**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.