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THE NATIONAL ACADEMY FOR STATE HEALTH POLICY 22ND ANNUAL STATE HEALTH POLICY CONFERENCE

OCTOBER 5-7, 2009 / LONG BEACH, CALIFORNIA

NATIONAL ACADEMY for STATE HEALTH POLICY
Minnesota’s New Mid-level Dental Practitioner

National Academy for State Health Policy

Michael Scandrett
Minnesota Safety Net Coalition
Halleland Health Consulting
Minnesota’s Dental Therapist Law
Chapter 95
enacted May 2009

Establishes a new type of licensed, mid-level dental practitioner, called a dental therapist, who will provide basic oral health and dental services to underserved patients and communities.
Presentation Outline

1. Background
2. MN’s Dental Therapist
3. Comparison to Other Programs
4. Politics and Policy
5. Lessons for Other States
1. Background

The events that led to the new law
Minnesota Safety Net Coalition

- Community health centers, hospitals, mental health centers, uninsured coverage programs, community dental clinics
- Shared learning and support
- Coordination of safety net services
- Joint projects
- Public policy advocacy
Safety Net Coalition
Public Policy Advocacy

- Coverage for the uninsured
- Access to health care services
- Health equity and disparities
- Health care reform
- Workforce
- Safety net funding
Halleland Health Consulting
Health Policy Practice

- State and local governments, associations, coalitions and task forces
- Access initiatives and coverage programs for the uninsured
- Initiatives in health care, dental, mental health, elderly, disabled, public health and other areas
- “From policy to practice”
Oral Health Access

• Long-term problem and getting worse
• Broader health implications
• Hardest hit:
  – Low-income
  – Racial and ethnic minorities
  – Elderly
  – Disabled
  – Rural communities
Root Causes of Access Problem

• Dental often not covered by insurance
• Policymakers often view it as lower priority
• Low reimbursement by gov’t programs
• Dental provider business model
• Shortage of dentists
• Lack of diversity in oral health work force
• Cultural, language and socio-economic barriers
Minnesota’s Access Problem

- Rural communities
- Nursing homes and group homes
- Community clinics and health centers
- Head Start programs
- Hospital emergency rooms
- Indian reservations
Past MN Steps to Improve Access

- Dental coverage through state programs
- Higher payment rate for disproportionate share dental providers ("critical access")
- Loan forgiveness program
- Grants to safety net providers
- Collaborative practice dental hygienists
- Expanded function auxiliaries
- Community health workers
Oral Health Access Trends

- Access problem for people on public programs is getting worse
- Majority receive no oral health services
- Average age of dentists is 55, 59 in rural
- 60% of dentists expected to retire in 15 yrs
- Long waiting lists to receive treatment
- Dentist chairs going unused
Safety Net Coalition: Oral Health Committee

- Improve oral health access
- Other initiatives: community health workers – oral health, higher rates for critical access dental clinics, loan forgiveness, state funding
- 2007: decided to pursue legislation establishing a mid-level provider
2008 and 2009 Legislation

• 2008 Law: skeleton framework for “oral health practitioner” established
• OHP Work Group established
• Work Group report completed Dec 2008
• Legislation introduced in January 2009
• Chapter 95 enacted in May 2009
2. MN’s Dental Therapist

About the new practitioner
Minnesota’s Goals

• Designed NOT to replace or compete with dentists – dentists are vital to model
• Improve access by filling gaps where there are not enough dentists
  – Extends capacity of existing dentists
  – Provides basic treatments where no dentists are available
• Part of a broader strategy to improve access -- not the silver bullet
Dental Therapist

- Two levels: basic and advanced practice
- Licensed by the Board of Dentistry
- Education programs approved by the BOD
  - Basic: Bachelor’s degree
  - Advanced: Master’s degree
- Supervised by a dentist through CMA
- Practice limited to underserved patients and populations
Scope of Practice and Supervision

- **Types of Supervision:**
  - **Direct** (dentist in the room)
  - **Indirect** (dentist on site)
  - **General** (supervising dentist need not be on site)

- State law limits scope of practice and specifies minimum supervision required
- Supervising dentist may further limit scope and require greater supervision
State Law Parameters

• **Dental Therapist** (basic)
  – Services allowed under general supervision
  – Services allowed under indirect supervision

• **Advanced Dental Therapist**
  – All DT services under general supervision
  – Additional services allowed under general

• **Dental Hygienist** (not in DT scope or training)
  – Separate DH license required for DH services
Dental Therapist: General
(Dentist need not be on site)

- Oral health education and counseling
- Charting
- X-rays
- Polishing
- Pulp vitality testing
- Desensitize teeth
- Remove space maintainers
- Make athletic mouth guards
Dental Therapist: Indirect
(Dentist On-Site)

- Drill and fill cavities
- Place temporary fillings and crowns
- Pulpotomies on primary teeth
- Pulp capping
- Repair prosthetics
- Administer nitrous & inject local anesthetic
- Scaling and root planing
- Soft tissue reline
Advanced Dental Therapist

• All of the dental therapist scope of practice may be performed under general supervision (without a dentist on site)

• Plus:
  – Oral evaluation, assessment and formulation of a treatment plan
  – Simple extractions of diseased teeth
  – Provide, dispense and administer analgesics, anti-inflammatories and antibiotics
Dental Therapists in the Clinic

(Dentist On-Site)

DT can perform basic dental procedures (like a physician’s assistant).

- increase clinic capacity to serve patients
- reduce costs
- free up dentist to deal with more serious and complicated patients
- extend career ladder for DA, DH
- diversify workforce
Dental Therapists in the Community
(No Dentist On-Site)

• Dental Therapist (basic) can do patient education, testing and screening, apply varnish and sealants, and other basic services without a dentist on site
  – Increase outreach, patient education and basic preventive services in the community at an affordable cost
Advanced Dental Therapists in the Community

- ADT can educate, examine, assess and provide basic treatment w/o dentist on site
  - Extend dental services to settings and communities where no dentists are available
  - Reduce cost of basic dental services
  - Promote a more diverse workforce
  - Creates another step in the oral health career ladder
Advanced DT Settings

• Community clinics
• Head Start programs
• Nursing homes and group homes
• Rural communities
• Public health clinics
• Hospital emergency rooms
• Homeless shelters
ADT/DH Combination

• **Dual license option**: licensed as both an advanced dental therapist and a dental hygienist
  – *Can clean teeth, provide preventive treatments and other DH services in addition to ADT services*
  – *Will be especially valuable in communities and treatment settings without a traditional dentist office*
Education Requirements

• **Dental Therapist**: Bachelor’s
• **Advanced Dental Therapist**: Master’s
• Education programs must be approved by the Board of Dentistry
• Education programs must be accredited when accreditation programs are established
• Two institutions started programs this Fall
Education Programs

1. U of M Dental School
   - Bachelor’s degree – 3-4 years
   - Training primarily for basic DT
   - Master’s ADT program possible in the future

2. Metropolitan State University/Normandale Community College
   - Prerequisite: bachelor’s DH + experience
   - Master’s ADT program
Licensure Requirements

• Licensed by the Board of Dentistry
• Graduate from approved educ. program
• Pass competency exam
• Satisfy licensing obligations
• Advanced DT:
  – Graduate from approved advanced program
  – Pass advanced competency exam
  – Register with Board
Collaborative Management Agreement with Dentist

- Written agreement with supervising dentist
- Protocols for authorized scope and supervision requirements
- Protocols for referral to dentist or specialized when needed
- Dentist must provide or arrange advanced treatment for DT’s patients when needed
Treatment Settings Where DTs May Practice

• “Critical Access Dental Providers”
• Settings authorized for collaborative dental hygiene practice (*includes nursing homes, community health centers, medical facilities, Head Start programs, etc.*)
• Federally designated dentist shortage areas
• Military and VA clinics and facilities
• Other settings if >50% of DT’s patients are low-income, disabled, chronically ill, uninsured
MN: Next Steps

1. First students began Fall 2009
2. Approval of educ. programs (Fall 2009)
3. Competency exams developed
4. Licensing and certification system
5. Reimbursement system
6. First students graduate:
   - U of M DTs: 2013
   - Metro State ADTs: 2011
3. **Comparison to Other Programs**

Minnesota’s practitioner compared to Alaska’s dental therapist and programs in other countries
### History, training and scope of practice of dental therapists (DT) in seven selected countries.

(Adapted from Dental Therapists: a global perspective by Tan et al.)

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#### Brief History

- Scandrett 36

- Pioneered training in Dental Therapists (DTs) in New Zealand in 1952. By 1960, there were 67 DTs trained.
- By 1970, 286 DTs graduated, and 249 are currently practicing.
- DTs are trained in the United Kingdom, New Zealand, and South Africa.
- DTs are trained in various programs in public health, community clinics, training institutions, and universities.
- DTs are trained in the United Kingdom, New Zealand, and South Africa.

#### DTs in Practice

- In New Zealand, DTs are employed by the Ministry of Health.
- In Norway, DTs are employed by the Ministry of Health.
- In Zimbabwe, DTs are employed by the Ministry of Health.
- In China, DTs are employed by the Ministry of Health.

#### Summary

DTs are trained in various programs in public health, community clinics, training institutions, and universities. They are employed by the Ministry of Health in various countries. The training and practice of DTs vary across countries, with some countries having more established programs than others. DTs are involved in various aspects of dentistry, including oral health education and ART. The role of DTs in the dental healthcare system is evolving in various countries. For more information, please refer to the reference "Dental Therapists: a global perspective by Tan et al."
Dental Therapists in Other Places

• **Alaska**: first state where mid-level practitioners provide dental treatment. Established under federal law for tribal communities.

• **Minnesota**: first state to enact licensing law and authorize practice outside of tribal land and for other patient populations.

• **Other Countries**: Over 50 countries have mid-level dental practitioner programs.
MN Compared to AK and Canada

• AK and Canada allow scope of practice and dentist supervision requirements similar to MN *advanced* dental therapist (Master’s level)

• Education required in AK and Canada is less than the *basic* DT requirement in Minnesota (2-3 year associate degree compared to Bachelor’s in Minnesota)
Other Countries

• Many countries’ programs focus on children and provide care in schools or in remote communities where dentists are not available
• Permanent tooth extractions are not allowed in some countries
• Some countries require a dentist to do an exam and diagnosis first
• Some countries are moving to combining DT and DH (Australia)
4. Politics and Policy

Major political and policy issues encountered in the development and enactment of MN’s law
The Major Players

MN Mid-level Alliance:
• Safety Net Coalition, safety net providers
• Community dental clinics
• MN Dental Hygienists Association
• Nursing homes and long-term care orgs
• Head Start programs
• Health insurance plans
• State government
• Disability organizations and advocates
The Major Players

Originally Opposed, but Agreement Reached:
- Minnesota Dental Association
- American Dental Association
- University of MN Dental School
Politics

• Initially: very strong opposition from dental associations
  – Grassroots
  – Lobbying
  – Media campaign
  – Pressure on dentists who spoke in support

• Proponents had less money but were well organized and had support from many health care and advocacy groups
Going to the Dentist Could Start to Become Painful

A risky proposal at the Minnesota legislature could mean some Minnesotans, including children and the elderly, might be treated by an experimental new dental practitioner. Some of these patients are our state's most medically challenged, but could have their teeth drilled and pulled by a dental practitioner who is not trained at a dental school. And worse, they would not even have a supervising dentist in the building when performing these irreversible procedures.

Minnesotans should not be used as an experiment! Do you want your family affected by this kind of dental health reform?

Call YOUR LEGISLATORS today! Tell them to require that this new practitioner be taught at a dental school AND be supervised by a dentist when doing surgical procedures.

Action will be taken at the legislature soon.
Please call today!
The last thing you want to hear when you’re getting dental care is “uh-oh.”

But at the state Capitol, Senator Ann Lynch wants to allow a new type of dental worker to perform unsupervised surgery on you and your family - even pull your teeth - without any training at an accredited dental school.

And worse, a dentist wouldn’t even have to be in the building if something goes wrong.

Minnesota’s lawmakers must ensure that only supervised, dental school trained professionals perform surgery.

Call Senator Ann Lynch and tell her unsupervised workers doing dental surgery is a bad idea.

Call Senator Ann Lynch today at 651-296-4848.

Paid for by the Minnesota Dental Association
130 Industrial Boulevard, Suite 300, Minneapolis, MN 55413-4847 • 866-236-0807
2008 Law

- Answered the question of “whether” to establish a mid-level practitioner
- Did not answer the “how” questions
  - Level of dentist supervision required
  - Education program requirements
  - Licensing and regulatory system
- Legislature created a work group, which recommended the “how” but this did not end the controversy
2009 Session

MDA and U of M Dental School offered alternative bill:

1. **MDA/U of M**: “physician assistant” model with dentist on site to do diagnosis and supervise treatment. Only the dental school could train:

2. **Safety Net Coalition**: “nurse practitioner” model to provide treatment where no dentists are available.
Compromise

1. Proposals merged: single practitioner, 2 levels
2. Not based on dental hygienist model
3. Only basic procedures including “simple” extractions
4. Supervising dentist requirements strengthened
5. No diagnosis, but may “assess”
6. No prescribing authority, but may “provide”
7. Clinical practice required before advanced practice allowed
8. Educational institutions not specified

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Policy Issues

- **Scope of practice**
  - Diagnosis by non-dentist
  - Defining “routine” or “simple” procedures
  - Extractions of permanent teeth
- **Level of supervision**
  - General supervision vs. indirect
- **Education level and accreditation**
- **Treatment settings**
5. Lessons for Other States
Keep the Focus on the Access Problem

• Untreated dental disease affects ability to learn, work, function in daily life
• Untreated dental disease results in higher costs
  – Lack of prevention and patient education
  – Delays result in more costly treatment
  – Treatment in hospital emergency rooms
• The most vulnerable patients suffer the most
Access to Dental Care for People on Public Programs is Declining in Most Minnesota Counties

CHANGE IN PERCENTAGE OF GENERAL ASSISTANCE ENROLLEES RECEIVING DENTAL SERVICES, 2001–2007

SOURCE: Minnesota Department of Human Services Data Warehouse, "FFS and Managed Care Dental Service Access by County of Residence / Major Program Group for Recipients Having 12 Consecutive Eligibility Months Per Year," Sept. 22, 2008.
Minnesota’s Dentist Shortage

Parts of 38 counties have been designated by the Minnesota Department of Health as dentist shortage areas because they do not have enough dentists to meet the needs of the population.
The Washington Post

For Want of a Dentist
Pr. George's Boy Dies After Bacteria From Tooth Spread to Brain

By Mary Otto
Washington Post Staff Writer
Wednesday, February 28, 2007; B01

Twelve-year-old Deamonte Driver died of a toothache Sunday.

A routine, $80 tooth extraction might have saved him.

If his mother had been insured.

If his family had not lost its Medicaid.

If Medicaid dentists weren't so hard to find.

If his mother hadn't been focused on getting a dentist for his brother, who had six rotted teeth.

By the time Deamonte's own aching tooth got any attention, the bacteria from the abscess had spread to his brain, doctors said. After two operations and more than six weeks of hospital care, the Prince George's County boy died.

Deamonte's death and the ultimate cost of his care, which could total more than $250,000, underscore an often-overlooked concern in the debate over universal health coverage: dental care.
Rely on Facts and Research

• Over 50 countries have programs that have been well-researched
• Mid-level providers have been shown to improve access for underserved populations and provide safe, high quality care
• Many research studies found quality as good or better than dentists for basic procedures
• No instances of patients being harmed by inferior care
Tailor Program to Needs & Resources

• **MN**: surplus of DHs, shortage of dentists, reimbursement available, widespread access problem across geography and demographics

• **Factors**:
  – Where and for whom is access a problem?
  – What levels of services are needed?
  – What funding or payment is available?
  – Will the program be accepted?
Avoid Turf Battles

• Avoid turf battles by involving all stakeholders in developing solutions

• Potential turf battles:
  – Dental hygienists vs dentists
  – Competing educational institutions
  – Rural vs. metro
  – Private dentists vs. safety net & public health dentists
  – Small dentist offices vs. large organizations
Work Together

- Seek collaboration among all stakeholders
- Document the need
- Tailor proposal to meet the greatest *unmet* needs, not to compete with private dentists
- Pattern program after well-proven models
- Engage dentists and dental educators, as well as other oral health and medical providers
Legislative Process

• Start early
• Build a coalition
• Prepare effective written materials
• Document access problems
• Tailor program to the greatest needs
• Lobby smart
• Use grassroots
Get Expert Help

Dentists, DHs, DAs, researchers, nurses, experts from other states and countries, people who work with the underserved, etc.

Scandrett
For More Information

• MN Dental Therapist Law:  
  www.revisor.leg.state.mn.us.  
  Look up Chapter 95, Article 3, of of 2009 MN Session Laws

• Minnesota Safety Net Coalition:  
  www.mnsafetynetcoalition.org

• MN Oral Health Practitioner Work Group:  
  www.health.state.mn.us/healthreform/oralhealth

• The Pew Center for the States: Oral Health  
  www.pewcenteronthestates.org
QUESTIONS?

Michael Scandrett
MN Safety Net Coalition
612-573-2923
mscandrett@halleland.com
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