New Mexico Dental Therapist Legislative Proposal

- Speaker Bios -

Health Action New Mexico

September 5, 2013 – Las Cruces, NM

PAMELA K. BLACKWELL, JD
Health Action New Mexico – Project Director, Oral Health Access
Albuquerque, NM

Originally from New Mexico, Pamela K. Blackwell, JD is the project director for oral health access for Health Action New Mexico, a statewide healthcare consumer advocacy organization. Blackwell's family has lived in New Mexico for more than six generations and she grew up in Santa Fe and Albuquerque.

Previously, Blackwell was the Associate Director for Federal Regulatory & Payment Policy for the American Association of Nurse Anesthetists (AANA) in Washington, DC. At the AANA, Blackwell was responsible for the management, strategy, policy development and implementation relating to federal regulatory and payment policy issues. Blackwell has worked directly with state and federal agencies (Medicare, FDA, DEA etc), legislators, and other organizations to develop and improve policy proposals and outcomes for her clients. Blackwell particularly enjoys educating others on the implications of federal and state policy and their very important role in influencing policy decisions.

Blackwell was a healthcare legislative assistant on Capitol Hill for Rep. Steve Schiff of New Mexico and Rep. Ralph Regula of Ohio, and served in the legal department of a major hospital system in Washington, DC. Blackwell is a board member of the New Mexico Telehealth Alliance (NMTHA) and the YMCA of Central New Mexico and has been a member of Women in Government Relations (WGR) since 2003.

Blackwell earned her BA in journalism at Colorado State University in Fort Collins, CO and her JD at George Mason University School of Law in Arlington, Virginia. Blackwell and her husband reside in Albuquerque with their three young children.

FRANK A. CATALANOTTO, DMD
Professor and Chair, Department of Community Dentistry and Behavioral Science
University of Florida College of Dentistry

Dr. Frank Catalanotto is currently Professor and Chair of the Department of Community Dentistry and Behavioral Science at the University of Florida College of Dentistry. He graduated from the College of Medicine and Dentistry of New Jersey in 1968 and completed a post-doctoral research fellowship in pediatric dentistry at Harvard School of Dental Medicine and the Children's Hospital Medical Center. He has been on the faculty of five dental schools including the University of Florida where he served as Dean from 1995-2002. While Dean, he initiated the University of Florida Statewide Network for Community Health to provide increased community based educational opportunities for dental students and residents, while also significantly increasing access to oral health care for the indigent and otherwise underserved.

Dr. Catalanotto has been active in dental education, research and advocacy organizations for much of his career. He has been a member of the following organizations:

- American Association for Dental Research (AADR), *(National Affairs Committee)*
- American Dental Education Association (ADEA)
    - *President, Chair, Vice-President of Deans, Legislative Advisory Committee, Administrative Board of the Council of Deans Legislative Advocacy Committee*
    - *ADEA President's Commission on Improving Access to Oral Health for All Americans: Roles and Responsibilities of Academic Dental Institutions.*

- Oral Health America (OHA) *(Vice-Chair, Board of Directors, Legislative Advocacy Committee founding chair)*
- American Dental Association, Commission on Dental Accreditation *(Consultant, Chair for accreditation site visit teams)*
- Health Resources and Services Administration (HRSA), Health Resources and Services Administration (HRSA) *(Vice-chair)*
- *The Compendium's* and *Inside Dentistry, (member of the Editorial Board)*

Dr. Catalanotto is the co-author of more than 70 scientific publications and has been the principal investigator or co-investigator for numerous federal, state and foundation grants since returning to a faculty position at UFCD. His research interests are clinical aspects of taste and smell function and oral health services. His dental education interests include community based dental education, ethics/social responsibility, advocacy for health care reform and access to dental care. Dr. Catalanotto and his faculty colleagues currently have funding for health services research related to access to dental care and two major grants from HRSA. These grants are focused on enhancing predoctoral dental education with a focus on public health, access to oral health care, health care disparities, cultural competency, faculty development and improving pedagogy. His current advocacy efforts are focused on the new emerging workforce models in collaboration with the Kellogg Foundation and the PEW Children's Oral Health Initiative. He is happy to report that there is life after being a dental school dean.

SARAH WOVCHA, JD MPH
Executive Director of Children's Dental Services
Minneapolis, MN
Sarah Wovcha is the executive director Children's Dental Services (CDS) in Minneapolis, MN. CDS is a non-profit corporation providing dental care to over 30,000 low-income and underinsured children and pregnant women annually at over five hundred clinical locations. CDS is the largest provider of school and Head Start-based dental care.

Ms. Wovcha served as Co-Chair of the Smiles Across Minnesota Oral Health Coalition, through which she expanded school-based dental services across the state. She is Treasurer of the Minnesota Oral Health Coalition, and Co-Chair of the Oral Health Committee of the Minnesota Safety Net Coalition through which she was an active supporter of Minnesota's 2009 Advanced Dental Therapy Legislation. Children's Dental Services employs two of the first graduates of the Advanced Dental Therapy program, one graduate of the Dental Therapy program, and provides tuition support and mentorship for two others completing the program.

As a result of her role in improving the oral health of Minnesota children and pregnant women Ms. Wovcha received the Betty Hubbard Maternal and Child Health Leadership Award in 2007. Under her leadership Children's Dental Services received the 2008 Mission Innovation Award from the Minnesota Council of Non-profits, and the 2009 Governor's Pollution Prevention Award for its voluntary efforts to use renewable energy and reduce toxins in its dental clinics across Minnesota. In 2012 she received the Macalester College Distinguished Citizen award for demonstrated leadership in civic, social and professional realms.

Ms. Wovcha holds a law degree from the University of Minnesota and a Masters in Public Health from the Harvard School of Public Health.

TERRY BATLINER DDS MBA

Associate Director - Center for Native Oral Health Research
Colorado School of Public Health
Owner - Sage Dental Care
Enrolled member - Cherokee Nation of Oklahoma

Terry Batliner, DDS MBA is a member of the Cherokee Nation of Oklahoma and spent the first 8 years of his career in the Indian Health Service. From there he went to Harvard Pilgrim Health care in Boston where he managed 7 large group practices as well as the optical program. He returned to Denver in 1995 to run the VA hospitals in the Rocky Mountain area until 2003. Since then Batliner has been involved with the University of Colorado. Batliner is now the associate director of the Center for Native Oral Heath Research, part of the Colorado School of Public Health and the owner of Sage Dental Care - a private practice near Boulder.

KATHLEEN BETTINGER, RDH, MS

Interim Dental Hygiene Program Director
Doña Ana Community College
Las Cruces, NM

Kathleen Bettinger RDH, MS is currently the interim dental hygiene program director and clinical coordinator for Doña Ana Community College (DACC). Bettinger has been a registered dental hygienist for 22 years, and earned her master's in dental hygiene from the University of New Mexico in 2009. Her master's thesis project was included in the "New Mexico Oral Health Report 2009 "3rd Grade Surveillance Project". Previously, Bettinger was a clinical dental hygienist in private practice. She spent 10 of her 22 years in a periodontal practice. She started her career as a dental lab technician and practiced as a certified dental assistant for 11 years prior to starting her career as a registered dental hygienist.

Bettinger has been a long-time active member in numerous dental associations and organizations including the following:

- New Mexico Dental Hygiene Association
- NMDA/NMDHA Liaison Committee
- New Mexico Dental Educators' Consortium
- New Mexico Oral Health Advisory Council, Past Chair
- BluePrint for Health New Mexico Advisory Network
- American Dental Hygiene Association
- American Academy of Public Health Dentistry

After her many years in private "fee for service" dental practices, Bettinger was overwhelmed by the needs of so many individuals, young and old, as she completed her community service hours for her master's degree at UNM. It changed her focus. Bettinger is now committed to educating the next generation, enabling them to provide quality dental care to all communities. As DACC faculty, Bettinger has led the effort to provide community dental clinics with the best possibly trained dental hygienists available. Her focus remains on public health.

Bettinger earned a BA in biology from Metropolitan State University in St. Paul, MN and her associate's degree in dental hygiene from Normandale Community College in Bloomington, MN. She is a mother of four grown children and four grandchildren (all who learned to floss their teeth at an early age).

Dental Therapist-Hygienists

A Community Workforce Solution
for Improving Access to Quality Dental Care
for Rural, Tribal & Underserved New Mexico

Pamela K. Blackwell, JD
Project Director, Oral Health Access
Health Action New Mexico

Legislative Health & Human Services Committee
Las Cruces, NM – September 5, 2013

NM Dental Health Crisis

- May 2013 - NM Healthcare Workforce Report to Legislature concluded:
  - NM 39th worst in U.S. in number of dentists/1,000 people.
  - 69% of dentists in NM metropolitan areas.
  - **1.31 million New Mexicans** (63%) are either in a shortage area or underserved (38% in DHPSA, 25% underserved)
  - NM needs 400 more dentists to meet need.
  - 9 NM counties either have none or 1 dentist and/or hygienist. (NM Dental Board licensure data)
  - 40 known long-standing vacancies for dentists in NM

(Adequacy of NM's Healthcare System Workforce, NM Dept. of Health Report to Legislative Finance Cmte. 5/15/13)

NM Dental Crisis…

Result of Shortage:

- 34% of all NM 3rd graders have untreated dental decay, worse for NA population.
- Thousands of New Mexicans –children, elders & persons with disabilities – do not have access to, or wait > 6 months for necessary dental care.
  - **Result:** Living in pain, missing school or work, low school performance, lost work productivity, life threatening medical emergencies, long-term serious health problems.
  - NM Mission of Mercy dental clinic, stand line/camp out for days for free dental services. (Oct. 2010, March 2012, Sept 2013)

Other Factors that Worsen Shortage:

- Very few dentists include Medicaid and non-insured patients as a significant portion of their patient mix.
- Aging dentist workforce: 51% age 55+
- **Demand will only increase:** Federal law mandates dental coverage for children up to 21 yrs., Medicaid expansion.

NM Healthcare Workforce Rpt. Recommendations

- The number of dental health professionals in the state and their maldistribution cannot adequately meet current or future demand.
- ***"The Legislature should also revisit the concept of dental therapists as an additional way to provide care to underserved areas under the supervision of dentists."***

Who are Dental Therapists?

- Dental providers, general supervision of off-site dentists, study after study show provide high quality, cost-effective dental services to rural and tribal communities. *(April 2012, Review of Global Literature on Dental Therapists, David A. Nash)*
  - ZERO of 1100 studies and reports have revealed a problem with the quality of care dental therapists provide.
- Home-grown, culturally competent, selected by their communities, practice in their home or similarly situated communities.
- Obtain rigorous, competency-based education, training and clinical experience.
- *With Dental therapist you get a dentist, team of dental providers.* - Expand the reach of dentists to underserved and remote communities using telemedicine.

Dental Therapists…

- Financially sustainable workforce model: Provide a range of billable, routine treatment and restorative care services as well as prevention and education services.
  - **NEW** - Cost employers less than 30 cents for every dollar they generate when serving underserved populations.
    - Studied AK & MN DHATs, DTs, ADTs.
    - *(Community Catalyst Report, May 2013)*
  - Can increase a dentist's productivity and profitability, including adding a 20% Medicaid patient mix. *(The Pew Center, Dec.2010)*
- Since 2005, provide care in remote Alaskan tribal villages and recently in Minnesota. Over 90 years, provided care in 53 countries including industrialized countries.
- 40,000 more Alaskans now receiving routine and preventative care because of dental therapists.

A Workforce Solution for NM

- **Jobs, Economic Opportunity & Career Pathways**
  - Career, jobs and economic opportunities for those in rural and tribal NM. (Con Alma rpt. 2010)
  - Career pathway for dental hygienists – With additional training dental hygienists can become dental therapists. This means providers serving the public sooner.
- **State Law Change Required to Restore Tribal Sovereignty and Rural Community Right to Self-Determination** - For NM rural communities, tribes, pueblos and nation to have the right to train and employ a dental therapist, NM state law must specifically allow dental therapists to practice in NM. Federal law took away these communities' rights to have dental therapists.

Dental Therapists: An Innovative, Tested Model for NM

- Proposals for a NM Dental Therapist program are not new to NM.
  - 2008 – Presentation to Interim HHS Cmte.
  - Jan. 2011 - Introduced HB 495, dental therapist legislation for the 2011 NM legislative session
  - Oct. 2011 -Proposal presented to Indian Affairs Cmte.
  - 2012 – Proposal presented to Interim HHS Cmte. Endorsed
  - 2013 – Introduced dental therapist-hygienist legislation
  - Sept.-Oct. 2013 – Present to legislative cmtes. – Health & Human Services, Indian Affairs, Economic & Rural Development
  - Dec. 2013 – Introduce legislation
  - Jan. 2013 – Legislative session, 30-day session

Support for Dental Therapist Model

- NM State Legislative Health & Human Services Committee – Endorsed dental therapist legislation (Nov.12)
- AARP New Mexico
- Albuquerque Area Indian Health Board (AAIHB)
- Center for Civic Policy
- Concilio CDS, Inc. - Las Cruces, NM
- Des Moines School Health Advisory Council
- Lutheran Advocacy Ministry of New Mexico
- Native American Professional Parent Resources, Inc. (NAPPR)
- Native Health Initiative
- Nizhoni Smiles Dental Clinic - Shiprock, NM
- Northern New Mexico College – Espanola, NM
- NM Alliance for Retired Persons
- NM Alliance for School-Based Health Care
- NM American Federation of Teachers Retirees
- NM Center on Law & Poverty
- NM Conference of Churches
- NM Dental Hygienists' Association
- NM Health Resources (NMHR)
- NM League of United Latin American Citizens
- NM Public Health Association (NMPHA)
- NM Religious Coalition for Reproductive Choice
- NM Telehealth Alliance
- NM Voices for Children
- NM Youth Development, Inc., ElevateNM
- Pueblo of Kewa/Santo Domingo Health Board - want dental therapists in their community.
- RESULTS - Santa Fe
- Rio Arriba Community Health Council
- Rio Arriba County Health & Human Services
- Southwest Women's Law Center
- Southwestern Indian Polytechnic Institute
- Tierra del Sol (Las Cruces) – affordable housing organization.
- Union County Health & Wellness Network want dental therapists in their community – Clayton, NM
- Union County General Hospital
- Women's Intercultural Center – Anthony, NM

Support cont…

- William H. Johnson, Jr. – Fmr. NM Cabinet Secretary for Human Services Dept.
- Alfredo Vigil, MD FAAP–Fmr. NM Cabinet Secretary for Health & Human Services - Taos, NM.
- Ronald J. Romero, DDS – Fmr. NM Dept. of Health Dental Director, Private practice dentist – Santa Fe, NM.
- Howard Rhoads, DDS: – Farmington, NM
- Bob Giannini, DDS – Fmr. NM Dental Board Chair
- Roger Ames, DDS
- Bill Niendorff, DDS
- Harris Silver, MD
- William H. Wiese, MD, MPH, Ret. UNM faculty; Fmr. NM DOH Public Health Division Director

NM Dental Crisis Demands Action

- We have a growing, committed coalition of supporters.
- We have reached out to and met with those who oppose our proposal, and we will continue to do so.
- However, the NM dental crisis is bigger than all of us.
- It demands action, an innovative and tested solution for all New Mexicans
- Solution: Legislation that allows for NM Dental Therapist-Hygienists, and a NM Dental Therapist-Hygienist education programs.

Call to Action

- **Dental care is a crisis in NM.**
- **We have a solution.**
  - Improve NM rural, tribal and underserved access to quality, cost-effective dental services,
  - Provide jobs, stimulate economic opportunity for these communities,
  - Restore community self-determination and tribal sovereignty, and
  - Allow the best of NM's training institutions and communities to partner to solve our dental care crisis.

Request: Support and recommend legislation that includes dental therapist-hygienists as part of New Mexico's dental team

-Thank you -

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UNIVERSITY OF FLORIDA College of Dentistry

New Mexico Needs Dental Therapists

New Mexico Legislative Health & Human Service Committee
September 5, 2013

Frank Catalanotto, DMD
Professor and Chair, Department of Community Dentistry and Behavioral Science
University of Florida College of Dentistry
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Who am I?

- Educated as a pediatric dentist, 39 year career in dental education, past president of the American Dental Education Association, served at 5 dental schools including Dean at University of Florida, now chair Department of Community Dentistry and Behavioral Science (Public Health) at the University of Florida.
- Committed to improving access to oral health care for the underserved by education of students and dentists, by oral health services research, and advocacy at local, state and national levels.
- Unpaid spokesperson for initiatives on dental therapists
- Consulted in New Mexico over a decade ago, recommended not opening a dental school but focus on dental residencies.

Indicators and effects of lack of access to oral health care

- Health Professional Shortage Areas
- CMS data on Medicaid Patients
- Hospital Emergency Room data, and why hospital ERs do not solve the problem. "Pay me now or pay me later."
- Negative impacts on success in schools; negative impact on getting out of poverty. Economic drain on the state.

A Costly Dental Destination Hospital Care Means States Pay Dearly

PEW CHILDRENS DENTAL CAMPAIGN- ISSUE BRIEF 2012

- Each year, many Americans seek dental care in hospital emergency rooms (ERs). The Pew Center on the States estimates that preventable dental conditions were the primary diagnosis in 830,590 visits to ERs nationwide in **2009—a 16 percent increase from 2006.** Emergency rooms are the first and last resort because their families struggle to find a dentist who either practices in their area or accepts Medicaid patients.

Pay me now or pay me later

- Hospital ER visits do not provide "treatment" of the underlying dental problem, only relief of symptoms of pain and infection.
- Hospital ER visits cost money to Medicaid and insurance but for the uninsured, the hospitals usually absorb those costs. In other words, you are already paying for dental care for these patients.
- Makes more sense to pay up front for increased access and preventive programs.
- You need oral health professionals to provide these preventive services but who are willing to work in underserved communities with working families who cannot afford traditional dental services; **dental therapists can do this!**

Outcomes of hospitalizations attributed to periapical abscess from 2000 to 2008: a longitudinal trend analysis.

J Endod. 2013 Sep;39(9):1104-10. doi: 10.1016/j.joen.2013.04.042. Epub 2013 Jul 11.

During the 9-year study period (2000-2008), a total of 61,439 hospitalizations were primarily attributed to dental/tooth infections in the US. **A total of 66 patients died in hospitals.**

This is not only a "cost issue", this is a life and death issue!

Impact of poor oral health on children's school attendance and performance

- **Children who missed school days because of dental problems did less well in school than children who missed school for other reasons.**

- Jackson SL, Vann WF Jr, Kotch JB, Pahel BT, Lee JY. Am J Public Health. 2011 Oct;101(10):1900-6. doi: 10.2105/AJPH.2010.200915. Epub 2011 Feb 17. PMID: 21330579 [PubMed - indexed for MEDLINE]

Children's dental health, school performance, and psychosocial well-being

- **STUDY DESIGN:** Analyzed data from the 2007 National Survey of Children's Health for 40,752-41,988 children.
- **RESULTS:** Dental problems were significantly associated with reductions in school performance and psychosocial well-being. Children with dental problems were more likely to have problems at school and to miss school and were less likely to do all required homework.
- **CONCLUSION:** Preventing and treating dental problems and improving dental health may benefit child academic achievement and cognitive and psychosocial development.

J Pediatr. 2012 Dec;161(6):1153-9. doi: 10.1016/j.jpeds.2012.05.025. Epub 2012 Jun 23. Guarnizo-Herreño CC, Wehby GL.

Who are the people with disparities of access and oral health?

- The first and most obvious group are those in POVERTY, patients on Medicaid, CHIP.
- Racial and Ethnic minorities
- Traditionally, children, the elderly, rural, single mothers.
- Increasingly in this recession, lower middle class and middle class families. WORKING FAMILIES
- The uninsured, including the working poor.
- Any who do not understand the importance of optimal oral health

Potential Solutions

- **Educate patients and change their behavior**
  - -Evidence based practices
  - -Culturally competent practitioners
  - -Practitioners trusted by patients
- **Workforce**
  - More dentists- a very expensive solution
  - Expanded work settings and reimbursement models for dental hygienists
  - New models of oral health care professionals

Dentists and low income/working families

- For the most part, dentists do not "look" like the patients they serve, particularly with respect to race/ethnicity. **Getting better!**
- Many dentists do not really understand the underserved patient. "My patients can get to see me anytime."
- Some dentists have real difficulties seeing Medicaid and otherwise underserved patients.

The Culture of Poverty

"Many of us have no real understanding of what poverty is. We may be broke most of the time, in debt, unsure of how we'll pay the phone bill. But those particular definitions can apply to middle class. Poverty is something else. Missed meals, a reliance on government aide, homes without power or telephone services- these are the earmarks of the culture of poverty."

J. Kevin Tumlinson, Online Magazine. www.viewonline.com, 2/13/08

Dentists and Medicaid Patients

- Low Reimbursement* (but increasing rates does not always work)
- Administrative hassles* (this is real)
- Medicaid patients do not keep appointments* (but they can!)
- Do not want to mix Medicaid and other patients in waiting/reception room*
- Sense of Social Justice*
- Social Stigma of being a Medicaid provider**

* Published; ** in preparation by my team

New models of oral health care professionals

- Community Dental Health Coordinators
- Dental Therapists

Advantages of Both

-come from the local community, cultural competency

-excellent capacity for case management

-inexpensive to educate and hire

New models of oral health care professionals
Disadvantages

- **Community Dental Health Coordinators**

- Great for case management BUT very limited scope of services, cannot provide any real treatment.

-No evidence base (although preliminary evidence looks promising- evaluation completed but not published)

-Accreditation and licensing issues

- **Dental Therapists**

- Multiple models across states-confusing, but may be good for New Mexico in giving state flexibility to create the program that best meets your needs.

Why do I support dental therapists?

- Overwhelming international **evidence** of safety and efficacy- 50 countries & 50 years.
- For their limited scope of practice, they are better trained than dentists.
  - -90 competencies vs. 500 competencies
  - -restorative procedures-
  - -motivational interviewing- changing behaviors
- I have read the papers about how well they function.

Why do I support dental therapists?

- I have visited the program in Alaska three times and seen them in action.
- Major emphasis on PREVENTION
- I have spoken with folks who educate and/or hire them and they are VERY PLEASED!
- DENTAL THERAPISTS are a really good fit in New Mexico where you have rural, geographically isolated communities with working families and other underserved who are ethnically diverse.

Thank you

Frank Catalanotto, DMD
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Sarah Wovcha JD MPH

Executive Director, Children's Dental Services – Minneapolis, MN
Testimony to NM HHS Committee – Las Cruces, NM – Sept. 5, 2013

- Chairpersons and members of the committee, I appreciate the opportunity to testify before you today. My name is Sarah Wovcha and I am the Executive Director of Children's Dental Services. Established in 1919 we are Minnesota's oldest non-profit providing dental care to low-income families. I am here today in support of allowing dental therapists to practice in New Mexico.

- Children's Dental Services serves children from birth to age 21, regardless of family income, low-income pregnant women, and the un- or under-insured. CDS is a community dental leader, and a hallmark of our dental services is that they are evidenced based. Because of this we are hailed as a local and national leader in provision of community-based dental care.

- We have quadrupled in size since 2000 due to lack of access to affordable dental care for low-income children and families. Today we are the single largest provider of on-site dental care in Minnesota schools and Head Start centers, serving over 30,000 patients in 2012.

- Because of the growing number of families who lack dental care in Minnesota we began to investigate ways to increase access to care in a financially sustainable way…after researching the success of dental therapy in 26 other countries including Great Britain and New Zealand we decided to pursue a dental therapy workforce model in Minnesota

- MN authorized two types of new dental providers in 2009—a dental therapist and an advanced dental therapist—similar to the new provider proposed in New Mexico.

- CDS has employed two graduates from the first class of ADTs and one graduate from the second graduating class. They passed rigorous testing authorized by the MN board of dentistry before entering practice, and this testing occurred in a blind setting alongside dentists…in other words the testers did not know if they were dentists and dental therapists in reviewing.

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

- Like New Mexico, Minnesota has a significant amount of rural and tribal land where shortages of dental providers are particularly acute. CDS' ADTs can also work in remote settings in rural Minnesota while their supervising dentists are often in the Twin Cities metro area. Through use of digital x-rays and electronic charts, ADTs are able to connect with their supervising dentist, regardless of location.

  So far our experience with dental therapists has been remarkable:

  1. Since August 2011 there have been no patient complaints about care from an ADT
  2. CDS' ADTs have consistently performed in the middle to top half of productivity when compared to staff dentists
  3. The cost of an ADT at approximately $45/hour is roughly half of the $75/hour cost to employ a new dentist…which results in a savings of $1,200 per week
  4. With a dental therapist added into our dental staffing mix our dentist are free to provide more complicated restorative care and their overall production has also increased.

- When the concept of a new dental provider was introduced in 2007 in met great opposition from organized dentistry—similar to the arguments you are hearing today.

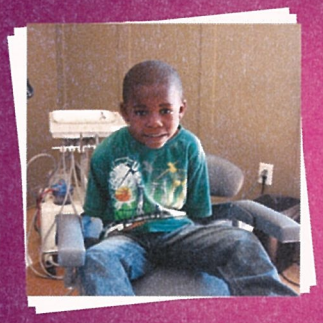
- But our experience in MN is that this is a model that works and is gaining in popularity among private practice dentists. We are currently paying 100% of tuition costs for two of our Registered Dental Hygienists to become ADTs because of the positive impact they have had on access and income for our organization. In an environment where we are experiencing cuts in funding and increased requests for care the dental therapy model has been the single most successful tool in increasing access to affordable, quality dental care.

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

Children's Dental Services

ADVANCED DENTAL THERAPY IN MINNESOTA: AN EMPLOYER'S PERSPECTIVE

Sarah Wovcha, J.D., M.P.H
Executive Director
Children's Dental Services



CHILDREN'S DENTAL SERVICES

- **CDS Mission Statement:** *Since 1919 Children's Dental Services is dedicated to improving the oral health of children from families with low incomes by providing accessible treatment and education to our diverse community.*

Children's Dental Services

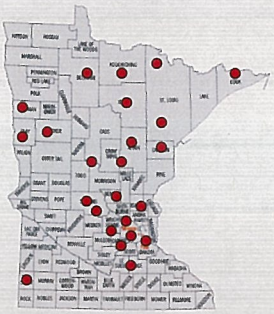
HISTORY

- CDS grew out of a Minneapolis charitable women's organization whose mission was to provide dental care to destitute Minneapolis orphans at a time when health safety nets were non-existent.
- In the 1960's CDS became the first provider of Head Start-based dental care in the nation.
- CDS has quadrupled in size since 2000 due to lack of access to affordable dental care for low-income children and families.
- Today CDS is the single largest provider of on-site dental care in Minnesota schools and Head Start centers.

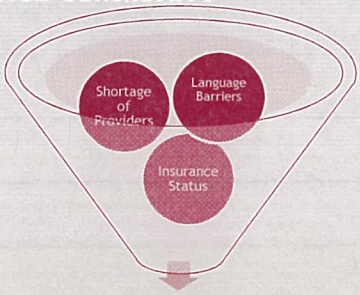
CDS TARGET POPULATION AND SCOPE OF SERVICE:

- Children from birth to age 21, regardless of family income.
- Low-income pregnant women, recognizing the relationship between the oral health of a pregnant women and that of her fetus.
- Un- or under-insured; CDS accepts all forms of public and commercial insurance, and **has a zero-based sliding scale for income eligible families.** Families who are below 100% of the federal poverty level receive free care. No one is denied care based on inability to pay.
- CDS provides specially targeted care programs to those who are blind, deaf, disabled, and autistic, and provides culturally targeted and translated care to the East African, Latino, Southeast Asian and Native American communities.
- CDS provides a full range of comprehensive dental care, including endodontia and hospital-based services.

MAP OF CDS SERVICE AREA



UNMET NEEDS FACED BY CDS' SERVICE COMMUNITY



Children and pregnant women go without needed services

UNMET NEEDS NATIONALLY

- The Pew Center on the States reports that by 2014, 5.3 million additional children will gain public insurance coverage under Affordable Care Act.
- Many dentists are unable or unwilling to provide dental care to children on Medicaid or to uninsured children

- Nearly 52 million school hours are lost annually because of childhood dental disease

WHY DENTAL THERAPISTS AS A SOLUTION?

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

CHARACTERISTICS OF ADTs AND DTs

- All ADT services can be provided under General Supervision.
- General Supervision is defined in Minnesota Rule 3100.0100: "The supervision of tasks or procedures that do[es] not require the presence of the dentist in the office or on the premises at the time the tasks or procedures are being performed, but requires that the tasks be performed with the prior knowledge and consent of dentist".
- ADTs will therefore directly increase access to care by providing care in rural or low-income area where access is a huge problem.
- DTs are more limited in their scope of practice and can only provide certain services under general supervision; all other services must be provided under indirect supervision
- Indirect Supervision is defined in Minnesota Rule 3100.0100 as the supervision of tasks or procedures when the dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed by the dental therapist

PROCEDURES PERFORMED BY ADTs

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

PROCEDURES PERFORMED BY ADTs

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

HIRING: THE FIRST ADTs IN MINNESOTA

- Christy Jo Fogarty, a graduate of Metropolitan State University, was the first ADT hired and credentialed in Minnesota.
- Employed at CDS since December 2011.
- Certified as Minnesota's first ADT in January 2013.

CDS hired Jamee Rosell, its second ADT from the Metropolitan State University Program, in June 2012

HIRING: CDS' FIRST DT

CDS also hired Meng Veng, a DT from the University of Minnesota Program. Meng will be credentialed and ready to start in December 2012.

Meng Veng is bilingual speaking Hmong. He targets care to the more than 2,000 Southeast Asian families CDS serves each year.

SUCCESSFUL INTEGRATION

Apple Tree Dental

Apple Tree Dental's mission is to improve oral health in the lives of people with special access needs who face barriers to care. Their programs in greater Minnesota are supplemented by a DT, who now is a certified ADT and able to see patients through rural Minnesota.

HealthPartners

Health Partners currently employs a Dental Therapist. Utilizing its past claims and production data, Health Partners is conducting an economic analysis of the impact of the Dental Therapist on dental productivity within Health Partners.

Children's Dental Services

Since 1919, Children's Dental Services (CDS) is dedicated to improving the oral health of children from families with low incomes by providing accessible treatment and education. CDS was the first clinic in Minnesota to hire a DT, who continued on to be the first certified ADT. CDS is also supporting two ADT students through the Metropolitan State University track, host students from both programs through their required rotations, and has since hired two more therapists to continue expanding care where it is needed most.

Hennepin County Medical Center

Through a grant from the Minnesota Department of Health, HCMC actively collaborates with Metropolitan State University in training dental therapy students. In 2009, HCMC hired one of the first dental therapist graduates from Metro State University (who is on track to becoming an ADT) to help meet the needs of the thousands of patients seeking care from one of the top federally qualified health centers in America since 1999 (Source: US News & World Report).

Main Street Dental Care

Dr. John T. Powers from Main Street Dental Care in Montevideo, MN was one of the first private dental practitioners to hire a dental therapist. The new dental therapist had worked in the community for over 15 years as a licensed dental assistant and is now been able to help Main Street Dental Care's provide services to more families than ever before.

RESULTS: CDS PRODUCTION 2011

Production Summary August 2011

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

RESULTS: CDS PRODUCTION 2012

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

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

RESULTS: CDS PRODUCTION 2013

Production Summary July 2013

DDS Code	Total Production Charges	Total Hours Worked	Total Production
DR11 Endo Provider	8,516	16	$532.25
DR20	19,343	43.15	$448.27
DR44	53,555	138.05	$387.58
ADT01	46,755	123.5	$378.58
DR24	53,507	144.91	$361.45
DR36	42,304	140.05	$302.06
DR01	41,008	144.96	$299.66
DT01	4,277	16.3	$262.39
DR43	3382	4.65	$207.48
DR12	57,856	171.87	$203.46
DR53	10,676	62.74	$170.16
DR04	487	3.05	$159.67

RESULTS: FINANCIAL IMPACT

Cost-Benefit Analysis based on 1 DT providing services covered under the DT statute for 40 hours/week in a public health dental clinic.

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THANK YOU

Questions?

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Oral Health:
NM Native American Communities, Dental Therapist Economic Viability

Terry Batliner, DDS, MBA
Sage Dental Care
Colorado School of Public Health
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NM Legislative Health & Human Services Committee
Las Cruces, NM – Sept. 5, 2013

US Comparison

- Total Untreated Decay:
  - US all races - 21% for ages 5 and up
  - Non-Hispanic Blacks adults – 40% adults 20 to 64
  - Below 100% of FPL – 42% adults 20 to 64

Oral Health of Native People

Phipps, et al reports higher rates of untreated caries in IHS administrative areas than are present in the general population

Ages 2-5

- Navajo – 66%;
- Albuquerque - 57%
- Alaska – 47%

A Pueblo: Percentage With Untreated Dental Caries

Gender	Total	Ages 3 -4	Ages 5 - 19	Ages 20 - 64	Ages > 65
Male	58.9	40.74	57.14	72.34	60
Female	56.09	52.17	51.85	66.32	25
Total	57.64	46.15	54.82	68.97	31.03

New Mexico

- Another SW Tribe: Percentage With Untreated Dental Caries

Age	Gender	N	Percentage
Age 3	Male	190	67.9
	Female	218	65.6
Age 4	Male	281	74.7
	Female	265	68.7
Age 5	Male	16	62.5
	Female	9	77.8
All Ages	Male	488	71.7
	Female	493	67.3
Male And Female	Age 3	408	66.7
	Age 4	546	71.8
	Age 5	25	68

New Mexico

- Knowledge does not directly correlate with behavior
- Why – life intervenes; social pressures; additional priorities; Lack of money and time; etc…

Knowledge Versus Behavior

Prevention versus Treatment

- A distinction that does not make sense
- Prevention can:
  - Prevent decay before it occurs
  - Prevent new decay in some people
  - Prevent decay after teeth are restored
- Dental decay – requires treatment and prevention will not fix it

Prevention

- "Dental decay is preventable" ???
- Education is the key – ???
- Think about obesity, heart disease, diabetes, etc.
- These things are preventable???
- These diseases are modifiable – not preventable

Cost Benefit

- Dentists are paid $85+ per hour
  Example: 30% of Production: .3 * $300 = $90
- Hygienist paid an hourly rate of $35 so a therapist would probably be paid $40 to $45
- Therapists can provide 70 to 80% of the services needed in many underserved areas
- It is not rocket science to see this will work!

Cost of Program

- Depends on many assumptions:
  - Length of program
  - Number of students
  - Start up or modification of existing program
  - Will there be clinical revenue?
- 15 to 20% more than a hygiene program and substantially less than a dentist

Thank you

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Kathleen Bettinger RDH MS

Testimony to LHHS Committee
Las Cruces, NM – Sept. 5, 2013

Kathleen Bettinger's background in brief- DACC- Dental Hygiene Clinical Coordinator; Interim Program Director. Not speaking on behalf of DACC or NMDHA. Open minded about DT's, but wanted to explore it further.

Observations made on educational site visit of Alaska Dental Therapist (DHAT) Education Program (Anchorage and Bethel, AK)

1. **Dental Therapist Students**
   a. Family member part of health care system and/or personal experience as a dental assistant. They have also been mentored by DT's in their villages.
   b. Mature, very committed to home village and "want to make a difference for their people." Want to become leaders in their villages, as some already have.
   c. Have had similar dental experiences with visiting DDS. Witnessed rampant decay in classmates-Missing 4 front teeth.
   d. Sponsorship comes from village and/or foundations. Often collaborations of entities.

2. **Dental Therapist Coursework**
   a. Total dedication to training program. Separation from family. Very concentrated curriculum. Long days, 6 am to midnight. Full day of classes followed by late nights reading and preparing for the next day's classes. Subjects are taught in a linear fashion, building on previous knowledge.
   b. Competency based. Students are required to meet subject knowledge and skill level requirements prior to moving ahead. Rigidly monitored.
   c. Ability to meet subject knowledge and skill levels are due to the amount of time spent on learning, not the amount of time spent in a classroom. Students are acquiring the full scope of knowledge necessary to provide the care within their scope of practice. There are no shortcuts.
   d. Begin serving the underserved communities within the first year of the program. Receive very extensive clinical experience.

3. **Supervision of Dental Therapists**
   a. Layers of supervision of both the students and the supervising DDS
   EX: Peer Review Referral Forms used for calibrating and monitoring DDS
   b. True Team Model, Symbiotic relationship between DT and DDS through standing orders. "With a DT you get a DDS."

c. General supervision is strictly adhered to through telephone and internet.

4. **Facilities**
   a. Modern, accessible to community.
   b. Welcoming for patients.

5. **Staff**
   a. Permanent staff is highly trained in field with years of experience to rely on for judgment/decision making.
   b. Supervising DDS are brought into the program from other states. Serve for a varying amount of time. While most DDS rotate through the program; the DTs remain in their communities maintaining access and continuity of care. The DTs bridge the gap between the DDS and the community.

Recommendations for New Mexico

1. In New Mexico, we know the need is here; I feel we're not far from developing a solution.
2. RDH curriculum closely mirrors that of DT without the expanded functions in a wider scope of practice. Six months of concentrated training including technology with tele-dentistry and advanced diagnostic radiology.
3. Training program for DDS to work at the level of supervision necessary to provide the oversight, additional instruction, and guidance to DTs.
4. Recruit young. Elementary school not too early. Role models in the community