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Testimony on Senate Bill 784

Senate Committee on Public Benefits, Licensing and State-Federal Relations
Representative Mary Felzkowski
35th Assembly District
February 14, 2018

Chairman Kapenga and Committee Members,

Thank you for hearing testimony on Senate Bill 784 to allowing for the licensure of dental therapists in Wisconsin.

WHAT DOES THE BILL DO?
The bill provides for the licensure of dental therapists who are members of the dental care team that would be able to engage in limited practices of dentistry, such as fillings and sealants. The bill requires that these health care practitioners always work under a dentist's general supervision.

As in other health care fields, dental therapists serve as a mid-level provider, like nurse practitioners and physician assistants. Providing dental practices the option to include these well-trained dental professionals in their dental teams will allow for increased access, lower patient costs, and savings for the state, all without compromising quality of care.

Dental therapists receive the same training as dentists for the procedures they are allowed to perform within their scope and must meet rigorous standards approved by the Commission on Dental Accreditation - the same entity overseeing the training of dentists. A systematic research review by the American Dental Association Council on Scientific Affairs found that dental care teams that employ mid-level providers such as dental therapists can reduce the rate of untreated tooth decay more than teams that employ only dentists.

WHAT PROBLEM WILL THE BILL SOLVE?
Access to Care
The provisions of this bill seek to increase access to care, especially for the 1.5 million Wisconsin residents currently living in areas with dentist shortages. According to federal statistics, a staggering 60 of the 72 counties in Wisconsin face dentist shortages. Even more concerning, there are currently over 1 million Wisconsinites who depend on Medicaid for dental benefits that face additional barriers – only 37% of current dentists in the state accept Medicaid patients. **Dentist availability plays a major role in why Wisconsin rates worst of all states in the number of Medicaid children who saw a dentist in 2016.**

Emergency Room Over-utilization
Research also shows dental therapists are needed to reduce the number of costly trips to emergency rooms for preventable dental conditions. In 2015, Wisconsin hospitals clocked more than 41,000 emergency room visits for which a preventable dental condition was the primary or secondary diagnosis (of these visits, 56% were paid for by Medicaid). If accounting for only primary diagnosis visits (33,113) at an average cost of $749 per visit (in 2012), this represents nearly $25 million in potentially avoidable hospital charges.

Opioid Crisis
This $25 million in hospital charges for dental ER visits is wasted because patients usually leave ERs with the same underlying problems they walk in with. ERs commonly stabilize these patients with antibiotics and pain killers and then tell the patient to find a dentist for needed treatment. Finding a dentist to administer the needed treatment is often not possible in many areas of the state. This bill would make connecting these underserved populations with dental care much more practical, and would have a positive impact on fighting the opioid crisis in Wisconsin by cutting down on unnecessary ER visits.

HOW CAN DENTAL THERAPISTS SOLVE THIS PROBLEM?
Mid-level providers in other fields of medicine were once a new concept and are now a mainstay in today's health care system. In addition to over 50 countries, dental therapists are currently authorized in Minnesota, Maine, and Vermont with tribal authorization in Alaska, Washington and Oregon. Several other states are currently considering legislation.

Dentists in other states who have embraced the concept and employed dental therapists report increased dental team productivity, increased profits, personnel cost savings, and improved patient satisfaction. A 2014 report released by Minnesota Board of Dentistry and Department of Health found clinics employing dental therapists could see more patients, over 80% of which were on Medicaid. These patients experienced decreased travel time and nearly one-third saw decreased wait times. Increasing access and savings from the lower costs of employing dental therapists made it possible for clinics to expand capacity to see more Medicaid and underserved patients.

Dental therapists are also cost effective. Under the current system, dentists are often providing routine care rather than providing procedures at the top of their scope. This is a highly inefficient use of Medicaid dollars. With dental therapists as part of the team, dentists are able to delegate more routine procedures to their dental hygienists and dental therapists, freeing their time to do more complex and costly procedures. This would lower a practice's labor costs, allowing them to serve Medicaid patients more cost effectively, even with the low reimbursement rate dentists currently receive.

The concept is non-partisan and has been embraced by conservatives and liberals alike. In a national poll conducted in 2016 by Americans for Tax Reform, 79% of all voters were in favor the idea. That included support from 77% of Republicans, 79% of independents and 80% of Democrats. The dental access crisis in Wisconsin directly affects the health of children, those living in rural areas, the disabled, the elderly, and veterans. The indirect effects are felt by employers, school districts, taxpayers, and the health care system. While dental therapy is not a silver bullet for solving access to care on its own, it can and should be a part of the overall solution in Wisconsin.

Thank you for hearing my testimony. I would be happy to answer any questions.

Dental Therapy in WI

Facts & Myths

MYTH:

"Dental therapists have not proven effective in other states and have fallen short on promises to improve access to care."

FACTS:

- A study conducted by the University of Washington (forthcoming in the *Journal of Public Health Dentistry*) showed that children living in Native Alaskan villages frequently visited by dental health aide therapists (DHATs) had fewer extractions and more preventive care than their peers in villages not visited by DHATs. Adults in villages frequently visited by DHATs had fewer extractions and more preventive care than those in villages that had no DHAT services. The study examined ten years of patient records from the Yukon Kuskokwim Health Corporation -- which serves about 25,000 Alaska Natives.
- In the first six years of the Saskatchewan school-based dental program, which utilized dental therapists to provide basic dental care to all school-aged children (ages 3-12), the average number of students who required fillings dropped by approximately 50%.
- DHATs were launched in Alaska to provide regular care to Alaska Natives living in remote villages that dentists were visiting only sporadically. DHATs have provided regular access to dental care to more than 45,000 Alaska Natives in more than 80 rural communities.
- A 2014 report released by Minnesota Board of Dentistry and Department of Health reported the following about clinics that were employing dental therapists:
    - More patients were being seen, and more than 80% of new patients seen by dental therapists were on Medicaid;
    - Patients experienced decreased travel time and nearly one-third saw decreased wait times, increasing access; and
    - Savings from the lower costs of employing dental therapists made it possible for clinics to expand capacity to see more Medicaid and underserved patients.
- The most recent estimates find that in 2017, Minnesota dental therapists provided more than 107,600 patient visits.
- A systematic research review released by the American Dental Association Council on Scientific Affairs in 2013 found that dental care teams that employ midlevel providers such as dental therapists can reduce the rate of untreated decay more than teams that employ only dentists.

MYTH:

"In Minnesota, dental therapists have been concentrated in urban settings, such as the Twin Cities, instead of the rural areas proponents claim they are intended to serve."

FACTS:

- Minnesota law reflects proponents' intent for dental therapists to improve access to care for the underserved, which include those in rural areas where there are dentist shortages, but other groups as well. The underserved also include those

Dental Therapy in WI

Facts & Myths

on Medicaid and those with low incomes. These population groups are in both rural and urban areas. Additionally, most dentists do not Medicaid. State reports find that dental therapists are reaching all of these populations.

- According to a 2016 Minnesota Department of Health report, dental therapists are more likely to work in a community based or non-profit practice – which generally serve larger numbers of uninsured and Medicaid patients than private practices – than any other dental professional.
- The same study found that, even in the relatively short time dental therapists have been practicing in Minnesota, more of them have gravitated to rural areas of the state over time. In 2016, 50 percent of dental therapists worked in the populous Twin Cities area, down from 73 percent in 2013. Further, dental therapists are distributed more closely to the Minnesota population than dentists; 63 percent of dentists (compared to 50 percent of dental therapists) are in the Twin Cities.

MYTH:

"In other states, educational institutions have failed to embrace dental therapy, and it is unlikely to take hold in Wisconsin."

FACTS:

- In Vermont, which passed dental therapy legislation in 2016, Vermont Technical College launched a dental therapy training program in June 2017. It hired a director and is in the process of developing curricula and applying for accreditation from the Commission on Dental Accreditation.
- In 2016 Ilisagvik Community College partnered with Alaska's tribal training program to offer the first community college associate's degree program in dental therapy. Students are already matriculating. In June, the college will apply for CODA accreditation.
- In Florida where dental therapy legislation was introduced in December 2017, Palm Beach State College has publicly voiced interest in starting dental therapy training programs.

MYTH:

"In Minnesota, there is little demand for dental therapy and no waiting lists at their training institutions."

FACTS:

- On average, there are about three applicants for every open slot in each of the two Minnesota dental therapy training programs, and about 14 new students entering training every year.
- Over time, the demand for dental therapists has increased. In 2016, 91% of dental therapists reported being employed, compared with 74% in 2014. Of the 9% unemployed in 2016, only 3% were actively looking for work. The increase in dental therapists working signifies that the profession is becoming a more established part of the dental team in Minnesota.

Dental Therapy in WI

Facts & Myths

MYTH:

"There is potential for significant state costs associated with training dental therapists."

FACTS:

- Neither of the Minnesota dental therapy education programs received any additional state appropriations or subsidies for their dental therapy programs. They have both administered these new training programs with their existing general funding and resources for health care education that they receive from various sources and from student tuition paid by those who are enrolled in the programs.

MYTH:

"The Wisconsin Legislature may need to increase Medicaid funding in the next biennium to reimburse dental therapists."

FACTS:

- Wisconsin operates a Medicaid program to provide medical and dental care to beneficiaries. In 2016 about 1,047,000 Wisconsinites (18% of the population) got their dental benefits through Medicaid. Medicaid expenditures for dental care are artificially low because most enrollees are not accessing dental care.
    - In 2016, more than 500,000 children had dental benefits through Medicaid; 68% received no dental care —the worst rate in the country.
    - In 2014 only 34 percent of adults in Medicaid's fee-for-service program accessed dental care (the majority of Medicaid dental benefits are provided through fee-for-service, and not managed care).
    - In 2014 only 30% of Wisconsin dentists treated any Medicaid patients.
- Dental therapists would help Medicaid achieve its goal of offering needed dental care to beneficiaries. And, because dental therapists earn significantly lower wages than dentists, practices can use the lower labor costs to serve more Medicaid patients with the revenues they collect. This is a win for state Medicaid budgets and patients.
- Increased access to care through the use of dental therapists would also mean fewer trips to emergency rooms for preventable dental conditions. In 2015, Wisconsin hospitals clocked more than 41,000 emergency room visits for which a preventable dental condition was the primary or secondary diagnosis; 56 percent of such visits were paid for by Medicaid.
    - If accounting for only primary diagnosis visits (33,113), at an average cost of $749 per visit (in 2012), this represents **nearly $25 million in hospital charges**.
    - This is money wasted, because patients usually leave ERs with the same underlying problems they walk in with. ERs commonly stabilize patients with antibiotics and pain killers and then tell the patient to find a dentist for needed treatment.

Dental Therapy in WI

Facts & Myths

MYTH:

"Wisconsin doesn't need dental therapists. Lawmakers should instead be focused on other solutions such as increasing dentist reimbursement rates."

FACTS:

- Increasing Medicaid payment rates does nothing for the 1.5 million Wisconsin residents (27% of the state population) who live in dentist shortage areas, where they already have trouble finding a dentist.
- Raising Medicaid payment rates for providers cannot help patients who face trouble getting to a dentist's office (e.g., school children, people in assisted living facilities and nursing homes, those with disabilities that limit their mobility). Dentists can send lower-cost providers like dental therapists to these locations.
- Raising Medicaid payment rates to perpetuate a system where only dentists – the highest paid member of the dental team -- provide routine restorative care is a highly inefficient use of Medicaid dollars. Today's dental trade journals include scores of articles on how to use auxiliary staff to create more efficient practices so that dentists can maximize productivity and revenues. Most dentists delegate lower-skill procedures such as teeth cleanings and x-rays to dental hygienists, freeing their time to do more complex and costly procedures. They can further raise productivity by allowing dental therapists to provide routine restorative care such as fillings. This would lower a practice's labor costs, allowing them to serve more Medicaid patients with the revenues they collect.
- Labor costs are the largest cost category of a dental practice's operating budget. With labor costs at one-third to one-half of that of starting dentists, dental therapists offer a cost efficient way to staff mobile care in community settings like schools or nursing homes, or satellite clinics in underserved areas – where lower labor costs can offset the additional costs of mobile equipment, transportation, lost productivity due to travel/set-up time and office space.

Legislative Bill/Resolution

2017-2018 Legislative Session

Senate Bill 784

Relating to: licensure of dental therapists and granting rule-making authority. (FE)

1

Alliance of Health Insurers, U.A.

For

Notified Date: 2/12/2018

2

Americans For Prosperity

For

Notified Date: 2/12/2018

3

Anthem, Inc. and Its Affiliates

For

Notified Date: 2/13/2018

4

Ascension Wisconsin

For

Notified Date: 2/9/2018

5

Children's Hospital of Wisconsin

For

Notified Date: 2/13/2018

6

Disability Rights Wisconsin

For

Notified Date: 2/13/2018

7

Disability Service Provider Network

For

Notified Date: 2/9/2018

8

Kids Forward

For

Notified Date: 2/9/2018

9

Marquette University

Against

Notified Date: 2/8/2018

10

Menominee Indian Tribe of Wisconsin

For
Notified Date: 2/12/2018

11

Sixteenth Street Community Health Centers

For
Notified Date: 2/13/2018

12

The Pew Charitable Trusts

For
Notified Date: 2/8/2018

13

Wisconsin Association of Health Plans

For
Notified Date: 2/13/2018

14

Wisconsin Association of Local Health Departments and Boards

For
Notified Date: 2/8/2018

15

Wisconsin Chapter of the American Academy of Pediatrics (WIAAP)

Undisclosed
Notified Date: 2/11/2018

16

Wisconsin Counties Association

For
Notified Date: 2/12/2018

17

Wisconsin Dental Association

Against
Notified Date: 2/9/2018

18

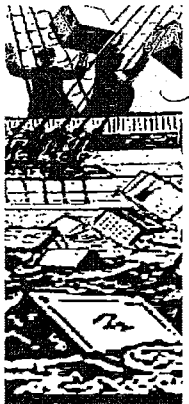
Wisconsin Dental Hygienists Association

For
Notified Date: 2/13/2018

19

Wisconsin Public Health Association

For
Notified Date: 2/8/2018



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February 12, 2018

To: Members of the Wisconsin House and Senate
Re: AB945 and SB784
From: Americans for Tax Reform

Dear Members of the Wisconsin House and Senate,

I write today in support of Assembly Bill 945 and its companion, Senate Bill 784. If approved, these bills would tear down an unnecessary government barrier to the dental services that Wisconsin small businesses can provide to consumers in the state. Often, proposals that increase health care options for underserved populations do so at a significant cost to taxpayers. AB945 and SB784, however, utilize the free market at no cost to the state.

Dentists who want to expand their practices to include educated and qualified mid-level practitioners should be free to do so. Dental therapists are highly educated, thoroughly trained and tested professionals who operate as part of a larger dental team, and focus on preventative and restorative treatments under the supervision of a dentist. Innovative ideas like this have faced intense opposition but are very similar to the fights that took place decades ago with the emergence of nurse practitioners. Physicians began working and collaborating with nurses that had clinical experience to fill a void left by specialization in the medical field. Today, nurse practitioners provide equivalent or superior care to that provided by physicians. **AB945 and SB784 responsibly follow the nurse practitioner model for dental practices.**

Americans for Tax Reform supports a wide range of free market solutions to today's health care issues. It is undeniable that there is a dentist shortage, particularly in underserved and rural areas of the state. **AB945 and SB784 would alleviate the dentist shortage by permitting, but not requiring, small businesses to hire dental therapists and the state should not stand in the way.**

I encourage the legislature to pass these bills because this legislation doesn't only benefit small businesses and consumers; it also benefits taxpayers who bear the burden of rising health care costs, including Medicaid. That may be why in a national poll conducted by ATR in 2016, **79% of voters expressed support for the creation of mid-level dental providers, including 77% of Republicans, and 80% of Independents and Democrats**. At no cost to taxpayers, AB945 and SB784 are common sense bills that serve as a model for free market health care reform in the states.

If you have any questions on these bills, feel free to reach out to Paul Blair, ATR's strategic initiatives director, at 202-785-0266 or by email at pblair@atr.org.

Sincerely,

Grover Norquist
President
Americans for Tax Reform

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 31, 2018

TO:
Senator David Craig
Senator Chris Kapenga
Representative Paul Tittl
Representative Nancy VanderMeer
Representative Mary Felzkowski
Representative Romaine Quinn
Representative Rob Swearingen

CC:
Senator Leah Vukmir
Secretary Linda Seemeyer
Representative Joe Sanfelippo
Liz Portz

The Minnesota Department of Health (MDH) recently had the opportunity to review the Wisconsin Dental Association's (WDA) materials on dental therapy (DT) in Minnesota and beyond. This letter is to clarify the claims noted with respect to the dental therapy profession in Minnesota, based on our experience providing information and technical assistance to community stakeholders and legislators on this topic, working with providers who have employed or are seeking to employ DTs, and evaluating the impact of DTs in Minnesota.

As background, MDH has had oral public health responsibilities since 1872. Our oral health staff includes dental health professionals, epidemiologists and health workforce researchers, and the department is accredited by the Public Health Accreditation Board.

The WDA material is imprecise on the start of dental therapy in Minnesota. The first Minnesota legislation on DT passed in 2009; the first DT in MN was licensed and employed in 2011; and in Sept 2011, the state's Medicaid agency enrolled the first DT as a billable provider. By 2014, when MDH published the first evaluation of the access impacts of DTs, there were 32 licensed DTs practicing in 15 dental clinics in MN as compared to 4,027 licensed dentists and 5,542 licensed dental hygienists statewide.[i] Currently, there are 79 DTs practicing in Minnesota, roughly one DT for every 70,000 Minnesotans. To get to this level of adoption of a new profession in such a short time, Minnesota's oral health community came together to assemble the basic foundation needed to support these workers and the clinics in which they practice, including developing educational programs, licensing and certification procedures, reimbursement policies, and helping interested dental practices to understand the new role and integrate it into their operations.

The 2014 evaluation offered our first look at the impact of these newly licensed professionals on access to and quality of oral health. The evaluation, which was based on patient data and interviews with oral health providers and clinic administrators, found that DT patients reported decreased travel and appointment wait times, and employers reported an increase in the number

of new Medicaid patients to the clinic in addition to increased productivity among the dental team providers, increased efficiency and flexibility with scheduling, and reduced clinic operating costs. Between 2011-2013, in their first few years of existence, DTs saw 6,338 new patients.[ii]

It is important to put the contributions of DTs into the broader context of long-standing oral health access challenges in Minnesota. Like many states, Minnesota struggles with providing consistent access to oral health care across the state, especially for Medicaid patients despite a dental Medicaid benefit. An aging dental workforce, historically low reimbursement rates for oral health services by public programs, and complex administrative and payment structures have resulted in low participation of dentists in Medicaid, thereby decreasing access and increasing oral health disparities for Medicaid populations. It was because of these long-standing access challenges that Minnesota's oral health community came together to explore, research and ultimately advocate for DT legislation. This was only one of a number of strategies for improving access that were advocated for and ultimately enacted by the Minnesota Legislature.

But because these access problems are caused by multiple complex factors, the responsibility for solving them cannot lie solely with DTs. While we know that DTs are opening up additional access points and expanding access, in particular for underserved populations, a cohort of less than 80 practitioners which is growing but still less than one percent of Minnesota's workforce cannot yet produce statistically valid changes in statewide or regional access and utilization data and even in the future will not be the entire solution to the longstanding, multi-faceted access problem. DTs must be part of a comprehensive package of strategies to support access to high-quality oral health services, including sufficient reimbursement across payers; administrative streamlining; and incentives to attract, recruit and retain all dental provider types to serve in urban and rural underserved areas.

As part of our oral health program's overall mission to promote, protect, and improve oral health, because it is critical to the health of all Minnesotans, MDH monitors the oral health workforce in Minnesota, including DTs. As part of this tracking, we know that DTs are now distributed throughout Minnesota's rural and urban areas in proportion to the distribution of the population at large. DTs are also one of the more diverse licensed health care providers in the state—a third of the providers are people of color, and they are serving an equally diverse patient base. DTs are also more likely to work in community based or non-profit settings or clinics as compared to any other dental profession (24 percent). About 35 percent of DTs work in community-based, nonprofit, faith-based clinics or community health centers/federally qualified health centers.[iii]

We also know that the number of patients receiving care from DTs is growing. In 2016 alone, DTs provided dental care in an estimated 94,392 patient visits. DTs still account for roughly less than one percent of the state's licensed oral health workforce of approximately 17,000 providers as compared to 23 percent who are dentists.[iv]

The WDA handout mentioned the lack of CODA-accredited dental therapy education programs in the U.S. The handout failed to point out that CODA only recently adopted accreditation standards and has not yet commenced accreditation activities. Existing training programs in

Alaska and Minnesota were established prior to CODA's accreditation program and have the authority to continue to operate without CODA accreditation. However, CODA's development of an accreditation program was initiated at the request of the University of Minnesota Dental School's education program and all three of the existing education institutions contributed significantly to the development of CODA's standards and would meet be able to meet CODA's standards if they pursued accreditation.

The body of evidence supporting dental therapy shows that dental therapists are a lower-cost provider that can improve access while providing safe, high-quality care. The evidence continues to grow as this workforce expands. In Minnesota like in other states, a multi-pronged approach is needed to solve the oral health crises but from our experience, dental therapists are opening access, welcoming new patients and addressing the needs of the underserved.

Thanks for the opportunity to review this material. If you have any questions, please do not hesitate to contact us for more information.

Sincerely,

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Prasida Khanal
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St. Paul, MN 55164-0882
651-201-3538
www.health.state.mn.us

Enclosures:
Dental Therapy in Minnesota – Fact Sheet
Minnesota's Dental Therapist Workforce - 2016

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[i] See http://www.health.state.mn.us/divs/orhpc/workforce/oral/dtlegisrpt.pdf

[ii] See http://www.health.state.mn.us/divs/orhpc/workforce/oral/dtlegisrpt.pdf

[iii] Figures as of December 2016. See http://www.health.state.mn.us/divs/orhpc/workforce/oral/2016dtb.pdf

[iv] See http://www.health.state.mn.us/divs/orhpc/workforce/oral/ohchartbook052016.pdf for Minnesota's oral health workforce composition

DEPARTMENT OF HEALTH

Minnesota's Dental Therapist Workforce, 2016

HIGHLIGHTS FROM THE 2016 DENTAL THERAPIST SURVEY

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Minnesota's Dental Therapist Workforce, 2016

HIGHLIGHTS FROM THE 2016 DENTAL THERAPIST SURVEY[i]

Overall

Dental therapists were first authorized to practice in Minnesota in 2009, with the Minnesota Board of Dentistry licensing its first dental therapist in 2011. Dental therapists are part of the dental team, providing basic restorative services and preventive care. By law, they are required to practice in settings serving primarily low-income, uninsured and underserved patients, or in areas designated as Health Professional Shortage Areas (HPSAs).[ii] Dental Therapy is considered an emerging profession and as such is still integrating into the oral health workforce.

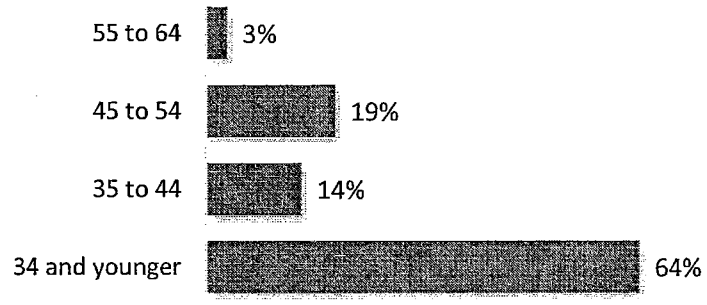
According to the Minnesota Board of Dentistry, there were **63** dental therapists (DTs) with active licenses in Minnesota as of December 2016.[iii]

Demographics

Sex. Eighty-nine percent of all Minnesota dental therapists are female. With a few exceptions, health care professionals are predominantly female.

Age. Demographically, dental therapists are young, with a median age of 32. Sixty-four percent are age 34 and younger and the remaining third of the workforce is between ages 35 and 54.

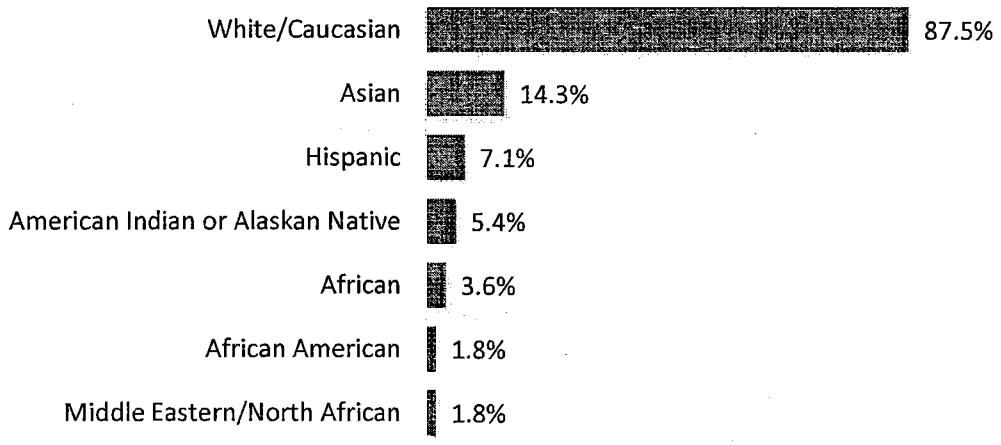
Age of Minnesota Dental Therapists



Source: Minnesota Board of Dentistry, March 2017. Analysis done by MDH. Percentages are based on all 63 Minnesota licensed dental therapists.

Race and Ethnicity. Typical of racial patterns among health care professionals, the majority (87.5 percent) of dental therapists are white. Additionally, 14.3 percent are Asian and 7.1 percent are Hispanic. Dental therapists are among the most diverse of the health care workforces in Minnesota.

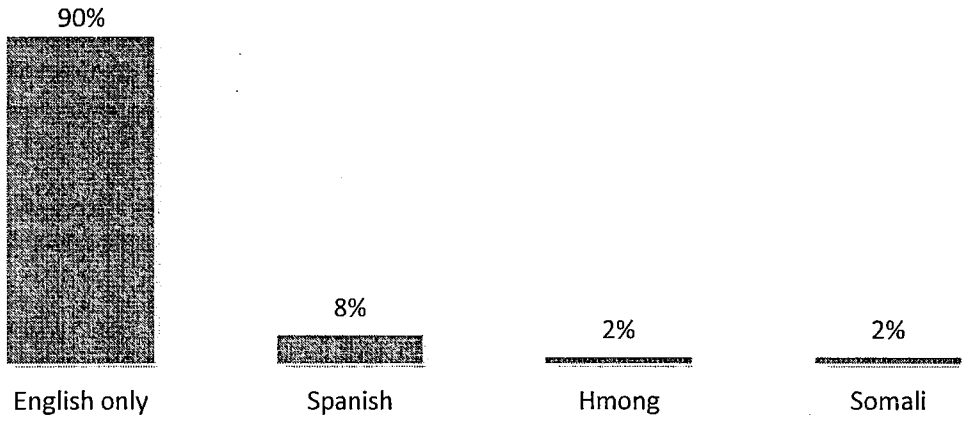
Race of Minnesota Dental Therapists



Source: MDH Dental Therapist Workforce Questionnaire, 2016. Respondents could select as many races as applicable.

Languages Spoken in Practice. The majority of dental therapists (90 percent) spoke only English in their practices. Spanish was the most common language other than English, spoken by 8 percent of dental therapists.

Languages Spoken by Minnesota Dental Therapists in their Practices



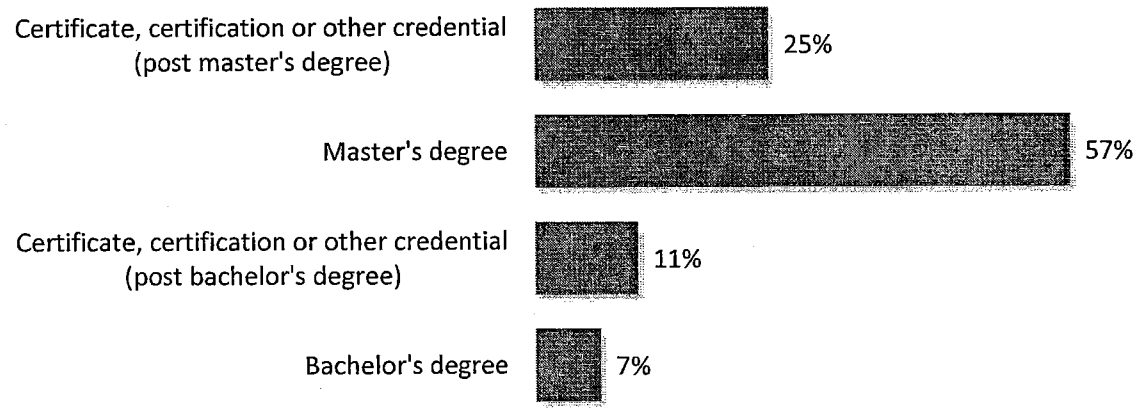
*Source: MDH Dental Therapist Workforce Survey, 2016. Respondents could select as many languages as applicable, but were instructed **not** to include languages spoken only through an interpreter.*

Education

Educational Attainment. Eighty-two percent of dental therapists have a master's degree. Dental therapists must attend one of two schools in Minnesota. Metropolitan State University, in partnership with Normandale Community College, admits students who are Minnesota licensed dental hygienists and offers a Master of Science in Advanced Dental Therapy degree. The University of Minnesota's School of Dentistry also trains dental therapists and does not require any previous dental related

degree. Initially the University of Minnesota's program graduated students with either bachelor's or master's degrees, then switched to only master's degrees in 2013. At the start of the 2016 school year, the university began offering a dual degree: a Bachelor of Science in Dental Hygiene and Master's in Dental Therapy.

Educational Attainment of Dental Therapists

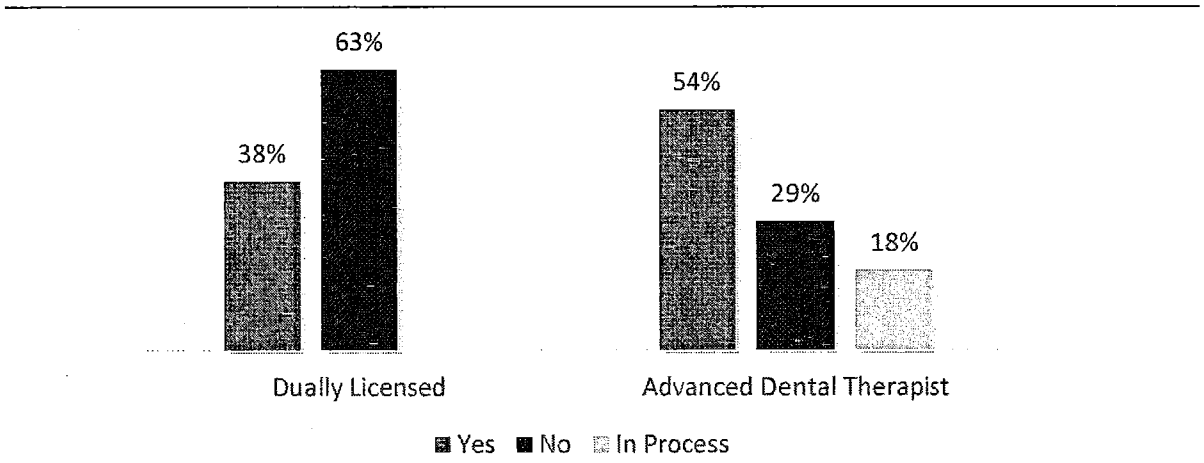


Source: MDH Dental Therapist Workforce Questionnaire, 2016. Percentages are based on 56 valid responses.

Additional Licensure. Dental therapists can also be licensed as a dental hygienist. As shown, 38 percent of dental therapists are dually licensed as both dental hygienists and dental therapists, and can perform services under both professions' scope of practice. Dental therapists with a master's degree can become certified as advanced dental therapists (ADTs) after completing 2,000 hours of practice and passing an ADT certification exam. ADTs can perform additional procedures and do all work without a dentist on site. Just over half of DTs reported holding an ADT certification, and an additional 18 percent are in the process of becoming ADTs.

In the Twin Cities area, dental therapists are more evenly split between those who are dually licensed and those who are DTs; 48 percent of DTs are dually licensed in the Twin Cities area while 20 percent are in Greater Minnesota (data not shown).

Dental Therapists with Additional Licensure or Certification



Source: *MDH Dental Therapist Workforce Survey, 2016. The chart is based on 56 valid survey responses.*

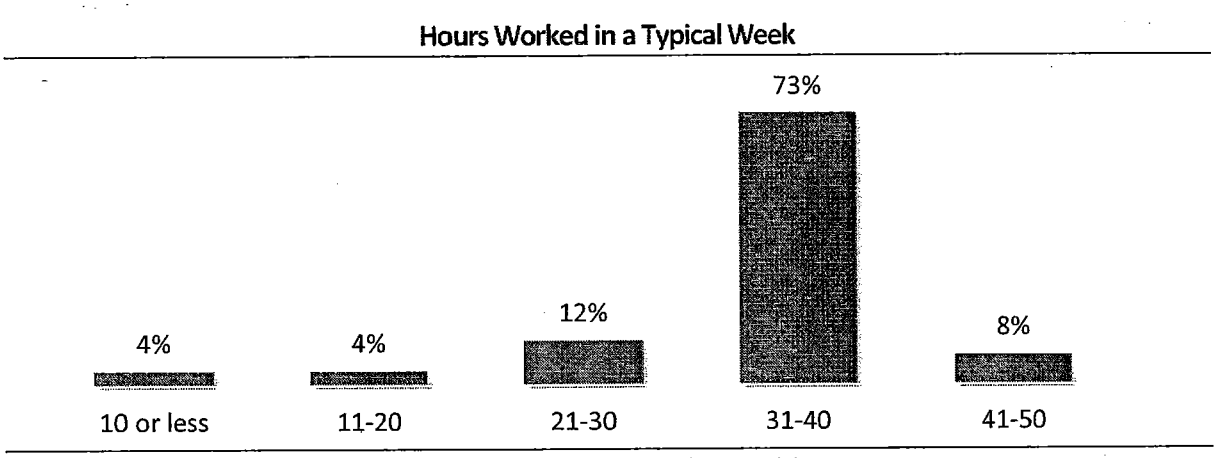
Employment, Hours and Future Plans

Share of Dental Therapists Employed. Ninety-one percent of Minnesota licensed dental therapists reported on the MDH survey that they were "working in a paid or unpaid position related to [their] license." Three percent of dental therapists were looking for work, three percent were not seeking a position and one percent was temporarily not working.

As time goes by, more dental therapists report being employed: in 2014, 74 percent reported that they were working; in 2015, 86 percent were working. As a new profession, dental therapists have had some challenges with job availability and acceptance. The increase in dental therapists working indicates the profession is becoming a more established part of the dental team in Minnesota.

Hours Worked. The median work week for dental therapists was 36 hours, and the majority worked between 31 and 40 hours per week. In the oral health field, working slightly less than 40 hours per week is commonly considered full-time. Dental therapists reported working similar hours in 2015.

Eighty-seven percent reported working a full-time schedule. More Twin Cities area dental therapists work full time (96 percent) than Greater Minnesota DTs (80 percent).



Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 52 valid survey responses.

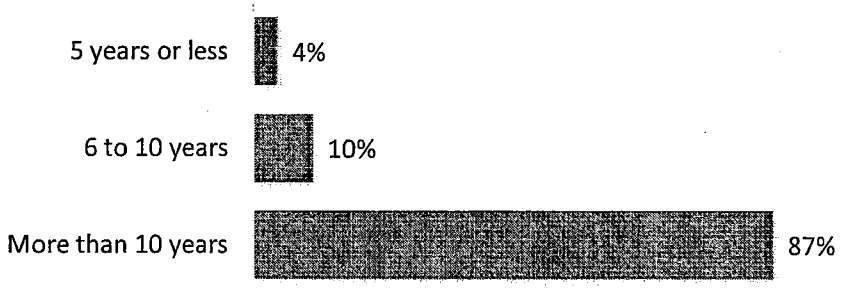
Dental therapists spent most of their time caring for patients; 92 percent reported on the MDH survey that they spent more than three-quarters of their time providing direct patient care (data not shown).

Dental Therapists at Work. Ninety-percent of dually licensed DTs reported spending some time on dental hygienist work. Most dually-licensed dental therapists focused their time on tasks dental therapists are authorized to perform. Sixty-seven percent reported spending *up to* 25 percent of their time on dental hygiene-related procedures with the remaining 75 percent or more of their time spent working within their dental therapist scope of practice (data not shown). With education program changes resulting in more dental therapists with dual licenses, it will be important to understand the best use of both sets of skills.

DTs spend their time on a mix of preventive and restorative tasks. DTs who hold the additional ADT certificate are able to provide additional restorative and surgical functions. The amount of time DTs reported spending on ADT procedures varied. For example, seven percent reported they spent no time, 33 percent spent up to a quarter of their time, and 23 percent spent more than three quarters of their time on ADT procedures (data not shown).

Future Plans. Dental therapy is a stable profession, with 87 percent of dental therapists planning to remain in the field for more than ten years. Just 4 percent responded they planned to leave the field within five years. Among that small number of DTs who plan to leave the field, no dental therapists plan to retire. With an emerging profession, it is important to understand reasons people are leaving the field. Of those who plan to leave the profession, the reasons were burnout or dissatisfaction and to pursue additional training.

"How long do you plan to continue practicing as a dental therapist in Minnesota?"



Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 52 valid survey responses.

Dental Therapists at Work

Work Settings. The survey also asked dental therapists to identify their primary work setting. Dental therapists are more likely to work in a community based or non-profit setting or clinic than any other dental profession (24 percent). As shown, most dental therapists work in either solo private practice or small group private practice, comparable to other oral health professionals. Similar to dentists' work locations, Greater Minnesota dental therapists are more likely to work in a solo or small group private practice than Twin Cities area dental therapists.

It is not uncommon for dental therapists to provide services in more than one location. While about two out of three dental therapists reported working at just one location, 29 percent work at two locations and 8 percent work at three or more locations (data not shown).

For those reporting a secondary work location, the most common location is similar to the primary location with most working at a small group private practice, (29 percent), followed by 18 percent working at a community health center or federally qualified health center (data not shown).

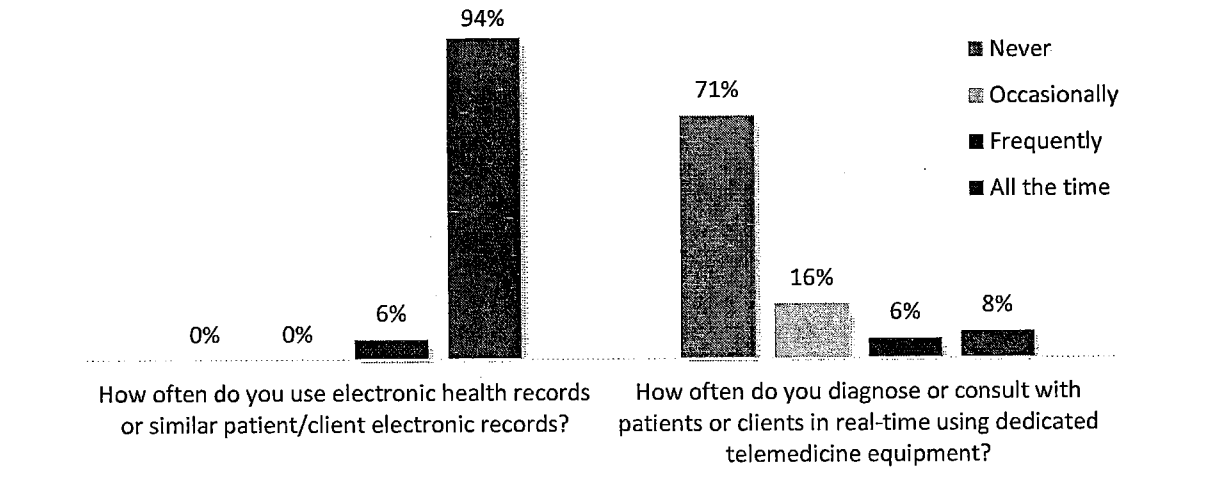
Dental Therapists' Primary Work Settings

Setting	Share of DTs Working in this Setting
Solo Private Practice	25.5%
Small Group Private Practice (2-4 dentists)	21.6%
Community Based Non-Profit (church, homeless shelter, etc.)	11.8%
Community Health Center/Federally Qualified Health Center Clinic	11.8%
Community/Faith-Based Organization Clinic	11.8%
Large Group Private practice	7.8%
Hospital	3.9%
Academic (Teaching/Research)	3.9%
Long-Term Care Facility	2.0%

Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 51 valid survey responses.

Technology at Work: The Use of EHRs and Telemedicine Equipment. The survey included items about the use of both electronic health records (EHRs) and dedicated telemedicine equipment. The results showed that 94 percent of dental therapists use EHRs "all the time," and 30 percent reported using telemedicine equipment at least occasionally. Telemedicne can help dental therapists serve clients in more non-clinic locations and allow for an efficent way to communicate with supervising dentists.

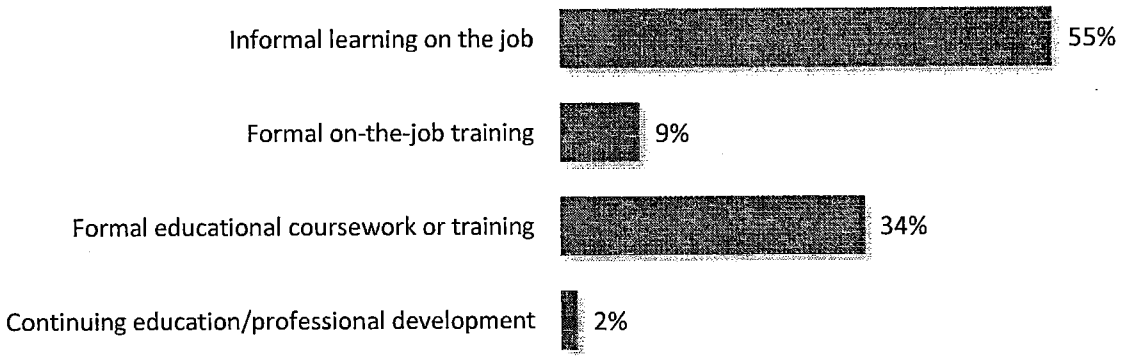
Dental Therapists' Use of Electronic Health Records and Telemedicine Equipment



Source: MDH Dental Therapist Workforce Survey, 2016. The charts are based on 51 survey responses.

Teamwork. Health care providers increasingly work in multidisciplinary teams, prompting educators and health policymakers to ask how best to train providers to communicate and coordinate across professions. MDH included a question on its survey to shed light on this issue. As shown, 64 percent of dental therapists reported that learning on the job (either informal or formal) *best* prepared them to work in multidisciplinary teams. Formal educational coursework or training was most helpful to about a third of dental therapists.

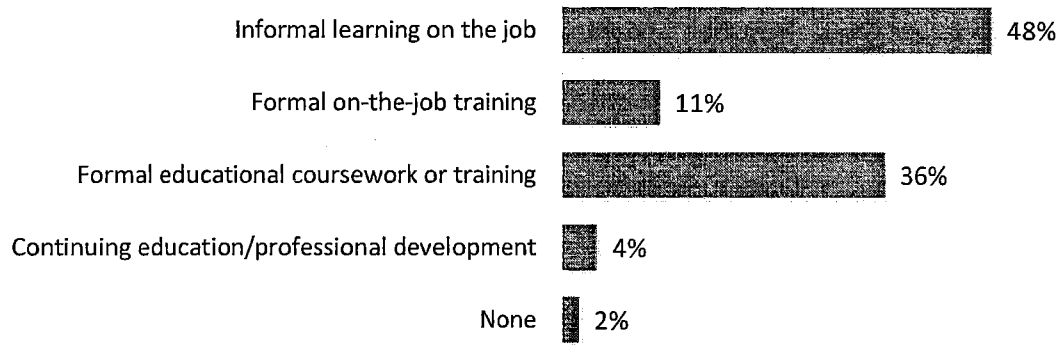
"Which of the following work or educational experiences best prepared you to work in a multidisciplinary team when providing care?"



Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 56 survey responses.

Cultural Competence. Minnesota health care professionals must navigate diverse racial, ethnic, and cultural norms in their work, also raising questions about the best way to prepare dental therapists to provide culturally competent care. The highest percent (59 percent) of dental therapists indicated that formal or informal learning *on the job* provided the best preparation for working with diverse groups of patients, followed by formal education or coursework.

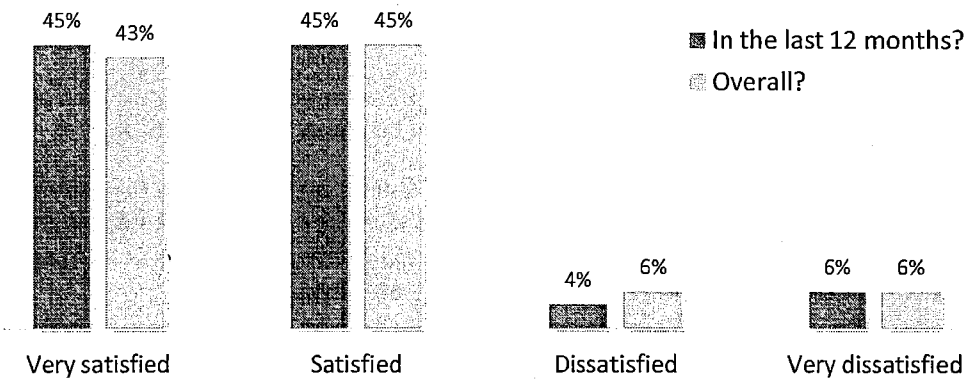
"Which of the following work or educational experiences best prepared you to provide culturally competent care?



Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 56 survey responses.

Work and Career Satisfaction. The majority of dental therapists indicated that they were either "satisfied" or "very satisfied," overall. Dental therapist satisfaction levels are similar to those of other Minnesota health care professionals for which data exists.

"How satisfied have you been with your career..."



Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 51 responses.

Dental therapists report the most satisfaction from being able to provide care to people who may not get it otherwise. The relationships they have with patients and working in a team care environment were also important.

Sources of professional dissatisfaction included lack of understanding and negative view of the profession, limitations on scope of practice and patients served, and low reimbursement amounts.

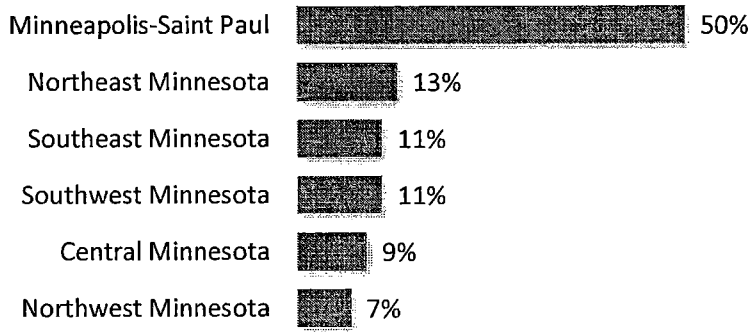
Geographic Distribution

Distribution by Region. To understand accessibility of dental therapist services around the state, the next chart provides a view of the geographic distribution of dental therapists. These analyses are based on geocoded practice addresses from the survey supplemented with addresses supplied to the Board of Dentistry during the license renewal process.

The chart below shows the distribution of dental therapists across the six planning areas around Minnesota[iv]. Dental therapists' current work location is similar to the Minnesota population distribution. For reference, the Twin Cities metro area is home to approximately 54 percent of the population. Dental therapists are also distributed more closely to the Minnesota population than dentists; 50 percent of dental therapists are in the Twin Cities compared to 63 percent of dentists.

Even in the short time they have been practicing in the state, the dental therapist distribution has changed. In 2013, 73 percent of dental therapists worked in the Twin Cities area. Currently, 50 percent of dental therapists work in the Twin Cities area, with small numbers working in other regions of the state.

Dental Therapist by Minnesota Region



Source: MDH Dental *Therapist Workforce survey, 2016. Percentages above are based on geocoding of 56 valid Minnesota addresses. To see regions defined, go to https://apps.deed.state.mn.us/assets/lmi/areamap/plan.shtml.*

The length of time dental therapists have been licensed in different regions also reflects the growth in Greater Minnesota with newly graduated dental therapists working more in Greater Minnesota. In Greater Minnesota 64 percent have been practicing two years or less. In comparison, 46 percent of Twin Cities area dental therapists have been practicing for the same length of time.

Slightly more Greater Minnesota DTs reported job dissatisfaction; 16 percent of Greater Minnesota dental therapists reported some level of career dissatisfaction compared to 4 percent of Twin Cities area dental therapists (data not shown).

Visit our website at http://www.health.state.mn.us/divs/orhpc/workforce/reports.html to learn more about the Minnesota healthcare workforce.

Minnesota Department of Health
Office of Rural Health and Primary Care
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Saint Paul, MN 55117
(651) 201-3838
health.orhpc@state.mn.us

[i] The Minnesota Department of Health (MDH) collected information on demographics, education, career and future plans of dental therapists during a workforce questionnaire in 2016. Unless noted, all data are based on information collected from that survey. The response rate for the 2016 DT survey was 92 percent.

[ii] For additional information, refer to Minn. Stat. 150A.105

[iiiii] All dental therapists licensed by the Minnesota Board of Dentistry work in the state of Minnesota. The dental therapist workforce survey collected addresses from those professionals who reported they were currently working in their profession. Not all survey respondents included their address. The Board of Dentistry also collects address information which supplemented the survey address in some cases.

[iv] To see regions defined, go to https://apps.deed.state.mn.us/assets/lmi/areamap/plan.shtml.

Dental Therapists in Minnesota
Fact Sheet
November 2017

Dental Therapist Numbers

- There are 77 licensed dental therapists in Minnesota.[i]
- 41 (53%) have achieved certification as an advanced dental therapist.
- 21 (27%) are dually licensed as in dental hygiene and dental therapy.
- Dental therapists are employed in 54 different clinic settings.
- 91% of licensed dental therapists are employed as dental therapists.

Dental Therapist Employment and Geographic Location

- 54% of dental therapists are employed by clinics in the 7-county Greater Twin Cities metro area. 55% of Minnesota's population lives in the same Greater Metro area.)
- 46% of dental therapists are employed outside of the 7-county Greater Twin Cities metro area. 45% of Minnesota's population lives outside of the same Greater Metro area.
- In addition to practicing in dental clinics, dental therapists provide services in community and rural settings at more than 370 mobile dental sites throughout the state in schools, Head Start programs, community centers, VA facilities and nursing homes.

Dental Therapy and Increased Access to Care

- Minnesota Statute requires that dental therapists provide care within a dental shortage area or to at least 50% of the total patients be Medicaid patients.
- In 2016, dental therapists provided dental care in an estimated 94,392 patient visits.
- Minnesota's Medicaid program has some of the lowest reimbursement rates for dental services in the country, which negatively impacts access. Dental therapy has not exacerbated the access issue in Minnesota, it has significantly mitigated it.

Dental Therapist and Financial Viability

- Dental therapists provide dental services within their scope of practice at a lower wage and reimbursed at the same rate as a dentist.
- Dental practices report increased productivity and increased earnings following the addition of a dental therapist to their dental care team.
- Minnesota's liability insurers report that there is no additional cost for professional liability coverage for employment of a dental therapist compared to the employment of another dental assistant or hygienist.

Dental Therapy Education

- There are two Master's level educational programs educating and training dental therapists in Minnesota.
- The joint MNSCU (Minnesota State Colleges and Universities) dental therapy program at Normandale Community College and Metropolitan State University began in September 2009. It admits six students per year.

- The dental therapy program at the University of Minnesota Dental School began in 2010 and admits 8 students per year.
- Both programs meet the standards set by the Commission on Dental Accreditation (CODA) in September 2015.

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[i] As of 1/30/18, there are 79 licensed DTs in MN

Minnesota Health Care Safety Net Coalition

January 31, 2018

TO:
Senator David Craig
Senator Chris Kapenga
Representative Paul Tittl
Representative Nancy VanderMeer
Representative Mary Felzkowski
Representative Romaine Quinn
Representative Rob Swearingen

CC:
Senator Leah Vukmir
Secretary Linda Seemeyer
Representative Joe Sanfelippo
Liz Portz

The Truth about Minnesota's Dental Therapists

I received a copy of the Wisconsin Dental Association's (WDA) handout "Dental Therapists Are Not the Answer." I saw these same types of handouts from the Minnesota Dental Association (MDA) when the Minnesota Legislature was considering enacting Minnesota's dental therapist law. I am the executive director of the Minnesota Health Care Safety Net Coalition and I partnered with dozens of other organizations in supporting Minnesota's legislation, which was enacted in 2009. Even though the MDA opposed the legislation, many dentists supported it and were quick to hire dental therapists when they completed their education and obtained a license. It has been an unqualified success in Minnesota.

As Wisconsin policymakers consider this concept, the WDA will continue to provide information disparaging Minnesota's dental therapists and the value of the concept for Wisconsin. I encourage you to go to credible sources for information about Minnesota's experience. The Safety Net Coalition, the Minnesota Department of Health and Minnesota's two dental therapy education programs are available to provide information and answer questions. Additionally, the dentists and dental clinics that have hired dental therapists are available and willing to give their testimonials for how well this is working for them.

A few facts you should know about dental therapists from Minnesota's experience:

1. Dental therapists will improve access to dental care for Medicaid and underserved Wisconsin patients and rural communities and reduce the cost of providing dental services.
2. Dentist and dental clinics will hire Wisconsin dental therapists because they make it possible for them to see more Medicaid and low-income patients while maintaining or improving their bottom line. The market has spoken and dental therapists are in demand.

3. Dental therapists make it feasible and affordable to provide dental care to underserved Medicaid patients in both dental clinics and in community settings such as schools, nursing homes and Head Start programs.

Dental therapists are not the silver bullet that will solve the dental access problem. Other factors such as low Medicaid reimbursement rates, an aging and retiring dentist workforce, declining practices in rural areas all contribute to declining access. But dental therapists are a proven method of improving access without the need for major investments of state dollars.

You will see and hear other messages from the WDA that are intended not to inform but to muddy the water and divert attention from the facts. I will point out one example:

- The WDA handout states "Dental therapists are an expensive and ineffective method of achieving the goal (of increased access)".
- The truth is:
    - Minnesota's dental therapists are paid less than dentists and reduce the costs of providing dental care. We can give you details from Minnesota dental clinics confirming this.
    - Minnesota's dental therapists are an effective method of improving access by every measure: more Medicaid patients served by the clinic, reduced wait times, shorter travel times, private dentists willing to serve more Medicaid patients, and reaching rural and underserved communities. We can provide both evaluations from out state public health department and information and testimonials from dentists and dental clinics.
    - Even though graduating classes of dental therapists are relatively small in Minnesota, we have now reached the point where nearly 80 dental therapists provide an estimated 125,000 patient visits a year and the numbers continue to grow as more dental therapists graduate and enter practice. We can provide detailed information on where Minnesota dental therapists are practicing and who they serve.

I would be happy to provide more information and answer any questions you may have about Minnesota's experience. I can also introduce you to dozens of dentists and dental employers who can give you the truth about dental therapists from their actual experiences.

Respectfully,

Michael Scandrett
Executive Director
Minnesota Health Care Safety Net Coalition
mscandrett@msstrat.com
612-790-2547

DAVID CRAIG

STATE SENATOR

Senate Committee on Public Benefits, Licensing and State-Federal Relations
February 14, 2018
Senate Bill 784
Senator David Craig, 28th Senate District

Chairman Kapenga and Committee Members:

Thank you for considering my testimony on behalf of my constituents in the 28th Senate District regarding SB 784 relating to the licensure of dental therapists.

This piece of legislation seeks to increase Wisconsinites access to dental care, especially for the 1.5 million Wisconsin residents currently living in areas with dentist shortages. Simply stated, this bill would allow for the licensure of dental therapists who are members of the dental care team that would be able to engage in limited practices of dentistry, such as fillings and sealants. The bill requires that these health care practitioners always work under a dentist's general supervision.

As in other health care fields, dental therapists serve as a mid-level provider, like nurse practitioners and physician assistants. Providing dental practices the option to include these well-trained dental professionals in their dental teams will allow for increased access, lower patient costs, and savings for the state, all without compromising quality of care.

Mid-level providers in other fields of medicine were once a new concept and are now a mainstay in today's health care system. In addition to over 50 countries, dental therapists are currently authorized in Minnesota, Maine, and Vermont with tribal authorization in Alaska, Washington and Oregon. Several other states are currently considering legislation.

It is important to emphasize that dental therapists receive the same training as dentists for the procedures they are allowed to perform within their scope and must meet rigorous standards approved by the Commission on Dental Accreditation - the same entity overseeing the training of dentists. A systematic research review by the American Dental Association Council on Scientific Affairs found that dental care teams that employ mid-level providers such as dental therapists can reduce the rate of untreated tooth decay more than teams that employ only dentists.

Passage of this legislation will help address several on-going problems including: (1) access to dental care; (2) over-utilization of emergency rooms for dental problems; and (3) over-prescription/abuse of opioids prescribed during emergency room visits.

Dentists in other states who have embraced the concept and employed dental therapists report increased dental team productivity, increased profits, personnel cost savings, and improved patient satisfaction. A 2014 report released by Minnesota Board of Dentistry and Department of Health found clinics employing dental therapists

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could see more patients, over 80% which were on Medicaid. These patients experienced decreased travel time and nearly one-third saw decreased wait times. Increasing access and savings from the lower costs of employing dental therapists made it possible for clinics to expand capacity to see more Medicaid and underserved patients.

Dental therapists are also cost effective. Under the current system, dentists are often providing routine care rather than providing procedures at the top of their scope. This is a highly inefficient use of Medicaid dollars. With dental therapists as part of the team, dentists are able to delegate more routine procedures to their dental hygienists and dental therapists, freeing their time to do more complex and costly procedures. This would lower a practice's labor costs, allowing them to serve Medicaid patients more cost effectively, even with the low reimbursement rate dentists currently receive.

The concept of licensed dental therapists is non-partisan and has been embraced by conservatives and liberals alike, a fact that was highlighted recently in an op-ed by Grover Norquist and Donald Berwick, CMS Administrator under President Obama, who wrote "allowing dental therapists to practice is a bipartisan solution that state legislators can adopt right now that benefits small businesses, helps patients, and eases the burden of rising health care costs, including Medicaid." In a national poll conducted in 2016 by Americans for Tax Reform, 79% of all voters were in favor the idea. That included support from 77% of Republicans, 79% of independents and 80% of Democrats.

The dental access crisis in Wisconsin directly affects the health of children, those living in rural areas, the disabled, the elderly, and veterans. The indirect effects are felt by employers, school districts, taxpayers, and the health care system. With this legislation, we can battle this crisis by improving the access to and quality of dental care across Wisconsin.

Thank you for your attention and consideration of my testimony.

State of Wisconsin
Department of Health Services
Scott Walker, Governor
Linda Seemeyer, Secretary

February 14, 2018

Public Benefits, Licensing and State-Federal Relations
Senate Bill 784

Chair Kapenga and members of the Senate Committee on Public Benefits, Licensing and State-Federal Relations, thank you for the opportunity to testify for information on Senate Bill 784. My name is Jennifer Malcore and I am the Assistant Deputy Secretary at the Department of Health Services.

Wisconsin ranks lowest in the nation in dental utilization among Medicaid children. While Wisconsin's dental utilization rates are lower than neighboring states, Wisconsin Medicaid's payment rates for dental care range from 89 percent to 155 percent of that of neighboring states.

Fortunately, under the leadership of many legislators and the dental community a few pieces of legislation have passed this session to help this issue. Those include Assembly Bill 146 enacted last June to increase the practice settings in which dental hygienists can independently provide care and an enhanced reimbursement rate for dental services provided at certain facilities that serve individuals with disabilities.

In 2015, the State legislature agreed to test the impact of payment rates on Medicaid enrollment of dentists by authorizing a dental pilot program. The pilot implemented a targeted rate increase for all dental services for children and for emergency dental services for adults in four pilot counties (Brown, Marathon, Polk and Racine).

The Department implemented the pilot in October 2016. While it is still too early to know the long-term impact of the dental pilot, preliminary data indicates more than $15 million has been spent for dental services in the four pilot counties, with more than half of that amount due to the increase in payment rates. In the first year of the pilot program (Oct 1, 2016-Sept 30, 2017), a total of 62 new dentists and 8 new dental hygienists enrolled as Medicaid providers with the pilot counties (Brown, Marathon, Polk, and Racine) and approximately 30,000 children and 10,000 adults received dental services eligible for the increased dental rates. By comparison, in the year immediately before the pilot a total of only 22 new dentists and dental hygienists enrolled in Medicaid within the pilot counties. The preliminary data does suggest an increase in Medicaid enrollment due to the pilot. However, we need to do more analysis to determine the full impact of this increase in enrollment, such as how many more members accessed care. Now that we have a complete year of claims data, we can start that analysis. DHS has contracted with the University of Wisconsin Population Health Institute's evaluation research group to lead an evaluation of the pilot.

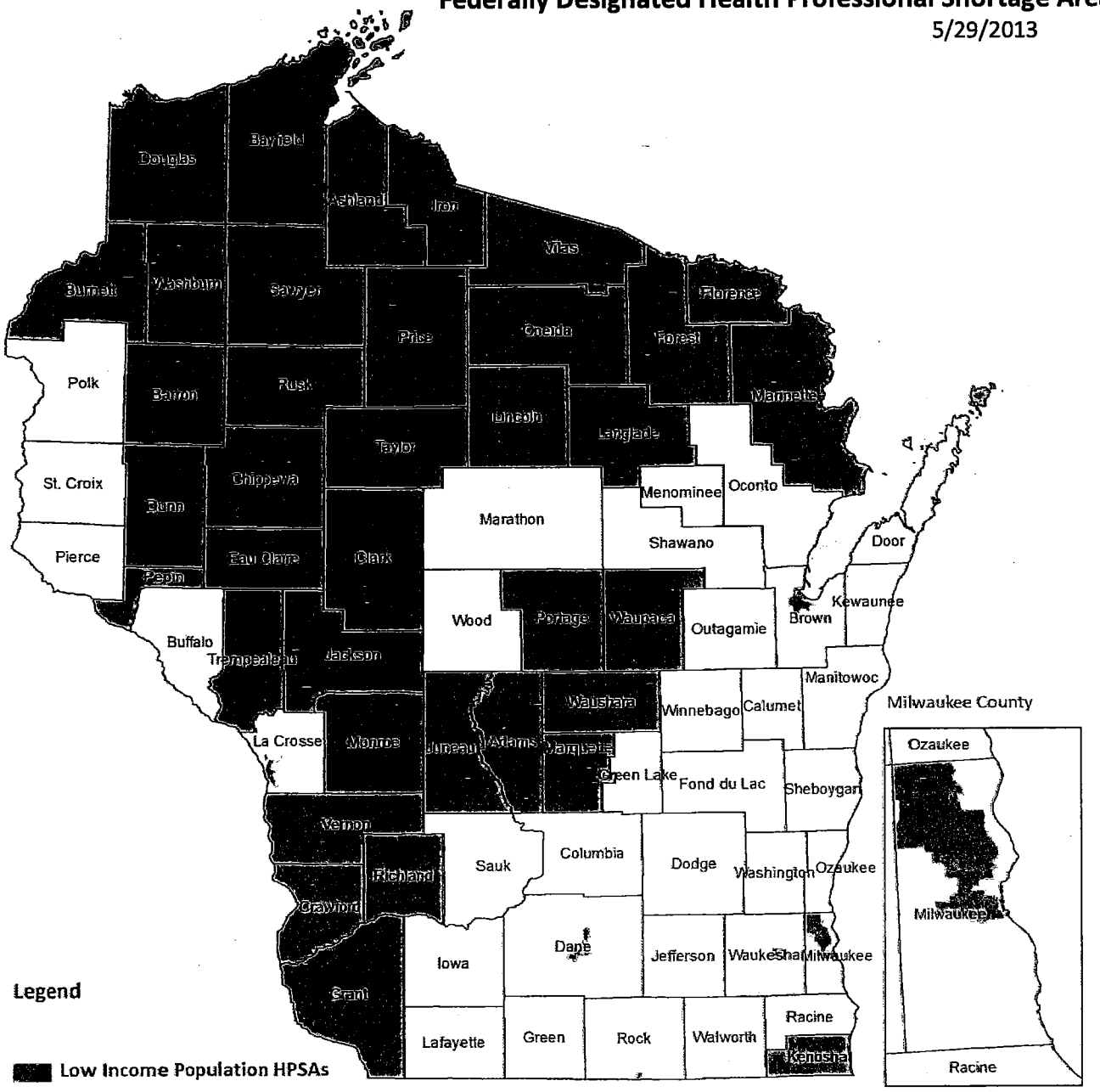
The goal of Senate Bill 784 would help dentists treat more patients by allowing them to hire dental therapists to provide cost-effective preventive and routine restorative care, including tooth extractions and fillings.

DHS is fully committed to working with our partners to increase access to dental care, particularly for some of our most vulnerable citizens. Thank you again for the opportunity to appear before you today. I would be more than happy to take any of your questions.

Wisconsin Dental Care HPSAs

Federally Designated Health Professional Shortage Areas

5/29/2013



* Data definitions in notes.

Wisconsin Department of Health Services
Division of Public Health
Wisconsin Primary Care Office
http://www.dhs.wisconsin.gov/health/primarycare/index.htm

Map Notes:

- This map shows the defined areas that have been federally designated as Dental Health Professional Shortage Areas – dental HPSAs at the time of this publication.
- Dental HPSAs have significant shortages of dentists and meet the following criteria for federal designation:
  - Rational service area (e.g., county or cluster of towns or census tracts),
  - Percent of the population below poverty,
  - Population to dentist ratio, and
  - Contiguous area resources not available.
- The dentists who are counted include general and pediatric. Other dental providers are not required to be counted at this time.
- Low-income population HPSAs reflect a dentist shortage for the area's population with family incomes below 200 percent of the federal poverty level and have a population to dentist ratio of $\geq$ 4,000 to 1.0 FTE.
- Data are not available to analyze eligibility for geographic dental HPSAs, which reflect a shortage of dentists for the general resident population in an area.
- Every low-income population HPSA must be reviewed and federally re-designated after three full years.
- This map does not show the other two types of federally designated HPSAs: facilities (e.g., state correctional facilities) or automatic safety net facilities (e.g., community health centers, tribal health centers, and certified rural health clinics).
- The Wisconsin Department of Health Services – Primary Care Office (PCO) collects data on Medicaid dental claims and dentists who provide sliding discounted fees to low-income populations and submits state applications to the Health Resources and Services Administration (HRSA) for federal designation of HPSAs.
- The complete and most current list of all federally designated HPSAs is available on HRSA's web page at: http://hpsafind.hrsa.gov/
- This map was prepared by the Wisconsin PCO and contracted HPSA staff at the Wisconsin Primary Health Care Association.
- More information on HPSAs and the linked federal and state benefits is available on the Wisconsin PCO web page.
  http://www.dhs.wisconsin.gov/health/primarycare/ShortageDesignation.htm

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February 14, 2018
Senate Committee on Public Benefits, Licensing, and State-Federal Relations
Testimony in opposition to Senate Bill 784
Matt Rossetto, Director of Government Services

Mr. Chairman and members,

Thank you for the opportunity to testify on Senate Bill 784, and to have a much needed discussion about access to oral health care in Wisconsin. The WDA is not opposed to new providers on the care team, and we are equally concerned about increasing access to oral health care for low income individuals. We are opposed to SB 784 for one reason: dental therapy, as a model, does not work.

When one does a comprehensive dive into the history of dental therapy as a model, both in the United States and around the world, several themes become clear:

- Dental therapy has never survived anywhere, long term, without significant government subsidy
- Far from being a free market solution, dental therapists only work in rural and underserved areas because those are the places in which they are required to spend a majority of their time
- Seven years of data on dental therapists makes clear that they do not solve the access to care problem
- The dental therapy programs that do work take a much different form than what is being proposed for Wisconsin

I would like to begin by discussing the several models of dental therapy which have been used as examples, and why almost none of them apply to the way a dental therapist would look in Wisconsin.

First, we should talk about Alaska's example of a Dental Health Aide Therapist, or DHAT. Dr. Dave Clemens, one of the WDA members here to testify, spent a significant amount of time working with them and can speak to his experience with them. Designed to treat Alaska's native populations in remote villages, their scope is different, and the program is funded almost entirely by both the federal government and tribal corporations. DHAT's bear absolutely no resemblance to any other delivery model in the United States and cannot be legitimately compared to a dental therapist.

Secondly, let's turn to the Canadian model of dental therapy. The program was first funded by the Canadian government in the early 1970's to attempt to address the problem of access to care in rural Canada. The government subsidized both the schools and the attendees for 40 years, with the idea that demand would eventually make the program self-sufficient. However, in 2011, the Canadian government shuttered the program, due to lack of interest and the withdrawal of subsidy.

I will leave further comment on the Canadian experience to Dr. Bill Lobb, the Dean of the Marquette University School of Dentistry, whose experience with dental therapists in his native Canada gives him a much more authoritative voice on this issue.

Finally, I will quickly address New Zealand, where dental therapists have existed for the better part of the last century. This is a case where the term dental therapist shouldn't be confused for what is proposed here. Dental therapists are mostly in schools in New Zealand, and serve similar functions to our already existing Seal-A-Smile program—providing sealants and fluoride treatments.

Apart from the subsidy required to make models work in other countries, we need to address the one truly existing program in the US; our next door neighbor, Minnesota.

Dental therapy was introduced to Minnesota in 2009, with programs at Metropolitan State University in the Twin Cities, as well as the University of Minnesota, with the first graduates emerging in 2011. After seven years of building the program, only 77 dental therapists are working in the state, the vast majority of which are in urban and suburban areas. While there are some practitioners in rural areas that have been able to take advantage of this new group of practitioners, the fact remains that it is simply not economically viable for many rural providers to hire therapists.

I would also note that the Medicaid pilot currently in place has, after just over a year, resulted in at least 70 new dentists signing up to see Medicaid patients in just four counties. The pilot has done in one year in four counties what has taken dental therapy seven years to accomplish statewide in Minnesota.

In your handouts, I would call your attention to a chart from the ADA Health Policy Institute, which tracks Medicaid reimbursement as a percentage of the cost of a procedure. Wisconsin, which is a fee-for-service state with the exception of six southeastern Wisconsin counties, ranks second to last in reimbursement, in front of only California, in paying 32.1%. Minnesota, which is primarily a managed care state for dental, ranks second from the bottom and amazingly, pays worse than Wisconsin, at 31.1% of cost.

Now, why does this matter? This next point is crucial to understanding why WDA landed where it did on this legislation. Proponents of this bill like to sell it as a largely non-fiscal solution to the access to care problem. We're here to say that the numbers prove that you cannot simply "flood the zone" with more providers and solve the problem.

Data from the Minnesota Department of Human Services shows a significant decline in the percentage of Medicaid enrollees with any dental service, from 2012 to 2016. In 2012, 33% of fee-for-service and 44% of MCO dental patients in Minnesota received some form of dental care. By 2016, those numbers had dropped to 27% and 38% respectively.

On April 26th, 2017, CMS wrote to the State of Minnesota, informing them that their access rates were so low, they risked being judged out of compliance with federal law. They were given 90 days to come up with a plan to make "substantive progress within 12 months toward increasing the number of children enrolled in Medicaid who receive dental services."

Two days later, Emily Piper, the Commissioner of the Minnesota Department of Human Services, wrote to their legislature. "Failure to take meaningful action will lead to corrective actions including, but not limited to, the withholding of needed federal funding. DHS does not have the authority to address this on our own. The Legislature must act if we are going to make meaningful strides toward improving access to dental care... Studies conducted by DHS at the direction of the Legislature in 2014 and 2015 show that, due to administrative complexity, preferential rates targeted to certain providers, and low

base reimbursement rates, many dentists are discouraged from serving public program enrollees. The Minnesota Office of the Legislative Auditor in 2013, also identified DHS' current administrative and payment structures as barriers to dentists participating in the program."

Near the end of her letter, Commissioner Piper makes herself clear. "Unfortunately, smaller measures have been tried and proven ineffective... and **access has continued to decline."** This is happening after seven years of dental therapists in Minnesota, and despite a requirement that dental therapists be limited to, "primarily practicing in settings that serve low-income, uninsured, or underinsured patients, or in a dental health professional shortage area" (from MN Statutes 105A.105 (2)). Not once, in either letter, are dental therapists mentioned at all as a way to help lessen the shortage.

I would point you to two instances in which therapists in Minnesota were hired, and later let go, by dental offices because their level of training was not high enough to deal with the significant cases often presented by patients who have not received regular oral care during their lifetimes.

The first is Dr. Anthony Hilleren, a solo practitioner in West Central Minnesota, whose practice hired a dental therapist in 2013, and later let him go. He hired, as he describes it, "a very nice young man who was one of the top students in his dental therapy class". Dr. Hilleran goes on to say the following...

The second comes from Jeanne Larson, the Executive Director of the Northern Dental Access Center in Bemidji, whose clinic sees only people who are low income, on MA, or MinnesotaCare. Her testimony is attached, but in short, she identified several key areas that led to them not retaining their dental therapist after she was hired.

- Dentists were unwilling or unable to sign CMA's taking full legal responsibility for the actions of a dental therapist that they did not directly supervise. In some cases, their liability carriers would not accept such a risk, or dropped those that did sign a DT.
- Dentists at the clinic spent the first year doing significant on the job training with the therapist, even after graduation
- Seeing 8-9 patients a day, on average, did not cover the cost of services or supplies for their hygienists; the better-paid dental therapists increased the gap in sustainability even further
- The dental therapist could not handle many of the more severe cases presented to the clinic, undermining the efficiency the clinic sought

The discussion on rates, while well-trodden, is important. Despite being regularly told that "everyone on Medicaid makes do with these low rates", that is not technically true. For instance, hospitals with an outsized share of Medicaid patients receive Disproportional Share Hospital, or DSH, payments in a dedicated funding stream from the state. Additionally, critical access hospitals in rural and underserved areas regularly receive subsidy from the federal government, where they are paid at 101% of "reasonable costs" for most services provided to Medicare patients. Finally, Federally Qualified Health Centers, or FQHC's, receive a significantly higher reimbursement rate for their services, outside of the normal Medicaid structure. While it is true that hospitals have to see all patients when they present, I would also note that the vast majority of medical professions outside dentistry practice in large groups, where cost shifting is much easier and more common. The vast majority of dentists are still small business owners, responsible for payroll, supplies, and other elements most doctors never have to worry about. It is also worth noting that less than 1% of state Medicaid spending is for oral health.

Governor Walker has always embraced the idea that raising reimbursement rates is directly tied to increased access for patients, starting with his support of the dental Medicaid pilot, and continuing through his current term. Last fall, Governor Walker announced an increase in Medicaid rates for behavioral health providers, and directly tied an additional investment to increasing the number of providers available. These actions clearly show that investment is needed to improve access.

I'd like to close by talking about the current efforts already underway to help increase access to care for those who need it. First and foremost, the Medicaid pilot program, which has been active since October of 2016, is already succeeding. In Brown, Marathon, Polk, and Racine counties, dentists are receiving increased reimbursement rates for pediatric procedures, as well as some adult emergency procedures. According to DHS, over 70 dentists who were not previously signed up to take MA patients are now participating in the program. More patients are being seen, and offices are expanding the number of chairs available to MA patients.

I'd like to draw special attention to an example in Brown County, where the BCOHP has opened a third clinic in Green Bay, on the city's west side. This expansion was made possible by the bump in Medicaid rates, and it allowed them to hire a new dentist, a graduate of UCLA's prestigious pediatric dentistry program, as well as two new hygienists. Families in Green Bay now have additional options for dental care directly because of this pilot program.

This fall, the UW Population Health Institute will issue a report to the legislature as required, on the results of the first two years. We are confident that this will show significant return on the state's investment.

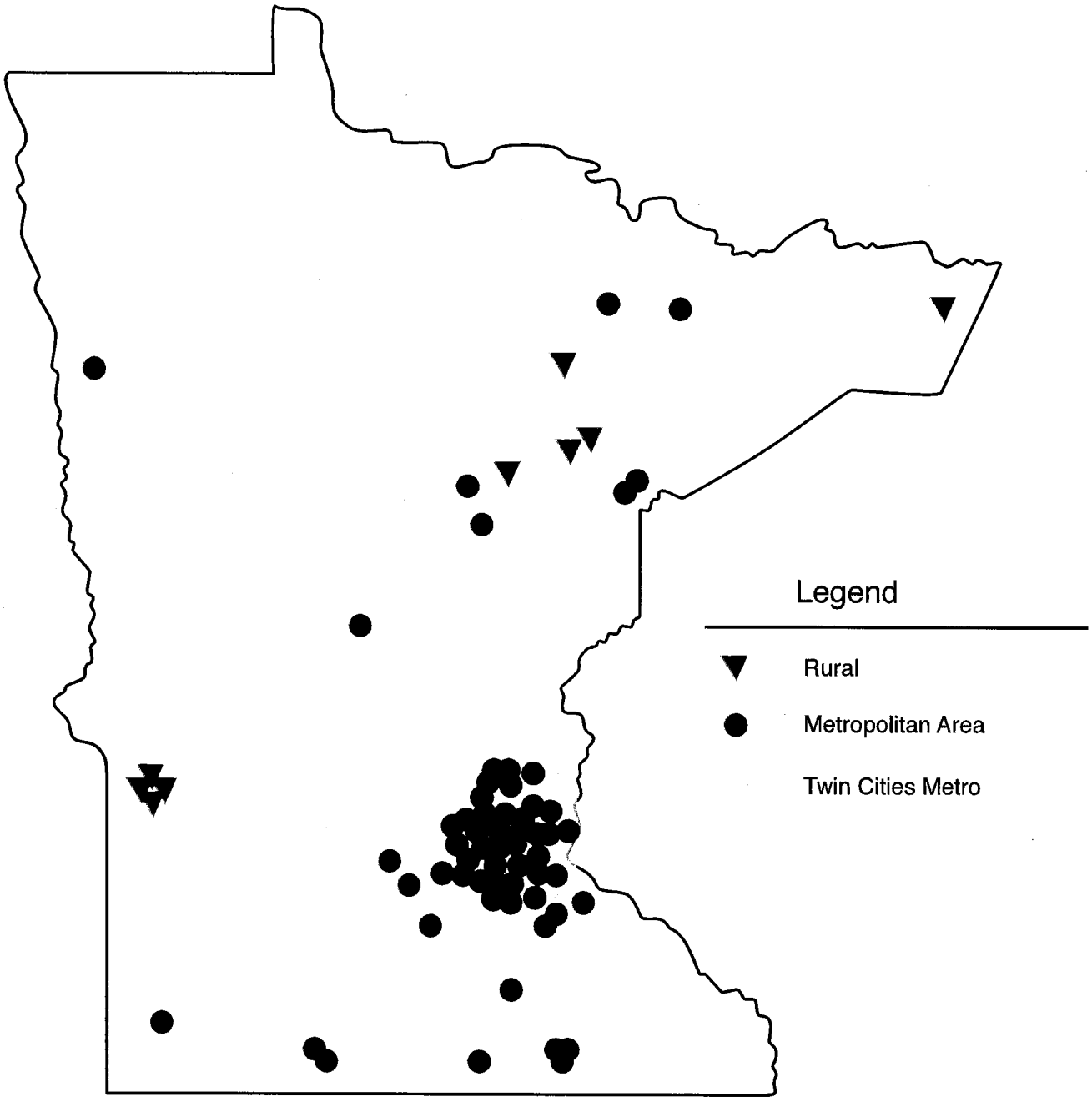
Secondly, the WDA supported Assembly Bill 146, which is now 2017 Wisconsin Act 20. The bill significantly expanded the settings in which hygienists are able to work without being under the direct supervision of a dentist, to include nursing homes, adult daycares, correctional facilities, and a number of others. In fact, a dental office is now the only place in which a hygienist has to be under the direct supervision of a dentist in order to practice.

Thirdly, a bill which the Assembly will vote on soon, and which is currently in this committee, is SB 635. It would allow for another member of the care team called an Expanded Function Dental Auxiliary, or EFDA. In use around the United States and in the military for over 40 years, EFDA's are another member of the dental care team trained to do certain procedures in an office, and allows the office to be more efficient and see more patients. The bill has bipartisan support in both the Assembly and Senate, and passed the Assembly Health Committee unanimously. We hope that this committee will do the same.

There are other efforts taking place—both Madison and Milwaukee have emergency room diversion programs designed to steer those who present at the ER with dental pain to an actual dental provider. This helps break the cycle of patients simply getting a block or pain meds in the ER without receiving the care they need. WDA is in the beginning stages of talks with the WHA about a larger, more comprehensive statewide program.

I appreciate your patience. This is a complex subject with much information to convey. I'm happy to answer any questions you may have.

Licensed Dental Therapists in Minnesota



State Fiscal Year 2012-2016 Dental enrollment and utilization Summary report

SFY	Payment System	Unique Dental Eligible Enrollees	Enrollee With Any Dental Svc	Pct of Enrollees with Any Dental Svc	With Any Preventive Svc	Pct of Enrollees with Any Prev Svc	With Any Restorative Svc	Pct of Enrollees with Any Restorativ Svc	Legislative action
2012	FFS	233,703	78,991	33.80%	53,227	22.78%	43,268	18.51%	3% rate reduction from 9/1/11-6/30/13, Changed CAD designation- to only the U of m and MnSCU , reduced CAD pmt for Mncare from 50% to 30%.
	MCO	654,390	288,937	44.15%	223,505	34.15%	151,268	23.12%	
2013	FFS	207,850	65,422	31.48%	45,518	21.90%	34,671	16.68%	
	MCO	690,872	300,009	43.42%	231,758	33.55%	155,013	22.44%	Increase CAD from 30% to 35%
2014	FFS	258,503	69,736	26.98%	49,352	19.09%	37,580	14.54%	CAD rate increase from 30% to 35%. Added benefits: house/extended facility call, adult prophy for up 4 times/year, behavior mgmt, add CAD for priv't practice - 55 new providers were added as a result.
	MCO	789,184	320,825	40.65%	246,914	31.29%	167,099	21.17%	
2015	FFS	268,616	73,115	27.22%	51,833	19.30%	38,548	14.35%	
	MCO	943,068	367,069	38.92%	280,297	29.72%	195,249	20.70%	5% base rate increase
2016	FFS	260,831	71,255	27.32%	51,938	19.91%	37,497	14.38%	9.65% rate increase for providers outside of seven county, removes the self-restriction requirement for private pay dentists enrolled in the critical access dental program, and increases CAD reimbursment by 2.5%
	MCO	956,119	367,349	38.42%	284,718	29.78%	195,375	20.43%	

Overall, dental utilizations were consistently on the decline since 2012.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

APR 2 6 2017

Marie Zimmerman
Medicaid Director
Minnesota Department of Human Services
540 Cedar St., P.O. Box 64983
St. Paul, MN 55167

Dear Ms. Zimmerman:

Due to longstanding concerns about access to and utilization of dental services by children enrolled in Medicaid and the Children's Health Insurance Program (CHIP), the Centers for Medicare and Medicaid Services (CMS) launched the Oral Health Initiative (OHI) in 2010 with the goal of increasing by ten percentage points the proportion of children ages 1-20 enrolled in Medicaid or CHIP who receive a preventive dental service. As a result, we have been closely monitoring dental utilization data submitted to us annually via the CMS 416 report, as well as other state-level dental data.

There are indications both that Minnesota children enrolled in Medicaid do not currently have sufficient access to dental services and that not enough dental providers participate in Minnesota Medicaid to ensure access to dental care for the state's child enrollees. Minnesota's Medicaid pediatric dental periodicity schedule calls for enrolled children to receive a first dental examination at the eruption of the first tooth or no later than 12 months of age, and to have a repeat examination every 6 months or as indicated by the child's risk status/susceptibility to disease.

- In Federal Fiscal Year (FFY) 2015, only 41 percent of all Minnesota Medicaid-enrolled children ages 1 to 20 received any dental service, compared to a national average of 50 percent.[1] Similarly, only 37 percent of Minnesota Medicaid-enrolled children ages 1 to 20 received a preventive dental service in FFY 2015, compared to a national average of 46 percent.[2] We note that Minnesota seems to have succeeded in recovering eight percentage points of performance in FFY 2013 on "preventive dental services" that it had lost in FFY 2012. Perhaps there are some lessons there for how to further improve performance now.

- Minnesota itself came to a similar conclusion about low utilization in its Access Monitoring Review Plan (AMRP), submitted to CMS on October 3, 2016. As a proxy for access to dental care, Minnesota used the HEDIS Annual Dental Visit (ADV) measure (children ages 2 to 20 enrolled for at least 11 continuous months who had at least one dental visit during the measure year). Minnesota concluded that, in Calendar Year (CY) 2014, just more than half

[1] Form CMS-416, Lines 1b and 12a, FFY 2015.
[2] Form CMS-416 Lines 1b and 12b, FFY 2015.

(55.31%) of Minnesota children enrolled in Medicaid managed care received a dental visit, and a much lower proportion (38.43%) of children enrolled in Fee-for-Service (FFS) Medicaid had a dental visit (AMRP Table V.B.1).

- A recent study by the American Dental Association's Health Policy Institute, which examined use of dental services by children in both Medicaid and the commercial environment, found that in 2014, 71% of commercially insured children in Minnesota had a dental visit, but just 42% in Medicaid did.

This evidence leads us to conclude that Medicaid-enrolled children in Minnesota are not receiving the dental services called for in the state's dental periodicity schedule. Further:

- Data included in the state's AMRP shows that Minnesota's Medicaid dental reimbursement rates are relatively low compared to other benchmarks. For example, Minnesota's base Medicaid FFS dental reimbursement rates was only 47% of the average State Employee Group Insurance Plan (SEGIP) payment. When Critical Access Dental (CAD) rates were added to the computation, the average Medicaid payment was found to be only 56% of the average SEGIP payment. These percentages are strikingly lower than the results from comparing Medicare rates to the Medicaid rates for other services such as primary care (87%), oncology (91%) and mental health (112%) (AMRP Appendix A).

- Reinforcing this point, another recent study by the American Dental Association's Health Policy Institute found that, in 2013, Minnesota's Medicaid FFS dental reimbursement for services to children, as a percentage of commercial dental charges in the state, was 27% (the lowest in the nation), compared to a national average of 49%, and had decreased by 41.3% between 2003 and 2013.

- Minnesota Medicaid enrollees themselves report the greatest level of difficulty in securing an appointment with a participating dental provider. In the 2015 Health Access Survey, 24.4% of respondents identified some kind of provider supply issue. Dental care was by far the highest provider type cited, with 39.5% of respondents reporting that a dentist did not accept their insurance and 61.7% reporting that the dentist was not accepting new patients (AMRP Figure 29).

CMS staff convened a call with Minnesota Medicaid staff on November 18, 2016, to discuss concerns about children's access to, and utilization of, dental services. CMS staff shared a range of potential approaches to addressing the state's relatively low utilization. Among other possible solutions, we discussed the possibility of increasing Medicaid dental reimbursement rates. We were subsequently pleased to learn that a 54 percent across the board rate increase for dental services has been proposed in the Governor's 2018-19 biennial budget. If implemented, this would bring dental reimbursement rates closer to commercial charges, which is likely to increase provider participation and thus access and utilization for children.

Unless significant improvement in children's access to dental services under Medicaid is achieved, however, CMS is concerned that Minnesota is at risk of non-compliance with sections 1902(a)(43)(B) and 1905(r)(3) of the Social Security Act ("the Act"). Under section 1905(r)(3)

of the Act, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit includes screening services provided in accordance with the State's pediatric dental periodicity schedule. Section 1902(a)(43)(B) of the Act requires states to provide or arrange for all EPSDT screening services, which includes dental services provided in accordance with the State's pediatric dental periodicity schedule. Please submit a plan within ninety (90) days of the date of this letter specifying steps that Minnesota will undertake to make substantive progress within twelve (12) months toward increasing the number of children enrolled in Medicaid in Minnesota who receive dental services.

CMS is committed to supporting Minnesota as it works to improve children's access to, and utilization of, dental services. If you have any questions or would like additional technical assistance please contact me at 410-786-5647.

Sincerely,

Anne Marie Costello
Director

DEPARTMENT OF HUMAN SERVICES

Minnesota Department of Human Services
Elmer L. Andersen Building
Commissioner Emily Piper
Post Office Box 64998
St. Paul, Minnesota 55164-0998

April 28, 2017

Senator Michelle Benson
Senator Jim Abeler
Senator Karin Housley
Senator Paul Utke
Senator Tony Lourey

Representative Matt Dean
Representative Joe Schomacker
Representative Tony Albright
Representative Deb Kiel
Representative Jennifer Schulz

Dear Conference Committee Members:

I have new information to share regarding a critical and urgent issue that the health and human services conference committee has the power to address this session. As you know, Minnesota has a two-tiered dental system; those who have private insurance see dentists and those who are on public health care programs go without. This is made painfully evident by the fact that nearly two-thirds of children living below the poverty line in Minnesota did not see a dentist last year.

The Minnesota Department of Human Services (DHS) was notified by the Centers for Medicare & Medicaid Services (CMS) that the number of children on Minnesota's Medicaid program, Medical Assistance (MA), who lack access to dental care has reached unacceptable levels (see attached).

CMS has given DHS 90 days to submit a plan specifying steps the state will take over the next year to make substantive progress to increase the number of children on Medical Assistance who receive dental services. Failure to take meaningful action will lead to corrective actions including, but not limited to, the withholding of needed federal funding. DHS does not have the authority to address this on our own. The Legislature must act if we are going to make meaningful strides toward improving access to dental care.

Major changes to our payment and administrative structure are needed to move the state into compliance. Studies conducted by DHS at the direction of the Legislature in 2014 and 2015, show that due to administrative complexity, preferential rates targeted to certain providers, and low base reimbursement rates, many dentists are discouraged from serving public program enrollees. The Minnesota Office of Legislative Auditor in 2013, also identified DHS' current administrative and payment structures as barriers to dentists participating in the program.

Governor Dayton has proposed a comprehensive approach that simplifies and streamlines the administrative and payment structure, including uniform and fair rates for dental services. The Governor's proposal addresses the lack of dental access for all public program enrollees, both kids and adults, particularly those in Greater Minnesota and those in the fee-for-service program. The CMS letter notes that Governor Dayton's proposal, if enacted, would be considered a meaningful effort by the state to address the lack of access to dental care.

By contrast, the House makes no serious investments to improve access to dental care and includes a provision to exempt rural dentists from Rule 101, which could make the problem worse. The Senate does propose to simplify the administration of the dental program and includes a rate increase that is smaller than that proposed by the Governor, while leaving some special rates intact. Unfortunately, smaller measures have been tried and proven ineffective. The state has enacted dental rate increases for targeted groups of dentists since 2012, mostly through changes to the critical access dental program, and access has continued to decline.

This decline in access affects families in every community. Public health care program enrollees are experiencing hardships we must address. There is Jonathan, whose mom recently took an afternoon off to drive him to the closest dentist accepting Medical Assistance, two hours away from home. They learned Jonathan had dangerous levels of tooth decay and that he would need to return to the clinic three times in the coming few months. She arranged for time off, without pay, to drive back and forth three times only to learn, at their final appointment, that their dentist was managing an emergency and they'd need to come back yet again. She couldn't make this final visit happen and Jonathan's procedures remain unfinished a year later.

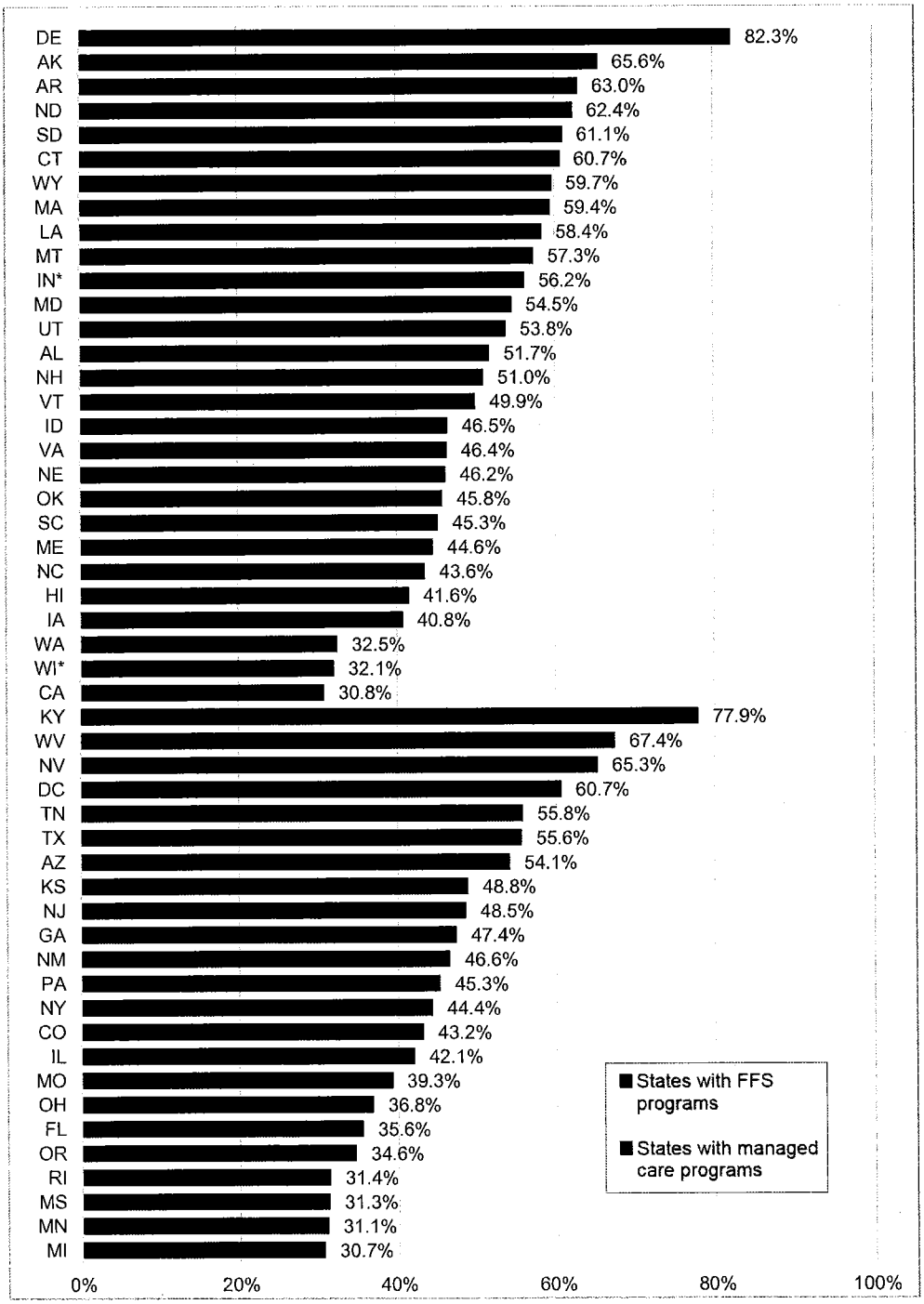
I urge the conference committee to adopt the Governor's proposal to increase access to dental care. Take this action to help ensure that children like Jonathan, and all 1.2 million Medical Assistance and MinnesotaCare enrollees, can access the care they need in their communities.

This recent action by CMS also highlights the importance of enacting the Governor's other proposed federal compliance initiatives, specifically efforts to comply with federal pharmacy, access monitoring, and managed care regulations. The federal government takes the state's efforts to comply with federal mandates seriously and the consequences for ignoring these directives can have major implications for our programs, the state's budget, and most importantly the people we serve.

Sincerely,

Emily Piper
Commissioner

Figure 1: Medicaid Fee-For-Service Reimbursement as a Percentage of Fees Charged by Dentists, Child Dental Services, 2016



Source: HPI analysis of Medicaid fee-for-service reimbursement data collected from state Medicaid agencies and FAIR Health. FFS versus managed care designation primarily based on analysis by the Kaiser Commission on Medicaid and the Uninsured. **Note**: Some states enroll only certain segments of Medicaid enrollees in managed care programs, or provide certain services through managed care programs. These states are denoted by *.

Children's Health Alliance of Wisconsin

To: **Senate Committee on Public Benefits, Licensing and State and Federal Relations**
From: **Matt Crespin, MPH, RDH, Associate Director, Children's Health Alliance of Wisconsin**
Date: **February 14, 2018**
Re: **Support for SB 784 – licensure of dental therapists and granting rule-making authority**

Good morning Chairman Kapenga and members of the committee. My name is Matt Crespin and I serve as the associate director at Children's Health Alliance of Wisconsin (Alliance). Thank you for the opportunity to share with you remarks in support of Senate Bill 784 (SB 784). The Alliance is a statewide organization, affiliated with Children's Hospital of Wisconsin, focused on raising awareness, mobilizing leaders, impacting public health and implementing programs proven to work. The Alliance has seven key initiatives including asthma, emergency care, early literacy, medical home, injury prevention, grief and bereavement and oral health. For nearly 25 years our oral health programming has focused on improving access to quality oral health services. In collaboration with the Wisconsin Department of Health Services and Delta Dental of Wisconsin we administer the Wisconsin Seal-A-Smile program. Wisconsin Seal-A-Smile provides school-based preventive oral health services in more than 825 schools across the state. Annually more than 40 percent of the children we see have oral health needs beyond what our programs can provide. Imagine, if you would for a minute, how difficult it would be to sit here and concentrate if you had a toothache. Now imagine how difficult it is for a 6-year-old child to learn if they are sitting in class with mouth pain.

The addition of dental therapists in school-based programs such as Seal-A-Smile would help improve the chances of children receiving the additional restorative care they need. Right next door in Minnesota, Children's Dental Services has realized this and has integrated dental therapy into their school-based model. This makes it easier and more efficient for children to obtain necessary oral health restorative care. In a recent visit to Minnesota one of the takeaways I had about dental therapy was how dental therapists work as part of the dental team. The therapists who I spoke with discussed working under general supervision through a collaborative management agreement and explained the amount of collaboration they did on a regular basis with the dentist they worked with. This is a commonly misunderstood aspect of dental therapy. Many believe dental therapists are meant to work completely independent or even replace dentists. This could not be any further from reality. This collaborative model is critical and mirrors what is being proposed in Wisconsin.

The Commission on Dental Accreditation (CODA) adopted standards for dental therapy education in 2016. This was a critical and important step for the profession. CODA also is responsible for accrediting all dental and dental hygiene educational institutions across the country. CODA requires that graduates meet a level of competency in all areas outlined in the standards. This also gives the public assurances that graduates of CODA institutions are able to provide high-quality care. Additionally, dental therapists are required to complete clinical licensure exams. Currently in Minnesota dental therapists are required to pass the same portions of the exam dental students pass for the procedures are able to provide.

Dental therapists in Minnesota are without question making an impact. More than 107,000 patient visits have occurred and data shows 80 percent of patients being seen are publically insured. Dental therapy students in Minnesota are being trained at two different educational institutions including the University of Minnesota - School of Dentistry. When visiting there last July another take away I found was their integrated educational model. Seeing dental, dental hygiene and dental therapy students who were all being trained together side-by-side, as a team, was amazing. The integrated training model helps all members of the dental team understand the importance of practicing at the top of their license in order to improve efficiency and effectiveness. Dental offices in Minnesota that employ dental therapists are able to see more patients and increase revenue. Dental therapy has been practiced across the globe for many years and it an opportunity for Wisconsin to enhance our state's dental delivery model.

The Alliance knows it will take a multi-pronged approach to address the oral health access problem in our state. We have supported recent legislation on increasing practice settings for dental hygienists, expanded function dental auxiliaries and the Medicaid pilot. We see merit in any and all of these and know not one single approach will solve this problem. The data, high quality educational standards and ability to improve oral health in Wisconsin is why the Alliance supports SB 784. Our goal is to find a way to get the most efficient care to the thousands of children we identify with disease every year. There are not any published studies that show any of the negative effects you might hear about dental therapy and I would challenge you to ask those who might oppose this innovative model to produce those. We appreciate the legislature's attention to exploring the many options to improving access to care this session. All have merit and should be highly considered including SB 784.

Respectfully submitted: Matt Crespin, MPH, RDH, Associate Director, Children's Health Alliance of Wisconsin, mcrespin@chw.org, (414) 337-4562.

Wisconsin State Subsidies for Marquette University Dental School

As written in statute, every year the Wisconsin legislature allots money to Marquette for the following two purposes:

Tuition assistance for dental students (general purpose revenue, $8,665 each for 160 students) = $1,386,400

Grants for dental services to underserved in Milwaukee, delivered by students and faculty, either in community clinics or in correctional centers =$2.5 million

Total annual state appropriation for Marquette Dental School: $3.886 million

In addition, since 2002 the state has given Marquette **$25 million** in capital funds to fund improvements and expansions for the School of Dentistry:

2002: $15 million
2001-13: $8 million
2016: $2 million
$25 million

DHS Dental Services Grant
https://docs.legis.wisconsin.gov/statutes/statutes/250/10
https://legis.wisconsin.gov/lab/media/1162/13-13full.pdf

Wisconsin Capital Budget Funding for Marquette School of Dentistry Expansion https://legis.wisconsin.gov/lab/media/1162/13-13full.pdf
https://www.bizjournals.com/milwaukee/news/2015/04/14/gov-walker-provides-2m-for-marquette-dental-school.html

Testimony of Jane Koppelman, Research Director, Pew Dental Campaign before the Senate Public Benefits, Licensing & State-Federal Relations Committee.

February 14, 2018

Distinguished Committee Members,

Thank you for the opportunity to testify at this hearing. My name is Jane Koppelman, and for the past five years I have been research director for the Pew Charitable Trusts Dental Campaign. Since 2008 the Dental Campaign has conducted research and advocacy on strategies for improving the dental care delivery system for the nation's underserved: those are rural Americans, Medicaid enrollees, low-income uninsured, the elderly, and people with disabilities.

Pew is a data-driven organization and stakes its reputation on having evidence drive policy decisions. Dental therapy is one of a number of strategies that my group has researched and come to support as a common sense, cost-effective means of improving access to dental care. Why? Because a strong and growing body of research and experience supports this position.

Today you'll hear from dental therapists, advocates, public health officials, policy experts and educators who will tell you why, from their unique perspectives, they see that dental therapists are a value added to a strained dental care delivery system for the underserved. I'd like to briefly offer you my perspective on what the research is saying about this growing discipline.

Are they safe and effective clinicians?

More than 1,100 studies and reports of dental therapists practicing in the U.S. and 53 other countries find that dental therapists are well-prepared to perform the limited number of dental procedures they are trained for – routine preventive and restorative procedures that include drilling and filling teeth and nonsurgical extractions.[i] Dental therapists are taught roughly 20 percent of the procedures that a dentist is trained to perform. And research and decades of experience finds that the two-to-three years of education required for dental therapists in Alaska and most other countries where they practice is sufficient.[ii]

Any lingering doubts about the ability of dental therapists to deliver high-quality care should have been resolved with the 2015 decision of the Commission on Dental Accreditation (CODA) to implement standards for dental therapy training programs.[iii] CODA is recognized by the U.S. Department of Education as the sole accrediting agency of dental education programs, including dental schools. With its charge to protect the public safety, CODA would not have developed the standards in the absence of compelling evidence that dental therapists can be trained to provide the same level of safe, quality care as dentists for the procedures they have in common.

The American Dental Association's own Council on Scientific Affairs conducted a systematic research review of dental therapy that stated "*the results of a variety of studies indicate that appropriately trained midlevel providers are capable of providing high-quality services, including irreversible procedures, such as restorative care and dental extractions.*"[iv]

Are they cost effective?

Labor is the most expensive part of a dental operation. A provider that can deliver routine care at about one-third to one-half the hourly wage of a dentist[v] would lower the labor costs of delivering dental care. This is especially relevant for Medicaid. More than one million Wisconsinites – about 27% of the population rely on Medicaid as their form of dental insurance, but most dentists in Wisconsin don't accept it. The latest data find that only 37 percent of Wisconsin dentists are enrolled in Medicaid, and fewer are actually serving patients.[vi] Low reimbursement rates are a chief reason for why dentists stay away from Medicaid. Dentists that employ dental therapists can make Medicaid payments go further.

Dental therapists are not necessarily a substitute for raising Medicaid reimbursement rates. At the very least, payment rates should cover the cost of delivering care. But shouldn't payment rates be based on a system that could run more efficiently – where the most expensive member of the dental team—the dentist—is not doing procedures that a qualified and lower-paid team member can do?

Studies support this premise. Pew's case study of the first private practice dentist in Minnesota to hire a DT found that he was able to serve an additional 200 Medicaid patients the year he hired a dental therapist and still turn a profit – this with one of the lowest Medicaid reimbursement rates in the country. Our study of the People's Center, the first FQHC in Minnesota to hire a dental therapist, found that …the dental therapist brought in $30,000 more in Medicaid collections than her costs of employment. This figure does not include any revenue generated by the 600 visits she conducted that patients or private insurance paid for. An analysis we conducted of an FQHC in Massachusetts found that if they hired a dental therapist revenue would exceed costs by more than $60,000 annually.

What's their potential for extending care to underserved areas and populations?

1.5 million Wisconsinites live in areas of the state the federal government categorizes as dentist shortage areas.[vii] Dental practices that hire dental therapists could deploy them to rural satellite clinics, nursing homes, schools, facilities for people with disabilities -- and other places where dentists are scarce or where people find it hard to travel to receive care. Some dental practices are already doing this with dentists but it's expensive. Many more – in the private and public sector-- would consider extending their reach if they had a competent and more affordable provider option.

Again, research bears this out. Apple Tree Dental Care, a large nonprofit operation in Minnesota, evaluated its use of a dental therapist who is providing on-site care at a Veterans nursing home. Between 71-79 percent of production charges in that nursing home are for procedures that a CODA-trained dental therapist can provide. When a provider is able to meet most of the need of the population he or she is serving, they call this "right sizing." Most of what she did was restorative care. By deploying a dental therapist and reducing the amount of time a dentist spent at the Veterans home, Apple Tree was able to save $52,000 a year.

Apple Tree also evaluated it's use of a dental therapist operating in a rural Minnesota clinic and found that her daily productivity – the total of fees charged for procedures conducted-- was 94% of that of the clinic's dentists.[viii] That would be a break-even venture if labor costs were at least 6 percentage points lower for DTs than for dentists. But in Minnesota we know that the average hourly wage of a dental therapist is between 1/3 to one-half that of a dentist.

So, research has found strong evidence of safety, quality and cost-efficiency – until recently one question remained unanswered in the U.S. about the ability of dental therapists to actually improve the oral health of the patients they serve. This month a study is being published in the Journal of Public Health Dentistry that found that Native Alaskans in villages frequented by dental therapists had lower rates of extractions and more preventive care than those in villages where dental therapists did not provide care.

I hope that Wisconsin allows the field of dentistry to benefit from the same efficiencies that medicine has for decades—I hope you authorize the practice of dental therapy and allow Wisconsin's delivery system to reach more of the millions who have trouble accessing care. The evidence strongly supports such a decision.

I'm happy to answer any questions.

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[i] Nash et.al., "A Review of the Global Literature on Dental Therapists," April, 2012, W.K. Kellogg Foundation. Available at https://www.wkkf.org/resource-directory/resource/2012/04/nash-dental-therapist-literature-review. Also Scott Wetterhall, James D. Bader, Barri B. Burrus, Jessica Y. Lee, and Daniel A. Shugars, "Evaluation of the dental health aide therapist workforce model in Alaska: final report," (Research Triangle Park: RTI International, 2010), http://www.rti.org/sites/default/files/resources/alaskadhatprogramevaluationfinal102510.pdf. Also [i] Gordon Trueblood, "A Quality Evaluation of Specific Dental Services Provided by Canadian Dental Therapists," Ottawa, Ontario, Canada: Epidemiology and Community Health Specialties, Health and Welfare Canada, 1992.

[ii] Ibid

[iii] Commission on Dental Accreditation Guidelines for Dental Therapy Programs (2015). Accessed on April 7, 2016 at http://www.ada.org/~/media/CODA/Files/dt.pdf?la=en; Report of the Task Force on Development of Accreditation Standards for Dental Therapy Education Programs, CODA, (Winter 2015)

[iv] Timothy Wright, "Do Midlevel Providers Improve the Population's Oral Health? " JADA, January 2013, Volume 144, Issue 1, Pages 92-94

[v]. Employer Presentations at University of Minnesota Dental Therapy Site Visit, July 2016; Minnesota Department of Health, "Dental Therapy Toolkit: A Resource for Potential Employers" (2017), accessed Jan 5, 2018 at http://www.health.state.mn.us/divs/orhpc/workforce/emerging/dt/2017dttool.pdf.

[vii] Health Resources and Services Administration, Designated Health Professional Shortage Areas (HPSA) Statistics, https://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx, data as of January 1, 2018.

[viii] An Advanced Dental Therapist in Rural Minnesota: Jodi Hager's Case Study, Apple Tree Dental, forthcoming case study soon to be available at http://www.appletreedental.org/

Wisconsin Senate Committee on Public Benefits, Licensing and State-Federal Relations
Senator Chris Kepenga, Chair
Wisconsin Assembly Committee on Health
Representative Joe Sanfelippo, Chair

Support for SB 784 / AB 945 – Licensure of Dental Therapists

AHI

Anthem BlueCross BlueShield

Ascension

Beloit Area Community Health Center

Children's Health Alliance of Wisconsin

Children's Hospital of Wisconsin

Service Provider

Kids Forward

Milwaukee AHEC

mlhc

Sixteenth Street Community Health Centers

UW Health

Leading experts agree and data shows that nationally Wisconsin ranks last in access to dental care. The connection between oral health and overall health is well documented and advocates agree SB 784 / AB 945 would directly impact access to care in our state. There are numerous documented cases across the country of patients dying, including 12-year-old Diamonte Driver in Maryland, because of preventable dental infections going untreated, and spreading to their brains or other organs. We do not want to see this in Wisconsin

The authorization of dental therapists in Wisconsin is an important step to improve access to dental care. There is no one silver bullet that will fix this problem. However, our neighbors in Minnesota have allowed dental therapists to practice and have well documented the success this change has made.

There are several important aspects of this legislation that should be understood.

1) Dental therapists are intended to be a member of the dental team and not work independent of a dentist. SB 784 / AB 945 requires a licensed dental therapist to enter into a collaborative management agreement with a licensed dentist. This allows the therapist and dentist to collaborate on treatment planning and the provision of care. Therapists may work under general supervision which would allow a therapist to provide care when the dentist is not physically present. However, the care would all be authorized by the dentist with whom the collaborative management agreement is with. This model is working well in Minnesota with nearly 80 licensed therapists practicing across the state since the first dental therapist graduates in 2011 became licensed.

2) Dental therapists are well trained and educated. The Council on Dental Accreditation (CODA) adopted standards for dental therapy education in 2016. CODA is the same body that accredits dental and dental hygiene schools across the country. CODA ensures dental therapy training programs educate their graduates to meet a level of competency in the services which they will be providing. The University Of Minnesota School Of Dentistry not only supports dental therapists in their state but trains them right alongside future dentists and dental hygienists.

3) Wisconsin currently has 1.5 million residents who live in dental shortage areas. In 2016, 50 percent of dental therapists worked in the populous Twin Cities area, a decrease from 73 percent in 2013. Further, dental therapists are distributed more closely to the Minnesota population than dentists; 63 percent of dentists (compared to 50 percent of dental therapists) are in the Twin Cities.

4) Dental therapists, similar to a physician assistant on a medical team, provide cost-effective preventive and routine restorative care. Dentists in Minnesota who have hired dental therapists are seeing more patients and increased revenue. A 2014 report released by the Minnesota Board of Dentistry and Department of Health shared in addition to more patients

being seen, more than 80 percent of new patients seen by dental therapists were publically insured. Patients experienced less travel time and decreased wait times. More recent estimates in Minnesota show dental therapists have provided more than 107,600 patient visits.

5) Dental therapists are being trained at two institutions in Minnesota including the University of Minnesota School of Dentistry and Metropolitan State University (in conjunction with Normandale Community College). Vermont, which passed dental therapy legislation in 2016, launched a dental therapy training program at Vermont Technical College in June 2017. They have hired a director and are in the process of developing curricula and applying for accreditation from CODA. With a CODA accredited dental school and eight CODA accredited dental hygiene schools in Wisconsin there is already an educational infrastructure to explore training programs in our state.

6) In Wisconsin more than 41,000 emergency room visits for preventable dental conditions were reported by hospitals in 2015. This represents nearly $25 million in hospital charges. Typically emergency rooms stabilize patients with antibiotics and pain medication but ultimately patients need to find a dentist for treatment of the larger issue at hand. Emergency rooms across Wisconsin are working to coordinate follow up care for patients however finding dentists willing to accept patients on Medicaid can be challenging.

It is for these reasons our organizations have joined together in agreement to support dental therapy in Wisconsin. Dental therapists will be well educated, trained, licensed and provide high quality and most importantly much needed care to many in Wisconsin who currently lack access to dental care. We urge you to support SB 784 / AB 945 and authorize dental therapy in Wisconsin.

Sincerely,

Alliance of Health Insurers
Anthem Blue Cross and Blue Shield
Ascension Wisconsin
Beloit Area Community Health Center
Children's Hospital of Wisconsin
Children's Health Alliance of Wisconsin
Disability Service Provider Network
Kids Forward
Milwaukee Area Health Education Center
Milwaukee Latino Health Coalition
Sixteenth Street Community Health Center
UW Health
UW Health – American Family Children's Hospital
Wisconsin Counties Association
Wisconsin Dental Hygienists Association
Wisconsin Oral Health Coalition
Wisconsin Primary Health Care Association
Wisconsin Public Health Association
Wisconsin Association of Local Health Departments and Boards

Testimony of Dr. William K. Lobb, D.D.S., M.P.H., M.S.
Dean of the Marquette University School of Dentistry
Senate Committee on Public Benefits, Licensing, and State-Federal Relations
Senate Bill 784
February 14, 2018

Good Morning Chairman Kapenga and Members of the Committee, my name is William Lobb and I serve as the Dean of the Marquette University School of Dentistry. I am here to testify against Senate Bill 784 related to the licensing of dental therapists in Wisconsin.

While this legislation may be very well intended, based on my own personal and professional experience, I feel very strongly that licensing dental therapists is not a practical way for Wisconsin to improve access to care, in rural or other areas of the state. If the state wants to improve access to care, particularly in rural areas, I have additional ideas to propose and ways the Marquette University Dental School could further assist to meet Wisconsin's oral health care needs.

I grew up in rural Northern Canada and subsequently worked as a dentist in my home community which included supervising dental therapists throughout the Canadian Arctic, so I have first-hand experience working with these providers. This proposal goes beyond the scope of services performed in Canada where the dentist was responsible for the patient's diagnosis and treatment plan and the therapist had a much more limited scope. In my experience, there is no such thing as a simple extraction. While the dental therapists may have removed an occasional primary tooth, they usually left the extractions for the dentist to complete as there can be complications and the management of these

complications were generally beyond their training. In 1972, the Canadian government created the School of Dental Therapy to solve the access problems in its rural northern areas. Initially, the School at Fort Smith in the Northwest Territories recruited students who would return to their rural home communities. Over time, however, students from southern Canada also applied to train as dental therapists and many of these students did not have an interest in working in the rural northern areas -- their goal was to attend dental school. In Canada, the success of dental therapists was tied to a strong stream of government funding and having the therapists work as government employees. When the government funding dwindled so, too, did the "success" of the dental therapists in serving their intended underserved patients. In 1987, the Saskatchewan government ended its universal children's Dental Plan and eliminated about 400 dental public health employees throughout the province. It should also be noted that in 2011, the Canadian National School of Dental Therapy in Prince Albert, Saskatchewan closed.

There has also been much made over the fact that the State of Minnesota has had a dental therapy program since 2009, but it, too, has not achieved the intended level of success. In fact, no dental therapy program in the United States has received accreditation status nor applied for accreditation with the Commission on Dental Accreditation (CODA). CODA was established in 1975 and is nationally recognized by the U. S. Department of Education as the sole agency to accredit dental and dental-related education programs and its mission is to serve the oral health care needs of the public.

You may hear from some testifying in support of this legislation that dental therapists may help reduce dental-related emergency room visits. If there is a

concern about emergency room visits for preventable dental conditions, given State investment, the Marquette University School of Dentistry is willing to partner with a hospital or hospital partners to develop a dental residency program to train the next generation of dentists to help alleviate this issue and provide the needed care. In my own educational background, I found a hospital residency program of great value. We need to make sure that individuals find a long-term dental home and not just use emergency rooms for episodic care.

I believe this legislation is well intentioned, but as the state's long-standing dental education partner, the Marquette University School of Dentistry does not believe that the track-record related to dental therapy programs will yield the results desired by the state.

In 2016-2017, the Marquette University School of Dentistry served nearly 18,000 patients in nearly 98,000 patient visits from 60 of Wisconsin's 72 counties. The value of the dental services provided is more than $17 million and more than seven times the value of the funding provided by the State of Wisconsin for dental services. The Marquette University School of Dentistry has no intention of educating and training dental therapists, nor do I believe other educational institutions in this state have the necessary experience to train dental therapists.

Again, thank you for the opportunity to express the concerns of the Marquette University School of Dentistry. I would be happy to answer any questions at this time.

WISCONSIN
Oral Health
COALITION
Children's Health
Alliance of Wisconsin

To: **Senate Committee on Public Benefits, Licensing and State and Federal Relations**
From: **Robyn Kibler, RDH, Steering Committee Chair, Wisconsin Oral Health Coalition**
Date: **February 14, 2018**
Re: **Support for SB 784 – licensure of dental therapists and granting rule-making authority**

Good morning Chairman Sanfelippo and members of the Assembly Committee on Health. Thank you for the opportunity to share with you remarks in support of Senate Bill 784 (SB 784). My name is Robyn Kibler and I am the chair for the Wisconsin Oral Health Coalition (Coalition). I am here today speaking on behalf of the Coalition. The Coalition is a statewide membership organization that mobilizes policies and initiatives proven to improve oral health for all Wisconsin residents. With more than 200 members, the Wisconsin Oral Health Coalition is comprised of health care providers, dentists, dental hygienists, educators, advocacy and provider organizations, state and local entities, and community members. I have attached the most current list of organizational members of the coalition to my testimony for your reference.

First and foremost, the Coalition's broad-based membership supports SB 784. One of the unique features of working within a coalition is that members come from diverse backgrounds and different viewpoints. They have to figure out how to respect each other's differences and collectively come together towards the good of the whole.

In August 2013, the Coalition and its partners released the state oral health plan, referred to as *Wisconsin's Roadmap to Improving Oral Health*. Within the plan are four high-level strategic areas and goals the Coalition identified as a starting point to improve the oral health of Wisconsin residents. Within the plan workforce was identified as one of the four strategic areas needing to be addressed. In 2016, the Coalition unanimously adopted policy priority statements to help determine support and guide policy development. The policy priority statements include a policy specific to the development of new oral health workforce models.

The Coalition supports SB 784 because it meets all three criteria required for Coalition support in the adopted policy statement. The Coalition supports oral health workforce models which culminate in: graduation from an accredited institution, professional licensure, and improved access to patient care. AB 784 satisfies all of these three requirements. For many years, we have heard from Coalition members regarding the challenges faced by their patients or community members in accessing even the most basic of dental services. Nationally, Wisconsin ranks last in access to dental care for Medicaid children. Wisconsin currently has 1.5 million residents who live in dental shortage areas. Dental therapists will be part of the dental team and be able to enter into collaborative management agreements with dentists. This allows dental therapists and dentists to work side-by-side to more efficiently and effectively treat patients. The authorization of dental therapists in Wisconsin is an important step to improve access to dental care. While there is no silver bullet to fix this problem, our neighbors in Minnesota have allowed dental therapists to practice and have well documented the success this change has made.

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Children's Health
Alliance of Wisconsin

We all acknowledge lack of access to oral health care for all ages remains a public health challenge. With such agreement, let us institute a strategy to help tackle this challenge. We, therefore, strongly encourage you to consider passing SB 784. Thank you for your consideration.

Respectfully submitted: Robyn Kibler, Steering Committee Chair, Wisconsin Oral Health Coalition, robyn.kibler@ascension.org or 414-595-3206.

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Member Agencies and Organizations

Access Community Health Centers
Adams County Public Health
American Academy of Pediatrics, Wisconsin Chapter
American Family Children's Hospital
Ascension St. Michael's Hospital, Stevens Point
Aspirus Langlade Hospital
Aurora Walker's Point Community Clinic
Automated Health Systems, Inc.
Bad River Health and Wellness Center – Dental Clinic
Bright Smiles
Boys and Girls Clubs of Greater Milwaukee
Brown County Health Department
Brown County Oral Health Partnership
Burnett County Department of Health & Human Services
Catholic Charities-Archdiocese of Milwaukee
Children's Health Alliance of Wisconsin
Children's Hospital of Wisconsin
City of Milwaukee Health Department
Clark County Seal-A-Smile
Columbia County Seal-A-Smile
Compassionate Mothers
Community Action Program Services, Portage County
Community Advocates Public Policy Institute
Community Health Systems, Inc.
Delta Dental of Wisconsin
Dental Associates
DentaQuest
Door County Medical Center Dental Clinic
Dunn County Human Services
Eau Claire City-County Health Department
Fond du Lac County Health Department
Forest County Health Department
Florence County Health Department
Gundersen Health System
Health Care Network, Inc.
Healthiest Manitowoc County
Healthy People Wood County
Healthy Smiles for Portage County
Ho-Chunk Health Care Center
Howe Community Resource Center
HSHS St. Joseph Hospital, Chippewa Falls
HSHS St. Nicholas Hospital, Sheboygan
Hughes Dental Clinic
Interfaith Conference of Greater Milwaukee
Jackson County Health Department
Jefferson County Community Dental Clinic
Juneau County Health Department
La Casa de Esperanza
La Crosse County Health Department
Lake Area Free Clinic – Dental Clinic
Latino Health Organization
Lincoln County Oral Health Coalition
Madison Metropolitan School District
Manitowoc County Health Department
Marathon County Health Department
Marquette University School of Dentistry
Marshfield Clinic-Family Health Center
Marshfield Clinic-Institute for Oral and Systemic Health
Mental Health Center of Dane County
Milwaukee Area Health Education Center
Milwaukee Public Schools
Milwaukee Public Schools Head Start Program
Molina Healthcare of Wisconsin, Inc.
North Lakes Community Dental
Northland Pines School District
Northwoods Dental Project
Oneida Community Health Center
Oneida County Health Department
Padre Pio Clinic at St. Anthony School
Parents Plus of Wisconsin
Partners of WHA, Community Health Education
Pierce County Department of Human Services
Prairies States Enterprises
Price County Public Health
Portage County Division of Public Health
Public Health, Madison & Dane County
Reedsburg Area Medical Center
Rehabilitation for Wisconsin in Action
Residential Services Association of Wisconsin
Rock County Public Health
Rural Health Dental Clinic, CESA #11
Rural Wisconsin Health Cooperative
Sauk County Health Department
Scenic Bluffs Community Health Centers
Sheboygan County Health and Human Services
Sixteenth Street Community Health Center
Social Development Commission, Milwaukee
Southwest Wisconsin Community Action Program
Special Olympics Wisconsin
St. Croix County Public Health Department
St. Croix Tribal Health Clinic
St. Elizabeth Ann Seton Dental Clinic
Theda Care Physicians
Tri-County Community Dental Clinic

United Way of Brown County
University of Wisconsin Hospital and Clinics
University of Wisconsin School of Medicine and Public Health
Valley View Manor Nursing Home
Vilas County Health Department
Volunteers of America of Wisconsin
Walworth County Public Health Department
Waukesha County Community Dental Clinic
Waupaca County Department of Health and Human Services
Waushara County Health Department
West Allis Health Department
Wisconsin Alliance for Women's Health
Wisconsin Council on Developmental Disabilities
Wisconsin Association of Pediatric Nurse Practitioners
Wisconsin Dental Association
Wisconsin Dental Hygienists' Association
Wisconsin Department of Public Instruction
Wisconsin Department of Health Services
Wisconsin Division of Health Care Financing
Wisconsin Hospital Association
Wisconsin Office of Rural Health
Wisconsin Primary Health Care Association
Wisconsin Public Health Association
Wisconsin Society of Pediatric Dentists
Wood County Public Health Department

Updated: 2/12/18

WISCONSIN DENTAL HYGIENISTS' ASSOCIATION

Wisconsin
Dental Hygienists' Association

To: Committee on Public Benefits, Licensing and State-Federal Relations

From: Linda Jorgenson, RDH, BS, RF, Director of Governmental Affairs and Advocacy – Wisconsin Dental Hygienists' Association

Date: February 14, 2018

RE: Support for SB-784 - licensure of dental therapists and granting rule-making authority.

Thank you Chairman Kapenga and Committee members for this opportunity to testify in support of the dental therapy bill on behalf of the Wisconsin Dental Hygienists' Association. WDHA is the organization representing the professional interests of the 5300 licensed dental hygienists in the state and advocates for them as well as the patients who seek out and benefit from their services.

My name is Linda Jorgenson, I am a dental hygienist and I serve as the Director of Governmental Affairs and Advocacy for WDHA. Today, I want to share with you the answer to the question of "Why?" Why would dental hygienists support this proposal? And in turn, why we are requesting that you enact the dental therapy proposal as well.

Dental hygienists are all about prevention. When the dental hygiene profession began just over 100 years ago, it's primary assignment was to apply proven preventive strategies to patients in dental offices and children in schools. The dentist who first proposed that teeth cleaning and patient education could be delegated to a newly named dental "hygienist" was met with arguments against the idea that are strikingly similar to the arguments against dental therapy we hear today. "Dental hygienists (and now therapists) are not trained to the same standard as dentists." "They won't know how to handle complex problems." "It won't really help." "Patients don't want to be treated by a lesser trained person."

One hundred years later, dental hygienists are accepted and appreciated as effective prevention specialists in oral health. There can be no doubt that there has been a positive impact on health and quality of life as a result of our work. We are a work force that is safe, effective and growing. That's the good news.

The bad news is that there are some gaps in the system. Many people have little or no access to dental services of any kind; neither comprehensive care by a dentist or preventive care by a hygienist. Most families are not able to afford dental services unless they have insurance; and those who have public assistance insurance have difficulty finding a dentist who will take care of them. The consequences to individuals who have fallen through those gaps can be devastating.

One such family is that of Alyce Driver and her two sons, one of which – Deamonte – lost his life in 2007 at age 12 from a brain infection that began as an infected tooth. The only providers she could gain access to were those in hospital emergency rooms. When the boys complained of tooth pain, she tried

and failed for over a year to get them in to a dentist who would take their Medicaid insurance. When things grew worse, she resorted to a nearby hospital ER for relief. Tragically for Deamonte, the tooth infection had spread to his brain and despite two surgeries and hospital expenditures of over $250,000, he died. I don't know of a dental professional who isn't deeply saddened by that story. We all asked, "What could have been done differently?" We all know that the initial decay was 100% preventable and that Deamonte might not have died if only ...

- The tooth had been extracted before the infection had spread to his brain. Cost: $80 – 100.00 (secondary prevention)
- A filling had been placed in the tooth before the decay affected the nerve. Cost: $100 – 150.00 (early detection, secondary prevention)
- A sealant had been placed in the molar before it ever became decayed in the first place. Cost: $35 – 45.00 (primary prevention)

Do we think it's possible that there are families like Deamonte Driver's in Wisconsin? We believe there are. We need only to look at the Wisconsin Hospital Association's statistics which reveal that in the year 2015, there were 41,000 visits to emergency rooms for problems that began in teeth. While dental therapy isn't the only answer or any kind of a silver bullet – we think that it is one way to improve the likelihood of kids like Deamonte receiving primary and secondary preventive care and earlier detection and treatment, along with people in other vulnerable populations, and to keep them from falling through the gaps and suffering needlessly.

The addition of properly-trained dental therapists to the dental workforce in Wisconsin is a common-sense solution to a growing problem. Armed with their training, their scope of practice, a license to practice, and collaborative practice management agreements, dental therapists stand a chance of improving access to dental care in our state and helping our citizens toward over-all health.

With our sincere thanks for your consideration, I'm happy to answer any questions you may have.

Linda Jorgenson, RDH, BS, RF – WI-DHA Director of Governmental Affairs and Advocacy
lmjorgensonrdh@yahoo.com (612) 599-9076; River Falls, WI.

Senate committee on Public Benefits, Licensing & State-Federal Relations.

William Heitzman, ADT

Good morning,
My name is Bill Heitzman and I am a licensed and certified Advanced Dental Therapist in the State of Minnesota and am the current President of the Minnesota Dental Therapy Association. I would like to thank this committee for considering the possibility of adding a new dental provider to the current oral health care team.

I became involved in dental therapy when I was considering a career change in 2008 and 2009. A bipartisan bill had just been passed authorizing the creation of a new practitioner in dentistry called the dental therapist. My friend and now my colleague Dr. Todd Christianson introduced me to dentists and helped me volunteer at a local community dental clinic. I was accepted into the second class of Dental Therapists and earned a master's degree from the University of Minnesota School of Dentistry in 2012 and became an advanced dental therapist in 2014. I was not a dental hygienist and had no previous dental experience other than volunteering and shadowing before going to dental school.

After graduation, I practiced at the University of Minnesota Pediatric Dental Clinic for 1 year. I then moved to Grand Marais, Minnesota which is located at the tip of the arrowhead, 250 miles northeast of the twin cities. I practiced in a solo private practice named Grand Marais Family Dentistry. There we started an oral health prevention program with help from a grant through the Delta Dental Foundation of Minnesota which included hiring a part time hygienist as a community oral health coordinator, school screenings, fluoride varnish applications at WIC clinics and well child exams and educating new mothers about the importance of oral health of their child and dental visits starting at 1 years of age.

True North

In April of 2017 I was approached by Dr. Todd Christianson who had the vision of creating a community clinic that was led and managed by an advanced dental therapist working collaboratively under general supervision. I jumped at the opportunity and True North Community Dental Clinic opened in Shakopee Minnesota, a suburb of Minneapolis on September 11th, 2017. The clinic is located adjacent to a private dental practice also owned by Dr. Christianson: River Rock Dental. Of the roughly 85 dental clinics in the three county area there are only two other clinics that are dedicated to seeing Medical Assistance patients.

Our mission is to provide safe, affordable, comprehensive oral health care to those who currently are not insured with private employer sponsored dental insurance. We currently do not accept any private dental insurance and have no outside funding through any governmental agency or private donor. We are a critical access dental provider and nearly 100% of our patients are insured through Minnesota Health Care Programs. Our clinic also has an affordable flat fee schedule for the uninsured and for services not covered through insurance. Our patients come from all walks of life including small business owners, those working low wage jobs, special needs patients, kids of all ages, immigrants, and the elderly.

Team Centered Care

How we accomplish our mission is by taking a team centered approach to dentistry. The advanced dental therapist, dental hygienist, assistant, and dentist to function at the very top of his or her license. The advanced dental therapist completes most primary care procedures including taking radiographs, exams, fillings, extractions of primary and periodontally involved permanent teeth, stainless steel crowns, and some routine denture repairs. The role of the dental hygienist remains the same in managing the soft tissues of the dentition, cleaning teeth, and providing home care instructions. All procedures that cannot be completed by an advanced dental therapist such as root canals, permanent tooth extractions, crowns, and dentures are provided by a part-time dentist during specific times. All other patient needs outside of these are referred out.

We are a team centered care clinic that emphasizes working together rather than individually. Everyone is cross-trained so we can all make an appointment, answer a phone call or sterilize instruments. The team does most of the information gathering including preliminary charting of the oral cavity, clinical assessment, and creation of an individualized treatment plan. Accurate and effective communication is emphasized.

Treatment plan authorization is completed by the supervising dentist using tele-dentistry. Todd can securely collaborate with me and view clinical notes in electronic dental record, intraoral photos and radiographs with a program called *log me in*. The collaborating therapist makes appropriate treatment decision based on our clinic protocols as outlined in the collaborative management agreement. We have innovated our way to have 1100 successful patient visits in five months of practice.

Collaborative Management Agreement

The collaborative management agreement (CMA) established a framework of clinical boundaries, protocols and procedures that insure quality care and patient safety. It specifically establishes a practice location, patient population to be served, and further practice limitations. In addition, the CMA establishes protocols age, how cases are selected, clinical assessment guidelines, image frequency. There are also sections that establish procedures for managing dental assistants' complex patient cases, and medical emergencies. Finally, guidelines are established for referrals, providing, administer and dispense antibiotics and NSAIDs, and the extraction of periodontally involved permanent teeth.

This document enables the advanced dental therapist to provide treatment that meets and exceeds current professional standards of care.

A Typical Day

Every day is different for me. I usually arrive early and prepare for the days appointment. I greet the staff with a smile then lead a team huddle, where we discuss the patient care for the day. I manage two dental assistants. I typically have 2 operatory chairs for restorative appointment and limited exam appointments. I also do one or two hygiene exams per hour most days as well. I do not practice hygiene, but it would be helpful at times because there are patients who have periodontal abscessed for patients who require more complex periodontal treatment planning. There are times when the doctor is in the office and it is "all - hands on deck". All the chairs are full and everyone is helping in one way or another. It's an exciting way to practice.

Reaction to Dental Therapy

Once the bill passed and programs were set up most in the dental profession didn't understand what a dental therapist is or what we could do.

In my experience I have been fortunate to have great relationships with my collaborating doctors, patients and staff. I think that most professionals they quickly look past your credential and care more about your character, personality, and skill set. I know that the small business owner was happy that I was there to see this population and to add value to her business.

Among other dental professionals, I am now perceived and accepted as full member of the care team and as a highly educated and dedicated professional who understands the human body, disease processes related to the dentition and treatment to manage and improve the oral health my patients

As time goes most patients are very grateful to be able to get an appointment and for me to participate in a part of their care. Many patients are used to seeing nurse practitioners or physician's assistants at their medical appointments, so their reaction has been mostly favorable and trusting.

I believe that incorporating dental therapists in Wisconsin can help reduce barriers to dental care and modernize the oral health work force. Thank you for considering this making a real difference in the lives of those who currently lack adequate dental care.

Testimony of Drew J Christianson to State of Wisconsin

2018 Senate Bill 784 Hearing

Wednesday February 14th, 2018

State Capital, Madison, Wisconsin

My name is Drew Christianson. I would like to start by saying thank you for your time and the opportunity to speak with you today. As a Wisconsin native living in Minnesota, it's always nice to come back home.

I am a 2014 graduate of the Master in Dental Therapy Program from University of Minnesota School of Dentistry. As a practicing Dental Therapist, it's a pleasure to be back in my home state speaking about my profession, with the hopes that I can inform and provide insight on this great profession of Dental Therapy. Growing up in Wisconsin, I had a great dentist in my small town. I don't think I ever went six months without seeing a dentist. I assumed this was case for all families. As I got older, I wanted to be in healthcare, whether that was on the medical side or dental side. I felt a strong connection to dentistry due to the ability to have always been seen and cared for. When I went to college, Pre-dent was the track for me.

It wasn't until I volunteered at the Mission of Mercy in Sheboygan, WI in 2010 that I realized that dental care is NOT a given, but for most it is a luxury. I witnessed hundreds of people camping out the night before outside of the Sheboygan North High School, waiting to be seen by a provider to help them get out of dental pain. Adults, children, elderly were all waiting to just be heard. It was at that moment I knew I wanted to be in dentistry, and help those that were truly in need.

I needed to find a profession that fit all of my goals I wanted to achieve while having a career in dentistry. Those goals included serving the underserved, working with children, and ability to lead by example. Dental Therapy helped me achieve all of those goals.

I traveled here today to share my experiences as working as not only as a Dental Therapist, but as a valued member of the Dental Team. I currently work in a Private Practice north of the Twin Cities, providing care to roughly 90% underserved or uninsured patients. I am also a Clinical Assistant Professor at the University of Minnesota School of Dentistry, instructing Dental Students, Dental Therapy Students, and Dental Hygiene Students, and provide care in downtown Minneapolis working in collaboration with a Nurse Practitioner Clinic, meshing both medical and dental midlevel providers. I work in collaboration with several dentists, ranging from oral surgeons to general dentists, orthodontists to periodontists, all while providing within my scope of practice. The collaboration at the Nurse Practitioner Clinic has allowed individuals in treatment for substance abuse receive both medical and dental care under the same roof, achieving my goal of serving the underserved.

The Dentist I work in collaboration with at his Private Practice Maple Grove, MN has since flourished after adding dental therapists to his team. Prior to this addition, he was working 6 days a week, providing care to underserved populations with barely getting a lunch break. He was overworked due to the demand of care needed. He added myself in October of 2014. We entered a collaborative management agreement, outlining my list of duties and my limitations. As progressive as he is, he allowed me to practice at the top of my scope, in hopes we can create a productive environment to allow him to focus less time at the bottom of his scope. In 2014 we were operating out a five dental chair clinic, trying this new approach to dentistry. Fast forward 3 ½ years, 2 dental therapists and a brand new 5 operatory clinic, we are still operating at a high quality and caring clinic. Our expansion of the clinic has given us the ability to more efficient and successful, and seeing more patients with special needs and small children, fulfilling another goal of mine. The dentist has been thankful for the opportunity to provide more care, for more people at his clinic all while now being able to focus more on the top of his scope of practice such as endodontic treatment and implant procedures. We have modeled this new approach to dental care, and have successfully shown how to lead by example.

In my small amount of time practicing as a Dental Therapist, it only took me a few months to see the impact that I was making on children and their families. Families that travel 4 hours away from home to be seen because their 6 year old has a toothache and nowhere to go. Families that have to take time away from work creating financial stress. Families who are unsure if there insurance will continue next month and are willing to wait 2 hours just to be seen by a Dental Therapist.

I am not here to convince or persuade, but to inform you of the impacts I have witnessed and experienced. There will be resistance to change, a negative annotation about dental therapy and their qualifications, and their economic viability. Those items are not going away any time soon. But for the patients that have sent thank you letters, shed tears in my chair, and the children who hug me for making their appointment fun, I can attest that DTs are making a difference. Populations who have not had the ability to be seen or heard, DTs have made a difference.

We can not pretend that the populations who are going unseen are going to disappear. We must provide another avenue for those that want to adopt this model of care. For those that oppose, change is difficult, but it is inevitable given the direction of current oral health needs.

I want to thank you for your time and I look forward to our future conversations. Thank you.

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February 14, 2018
Senate Committee on Public Benefits, Licensing, and State-Federal Relations
Testimony in opposition to Senate Bill 784

My name is Monica Hebl and I am a private practicing dentist from Milwaukee. Thank you for the opportunity to testify in opposition to Senate Bill 784. I have been a Medicaid (MA) provider since I graduated from Marquette Dental School in 1985. It became clear that the viability of the central city practice that I joined was in jeopardy when the payor mix was becoming too reliant on MA. We moved the practice, but purposely remained in the city on three bus lines to remain accessible for those using public transportation.

I have been working on the access problem for over 30 years. I'm in the trenches and on the front lines serving on many committees and initiatives, participating in a local emergency department referral program and many charitable events. I hope that my participation in the underfunded MA program for my entire career earns credibility with legislators and policy-makers when talking about ways to improve access to care for the patients enrolled in the Medicaid

I grew up in a disadvantaged family so I am empathetic to the families that are trying to make it on limited incomes. I feel privileged to make someone who is afraid, enjoy coming to the dentist. Once providers establish a relationship of trust and patients embrace the value of prevention, the results of increased oral health and overall health for the entire family become a reality.

I have read the memo supporting this legislation and I'd like to address some of the points that have been made.

Dental disease is preventable. We will never surgically repair our way out of this problem. We don't need a provider with very limited surgical skills on the front lines. We need preventive services, education, and navigation to care. Hygienists have recently been authorized to practice independently in almost all settings and they are already able to triage and develop referral networks for those that are experiencing preventable dental infections. The recognition of the problem and the referral to appropriate care is what is going to help prevent a Diamonte Driver type death. The treatment Diamonte needed would not have been within the scope of dental therapy. A study done by the American Dental Association Health Policy Institute (ADA HPI) states that 96% of Medicaid eligible children live within 15 miles of a dental office that accepts Medicaid. We don't need to create another type of provider to solve the navigation and referral problem that exists.

Leading experts agree and data shows that nationally Wisconsin ranks last in access to dental care. Data also shows that WI is second to last in reimbursement. The state implemented a reimbursement pilot in four counties last session and with *no* marketing by the department there have been at least 70 dentists that have enrolled as providers in the 4 counties (as reported by a DHS representative at the Wisconsin

Health News Panel on Oral Health). What would happen to access if the reimbursement pilot was expanded statewide?

A Dental therapy billed passed in 2009 in Minnesota. Nine years after passage, there are 78 graduates from two programs. There have been many case studies where patients and practice owners are asked how they like their therapist and this is presented as proof that they are working. The fact that therapists are seeing MA patients is not disputed, but the important question is whether they solve access. From the Minnesota Department of Health's own data (the same report that is quoted in the circulating memo in favor of therapists), there has been a 5% decrease in percent of MA patients receiving a dental service from 2012-2016. If therapists are the answer, overall utilization should be increasing. I would encourage you to apply the same success metrics to the therapy pilot in Minnesota as you do to the reimbursement pilot to ensure you are getting the best results.

There are many states and studies that show dramatic improvements when a financial investment is made to dental Medicaid programs. In fact, in Texas, Medicaid covered children receive a dental service more often than privately insured kids. Texas doesn't have therapists, but they did increase their reimbursement rates.

I find it interesting that the four county pilot was implemented as a pilot (when multiple states have shown increased reimbursement is a successful strategy) and yet dental therapy (which is a much bigger undertaking) is being recommended with full implementation. This bill involves the creation of a new profession, an educational and training program and licensing of a new profession. This will use scarce resources, have limited affect and take years to implement.

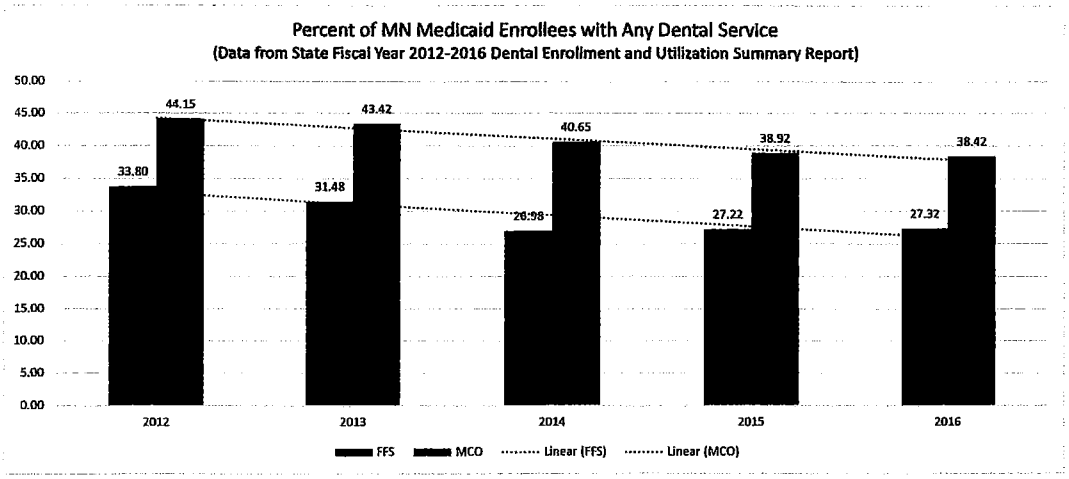
After studying the latest Medicaid remittances in my practice, I found that reimbursement for services was under 30%. The state pays the same whether a dentist or dental therapist does the work so the state does not save money using therapists. Therapists will generate revenue, but that does not mean they generate profit. Overhead including space and equipment required to provide the services included in the limited scope of a therapist is the same needed for full service dentistry. Few dentists are going to be excited about the prospects of entering into collaborative agreements knowing they are ultimately responsible unless the profits make it worthwhile. Thirty cents on the dollar does not go a long way to cover the overhead no matter who is providing the care. The American Dental Association Health Policy Research Institute has reported that dentists have capacity to serve more patients and anecdotally I hear that hygienists are underemployed. **What we are really talking about today is an economic problem, not a workforce issue.**

I was a member of Governor Doyle's Oral Health Taskforce in 2005. We made twenty recommendations to solve the access problem. Many that were implemented had to do with workforce, and none to address the low reimbursement rates. Here we are in 2018, trying to solve the access problem again without addressing the reimbursement issues that exist. The reason I am so opposed to this bill and ask you to oppose it also is because it dilutes the efforts that are needed to truly solve this problem. In Wisconsin, the state of Wisconsin spends less than 1% of the MA budget on oral health when others, including the American Academy of Pediatricians recommend 20%.

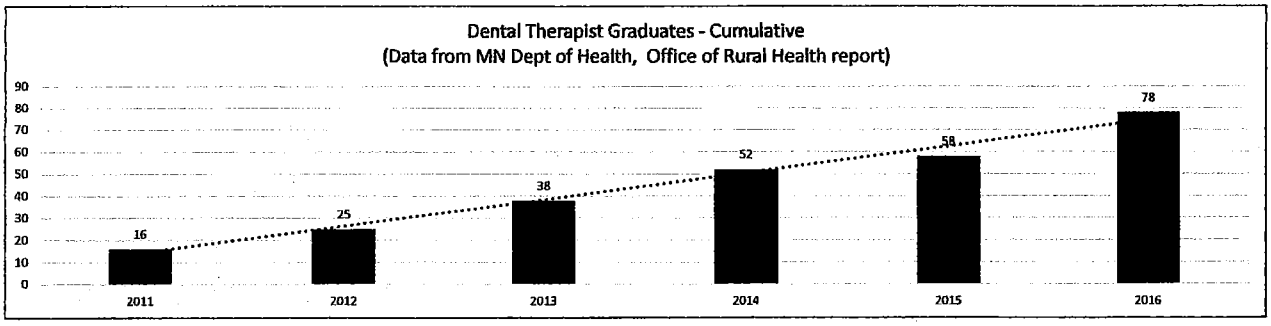
In summary, I ask you to measure the expense and time to implement this program and compare the results of the reimbursement pilot to the results therapists are achieving in MN before assuming that this is the best answer to improving access to care in Wisconsin. Due to the historically low priority

placed on oral health funding, we can't afford to spend any resources on initiatives that don't result in enough change to really help those that are relying on us to make the program work for them.

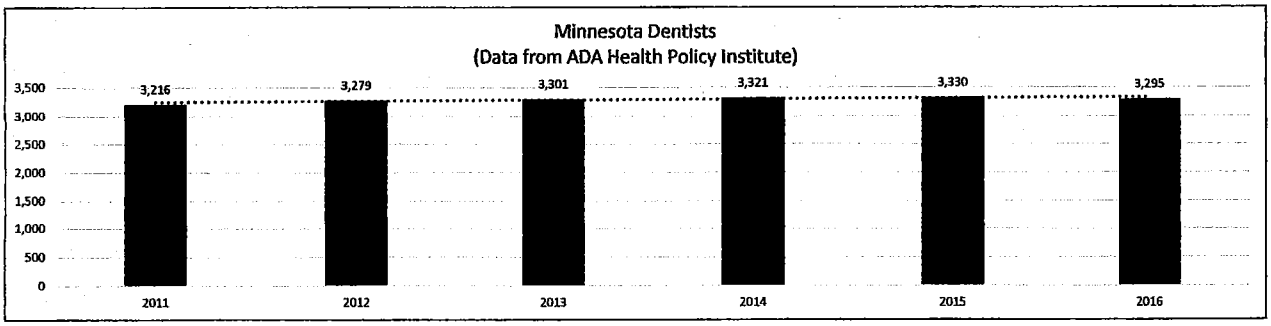
I would be happy to answer any questions you might have.



FFS=Fee For Service MCO=Managed Care Organization



As the number of Dental Therapist Graduates is increasing, Utilization is decreasing



Karl Self, DDS, MBA
Testimony for the Wisconsin Senate Committee
February 13, 2018

Thank you, Mr. Chairman and members of the committee. My name is Dr. Karl Self. I have been a dentist for 34 years, and I have worked in a variety of practice settings, but I've spent most of my 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 appreciate the opportunity to speak with you about the University of Minnesota's experience educating dental therapists as well as the State of Minnesota's experience utilizing dental therapists. I am here because nine years ago, Minnesota acknowledged the same basic challenge that you are dealing with today: that despite all of the exceptional dental providers and policies in place to increase access to dental care for underserved and rural communities, gaps in dental care remain.

The University of Minnesota has educated 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, 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, 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.

Since our first dental therapy class graduated in 2011, the U of M has graduated 57 individuals, and another school in Minnesota has graduated 33 individuals for a total of 90 dental therapists in our state. While 90 graduates in eight years may sound like a small number of providers, historically we have limited our class sizes to balance the supply of dental therapists with the demand of the dental market.

Currently I would consider the dental therapy profession in Minnesota to be at full employment with more dentists looking to employ dental therapists than we have licensed dental therapists. Data from this past fall showed dental therapists work 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. All dental therapists provide care in clinics that meet Minnesota's statutory requirement that dental therapists are "limited to primarily practicing in settings that serve low-income, uninsured, and underserved patients or in a dental health professional shortage area". Thus, all dental therapists are having an impact in improving access to care.

I continue to be excited that I have the opportunity to lead the dental therapy education program at the University of Minnesota, and I am proud of our dental therapists that care for underserved people in Minnesota every day. They are amazing individuals and they are truly pioneers of this new profession. For nearly 30 years I have advocated for healthcare for underserved populations and I am personally thrilled that Minnesota as a state chose not to stay with the status quo but to try something different to improve access to dental care and to help reduce oral health care disparities. So too are the underserved patients of Minnesota who have been very happy to be able to receive care from a dental therapist these past 7 years.

Finally, dental therapy is not a miracle cure that will eliminate all of our barriers to care. But it is a tool, a tool that is showing positive results with the practices that have chosen to adopt it. Additionally, as would be expected with the initiation of any new profession, there are folks who went into the dental therapy profession and have found that it was not what they were looking for. Yet a 2015, Minnesota Department of Health survey found 89% of dental therapists were either satisfied or very satisfied with their career. Similarly, there are dentists who have

explored adding a dental therapist to their dental team and determined it did not fit into their practice. Yet most dentists are finding that dental therapists are adding value to their practice and their dental team. In fact, roughly 45% of dentists and clinics which currently employ a dental therapist employ more than 1 dental therapist in their practice or clinic.

While no dentist in my state will ever be forced to hire a dental therapist, those who choose to will continue to see firsthand the therapists skills and abilities, their dedication to serving those individuals and communities who otherwise would not have access to dental care, and the value they bring to the dental team working under the supervision of a dentist. This is why I strongly believe the profession of dental therapy will continue to grow and dental therapists will continue to be well accepted, valued members of the dental team both in Minnesota and around the country.

I support dental therapy as an effective tool for closing gaps in access to care and the University of Minnesota dental therapy program stands ready to work with Wisconsin stakeholders to educate dental therapists to help address Wisconsin's access to care concerns. Thank you for the opportunity to speak here today. I am happy to answer any questions you may have.

Scope of Practice & Licensing Factors

- **Unmet health care needs** ✓
- **Body of Knowledge & Science Basis** ✓
- **Curriculum, Education Programs** ✓
- **Statutory/regulatory structure – licensing, disciplinary process, etc.** ✓
- **Supervision and/or continuing education** ✓
- **Acceptance by patients** ✓
- **Potential employers** ✓
- **Reimbursement** ✓
- **Availability of liability insurance** ✓
- **Support/acceptance by related professions** ✓

Dental Therapists in Minnesota
Fact Sheet
November 2017

Dental Therapist Numbers

- There are 77 licensed dental therapists in Minnesota.[1]
- 41 (53%) have achieved certification as an advanced dental therapist.
- 21 (27%) are dually licensed as in dental hygiene and dental therapy.
- Dental therapists are employed in 54 different clinic settings.
- 91% of licensed dental therapists are employed as dental therapists.

Dental Therapist Employment and Geographic Location

- 54% of dental therapists are employed by clinics in the 7-county Greater Twin Cities metro area. 55% of Minnesota's population lives in the same Greater Metro area.)
- 46% of dental therapists are employed outside of the 7-county Greater Twin Cities metro area. 45% of Minnesota's population lives outside of the same Greater Metro area.
- In addition to practicing in dental clinics, dental therapists provide services in community and rural settings at more than 370 mobile dental sites throughout the state in schools, Head Start programs, community centers, VA facilities and nursing homes.

Dental Therapy and Increased Access to Care

- Minnesota Statute requires that dental therapists provide care within a dental shortage area or to at least 50% of the total patients be Medicaid patients.
- In 2016, dental therapists provided dental care in an estimated 94,392 patient visits.
- Minnesota's Medicaid program has some of the lowest reimbursement rates for dental services in the country, which negatively impacts access. Dental therapy has not exacerbated the access issue in Minnesota, it has significantly mitigated it.

Dental Therapist and Financial Viability

- Dental therapists provide dental services within their scope of practice at a lower wage and reimbursed at the same rate as a dentist.
- Dental practices report increased productivity and increased earnings following the addition of a dental therapist to their dental care team.
- Minnesota's liability insurers report that there is no additional cost for professional liability coverage for employment of a dental therapist compared to the employment of another dental assistant or hygienist.

Dental Therapy Education

- There are two Master's level educational programs educating and training dental therapists in Minnesota.
- The joint MNSCU (Minnesota State Colleges and Universities) dental therapy program at Normandale Community College and Metropolitan State University began in September 2009. It admits six students per year.

- The dental therapy program at the University of Minnesota Dental School began in 2010 and admits 8 students per year.
- Both programs meet the standards set by the Commission on Dental Accreditation (CODA) in September 2015.

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[i] As of 1/30/18, there are 79 licensed DTs in MN

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Minneapolis, MN 55414-3246
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Early Impacts of Dental Therapists in Minnesota

Minnesota Department of Health
Minnesota Board of Dentistry
Report to the Minnesota Legislature 2014

- DT workforce is growing & appears to be serving low-income, uninsured and underserved patients.
- DTs appear to be practicing safely. Clinics report improved quality and high patient satisfaction.
- Clinics with DTs seeing more new patients, most underserved.
- DTs have made it possible to decrease travel time and wait times for some patients, increasing access.
- Benefits include direct costs savings, team productivity, improved patient satisfaction and lower fail rates.
- Savings making it more possible to expand capacity.
- Start-up is varied: employers expect continuing evolution.
- Most considering hiring additional DTs after 1 year.
- DTs have potential to reduce unnecessary ER visits.
- With same rates for DDS & DT, not necessarily an immediate savings to the state on each claim paid; however, differential between state rates and clinics' lower costs for DTs appears to be contributing to more patients being seen.

DEPARTMENT OF HEALTH

Minnesota's Dental Therapist Workforce, 2016

HIGHLIGHTS FROM THE 2016 DENTAL THERAPIST SURVEY

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Minnesota's Dental Therapist Workforce, 2016

HIGHLIGHTS FROM THE 2016 DENTAL THERAPIST SURVEY[i]

Overall

Dental therapists were first authorized to practice in Minnesota in 2009, with the Minnesota Board of Dentistry licensing its first dental therapist in 2011. Dental therapists are part of the dental team, providing basic restorative services and preventive care. By law, they are required to practice in settings serving primarily low-income, uninsured and underserved patients, or in areas designated as Health Professional Shortage Areas (HPSAs).[ii] Dental Therapy is considered an emerging profession and as such is still integrating into the oral health workforce.

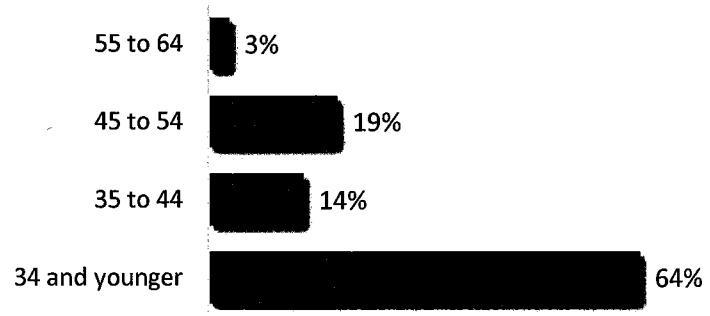
According to the Minnesota Board of Dentistry, there were **63** dental therapists (DTs) with active licenses in Minnesota as of December 2016.[iii]

Demographics

Sex. Eighty-nine percent of all Minnesota dental therapists are female. With a few exceptions, health care professionals are predominantly female.

Age. Demographically, dental therapists are young, with a median age of 32. Sixty-four percent are age 34 and younger and the remaining third of the workforce is between ages 35 and 54.

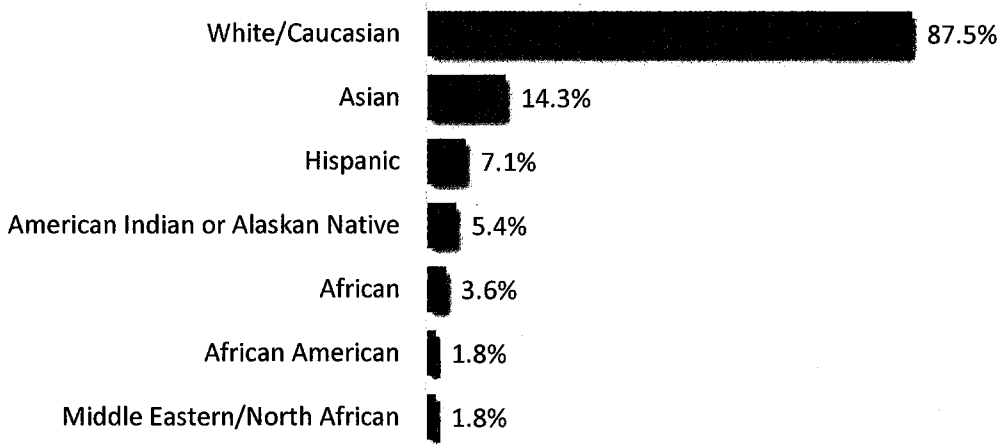
Age of Minnesota Dental Therapists



Source: Minnesota Board of Dentistry, March 2017. Analysis done by MDH. Percentages are based on all 63 Minnesota licensed dental therapists.

Race and Ethnicity. Typical of racial patterns among health care professionals, the majority (87.5 percent) of dental therapists are white. Additionally, 14.3 percent are Asian and 7.1 percent are Hispanic. Dental therapists are among the most diverse of the health care workforces in Minnesota.

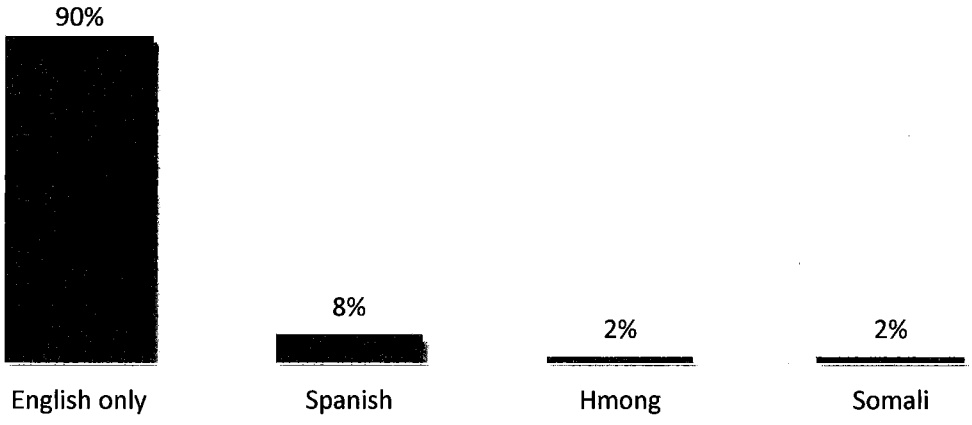
Race of Minnesota Dental Therapists



Source: MDH Dental Therapist Workforce Questionnaire, 2016. Respondents could select as many races as applicable.

Languages Spoken in Practice. The majority of dental therapists (90 percent) spoke only English in their practices. Spanish was the most common language other than English, spoken by 8 percent of dental therapists.

Languages Spoken by Minnesota Dental Therapists in their Practices



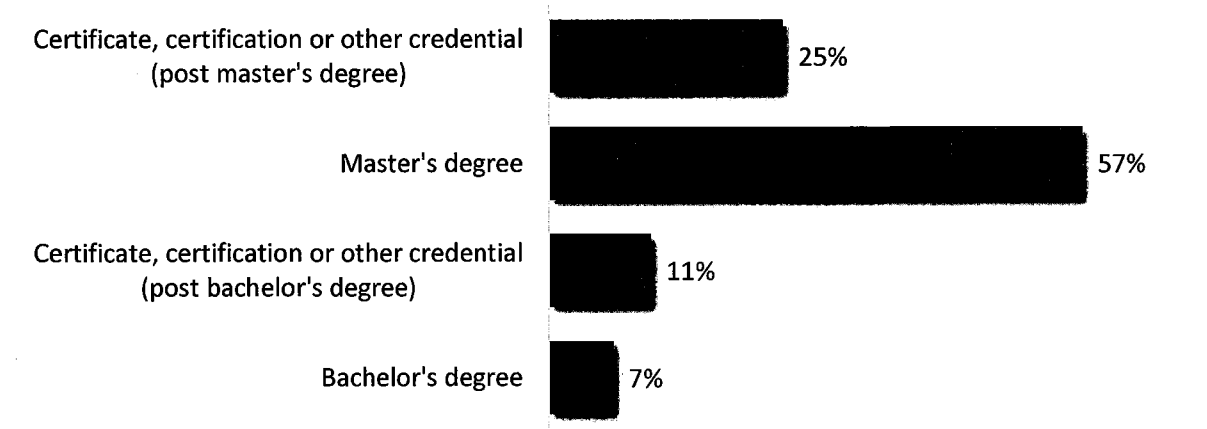
*Source: MDH Dental Therapist Workforce Survey, 2016. Respondents could select as many languages as applicable, but were instructed **not** to include languages spoken only through an interpreter.*

Education

Educational Attainment. Eighty-two percent of dental therapists have a master's degree. Dental therapists must attend one of two schools in Minnesota. Metropolitan State University, in partnership with Normandale Community College, admits students who are Minnesota licensed dental hygienists and offers a Master of Science in Advanced Dental Therapy degree. The University of Minnesota's School of Dentistry also trains dental therapists and does not require any previous dental related

degree. Initially the University of Minnesota's program graduated students with either bachelor's or master's degrees, then switched to only master's degrees in 2013. At the start of the 2016 school year, the university began offering a dual degree: a Bachelor of Science in Dental Hygiene and Master's in Dental Therapy.

Educational Attainment of Dental Therapists

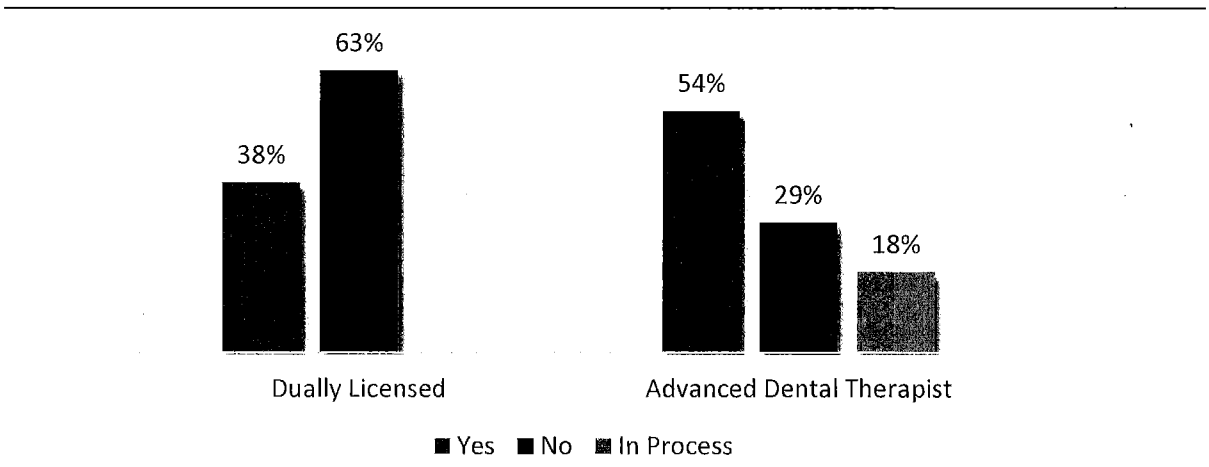


Source: MDH Dental Therapist Workforce Questionnaire, 2016. Percentages are based on 56 valid responses.

Additional Licensure. Dental therapists can also be licensed as a dental hygienist. As shown, 38 percent of dental therapists are dually licensed as both dental hygienists and dental therapists, and can perform services under both professions' scope of practice. Dental therapists with a master's degree can become certified as advanced dental therapists (ADTs) after completing 2,000 hours of practice and passing an ADT certification exam. ADTs can perform additional procedures and do all work without a dentist on site. Just over half of DTs reported holding an ADT certification, and an additional 18 percent are in the process of becoming ADTs.

In the Twin Cities area, dental therapists are more evenly split between those who are dually licensed and those who are DTs; 48 percent of DTs are dually licensed in the Twin Cities area while 20 percent are in Greater Minnesota (data not shown).

Dental Therapists with Additional Licensure or Certification



Source: *MDH Dental Therapist Workforce Survey, 2016. The chart is based on 56 valid survey responses.*

Employment, Hours and Future Plans

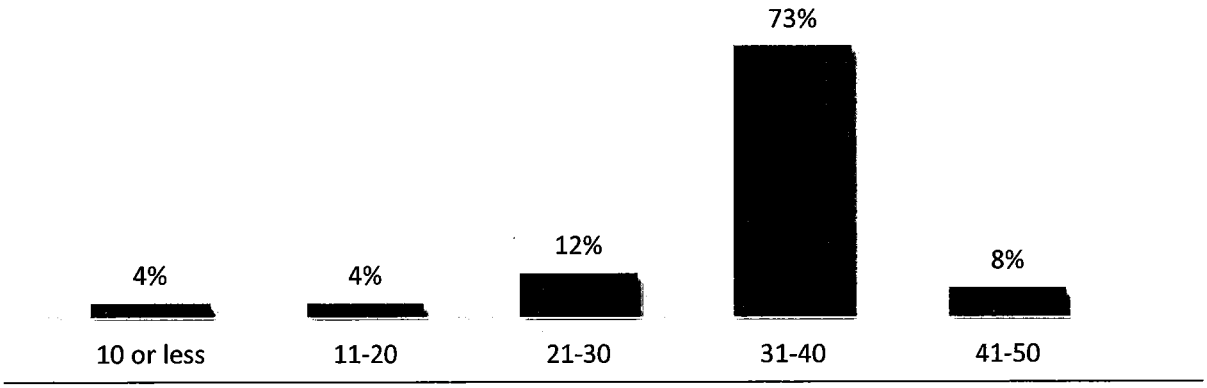
Share of Dental Therapists Employed. Ninety-one percent of Minnesota licensed dental therapists reported on the MDH survey that they were "working in a paid or unpaid position related to [their] license." Three percent of dental therapists were looking for work, three percent were not seeking a position and one percent was temporarily not working.

As time goes by, more dental therapists report being employed: in 2014, 74 percent reported that they were working; in 2015, 86 percent were working. As a new profession, dental therapists have had some challenges with job availability and acceptance. The increase in dental therapists working indicates the profession is becoming a more established part of the dental team in Minnesota.

Hours Worked. The median work week for dental therapists was 36 hours, and the majority worked between 31 and 40 hours per week. In the oral health field, working slightly less than 40 hours per week is commonly considered full-time. Dental therapists reported working similar hours in 2015.

Eighty-seven percent reported working a full-time schedule. More Twin Cities area dental therapists work full time (96 percent) than Greater Minnesota DTs (80 percent).

Hours Worked in a Typical Week



Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 52 valid survey responses.

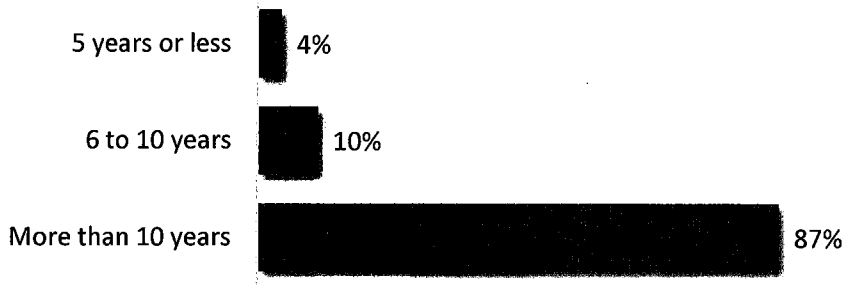
Dental therapists spent most of their time caring for patients; 92 percent reported on the MDH survey that they spent more than three-quarters of their time providing direct patient care (data not shown).

Dental Therapists at Work. Ninety-percent of dually licensed DTs reported spending some time on dental hygienist work. Most dually-licensed dental therapists focused their time on tasks dental therapists are authorized to perform. Sixty-seven percent reported spending *up to* 25 percent of their time on dental hygiene-related procedures with the remaining 75 percent or more of their time spent working within their dental therapist scope of practice (data not shown). With education program changes resulting in more dental therapists with dual licenses, it will be important to understand the best use of both sets of skills.

DTs spend their time on a mix of preventive and restorative tasks. DTs who hold the additional ADT certificate are able to provide additional restorative and surgical functions. The amount of time DTs reported spending on ADT procedures varied. For example, seven percent reported they spent no time, 33 percent spent up to a quarter of their time, and 23 percent spent more than three quarters of their time on ADT procedures (data not shown).

Future Plans. Dental therapy is a stable profession, with 87 percent of dental therapists planning to remain in the field for more than ten years. Just 4 percent responded they planned to leave the field within five years. Among that small number of DTs who plan to leave the field, no dental therapists plan to retire. With an emerging profession, it is important to understand reasons people are leaving the field. Of those who plan to leave the profession, the reasons were burnout or dissatisfaction and to pursue additional training.

"How long do you plan to continue practicing as a dental therapist in Minnesota?"



Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 52 valid survey responses.

Dental Therapists at Work

Work Settings. The survey also asked dental therapists to identify their primary work setting. Dental therapists are more likely to work in a community based or non-profit setting or clinic than any other dental profession (24 percent). As shown, most dental therapists work in either solo private practice or small group private practice, comparable to other oral health professionals. Similar to dentists' work locations, Greater Minnesota dental therapists are more likely to work in a solo or small group private practice than Twin Cities area dental therapists.

It is not uncommon for dental therapists to provide services in more than one location. While about two out of three dental therapists reported working at just one location, 29 percent work at two locations and 8 percent work at three or more locations (data not shown).

For those reporting a secondary work location, the most common location is similar to the primary location with most working at a small group private practice, (29 percent), followed by 18 percent working at a community health center or federally qualified health center (data not shown).

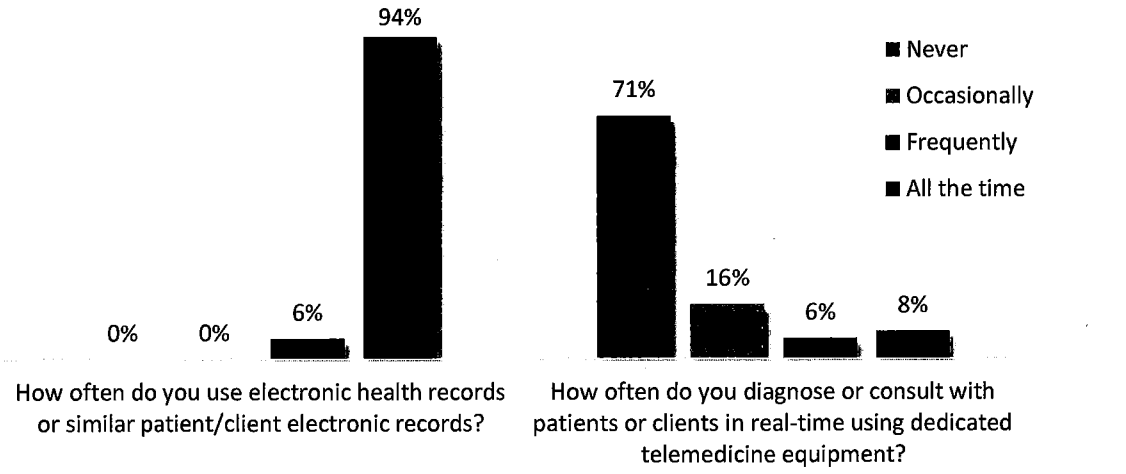
Dental Therapists' Primary Work Settings

Setting	Share of DTs Working in this Setting
Solo Private Practice	25.5%
Small Group Private Practice (2-4 dentists)	21.6%
Community Based Non-Profit (church, homeless shelter, etc.)	11.8%
Community Health Center/Federally Qualified Health Center Clinic	11.8%
Community/Faith-Based Organization Clinic	11.8%
Large Group Private practice	7.8%
Hospital	3.9%
Academic (Teaching/Research)	3.9%
Long-Term Care Facility	2.0%

Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 51 valid survey responses.

Technology at Work: The Use of EHRs and Telemedicine Equipment. The survey included items about the use of both electronic health records (EHRs) and dedicated telemedicine equipment. The results showed that 94 percent of dental therapists use EHRs "all the time," and 30 percent reported using telemedicine equipment at least occasionally. Telemedicne can help dental therapists serve clients in more non-clinic locations and allow for an efficent way to communicate with supervising dentists.

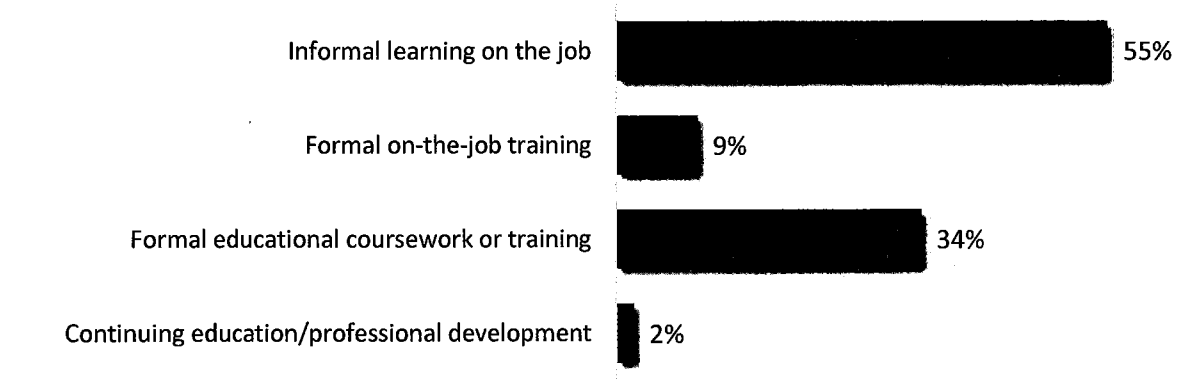
Dental Therapists' Use of Electronic Health Records and Telemedicine Equipment



Source: MDH Dental Therapist Workforce Survey, 2016. The charts are based on 51 survey responses.

Teamwork. Health care providers increasingly work in multidisciplinary teams, prompting educators and health policymakers to ask how best to train providers to communicate and coordinate across professions. MDH included a question on its survey to shed light on this issue. As shown, 64 percent of dental therapists reported that learning on the job (either informal or formal) *best* prepared them to work in multidisciplinary teams. Formal educational coursework or training was most helpful to about a third of dental therapists.

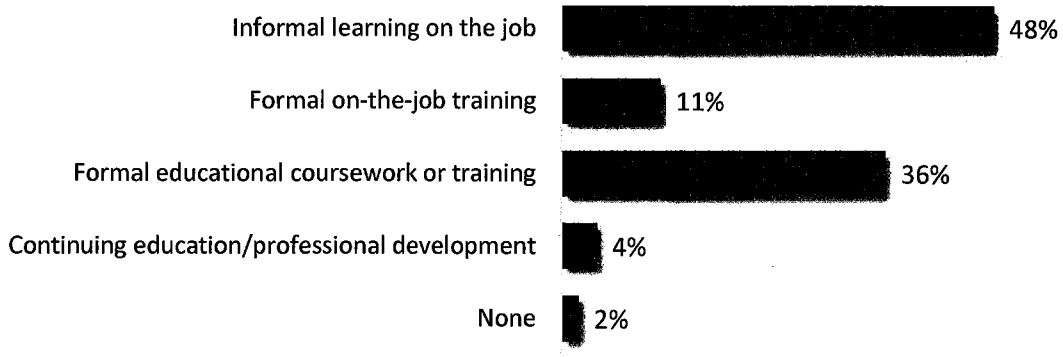
"Which of the following work or educational experiences best prepared you to work in a multidisciplinary team when providing care?"



Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 56 survey responses.

Cultural Competence. Minnesota health care professionals must navigate diverse racial, ethnic, and cultural norms in their work, also raising questions about the best way to prepare dental therapists to provide culturally competent care. The highest percent (59 percent) of dental therapists indicated that formal or informal learning *on the job* provided the best preparation for working with diverse groups of patients, followed by formal education or coursework.

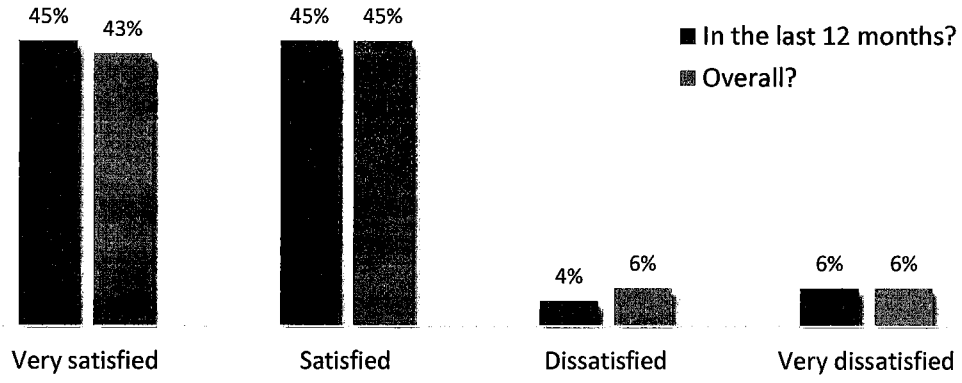
"Which of the following work or educational experiences best prepared you to provide culturally competent care?



Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 56 survey responses.

Work and Career Satisfaction. The majority of dental therapists indicated that they were either "satisfied" or "very satisfied," overall. Dental therapist satisfaction levels are similar to those of other Minnesota health care professionals for which data exists.

"How satisfied have you been with your career..."



Source: MDH Dental Therapist Workforce Survey, 2016. The chart is based on 51 responses.

Dental therapists report the most satisfaction from being able to provide care to people who may not get it otherwise. The relationships they have with patients and working in a team care environment were also important.

Sources of professional dissatisfaction included lack of understanding and negative view of the profession, limitations on scope of practice and patients served, and low reimbursement amounts.

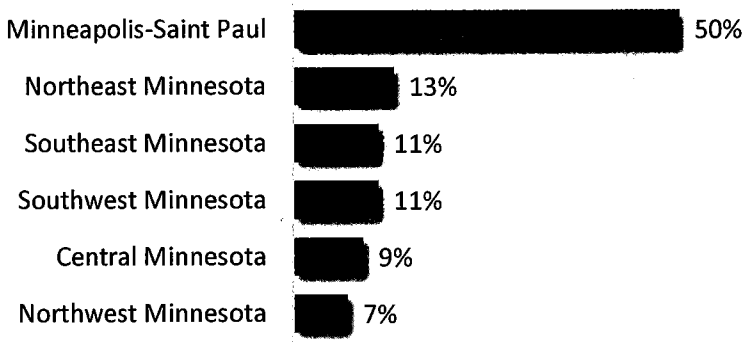
Geographic Distribution

Distribution by Region. To understand accessibility of dental therapist services around the state, the next chart provides a view of the geographic distribution of dental therapists. These analyses are based on geocoded practice addresses from the survey supplemented with addresses supplied to the Board of Dentistry during the license renewal process.

The chart below shows the distribution of dental therapists across the six planning areas around Minnesota[iv]. Dental therapists' current work location is similar to the Minnesota population distribution. For reference, the Twin Cities metro area is home to approximately 54 percent of the population. Dental therapists are also distributed more closely to the Minnesota population than dentists; 50 percent of dental therapists are in the Twin Cities compared to 63 percent of dentists.

Even in the short time they have been practicing in the state, the dental therapist distribution has changed. In 2013, 73 percent of dental therapists worked in the Twin Cities area. Currently, 50 percent of dental therapists work in the Twin Cities area, with small numbers working in other regions of the state.

Dental Therapist by Minnesota Region



Source: MDH Dental *Therapist Workforce survey, 2016. Percentages above are based on geocoding of 56 valid Minnesota addresses. To see regions defined, go to https://apps.deed.state.mn.us/assets/lmi/areamap/plan.shtml.*

The length of time dental therapists have been licensed in different regions also reflects the growth in Greater Minnesota with newly graduated dental therapists working more in Greater Minnesota. In Greater Minnesota 64 percent have been practicing two years or less. In comparison, 46 percent of Twin Cities area dental therapists have been practicing for the same length of time.

Slightly more Greater Minnesota DTs reported job dissatisfaction; 16 percent of Greater Minnesota dental therapists reported some level of career dissatisfaction compared to 4 percent of Twin Cities area dental therapists (data not shown).

Visit our website at http://www.health.state.mn.us/divs/orhpc/workforce/reports.html to learn more about the Minnesota healthcare workforce.

Minnesota Department of Health
Office of Rural Health and Primary Care
85 East 7th Place, Suite 220
Saint Paul, MN 55117
(651) 201-3838
health.orhpc@state.mn.us

[i] The Minnesota Department of Health (MDH) collected information on demographics, education, career and future plans of dental therapists during a workforce questionnaire in 2016. Unless noted, all data are based on information collected from that survey. The response rate for the 2016 DT survey was 92 percent.

[ii] For additional information, refer to Minn. Stat. 150A.105

[iiiii] All dental therapists licensed by the Minnesota Board of Dentistry work in the state of Minnesota. The dental therapist workforce survey collected addresses from those professionals who reported they were currently working in their profession. Not all survey respondents included their address. The Board of Dentistry also collects address information which supplemented the survey address in some cases.

[iv] To see regions defined, go to https://apps.deed.state.mn.us/assets/lmi/areamap/plan.shtml.

Catalog of Dental Terapy Research Publications and Studies

	Report/Project Title	Author	Lead Organization	Year	Data Collection Method 1	Data Collection Method 2	Data Sources	Research Focus 1	Research Focus 2
1	An Opportunity for Change	Karl Self, DDS, MBA	*University of Minnesota*	2009	Observation		Organization	Access	Workforce
2	Beginning the Socialization to a New Workforce Model: Dental Students' Preliminary Knowledge of and Attitudes about the role of the Dental Therapist. Journal of Dental	Christine Blue, B.S.D.H., M.S., Robert Phillips, David Born, Ph.D. and Naty Lopez,	*University of Minnesota*	2011	Survey		Students in the UMN dental classes of 2012 and 2013.	Workforce	
3	Socialization of New Dental Therapist on Entering the Profession. Journal of Dental Education	Naty Lopez, Ph.D, and Christine Blue, BSDH, MS	*University of Minnesota*	2011	Interview/focus group		9 UMN dental therapy students; the class of 2011	Workforce	
4	Towards Building the Oral Healthcare Workforce: Who Are the New Dental Therapists? Journal of Dental Education	Christine Blue, BSDH, MS and Naty Lopez, Ph.D.	*University of Minnesota*	2011	Survey		Ten students in the first dental therapy class at the University of Minnesota.	Workforce	
5	Dental School Faculty Perceptions of the New Dental Therapy Model. Journal of Dental Education	Christine Blue, BSDH, MS and Naty Lopez, Ph.D., Dr. Karl Self, DDS, MBA	*University of Minnesota*	2012	Interview/focus group			Quality	
6	Economic Viability of Dental Therapists	Frances M. Kim, DDS, DrPH	*Community Catalyst*	2013	Exisiting data (admin, claims, board)			Cost	Financial viability
7	Analyze the costs and effects of employing dental therapists from societal and dental practice perspectives		*Health Partners*	2013					
8	Utilization of Non-Dentist Providers and Attitudes Toward New Provider Models: Findings from The Dental Practice-Based Research Network. Journal of Public Health Dentistry	Christine M. Blue, MS, D. Ellen Funkhouser, DrPH, Sheila Riggs, DDS, DMSc, D. Brad Rindal, DDS, Donald Worley, DDS, Daniel J. Pihlstrom, DDS, Paul Benjamin, DDS, Gregg H. Gilbert, DDS, MBA, and for The National DPBRN Collaborative Group	*University of Minnesota*	2013	Survey		All network practitioner investigators who had participated in one or more network studies of any type previously, and who were in current practice with an active practice address.	Cost	
9	New Profession Aims to Ease Health Care Shortage	Karl Self, DDS, MBA	*University of Minnesota*	2013					
10	Early Impacts of Dental Therapists in Minnesota: Report to the Legislature	MDH	*Minnesota Department of Health (MDH)*	2014	Survey	Interview/focus group	(1) DT patient survey (2) Informational interview of staff at clinics employing	Access	Financial viability
11	Expanding the Dental Team: Increasing Access to Care in Public Settings	The Pew Charitable Trusts, Children's Dental Campaign	*Pew Research Center*	2014	Observation	Interview/focus group	1) People's Center Health Services, 2) Norton Sound	Access	
12	Dental Therapy: Evolving in Minnesota's Safety Net, American Journal of Public Health	Karl Self, DDS, MBA, David Born, PhD, and Amanda Nagy, MPH	*University of Minnesota*	2014	Survey		Individuals who had previously been identified as Minnesota safety net dental clinic leaders as well	Workforce	
13	Minnesotan's awareness and attitudes about dental therapists as a function of health literacy and caries risk		*University of Minnesota*	2014	Survey		MN State Fair	Access	
14	Dental Therapist Compensation		*University of Minnesota*	2014	Survey		DT Employers	Cost	
15	Employer Guide for Hiring a Dental Therapist/Advanced Dental Therapist	Patricia Glasrud, Karl Self, Colleen Brickle	*University of Minnesota*	2014	Existing knowledge/multiple data sources	Interview/focus group	Educational programs, dental therapy employers, dentists looking to employ DTs, dental therapists	Additiudes and knowledge	Access

16	Student Intern Research Project and Survey		*Minnesota Department of Health*	2015	Survey		Clinic administrative data	Financial viability	Financial viability
17	Developing minority faculty and reducing community oral health disparities in an innovative Dental Therapy program		*University of Minnesota*	2015	Exisiting data (admin, claims, board)		School based care settings.	DT & School Based Care	
18	Dental Therapy Practice Patterns in Minnesota: A Baseline Study. Community Dentistry and Oral Epidemiology.	Chris Blue, Mary Beth Kaylor	*University of Minnesota*	2016	Interview/focus group	Exisiting data (admin, claims, board)	Four dental practices representing different practice models who	Workforce	
19	A Review of the Minnesota Dental Therapist Model	Academy of General Dentistry	*Academy of General Dentistry/Foley & Lardner LLP*	2016	Observation	Interview/focus group	Dental therapist inteviews, state laws, existing reports	Access	
20	Dental Therapist Employer Toolkit		*Minnesota Department of Health*	2016	Interview/focus group	Survey	Clinic staff	Financial viability	
21	Evaluating Dental Therapy	Debra J. Rog, Pd.D, Craig Love, Pd.D, Joseph Hawkins, M.A.	*Westat*	2016			Literature review, conversations	Evaluation plan NA	
22	Good for Patients, Good for Dentists	Karl Self, DDS, MBA	*University of Minnesota*	2016					
23	Case Studies: Midwest Dental and Grand Marais Family Dentistry	Melanie Ferris, Research Scientist; Jose Diaz, Research Scientist	*Wilder Research*	2017	Interviews, observation, patient surveys, production data, clinic financials		Clinic data	Access to Care, Financial Viability, Quality of Care	
24	Dental School Faculty Attitudes towards Dental Therapy – a Four Year Follow up. Journal of Dental Education	Karl D. Self, DDS, MBA, Naty Lopez, PhD, Chris Blue, DHSc, MS	*University of Minnesota*	2017	Survey		University of Minnesota School of Dentistry faculty		
25	Minnesota Dentists' Attitudes Toward the Dental Therapist Workforce Model. Healthcare	Chris Blue, Todd Rockwood, Sheila Riggs	*University of Minnesota*	2015	Survey		Minnesota dentists.	Workforce	
26	Workforce reports: Minnesota's Oral Health Workforce 2012-2014 Minnesota's Dental Therapist Workforce, 2015 and 2016 (on-going)	Laura McLain	*Minnesota Department of Health (MDH)*	2015 and 2016	Survey		Board of Dentistry MDH oral health workforce biennial license renewal survey	Workforce	
27	Research impact of dental therapists to demonstrate the potential for the model to expand access to care and build awareness and support		*Pew Research Center*	2016-2019					
28	Dental Therapy in Minnesota: A Study of Quality and Efficiency Outcomes	Sarah Wovcha, JD, MPH and Emily Pietig, DDS	*Children's Dental Services*	On-going			Clinic and employee data		
29	Two Case Studies: Analysis of the contributions of an Advanced / Dental Therapist in 1) a nursing home and 2) in a rural clinic.		*Pew Research Center/Apple Tree Dental*				Apple Tree Dental information systems (EHR, HR, billing, etc.), staff and		
30	Dental Therapy: A user guide for workforce expansion with Dental Therapists and Advanced Dental Therapists in Minnesota's oral health community		*Children's Dental Services*	2013					
31	Impact of Dental Therapists on Dentists' Scope of Practice		*Health Partners*				Clinic information		
32	Integrating Oral Health and Primary Care In a Nurse Practitioner Clinic		*University of Minnesota*						
33	Evaluating Dental Therapy: A plan for Implementation, Outcome, and Cost Evaluation	Debra Rog, Craig Love, Joseph hawkins	*Westat*	2016	Existing knowledge/multiple data sources	Interview/focus group	Literature and document review, conversations	Financial viability	
34	Review of the Minnesota Dental Therapy Landscape	Jeremy Green	*St. Louis University, Dpeartment of Health Management & policy, College of Public Health*	2016			Review of MN Dental Therapist Toolkit		
35	Review of the Dental Therapy Toolkit - Environmental Scan	Kalyan Pasupathy	*Mayo Clinic*	2016			Review of MN Dental Therapist Toolkit		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 31, 2018

TO:
Senator David Craig
Senator Chris Kapenga
Representative Paul Tittl
Representative Nancy VanderMeer
Representative Mary Felzkowski
Representative Romaine Quinn
Representative Rob Swearingen

CC:
Senator Leah Vukmir
Secretary Linda Seemeyer
Representative Joe Sanfelippo
Liz Portz

The Minnesota Department of Health (MDH) recently had the opportunity to review the Wisconsin Dental Association's (WDA) materials on dental therapy (DT) in Minnesota and beyond. This letter is to clarify the claims noted with respect to the dental therapy profession in Minnesota, based on our experience providing information and technical assistance to community stakeholders and legislators on this topic, working with providers who have employed or are seeking to employ DTs, and evaluating the impact of DTs in Minnesota.

As background, MDH has had oral public health responsibilities since 1872. Our oral health staff includes dental health professionals, epidemiologists and health workforce researchers, and the department is accredited by the Public Health Accreditation Board.

The WDA material is imprecise on the start of dental therapy in Minnesota. The first Minnesota legislation on DT passed in 2009; the first DT in MN was licensed and employed in 2011; and in Sept 2011, the state's Medicaid agency enrolled the first DT as a billable provider. By 2014, when MDH published the first evaluation of the access impacts of DTs, there were 32 licensed DTs practicing in 15 dental clinics in MN as compared to 4,027 licensed dentists and 5,542 licensed dental hygienists statewide.[i] Currently, there are 79 DTs practicing in Minnesota, roughly one DT for every 70,000 Minnesotans. To get to this level of adoption of a new profession in such a short time, Minnesota's oral health community came together to assemble the basic foundation needed to support these workers and the clinics in which they practice, including developing educational programs, licensing and certification procedures, reimbursement policies, and helping interested dental practices to understand the new role and integrate it into their operations.

The 2014 evaluation offered our first look at the impact of these newly licensed professionals on access to and quality of oral health. The evaluation, which was based on patient data and interviews with oral health providers and clinic administrators, found that DT patients reported decreased travel and appointment wait times, and employers reported an increase in the number

of new Medicaid patients to the clinic in addition to increased productivity among the dental team providers, increased efficiency and flexibility with scheduling, and reduced clinic operating costs. Between 2011-2013, in their first few years of existence, DTs saw 6,338 new patients. [ii]

It is important to put the contributions of DTs into the broader context of long-standing oral health access challenges in Minnesota. Like many states, Minnesota struggles with providing consistent access to oral health care across the state, especially for Medicaid patients despite a dental Medicaid benefit. An aging dental workforce, historically low reimbursement rates for oral health services by public programs, and complex administrative and payment structures have resulted in low participation of dentists in Medicaid, thereby decreasing access and increasing oral health disparities for Medicaid populations. It was because of these long-standing access challenges that Minnesota's oral health community came together to explore, research and ultimately advocate for DT legislation. This was only one of a number of strategies for improving access that were advocated for and ultimately enacted by the Minnesota Legislature.

But because these access problems are caused by multiple complex factors, the responsibility for solving them cannot lie solely with DTs. While we know that DTs are opening up additional access points and expanding access, in particular for underserved populations, a cohort of less than 80 practitioners which is growing but still less than one percent of Minnesota's workforce cannot yet produce statistically valid changes in statewide or regional access and utilization data and even in the future will not be the entire solution to the longstanding, multi-faceted access problem. DTs must be part of a comprehensive package of strategies to support access to high-quality oral health services, including sufficient reimbursement across payers; administrative streamlining; and incentives to attract, recruit and retain all dental provider types to serve in urban and rural underserved areas.

As part of our oral health program's overall mission to promote, protect, and improve oral health, because it is critical to the health of all Minnesotans, MDH monitors the oral health workforce in Minnesota, including DTs. As part of this tracking, we know that DTs are now distributed throughout Minnesota's rural and urban areas in proportion to the distribution of the population at large. DTs are also one of the more diverse licensed health care providers in the state—a third of the providers are people of color, and they are serving an equally diverse patient base. DTs are also more likely to work in community based or non-profit settings or clinics as compared to any other dental profession (24 percent). About 35 percent of DTs work in community-based, nonprofit, faith-based clinics or community health centers/federally qualified health centers.[iii]

We also know that the number of patients receiving care from DTs is growing. In 2016 alone, DTs provided dental care in an estimated 94,392 patient visits. DTs still account for roughly less than one percent of the state's licensed oral health workforce of approximately 17,000 providers as compared to 23 percent who are dentists.[iv]

The WDA handout mentioned the lack of CODA-accredited dental therapy education programs in the U.S. The handout failed to point out that CODA only recently adopted accreditation standards and has not yet commenced accreditation activities. Existing training programs in

Alaska and Minnesota were established prior to CODA's accreditation program and have the authority to continue to operate without CODA accreditation. However, CODA's development of an accreditation program was initiated at the request of the University of Minnesota Dental School's education program and all three of the existing education institutions contributed significantly to the development of CODA's standards and would meet be able to meet CODA's standards if they pursued accreditation.

The body of evidence supporting dental therapy shows that dental therapists are a lower-cost provider that can improve access while providing safe, high-quality care. The evidence continues to grow as this workforce expands. In Minnesota like in other states, a multi-pronged approach is needed to solve the oral health crises but from our experience, dental therapists are opening access, welcoming new patients and addressing the needs of the underserved.

Thanks for the opportunity to review this material. If you have any questions, please do not hesitate to contact us for more information.

Sincerely,

Diane Rydrych
Director, Health Policy Division
PO Box 64882
St. Paul, MN 55164-0882
651-201-3564
www.health.state.mn.us

Prasida Khanal
Director, State Oral Health Program
PO Box 64882
St. Paul, MN 55164-0882
651-201-3538
www.health.state.mn.us

Enclosures:
Dental Therapy in Minnesota – Fact Sheet
Minnesota's Dental Therapist Workforce - 2016

[i] See http://www.health.state.mn.us/divs/orhpc/workforce/oral/dtlegisrpt.pdf

[ii] See http://www.health.state.mn.us/divs/orhpc/workforce/oral/dtlegisrpt.pdf

[iii] Figures as of December 2016. See http://www.health.state.mn.us/divs/orhpc/workforce/oral/2016dtb.pdf

[iv] See http://www.health.state.mn.us/divs/orhpc/workforce/oral/ohchartbook052016.pdf for Minnesota's oral health workforce composition

Northcentral TECHNICAL COLLEGE

Assembly Bill 945/Senate Bill 784 Testimony – NTC President Lori A. Weyers

Technical Colleges are closer to business and industry than any other educational system. Through advisory committee and industry feedback, Northcentral Technical College (NTC) and other Wisconsin Technical College System (WTCS) colleges are able to quickly respond to changing market needs, constantly cutting, modifying or starting programs driven by local and regional needs. Should there be an opportunity to explore dental therapy programs in Wisconsin to help expand dental coverage to low-income populations that normally wouldn't be able to afford the cost of a dentist, we would be well poised to respond with educational offerings that meet industry needs.

NTC currently offers both a Dental Hygienist associate degree program and a Dental Assistant technical diploma program. The Dental Hygiene program prepares students to be a practicing hygienist who helps individuals maintain oral health and prevent oral diseases. Under the supervision of a dentist, the hygienist inspects the mouth, removes stains and deposits from teeth, applies preventative agents, prepares clinical and diagnostic tests, completes dental x-rays and performs many other services related to oral care. Dental Hygienists counsel patients about preventive measures such as nutrition, oral hygiene and dental care, while Dental Assistants work with dentists as they examine and treat patients.

With an accredited Dental Hygiene program currently in place at NTC, we would be willing to explore a pilot program that bridges from our Dental Hygiene associate degree to a dental therapist program similar to models found in Minnesota and Vermont. This model could allow for NTC dental hygiene and dental assistant graduates to earn advanced standing for coursework already completed toward the dental therapy program, which would allow them to enter the workforce sooner while addressing growing concerns regarding access to oral health care.

Thank you for allowing me to submit written testimony, I apologize that I was unable to attend the public hearing in person. If any members or stakeholders have questions regarding my testimony, please feel free to contact me.

Sincerely,

Lori Weyers
President
Northcentral Technical College

Survival Coalition
of Wisconsin Disability Organizations

P.O. Box7222, Madison, Wisconsin 53707

DATE: February 14, 2018

TO: Senator Chris Kapenga, Chair, Senate Committee on Public Benefits, Licensing, and State-Federal Relations
FROM: The Survival Coalition of Wisconsin Disability Organizations

RE: Support for Senate Bill 784, licensure of dental therapists

The Survival Coalition of Wisconsin Disability Organizations is comprised of over 30 statewide groups representing people with all disabilities and all ages, their family members, advocates, and providers of disability services. We would like to voice our support for Senate Bill 784, which seeks to address the serious dental care access issues across the state of Wisconsin.

Survival Coalition appreciates the Legislature's efforts to address oral health care disparities in Wisconsin. SB 784 will expand the availability of dental care to underserved populations and will start to address dental care access issues faced by people with disabilities.

People with disabilities in Wisconsin experience difficulties in obtaining regular dental care, resulting in many preventable extractions, a high incidence of periodontal disease, and other reduced health outcomes. Data provided by the Wisconsin State Health Plan, *Healthiest Wisconsin 2020,* indicates that 29% of adults with disabilities reported having at least one permanent tooth removed over the past year, and 26% said they had not visited a dentist within the past year. Adults with a disability are also less likely to visit the dentist for a cleaning, check-up, or exam than people without disabilities (47% and 76%, respectively). They are more likely, however, to visit the dentist when something was wrong or causing pain (29% and 12%, respectively), as compared to adults without a disability.

One major cause of the oral health care gaps for people with disabilities is the low reimbursement rates for dental procedures in Medicaid, and the resulting small number of dentists willing to accept these rates. The Department of Health Services issued a Medicaid Plan for Monitoring Access to Fee-for-Service Health Care in 2016, which highlighted this issue. DHS found that only 37% of licensed dentists in Wisconsin were enrolled in the Medicaid program. Of those dentists that were enrolled as Medicaid providers, the majority (53%) were either inactive or had only limited participation. Minnesota has utilized dental therapists and found that 80% of new patients seen were on Medicaid and that dental therapists were more likely to work in settings, such as non-profit or community based practices, that served underserved populations. It is our hope that dental therapists in Wisconsin would demonstrate similar outcomes in providing greater access to dental services for people with disabilities.

Building provider capacity and improving access to oral health care are complicated issues, and we applaud the Legislature for continuing this important dialogue. Several potential strategies for improving access to oral health care for people with disabilities recommended by Survival Coalition include:

- Correcting the current inequity in the SSI Managed Care Program (dental care is included in SSI MC in some southeast Wisconsin counties but not in the other SSI MC counties);
- Expanding the availability of dental care at community health clinics;
- Increasing the number of dentists and facilitates that accommodate sedation dentistry;
- Improving the Medicaid reimbursement rates for dental care; and
- Ensuring that all dentists offices and services are accessible to people with disabilities; i.e. physical accessibility of office and equipment and communication access, such as providing interpreters.

Thank you for the opportunity to provide input on this legislation. We look forward to working with you in the future on ways to improve access to quality dental care for people with disabilities.

Please support SB 784.

Sincerely,

Survival Co-Chairs:

Maureen Ryan, moryan@charter.net; (608) 444-3842;
Beth Swedeen, beth.swedeen@wisconsin.gov; (608) 266-1166;
Kristin M. Kerschensteiner, kitk@drwi.org; (608) 267-0214;
Lisa Pugh, pugh@thearc.org; (608) 422-4250

Survival Coalition Issue Teams: education, employment, housing, long term care for adults, long term care for children, mental health, transportation, workforce, voting, Medicaid and health care.

Real Lives, Real Work, Real Smart, Wisconsin
Investing in People with Disabilities

disabilityrights | WISCONSIN
Protection and advocacy for people with disabilities.

To: Senator Kapenga, Chair, Senate Committee on Public Benefits, Licensing, and State-Federal Relations
Members, Senate Committee on Public Benefits, Licensing, and State-Federal Relations
From: Disability Rights Wisconsin, Amy Devine, Public Policy Coordinator
Date: February 14, 2018
Re: Testimony in support of SB 784, licensure of dental therapists

Disability Rights Wisconsin (DRW) is the designated Protection and Advocacy system for Wisconsinites with disabilities. DRW is charged with protecting and enforcing the legal rights of individuals with disabilities, investigating systemic abuse and neglect, and ensuring access to supports and services. DRW appreciates the Legislature's efforts to address oral health care disparities in Wisconsin. SB 784 will expand the availability of dental care to underserved populations and will start to address dental care access issues faced by people with disabilities.

People with disabilities in Wisconsin face obstacles in obtaining regular dental care, resulting in preventable extractions, a high incidence of periodontal disease, and other reduced health outcomes. Data provided by the Wisconsin State Health Plan, *Healthiest Wisconsin 2020,* indicates that 29% of adults with disabilities reported having at least one permanent tooth removed over the past year, and 26% said they had not visited a dentist within the past year. Adults with a disability are also less likely to visit the dentist for a cleaning, check-up, or exam than people without disabilities (47% and 76%, respectively).

Reimbursement rates for dental procedures in Medicaid are low, and as a result, a small number of dentists are willing to accept these rates. The Department of Health Services issued a Medicaid Plan for Monitoring Access to Fee-for-Service Health Care in 2016, finding that only 37% of licensed dentists in Wisconsin were enrolled in the Medicaid program. Of those dentists that were enrolled as Medicaid providers, the majority (53%) were either inactive or had only limited participation.

Minnesota has utilized dental therapists and found that dental therapists were more likely to work in settings such as non-profit or community based practices that served underserved populations. They also found that 80% of new patients were on Medicaid. It is our hope that dental therapists in Wisconsin would demonstrate similar outcomes in providing greater access to dental services for people with disabilities. Thank you for the opportunity to provide input on SB 784. We look forward to working with you in the future on ways to improve access to quality dental care for people with disabilities.

MADISON	MILWAUKEE	RICE LAKE	
131 W. Wilson St. Suite 700 Madison, WI 53703	6737 West Washington St. Suite 3230 Milwaukee, WI 53214	217 West Knapp St. Rice Lake, WI 54868	disabilityrightswi.org
608 267-0214 608 267-0368 FAX	414 773-4646 414 773-4647 FAX	715 736-1232 715 736-1252 FAX	800 928-8778 consumers & family

AMERICANS FOR PROSPERITY
WISCONSIN

TO: Members of the Senate Committee on Public Benefits, Licensing and State-Federal Relations

FROM: Eric Bott, Americans for Prosperity State Director

DATE: February 14, 2018

RE: Support Senate Bill 784, Licensed Dental Therapy

Chairman Kapenga, Vice-Chair Olsen, and Members of this Committee thank you for holding this hearing and for the opportunity to provide testimony. I also want to thank Senators Craig and Kapenga and Representatives Felzkowski and Swearingen for authoring this legislation.

On behalf of the more than 130,000 Americans for Prosperity activists in Wisconsin, I urge you to support Senate Bill 784, which will expand access to dental care for approximately 1.5 million Wisconsin residents and create new avenues of opportunity for Wisconsin workers.

SB 784 allows for the licensing of dental therapists, a mid-level position comparable to physician assistants or nurse practitioners. This change will improve access to dental care, providing a common-sense solution to a problem affecting Wisconsinites in underserved populations throughout the state. Currently, more than 1 million Wisconsinites covered under Medicaid have severely limited access to dental care.

As a result, Wisconsin hospitals had 41,000 emergency room visits in 2015 that would have been preventable had patients been provided with proper access to dental care. Worse yet, emergency room visits do not necessarily result in treatment of underlying dental problems and can serve as an unfortunate access point to opioids.

This legislation is urgently needed. In 2016, Wisconsin ranked dead last when it came to the portion of Medicaid children seeing a dentist. With only 37% of dentists in Wisconsin currently accepting Medicaid patients, this situation is unlikely to improve without change. We must do better and we can. SB 784 will serve as an effective means of improving access and lowering costs by removing a government imposed barrier to care.

Thank you for your time and consideration.

Americans for Prosperity (AFP) exists to recruit, educate, and mobilize citizens in support of the policies and goals of a free society at the local, state, and federal level, helping every American live their dream – especially the least fortunate. AFP has more than 3.2 million activists across the nation, a local infrastructure that includes 36 state chapters, and has received financial support from more than 100,000 Americans in all 50 states. For more information, visit www.AmericansForProsperity.org.

KIDS FORWARD

Every Kid. Every Family. Every Community.

DATE: February 14, 2018

TO: Senate Committee on Public Benefits, Licensing and State-Federal Relations

FR: Jon Peacock, Research Director
608.284.0580 ext. 307
jpeacock@kidsforward.net

RE: Support of SB 784 – Licensing of dental therapists in Wisconsin

Chairperson Kapenga and Committee:

Thank you for this opportunity for our organization, Kids Forward, to submit testimony on Senate Bill 784, which we strongly support.

Kids Forward aspires to make Wisconsin a place where every child thrives by advocating for effective, long-lasting solutions that break down barriers to success for children and families. Using research and a community-informed approach, Kids Forward works to help every kid, every family, and every community thrive.

Wisconsin ranks worst in the nation for children on Medicaid's access to dental care. In 2016, less than one out of three children on Medicaid received any dental care. According to the Department of Health Services, nearly one in four preschoolers in Head Start programs had untreated tooth decay. A 2015 National Health and Examination Nutrition Survey found that Black and Latino children eight years and under were more likely to have cavities than white children.

Nearly 30% of low-income adults struggle with untreated tooth decay. One in three senior citizens in 2014 had at least six teeth removed because of tooth decay or gum disease. Over 25% of Wisconsinites live in areas that the federal government has designated as having a shortage of dentists. In 2014, less than 40% of Wisconsin dentists were enrolled in Medicaid, but far fewer of them served more than 25 Medicaid patients.

Numerous studies have shown the correlation between oral health and overall health. Kids can't concentrate in school if they are in pain because of unmet dental needs, and lower-income children are less likely to get needed care. Communities of color are more likely to face structural and systemic barriers to accessing dental care.

Lack of access to dental care disproportionately impacts communities of color and reservations. According to the Department of Health Services, one in three Asian, Black, or Hispanic third-grade children had untreated tooth decay, compared to one in six White children. High school students face similar racial disparities in access. State data on dental access among ninth graders show that in 2015 almost 38% of non-Hispanic

Black students did not see a dentist or dental hygienist, compared to 33% of Hispanic students and 14% of non-Hispanic white students. This disparity continues into adulthood.

Dental therapists are a step to addressing this significant racial equity issue and improving access to dental care, especially for low-income families and those living in areas with a shortage of dental providers. Dental therapists will not fix every issue and the legislature should continue to look at other options for increasing access, but this legislation represents an important step in the right direction.

Allowing dental therapists to perform preventative and routine restorative care, under general supervision of a dentists, is likely to result in more people being able to access dental care. Since dental therapists are paid significantly less than dentists, their lower labor costs could allow practices to serve more Medicaid patients.

Dental therapists are not a cure-all for the countless issues low-income kids and families have when it comes to accessing affordable, quality dental care, but similar models in other states have shown that they can help serve more people in under or unserved areas. A 2014 report released in Minnesota, showed that four out of five new patients seen by dental therapists received publicly funded health insurance and patients reported less travel and wait time to get care.

Kids Forward supports this legislation because it is a step in the right direction toward being able to provide dental care for every kid, every family, and every community. Thank you.

MacIver Institute
The Free Market Voice for Wisconsin

TEXAS PUBLIC POLICY
FOUNDATION

Policy Brief: Dental Therapy In Wisconsin

A simple, cost-effective way to ease the shortage of dental care in Wisconsin

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and

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Introduction

Strict licensure requirements, a general shortage of dental providers, and geographic constraints are limiting access to critical dental care in Wisconsin. In fact, 65 of Wisconsin's 72 counties have at least one area that qualifies as experiencing a shortage of dental providers. The problem is particularly acute in areas with higher populations of low-income and minority individuals. Our research shows that easing regulations and allowing more dental professionals to conduct routine dental work, under the supervision of a licensed dentist, is a pragmatic and sensible solution to Wisconsin's dental shortage.

If Wisconsin allowed the practice of dental therapy, there would be more access to important dental care. Dental therapists are mid-level dental practitioners, similar to nurse practitioners or physician assistants in medicine. Under general supervision of a dentist, dental therapists can perform a wider range of routine procedures than a dental hygienist, including drilling, filling cavities, and performing nonsurgical extractions.

The shortage of adequate dental providers means many people in Wisconsin are not getting the dental care they need.

The problem is particularly concerning where it involves children's access to dental care. In 2016, more than 550,000 children (ages 1-18) had dental benefits through Medicaid in Wisconsin.

Sixty-five of Wisconsin's 72 counties have at least one area that qualifies as a dental shortage.

However, even though these children had dental coverage, the vast majority of them, 67 percent, received no dental care—the worst rate in the country.

Clearly, improving access to dental care is critical to making progress on health care issues in Wisconsin.

Oral Health In Wisconsin

Oral health plays a significant role in a person's physical and mental wellbeing. In 2000, the Surgeon General released a report on oral health that featured evidence of association between oral infections and diabetes, heart disease, stroke, and adverse pregnancy outcomes (HHS, 109). Dental disease causes children to miss over 51 million hours of school each year, and adults lose over 164 million hours of work (2-3). Furthermore, oral conditions can negatively affect self-esteem. Twelve percent of Wisconsin adults report that the appearance of their teeth affects their ability to interview for a job (ADA).

Dental care is a lifelong necessity. Routine preventive care and healthy oral habits early on can prevent painful and costly dental disorders in the future.

The rate of dental disease and dental utilization among Wisconsinites gives us a better picture of oral health needs across the state.

In 2014, the Wisconsin Department of Health Services (DHS) published a survey of oral health among Wisconsin Head Start children, age three to five. It found that 41 percent of Head Start children had experienced tooth decay, 23 percent had untreated tooth decay, and 20 percent had early childhood tooth decay (DHS, 8).

The Head Start survey also showed that 69 percent of Asian children had experienced tooth decay, compared to 39 percent of Hispanic children, 38 percent of African-American children, and 36 percent of white children (11). African-American children had the highest rates of untreated tooth decay (28 percent), compared to 20 percent among white children.

More than 550,000 Wisconsin children were eligible for Medicaid for 90 continuous days in 2016, about 43 percent of all Wisconsin children (FY 2016 CMS-416). However, only 42 percent of these Medicaid children received any dental or oral health services during the year. Thirty-one percent received dental services from a dentist or practitioner under the supervision of a dentist, while 14 percent received oral health services from a non-dentist practitioner, such as a primary care provider.

The dental care picture for adults in Wisconsin is not much better. A DHS survey found that 15 percent of Wisconsin adults had untreated tooth decay, 17 percent had gum disease, and 16 percent needed treatment for oral decay, abscesses, or lesions (DHS, 10-14).

Oral health among adults varies widely across income groups, racial/ethnic groups, and groups with different levels of education. Twenty-nine percent of low-income adults, those earning less than $25,000 per year, had untreated decay, compared to 16 percent of adults in the next highest income group, earning $25,000 to $49,999 per year (12). Thirty-two percent of low-income adults needed dental care for decay, abscesses, or lesions, compared to 18 percent of adults in the next highest income group.

Among low-income adults who had not visited a dentist in the past 12 months (2015), 50 percent cited cost as a reason, 42 percent cited trouble finding a dentist as a reason, and 42 percent cited inconvenient time or location as a reason (ADA).

The DHS survey also found that "[African-Americans] were significantly twice as likely to have untreated decay and a need for dental care as whites...while racial/ethnic groups were also significantly more likely to report having oral health problems and difficulty gaining access to dental services" (4). Sixty percent of African-American adults reported having poor oral conditions, compared to 39 percent of Hispanic adults, and 23 percent of white adults (15).

Education was also associated with oral health. Thirty-nine percent of adults with less than a high school education had untreated tooth decay, and 42 percent needed treatment for decay, abscesses, or lesions. Only 20 percent of adults with a high school degree or equivalent had untreated decay, and 21 percent needed treatment (12).

According to the Wisconsin Oral Health Coalition (WOHC), "there are many special populations in the state with an increased disease burden that needs to be addressed, including: people with disabilities, long-term care residents, individuals with HIV/AIDS and those in the corrections system" (WOHC, 11). These populations tend to be more susceptible to dental disease and may have difficulty maintaining healthy oral habits at home.

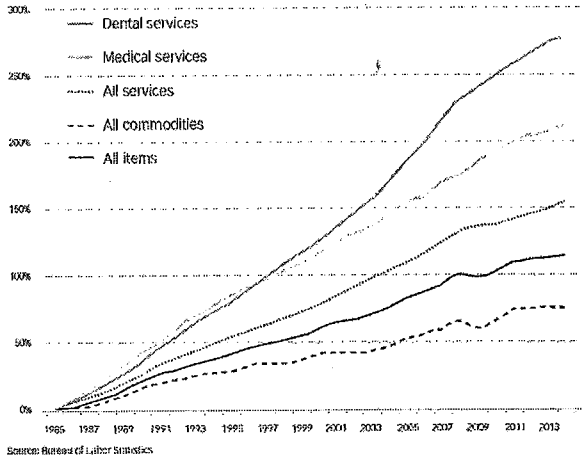
For example, adults with disabilities had higher rates of untreated tooth decay and were more likely to report poor oral conditions than adults without disabilities (4). Forty-two percent of adults living in nursing homes had untreated tooth decay and only 52 percent reported visiting a dentist in the past year.

Wisconsinites are not receiving dental care early or regularly enough. Furthermore, the prevalence of socioeconomic disparities across all age groups suggests that the burden of oral disease is linked to access to care challenges. While certain populations have greater oral health needs than others, all Wisconsinites can benefit from better oral health strategies and plenty of dental care options.

Access To Dental Care In Wisconsin

One in five Wisconsin adults reported having a need for dental care and not getting it in 2015 (DHS, 14). A survey of those with unmet needs found the top three reasons for not receiving care were unaffordable costs (68 percent), inadequate insurance coverage (26 percent), and a lack of convenience getting care (23 percent). If policymakers want to increase access to dental care, they should consider market-based, supply-side reforms that address Wisconsinites' top three barriers to getting care.

FIGURE 3 – Percent change in the CPI



Costs

According to Dental Economics, "Since 1985, there has been a 279% increase in the cost of dental services," far outpacing the growing cost of medical services and overall inflation.

Some of the most common dental procedures are fillings, root canals, extractions, and sealants. According to the American Dental Association's (ADA) Survey of Dental Fees, an amalgam (metal) filling costs $130.16 on average in the East North Central Division, including Wisconsin, Illinois, Indiana, Michigan, and Ohio (ADA 2016, 34-45). Tooth-colored resin fillings costs $168.16, surgical extractions cost $264.04, and sealants cost $51.46 per tooth. These charges are expensive for Wisconsin families, and they add up fast for those who need multiple procedures at a time.

The cost of dental care is rapidly increasing from year to year. For example, the cost of molar root canals rose from $945.51 in 2013 to $995.92 in 2016, a $50 increase in only three years (ADA 2013, 34-45).

In a free market, service prices are determined by supply and demand, and competition puts constant downward pressure on costs. That is not always the case in dentistry. Wisconsin's supply of dental care is constrained by the state dental practice act (Wisconsin Statutes Chapter 447) and licensure regulations (Wisconsin Administration Code Chapter DE). Under current law, dentists have a monopoly on performing the most needed dental procedures, such as fillings and extractions. Without competing delivery systems, there is no pressure on dentists to innovate or lower their charges. Dental care will continue to become less and less affordable until Wisconsin rolls back its licensure regulations, generates competition among providers, and allows them to adapt to Wisconsinites' diverse needs.

Inadequate Insurance

Like the cost of dental services, the cost of dental insurance continues to rise. Private dental plan charges increased 10 percent for children and 7.7 percent for adults between 2003 and 2013—one of the highest overall increases in the country (ADA, 163). Dental coverage does not always translate into dental care. In 2013, 67 percent of children and 63 percent of adults with private dental plans visited a dentist. While these utilization rates were slightly higher than the national averages, they exhibited a decline in dental visits in Wisconsin since 2005.

Wisconsinites enrolled in public health insurance programs have even more difficulty accessing dental care. In addition to having limited coverage, they have narrow dental provider networks. Only 32 percent of Wisconsin dentists accept Medicaid or CHIP patients, compared to a national average of 38 percent (ADA). A DHS report on Wisconsin's fee-for-service (FFS) Medicaid program shows that dentists' participation rates are lower than other Medicaid provider types (DHS, 24).

Low participation rates among dentists likely contribute to low utilization rates among Medicaid enrollees. In 2016, more than 550,000 children received dental benefits through Medicaid, yet 67 percent received no dental care—the worst rate in the country (CMS).

Trouble Getting Care

Costs and inadequate insurance are not the only barriers to care. People who have coverage and can pay for dental services may have difficulty finding a provider, making a timely appointment, getting to the dental office, and maintaining regular visits. The shortage of dental care in Wisconsin stems from an inadequate network of providers and an over-regulated delivery system.

There are approximately 3,233 dentists in Wisconsin, or 56 dentists per 100,000 people (ADA). By the numbers, this seems like enough dentists to treat most Wisconsinites. In fact, a 2010

report commissioned by the Wisconsin Dental Association (WDA) asserts, "Wisconsin appears to have an adequate dental workforce to meet the current and future demand for dental services by the population that has high enough incomes and/or private dental insurance to purchase care in the private sector" (Beazoglou et al., 8). However, oral health outcomes and dental utilization rates indicate that millions of Wisconsinites in the private sector are not getting care. The reason for this is that care shortages are not simply driven by the *number* of providers relative to the state population. The *type* of providers available and how they are distributed across the state play a large role in determining when and where dental care is delivered.

According to the U.S. Department of Health and Human Services (HHS), there are 138 dental health professional shortage areas (HPSA) in the state of Wisconsin (HRSA). Dental HPSAs are geographic areas, populations, or facilities that are experiencing a shortage of dental practitioners. To qualify as a dental HPSA, a geographic area must comprise 5,000 or more people per single dental provider, a population must comprise 4,000 or more people per provider, and a facility must comprise 1,500 or more people per provider. While dental HPSAs paint an incomplete picture of the state's dental care shortage, again because it is purely quantitative, it is a useful measure of provider distribution. Sixty-five of Wisconsin's 72 counties have at least one area that qualifies as a dental shortage.

Supply is only half the story. For example, Wisconsin has a large rural population that can benefit from alternative dental provider options. One in four Wisconsinites live in rural areas, about 1.5 million people (RHIH). While the 2010 WDA report identified a quantitative surplus of dentists in rural areas, it also found that rural residents "are in poor oral health relative to people in the larger counties" (Beazoglou et al., 6). In other words, supply is not the only factor driving the provision of dental care. Rural areas tend to have lower income and higher percentages of people enrolled in public health insurance programs than urban areas (6). They could benefit from a provider model that brings care closer to them, instead of requiring them to visit a dental office, and that utilizes mid-level dental practitioners who have lower labor costs than dentists, creating the potential for lower-cost services.

By expanding access to basic dental care, dental therapy could also help reduce emergency room visits. In 2015, there were 41,387 emergency department visits in Wisconsin for which a preventable dental condition was the primary or secondary diagnosis (WHA, 5). In 33,113 of those visits, preventable dental conditions were the primary diagnosis. At an average cost of $749 per emergency visit, that amounts to $25 million in preventable hospital costs (ADA 2015, 1). Fifty-six percent of dental-related ER visits were paid for by Medicaid. Further, since ERs are not equipped to provide comprehensive dental care, patients leave with the same underlying problems they come in with.

Increasing access to dental care with dental therapists can also help reduce opioid prescriptions. From 2007-2010, 1.7 percent of all ER visits were for non-traumatic dental conditions (NTDCs), and 50.3 percent of NTDC visits resulted in an opioid prescription, compared to 14.8 percent of non-NTDC visits (Okunseri et. al, 2). Furthermore, the prescription of opioids was highest among patients aged 19-33 years. This is a problem the Wisconsin legislature has sought to address—2015 Wisconsin Act 269 asked the Dentistry Examining Board to issue guidelines regarding best practices in the prescription of controlled substances (DEB). Expanding access to basic dental care and preventing tooth decay could stave off the need for opioid pain medications.

What Are Dental Therapists?

Dental therapists are mid-level practitioners in the dental profession, much like a physician assistant or nurse practitioner in medicine. These professionals would be trained in much the same way as other similar professions. They would be trained according to national standards developed by the Commission on Dental Accreditation (CODA), the sole agency recognized by the U.S. Department of Education to accredit dental education programs. CODA accreditation indicates a program has achieved a nationally accepted level of safety and quality.

Dental therapy is relatively new to the United States, but has been practiced abroad since the 1920s (WKKF, 2). Six states have made room for the profession, and it is flourishing in rural and underserved areas of Minnesota, one of just three states that allow dental therapists to practice statewide.

Dental therapists operate under the general supervision of a licensed dentist, which means the dentist is not required to be on-site. This enables dental therapists to travel to satellite sites away from the dental practice to perform basic care. Satellite sites might include rural satellite clinics, nursing homes, schools, facilities for people with disabilities, and other places where people would benefit from dental care coming to them instead of them traveling for dental care. This would help to solve the problem of geographic disbursement of dental practices and licensed dentists in rural and underserved areas. Dental therapists could take advantage of telehealth technology to consult with their supervising dentist when needed, and dentists would be responsible for determining the scope of practice, within legal bounds, of the dental therapists under their supervision.

Many of the consequences of dental disease such as pain, missed school, and missed work are caused by untreated tooth decay. However, under state law only dentists are allowed to fill cavities. Creating a new level of dental provider with a wider scope of practice could increase the number of trained, licensed professionals able to fill cavities and perform many other routine procedures.

Authorizing the licensure of dental therapists would not involve the creation of new bureaucracy or significant expenses to taxpayers. The Dentistry Examining Board would simply be directed to grant dental therapist licenses to those who meet the criteria, which would include the successful completion of relevant educational programs and examinations.

Conclusion

As our research has shown, a variety of factors are causing a growing shortage of dental care in Wisconsin, and the impact is being felt by all. From the very young to our grandparents living in nursing homes, Wisconsinites need more and better access to quality dental care. If Wisconsin permitted dental therapists, it would help to alleviate this crisis.