Testimony to the Health Services Committee

July 27, 2016

Frank Catalanotto, D.M.D.

University of Florida

Professor, Department of Community Dentistry and Behavioral Science

My name is Frank Catalanotto, I am the former dean of the University of Florida College of Dentistry, a past president of the American Dental Education Association, representing all of dental education in the US and Canada, and currently professor of Community Dentistry at the University of Florida College of Dentistry. I am also a pediatric dentist. My research and advocacy work since 2002 has focused on access to oral health care.

I commend North Dakota's leadership for studying access to dental care and attempting to pass legislation that would allow dentists to hire advance practice dental hygienists. Similar providers are making a real difference in Minnesota and Alaska and I know it will do the same here in North Dakota.

There are two aspects of my background that are directly relevant to my discussion of the legislation you are considering. First, I have been actively involved in dental therapist issues for over a decade. I have been to Alaska and Minnesota several times to see dental therapists working to improve the oral health of underserved patients. I have also reviewed much of the published literature about safety, quality and effectiveness of dental therapists. I have seen dental therapists at work and I have been impressed!

In addition, I have served on Commission on Dental Accreditation (or CODA) subcommittees, participated in accreditation site visits and have been a consultant to CODA. CODA, you recall, is the body that accredits dental educational programs. In other words, I have worked closely with CODA on developing and implementing standards for dental education, and hope to help walk you through the recently adopted national standards for dental therapy as they apply to the legislation that was considered last session.

WHY ARE WE RECOMMENDING DENTAL THERAPY AS AN ADDITION TO THE ORAL HEALTH WORKFORCE?

The plain and simple answer is access. For a variety of reasons – financial being a key issue – there are many people in this country who cannot access routine dental care in dentists' offices the way many of us can. We either have the financial resources to pay for dental care, or we have dental insurance. We also have a certain amount of oral health literacy – we know routine dental care is important. We know that oral health is linked to overall health. We have a car or can pay for transportation to a dental

office; many truly underserved patients have transportation problems, especially in rural areas of the state. This can be especially true for seniors or the disabled.

The data I have seen about your state is frankly chilling to me. About 70% of kids on Medicaid didn't see a dentist last year, one-third of seniors report dental problems, and rural children have worse oral health than urban ones. Native American children also have worse oral health than non-Natives. Only about half of dentists accept any Medicaid patients, and according to new statistics from the UND Center for Rural Health, nearly half of North Dakota counties have only one dentist or none at all. Another important factor to consider is hospital Emergency Department visits for preventable dental conditions. In 2011, dental complaints were the third most common of all complaints reported by ER patients in a survey of a large ND hospital. (Center for Health Workforce Studies, School of Public Health, University at Albany, Oral Health in North Dakota: A Background Report, 2012, p. 46.). An important factor to consider here is that many of those patients are self-insured which means that the hospital has to absorb the costs and this is not reflected in tracking Medicaid or other insurance outlays.

One other factor is that there is a maldistribution of dentists and many would argue a shortage of dentists in some areas of the country. This may be particularly true in your state with about 35% of those practicing intending to retire within 15 years (by 2028).Where are your new dentists going to come from?

So, how can dental therapists help?

-First of all, they are less expensive to educate than dentists- 2-3 years versus a minimum of 8 years for dentistry. This is because they focus on a much more limited set of routine dental procedures.

-Second, they are less expensive to employ. And I will say more about employment in a few minutes.

-Third, they frequently come from the underserved communities they eventually serve – such as rural areas – and they are very employable and willing to work in what I call access settings such as Federally Qualified Health Centers and County Health Departments and rural, underserved areas.

-Fourth, no matter what the opponents of dental therapy say, the quality and effectiveness of their dental health services is first rate. That is a plain, data-driven and factual conclusion. In an evaluation of the world literature where dental therapy has been used in over 50 countries, many of which are modern and industrialized, for about 100 years, there is no evidence of poor quality, in fact, just the opposite. A 2013 paper in the Journal of the American Dental Association reported good quality of care. To emphasize, this was in the ADA's journal. And all other reports say the same thing. There is absolutely no issue about quality of care. My favorite question to ask an opponent of DT who raises quality concerns is, "I appreciate your personal opinion about safety and quality but can you point out just one study which has demonstrated your concerns." The response is usually silence. There is no literature that can demonstrate problems with dental therapists' care of patients.

-Finally, In MN and Alaska, therapists have been shown to be very effective in reducing wait times at safety net clinics, work well in collaboration with their supervising dentists, decreased use of hospital emergency departments, and other good indicators of improved access. <u>All the published studies say this and there are NO published studies showing any contrary evidence.</u>

WHAT STATE INFRAFSTRUCTURE IS NEEDED TO IMPLEMENT THIS LEGISLATION?

All North Dakota needs to do at this point is to pass the legislation to allow licensure for advance practice dental hygienists. Your state does not need not set up any educational curriculum as local residents can become educated in one of the two programs in Minnesota, which is the state where many North Dakota dentists are already educated. In addition, Minnesota has also already established the necessary regulations through its dental board to license dental therapists and its Medicaid agency is able to reimburse dentists for services provided by the Dental Therapists they employ. With these templates in place, it should not take much to implement the same in North Dakota."

WHAT IS THE COMMISSION ON DENTAL ACCREDITATION OR CODA?

All dental educational programs are accredited by CODA which is made up of representatives of organized dentistry, educational programs, licensure groups, specialty organizations and the public. CODA is authorized by the US Department of Education.

The fact that CODA has now recognized dental therapy as a legitimate dental educational program by developing and implementing accreditation standards gives legitimacy to dental therapy. Just as CODA accreditation ensures that dentists graduate at the highest standards possible, CODA accreditation assures that dental therapists will also graduate with the highest standards of quality. It is essentially the Good Housekeeping seal of approval. In addition to over 1,100 studies showing that dental therapists provide care safely and effectively and a 2013 paper in the Journal of the ADA that reported excellent quality of care, CODA's approval of standards are a recognition of the safety and efficacy of dental therapists in taking care of patients.

CODA ON EDUCATION OF DENTAL THERAPISTS

CODA's accreditation standards stipulate three academic years of education but do NOT require a specific degree. This is to give individual states and their local educational institutions flexibility in developing programs, which are encouraged by CODA, to provide for educational mobility and career laddering (for instance, for dental hygienists or assistants to pursue dental therapy education).

One of the important questions we are frequently asked about dental therapists is how they can be educated in this shorter timeframe that the 8 years for dental education- four years of college and four years of dental school. The answer is very straightforward. As a dentist, I learn about 500 or so skills or what we call competencies. But a Dental Therapist only learns about 50-60 depending on the nature of the program. In other words, Dental Therapists only perform a small fraction of the procedures that a dentist performs. For example, dentists learn how to do root canal therapy. A Dental Therapist does not

learn this because it is not in their scope of practice. Dentists learn how to remove teeth that are buried in bone- we call that an impacted tooth- Dental Therapists do not do this.

More importantly, for those procedures within their scope of practice, Dental Therapists frequently do more of those procedures while in school than dental students do. A great example is stainless steel crowns (SSCs); therapy students perform many more in school than the typical dental student.

DTs are trained to do what are the routine, what some might call the "bread and butter" of dental practices, fillings, preventive treatments, extractions, Stainless Steel Crowns and pulpotomies/nerve treatments. Why wouldn't the state want to give North Dakotan residents access to more providers who dentists can hire to safely and effectively and less expensively perform these procedures?

IMPORTANCE OF SUPERVISION FLEXIBILITY

Giving dentists flexibility in supervision is critical. Why? Because many patients struggle to visit a dentist during traditional hours and some can't get to the office at all because they're non-ambulatory. Allowing dentists to supervise dental therapists while not at the same location can allow private practices to keep their doors open into the evening or even open on the weekend for routine care. It can also allow hub-and-spoke programs to do more with limited resources. In this model, a supervising dentist is located in a "hub" office while a dental therapist can provide care in settings like schools and nursing homes through a "spoke" system. Often they use telehealth technology to share information with their supervising dentist. This has been done for over a decade in Alaska and for five years in Minnesota, where one program focuses on caring for children in schools and another serves seniors in nursing homes using hub-and-spoke.

WHAT DOES CODA SAY ABOUT SUPERVISION?

While CODA was considering its standards, the Federal Trade Commission stated that CODA should remove restrictive supervision language that could impede competition. CODA agreed.

The bill you are considering has excellent supervision language – It does so by allowing general supervision and by placing supervision completely in the hands of the supervising dentist using a written practice agreement – a contract between the advance practice dental hygienist and the dentist. This makes sense, and allows dentists to use dental therapists in mobile settings such as schools and nursing homes, but also allows private practice dentists to keep their doors open more hours. Your legislation is very similar to how physician assistants work with physicians in medical homes – all based on teamwork with the doctor in the driver's seat. By allowing general supervision and requiring that the dental therapist be subject to a collaborative management agreement which may voluntarily limit the procedures they do to what the supervising dentist thinks is appropriate ensures a real potential to improve access for underserved patients in North Dakota. Based on these factors, I also support the bill's prohibition on independent practice.

WHAT ELSE DO I LIKE ABOUT LAST SESSION'S LEGISLATION

I really like the fact that the legislation was generated as a top priority in a comprehensive oral health report completed by the Center for Rural Health at UND. One of the top recommendations was to expand the duties of hygienists. Last session's legislation allows the creation of an Advance Practice Dental Hygienist, just as an registered nurse can get more education to provide more services as an Advance Practice Registered Nurse in North Dakota.

The bill would have allowed an advance practice dental hygienist to administer block and infiltration anesthesia; this is really critical. Without this skill, there really would be no improvement in access to care.

I also like the prohibition on prescribing any drug except analgesics, anti-inflammatories, and antibiotics.

Like Minnesota, I was glad to see the bill required 2-year report by the Department of Human Services to examine the impact of dental therapists on access to care in the state. Let me add something here about Minnesota. I got an advance preview of the new 4-year report by the Minnesota Department of Health and the results are even better than in the 2-year report in Minnesota, which found dental therapists safely and effectively increased access to care in private practice, safety net, and other settings. Let me discuss a few key findings of that report.

FINAL RECOMMENDATIONS AND CONCLUSIONS

-DENTAL THERAPISTS ARE A TOOL FOR DENTISTS IN NORTH DAKOTA TO REACH THE MANY PATIENTS WHO NEED CARE- In fact, data from Minnesota shows that when a private practitioner hires a dental therapist (who in that state is required to see a minimum of 50% Medicaid patients), that the dentist is freed up to work at the top of his or her scope of practice, doing more complex procedures, and can increase practice income and profitability. We can get those studies to you if you would like to have them.

-EMPLOYABILITY- I wanted to address the issue of employability of dental therapists. You may know that when dental therapy was implemented in MN, there were strong objections from organized dentistry. Well, the reality of what happened after implementation is remarkable to me! MN has now graduated 56 dental therapists. Most are fully employed but where they are employed should really excite you. 20 are employed in private dental practices, both in urban and rural areas, and the others are in non-profit clinics, FQHCs, and other similar facilities. And you should be very interested in this number – 15 of them work in HRSA designated rural areas which is a major issue here in North Dakota. So, would I be concerned about dentists hiring them in North Dakota- absolutely NOT!

LICENSURE- The other issue I wanted to mention is licensure. Because the therapists in Alaska work for the Native American corporations and have their own "licensure" through the Indian Health Service, there is not much we can learn from them on this issue. But in MN, the therapists take the same exam as the dental students, limited to those procedures within their scope of practice. They take a large regional exam called CRDTS Central Regional Dental Testing Service; they only perform the procedures within their scope of practice and the examiners use identical grading criteria for dentists

and for Therapists. So, whatever exam your dentists and dental hygienists take for licensure in North Dakota will suffice for the therapists. You should have no concerns about licensure.

CLOSING- The North Dakota bill is a reasonable approach to improving access to care for your underserved residents in the state in a way that is consistent with existing international and US-based models, consistent with the CODA standards, and would protect the public's safety. I would urge you to move forward with this legislation.

I am happy to answer any questions you may have.