. Anthony Hilleren. I have practiced dentistry in West Central Minnesota in Benson, MN since 1999. I tried the dental therapist experiment for several years in my rural Minnesota dental practice. I was looking for a way to care for the underserved in my region. I was presented with much of the information that you as legislators are being presented. After an earnest effort, I had many more questions about this model of care.

1. **Is it possible the public is being misled when dental therapists are described as the equivalent of a medical mid-level practitioner?** Usually a medical mid-level has enjoyed the benefit of significantly more years of training in an accredited program. Usually a medical mid-level does not do irreversible surgical procedures.

2. **Are dental therapists really receiving the same amount of training to do the same procedures as their dental student counterparts?** The 3-year dual degree dental hygiene/dental therapist program at the University of Minnesota only has about 1 year of the curriculum dedicated to dental therapy training. We don't feel this is enough. As a practicing dentist, I do not feel the clinical repetitions are enough in this curriculum to attain minimal clinical skills for doing fillings, extractions, stainless steel crowns, and pulpotomies. The employment in my office of a dental therapist was a stark revelation of this opinion for me.

3. **How extensive is the oral surgery training for dental therapists?** Usually a dentist receives training during rotations in an Oral Maxillofacial training center under the supervision of many oral surgeons. There is no such thing as a typical simple tooth extraction. What will happen if there is a complication and no dentist present onsite? A dental therapist's allowed duties typically restrict extractions that dental therapists can do to "loose" teeth. Who defines "loose" and how does this provide access for a patient in a rural area if the dental therapist can only remove "loose" teeth? This model does not make sense to most dentists.

4 **Are all treatment options going to be offered by a dental therapist?** Will an extraction become the standard of care for patients treated by a dental therapist? Will other possible treatment options be offered, if not directly supervised by a dentist? What would happen if the patient had oral pathology and was never examined by a dentist qualified to recognize early malignancies?

5. **Will we ever see surveys that include all dentists who have employed dental therapists regarding their skill level?** As an employer of a dental therapist, I never was surveyed about my assessment of the level of clinical skill and training of the dental therapist that I employed. Attached is the survey sent to me by the MN Department of Health and nowhere are there questions about assessments of skill and training. Would the assessment of this clinical training and skill differ between private practice dentists and community health centers/corporate practices?

6. **Does the 'encounter fee per patient" form of Medicaid reimbursement for community health centers impact the efficiency and cost impact of dental therapists?** Is money truly saved for public programs or translates into lower costs to patients? There is no evidence of that in Minnesota.

7. **Why is the therapist model always presented as the answer for the underserved?** Usually the underserved have much more complex needs medically, dentally, and behaviorally. If we do not allow them as much access to a dentist would we be actually allowing two levels of care? Would the underserved be more likely to end up with an extraction? Do we really know the answer to these questions?

8. **Is there the potential for abuse of the Collaborative Management Agreement between the dentist and dental therapist?** Given the types of services that dental therapists are doing in MN, are there instances currently of procedures being done in remote settings that are either not allowed by rule or for which the dental therapist has not had adequate training? Has this really been adequately studied?

In summary, please consider a measured, evidenced-based approach before approving any rules that allow dental therapists in North Dakota. As a previous employer of a dental therapist, I urge you to allow Minnesota's experiment to produce more answers to the above questions before moving forward with this relatively untested model.

Thank you very much.

Dr Anthony Hilleren
210 13th St S, Benson, MN 56215
320-842-4191

Hello,

MS Strategies is working with the Minnesota Department of Health, Minnesota's dental therapy educational programs, and Pew Charitable Trusts to put together a more comprehensive impact statement and a financial analysis of dental therapists in Minnesota. As Minnesota was the first state to pass this legislation, there is interest in learning about the Minnesota experience both in Minnesota and at the national level.

As an employer of dental therapists, your help is vital to this analysis and we ask for your assistance in gathering data that will inform this analysis. We hope you are able to help in this project. We are asking that your clinic: 1. Complete the questionnaire below and 2. Be available for a follow-up phone call if needed. We are asking for a quick turn-around for this analysis to be completed as soon as possible.

All information you provide will be kept confidential. Information you provide will be used to develop aggregated statewide information that will not tie any data provided to your practice or any other individual practice.

The focus of our analysis is on the impact of your clinic's hiring of an DT or ADT on:

1. Your practices overall financial position
2. Productivity of your dental team
3. Number of patients you are able to serve
4. Your ability to provides services to MA, Minnesota Care and uninsured patients
5. Appointment wait times
6. Type of services provided by your dental therapist(s)

<u>Questions:</u>

1. How many dental therapists are employed at your clinic?

2. How many of your dental therapists have advanced practice certification?

3. When was each dental therapist hired?

4. What average hourly wage do you pay your:

a. Dental Therapist
b. Dental Therapist with Advance Practice Certification
c. Dentist
d. Dental Hygienist

We know that the impact of hiring a dental therapist on a dental practice can be affected by other factors such as other staffing changes, equipment or chair capacity changes, changes that affect patient demand, but we ask that you answer the following questions after adjusting for other factors and after excluding the initial ramp up time/cost after you first hired a dental therapist.

5. Factoring out other changes, has employing a dental therapist changed your organization's overall productivity and ability to generate patient revenue?
a. In what way (for example: overall productivity has increased or decreased, revenues have increased because the dentist is doing more complex procedures that pay higher rates, or other)? Please explain.
b. If you are able, provide quantitative data that supports your dental practice's overall productivity or revenue changes?

6. Factoring out other changes, has employing a dental therapist had an impact on your clinic's financial strength and if so in what way (for example: better off than before, no change in financial strength, worse off, etc.)?
a. If the dental therapist has had an impact on your organization's financial strength, please estimate the dollar impact and percentage impact on your bottom line profit (loss)?
b. If you are able, please provide specific data or numerical estimates quantifying the impact on your bottom line profit and clinic's financial strength.

7. After adjusting for any other changes in your practice that were unrelated to hiring a dental therapist,
a. How many *more* patients have you been able to serve because of hiring a dental therapist?
b. If you are able, provide specific data or numerical estimates quantifying the impact

8. Factoring out other changes, has employing a dental therapist by your clinic allowed your clinic to see more MA, Minnesota Care or uninsured patients?
a. Are you able to quantify the increased (decreased) number of underserved patients your clinic has seen because of hiring a dental therapist? Provide specific data or numerical estimates quantifying the impact.
b. Number of MA, MNCare or uninsured patients in the year before hiring a dental therapist?
c. Number of MA or MNCare or uninsured patients in each subsequent year?
d. Percentage of total patients who are MA, MNCare or uninsured in the year before hiring a dental therapist?
e. Percentage of total patients who are MA, MNCare or uninsured in each subsequent year?

f. What role has the hiring of a dental therapist had in this change?

9. Factoring out other changes, has employing a dental therapist had an impact on patient wait times for appointments? Please explain.
a. Are you able to quantify the impact of your dental therapist on patient wait times? Please provide specific data or numerical estimates quantifying the impact.

10. Using broad categories, what services are being provided by your clinic's dental therapist?
a. Please provide specific data quantifying the impact.

11. Who is the best person to contact for a follow-up phone call? What is their contact information?

If you have questions, please contact me directly.

Thank you,

Pat White
MS Strategies
612-790-0442
pwhite@msstrat.com

HB1426
#17
1/21/19
Page 6

Red River Valley Dental Access Project
715 N 11th St #26
Moorhead, MN 56560

January 15, 2019

Re: HB 1426

A Bill for an Act to create and enact four new sections to chapter 43-20 of the North Dakota Century Code, relating to regulation of dental therapists; and to amend and reenact sections 43-20-01.1 and 43-20-08 of the North Dakota Century Code, relating to dental therapist definition and unlawful practice of dental hygiene, dental therapy, and dentistry.

North Dakota House Human Services Committee
North Dakota Legislative Branch

Dear Member(s) of the North Dakota Health Services Committee:

The Red River Valley Dental Access Project (RRVDAP) is a dental non-profit that works to provide immediate relief of pain for low-income dental patients. While most of our patients come from the Red River Valley, we serve patients over a broad area. Approximately 80% of our patients have impacted, fractured, or otherwise complicated presentations that require surgical extraction or referral to a specialist for treatment.

RRVDAP opposes HB 1426. HB 1426 does not propose a solution to barriers to care. North Dakota's rural character creates several unique challenges to accessing dental care including geographic isolation, a lack of adequate transportation, higher poverty rates in non-urban areas, a higher percentage of the rural population is elderly, rural provider shortages, and concerns related to Medicaid reimbursement rates for dental procedures.

HB 1426 and the proposed introduction of dental therapists does nothing to address socioeconomic and structural barriers to care. Rather, it creates another barrier to care by increasing the complexity of the dental care system. Further, HB 1426 continues the progression towards a bifurcated oral health system in which some people, by virtue of their socioeconomic status, receive care from a lesser-qualified provider. Quite frankly, different standards of care based on one's socioeconomic status will not meet the needs of our patients who desperately need access to primary oral healthcare by fully qualified dentists who can deliver comprehensive care and case management.

The proposed legislation presupposes that those who are socioeconomically disadvantaged do not merit care from the most qualified member of the dental care team: the fully educated, trained, and licensed dentist. Rather than improving market conditions to incentivize the acceptance of Medicaid or similar programs, the proposed legislation adds another layer between the patient and the dentist. Rather than reducing the complexity of the healthcare system, it exacerbates it. For our patients with complex oral health needs, the legislation does not solve the problem with access to care. A legislative fix that would address the causes of barriers to care should include improving market conditions through improvements to Medicaid

coverage and reimbursement, leveraging existing allied dental professionals, and facilitating comprehensive oral healthcare and case management. A real-world solution is based on education, prevention, collaboration, and outreach to vulnerable populations. The addition of an unnecessary middleman to the dental office does none of those things.

In sum, the RRVDAP and our patients in pain that have extensive needs would not benefit from dental therapists. Additionally, we feel low-income patients with barriers to care deserve the same access to high-quality care by dentists that all citizens do. We urge the rejection of HB 1426.

Respectfully,

Marsha Krumm, CDA, RDA, LDA, CDHC
Co-Executive Director
Red River Valley Dental Access Project

Jennifer Ruud, LDA
Co-Executive Director
Red River Valley Dental Access Project

Matthew Alm, DDS
President
Red River Valley Dental Access Project

HB1426
#18
1/21/19
page 1

**House Human Services Committee**
**Monday, January 21, 2019, 2:15 PM**
**Fort Union Room, State Capitol**

Testimony presented by Rita Sommers, Executive Director
North Dakota Board of Dental Examiners
**HB 1426 - Opposition**
Relating to regulation of dental therapists

Good morning Chairman Weisz and members of the Committee. I am Rita Sommers, Executive Director of the North Dakota Board of Dental Examiners and I am here to speak in opposition and offer a friendly amendment to HB 1426 as follows:

**SECTION 1. AMENDMENT.** Section 43-20-01.1 of the North Dakota Century Code is amended and reenacted as follows:

**43-20-01.1. Definitions. (NDBDE Amendments italicized)**

As used in this chapter and chapter 43-28, unless the context otherwise requires:

*1. "Assessment" means collecting information about a patient's oral health status to identify specific needs and any risks to oral health for the interpretation by a dentist. An assessment may be provided by a dental hygienist under the general supervision of a dentist. An assessment of clinical findings is not a diagnosis but may result in a referral to a dental provider.*

~~1~~2. "Dental assistant" means an individual who provides dental assistance under the supervision of a dentist and within the scope of practice established by rule and section 43-20-13.

~~2~~3. "Dental hygienist" means an individual licensed to practice dental hygiene.

~~3~~4. "Dental therapist" means an individual licensed to practice dental therapy.

45. "Federally qualified health center look-alike" means a community-based health care provider that meets the requirements of the federal health resources and services administration health

center program but does not receive health center program funding.

~~5~~6. "Qualified dental assistant" means an individual registered as a qualified dental assistant to provide dental assistance as established by rule.

~~4.~~7. "Registered dental assistant" means an individual registered as a registered dental assistant to provide dental assistance as established by rule.

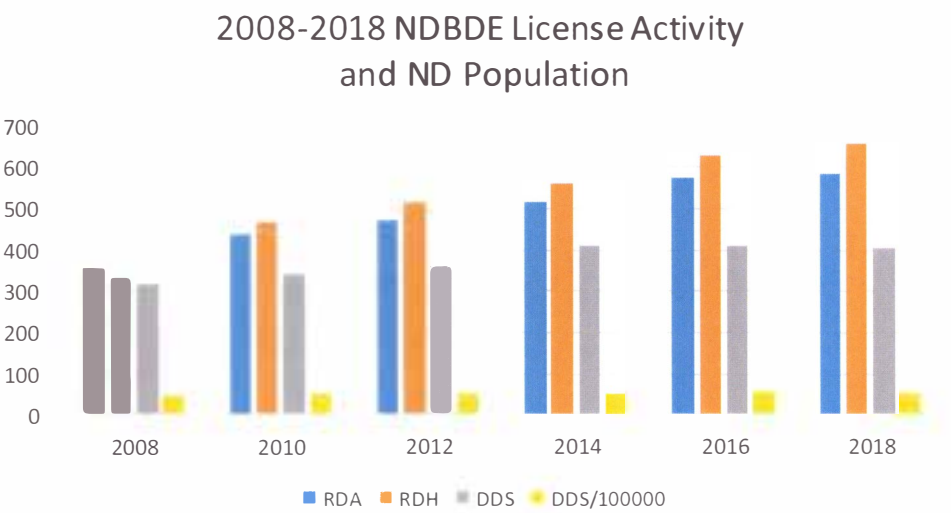
*8. "Screening" is a means to identify oral health history, risks and behaviors, to detect treatable problems early in order to avoid further serious health conditions and may be provided by a dental hygienist. A screening may result in a referral to a dental provider.*

When your doctor submits her bill to insurance for reimbursement, each service described by a Current Procedural Terminology (CPT) code must be matched to an International Classification of Disease (ICD) code. If these two codes don't align correctly with each other, payment may be rejected.[1] The United States has used the new ICD-10 codes since October 1, 2015, the classifications of which are provided by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS).

Another way payment is rejected is when a member of the dental team is not authorized by statutes to provide services billed to Medicaid. Providing definitions for both assessment and screening is only the first step in activating Medicaid assessment/screening codes. These codes (DO190 & DO191)[1] for screening or assessment are activated and utilized in thirteen other states. Centers for Medicare in their Resident Assessment Instrument require an initial, quarterly and annual oral health assessment for residents in long term care facilities. The long term care nursing staff and dental providers would feel most confident if a member of a dental

team performed the initial dental assessment. This initial dental assessment is the groundwork of the daily oral healthcare plan which the long term care nursing and nurse aid staff follow for each resident. Defining both "assessment" and "screening" terms will assist ongoing work with Medicaid for activation of codes DO190 &DO191 in North Dakota. The ability to utilize these codes will benefit long term care facilities as well as school, community, and public health settings where hygienists assess, provide teeth cleaning procedures and apply sealants and fluoride treatments.

A win-win for both dentistry and North Dakotans took place with recent modifications in the dental practice act that expanded allowable dental hygiene procedures within relaxed supervision requirements. At the same time, numbers of licensed dental hygienists in the state have increased each year during the previous ten years, proportionately keeping pace with the increases in the ND population. [2] Utilizing the assessment codes would provide another service by dental hygienists to further improve access care.



At its January 16, 2019 meeting, the ND Board of Dental Examiners moved to oppose the addition of the dental therapist as recognized and licensed dental providers in our state. The NDBDE's primary responsibility is to protect the public in various ways, including through the licensure process. The Board does not believe that the dental therapist has adequate training and education required for all duties proposed they would perform. In the opinion of the Board, dental therapists performing surgical procedures remains a significant public safety issue. The Board discussed and recognizes the potential for dental therapists to be utilized within tribal community considering their sovereignty as well as within the military settings[3] in the state and believes that both continue to be entitled to provide dental services (including those of a dental therapist) that are not under the jurisdiction of the Board.

Thank you for your time today. I would be happy to answer any questions.

[1] How to Look Up and ICD Code for Your Diagnosis
https://www.verywellhealth.com/finding-icd-codes-2615311

[2] http://worldpopulationreview.com/states/north-dakota-population/ and
https://www.google.com/search?q=population+ND+2016&oq=population+ND+2016&aqs=chrome..69i57j0l5.8687j1j7&sourceid=chrome&ie=UTF-8

[3] 43-28-02. Exceptions. The provisions of this chapter do not apply:
5. To the practice of dentistry in the discharge of their official duties by graduate dentists or dental surgeons in the United States army, navy, air force, public health service, coast guard, veterans' bureau, or director of the dental division of the state department of health.

Page 3 Chart based on the NDBDE License & ND population statistics

| Licensee | 2008 | 2010 | 2012 | 2014 | 2016 | 2018 |
|---|---|---|---|---|---|---|
| RDA | 358 | 442 | 473 | 519 | 573 | 584 |
| RDH | 332 | 471 | 518 | 562 | 627 | 658 |
| DDS | 320 | 344 | 360 | 410 | 411 | 407 |

| | | | | | | |
|---|---|---|---|---|---|---|
| DDS/100,000 | 48.66 | 52.78 | 53.89 | 54.02 | 56.52 | 53.89 |
| ND population | 657569 | 674499 | 711380 | 738658 | 755548 | 755083 |

#1 HB1426
2/5/19
p1.

PROPOSED AMENDMENT TO HOUSE BILL NO. 1426

Page 5, line 5 replace "general" with "indirect supervision, or under general supervision if authorized by rules adopted by the board,"

Page 5, remove lines 19-24

Renumber Accordingly