Policy Brief

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The Case for Licensing Dental Therapists in North Dakota

By Michael T. Hamilton, Bette Grande, and John Davidson*

Introduction

The question of whether North Dakota should permit the licensing and practice of midlevel providers of oral care known as *dental therapists* is frequently posed to lawmakers as a choice between high standards of patient care and greater access for underserved patients.[1]

Proponents of licensing dental therapists reject this quality vs. access dichotomy.[2] Opponents embrace it.[3]

This policy brief frames the decision more starkly. The question really facing North Dakota lawmakers is, "Does licensing dental therapists in North Dakota pose a risk to public health great enough to justify depriving (1) dentists of their right to employ and

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[1] North Dakota Legislative Assembly. Health Services Committee, *Minutes of the Health Services Committee,* 64th Assembly, Interim Session, September 21, 2016, pp. 2–6.

[2] John Powers, Letter to Interim Health Services Committee, North Dakota Legislative Assembly, November 21, 2016, https://www.heartland.org/publications-resources/publications/letter-praising-dental-therapy-from-dr-john-powers-to-nd-interim-health-services-committee (January 3, 2017).

[3] North Dakota Legislative Assembly, *supra* note 1, Appendix I.

supervise dental therapists and (2) patients of their right to access providers of their choice?"

The answer is clearly no. The imagined risk of licensing dental therapists does not justify depriving North Dakota dentists and patients of their rights. Moreover, far from jeopardizing the public health, licensing dental therapists would likely expand patient access to high-quality oral care services and reduce oral care costs in North Dakota.

Failing to permit the licensure of dental therapists would unjustly diminish provider liberty, patient access, and sound stewardship of North Dakota tax dollars.

This policy brief first examines the harm oral care shortages do to North Dakotans of various ages, locations, and income levels. Next, the authors review the scope of practice, education, and training requirements of dental therapists practicing in other states. We then demonstrate dental therapy's proven track record of expanding oral care access for underserved patients, as well as dental therapy's potential to increase efficiency for dental practices and savings for the state. Finally, we rebut common objections to dental therapy, concluding that failing to permit the licensure of dental therapists would unjustly diminish provider liberty, patient access, and sound stewardship of North Dakota tax dollars.

1. North Dakota's Oral Care Shortage

The value North Dakota officials place on oral health care would seem evident by the placement of the statement, "Oral health is essential to general health and well-being at every stage of life," atop the Department of Health (NDDoH) website, quoting the U.S. Surgeon General's "National Call to Promote Oral Health."

Unfortunately, these aspirations to promote affordable access to oral health care do not necessarily translate into an effective policy reality, as North Dakotans young and old, rural and urban, on Medicaid and off, are experiencing.

Aging Population

Illustrating this disparity between intention and reality is NDDoH's *Smiles for Life*, an online oral health training curriculum for which physicians, physician assistants, pediatricians, and nurses can obtain continuing medical education (commonly "CME") credit.[4]

When surveyed by the Center for Rural Health (Center) at the University of North Dakota School of Medicine and Health Sciences in 2016,[5] only 14 percent of operators of long-term care (LTC) facilities, including skilled nursing and basic facilities, said they had heard of *Smiles for Life* in 2016, even though 78 percent of LTC facilities operators said they provide oral care training to staff.

[4] North Dakota Department of Health. Oral Health Program, "Smiles for Life Online Training," 2015, http://www.ndhealth.gov/oralhealth/NDSmilesForLife.htm. Accessed December 30, 2016.

[5] Shawnda Schroeder, "Oral Health Care in North Dakota Long Term Care Facilities, *Fact Sheet* 2, Center for Rural Health, School of Medicine & Health Sciences, University of North Dakota, June 2016. https://ruralhealth.und.edu/pdf/north-dakota-oral-health-long-term-care.pdf. Accessed December 30, 2016.

Put differently, more than four out of five LTC facilities responding to the Center's survey had not heard of NDDoH's oral care curriculum. More than one out of five LTC facilities do not train staff with any oral care curriculum.

LTC facilities are (and should remain) free to choose their own high-quality oral care training materials. But these facilities generally exhibit a lack of preparedness to identify, prevent, and address oral health needs as they arise. LTC facilities would therefore benefit from having another staffing option for giving residents needed care.

Long-term care facilities generally exhibit a lack of preparedness to identify, prevent, and address oral health needs as they arise.

Only 7 percent of facilities responding to the Center's survey said a dental professional completes residents' initial oral health exams. This low percentage undermines the stated intentions of the 72 percent of LTC facilities operators who say they highly prioritize oral health for residents. When oral care needs arise, approximately 75 percent of basic care and 43 percent of skilled nursing facilities lack a written plan for dealing with them.[6]

The potential for LTC facilities operators, even those who consider oral health a "high" or "essential" priority, to overlook or undertreat residents' needs is alarming, considering more than one-third of all elderly North Dakotans (aged 65 and older) with teeth needed "early or urgent dental care" in 2016, according to a separate analysis by the Center.[7]

Medicaid Adults and Children

North Dakotans of all ages enrolled in Medicaid disproportionately suffer from the state's oral health care shortage.

Of the almost one-third of nursing home residents who "had total tooth loss" in 2016, almost two-thirds were Medicaid enrollees. Nursing home residents on Medicaid can fare worse than those without dental insurance or with private health insurance. Medicaid enrollees are likelier to "be edentulous [i.e., lack teeth]; have substantial tooth loss; experience untreated decay; have prevalence of root fragments; have severe gingivitis; and, need periodontal care," a fact sheet from the Center states.[8]

North Dakota's oral care shortage is best illustrated, however, by the state's child Medicaid population – starting with pregnant mothers. "A higher proportion of Medicaid (69%) than non-Medicaid (52%) recipients did not go to the dentist during their pregnancy" in 2002, the birth year of children around age 14 today, according to the NDDoH report *Oral Disease in North Dakota: Burden of Disease and Plan for the Future, 2012–2017*.[9]

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[6] *Ibid*.

[7] Shawnda Schroeder, "Oral Health among North Dakota Elderly," *Fact Sheet* 9. Center for Rural Health, School of Medicine & Health Sciences, University of North Dakota. October 2016, https://ruralhealth.und.edu/pdf/oral-health-nd-elderly.pdf. Accessed December 30, 2016.

[8] *Ibid.*

[9] North Dakota Department of Health. Division of Family Health. Oral Health Program, *Oral Disease in North Dakota: Burden of Disease and Plan for the Future, 2012–2017, 2013,* pp. 46–7,

Out of 51,281 "children" (i.e., aged 20 and younger) enrolled in North Dakota's Medicaid program, approximately 36,922 "had no preventive dental visit" in 2015, the Center states.[10] In other words, 72 percent of children did not use preventive dental care for which they were eligible, a failure rate virtually unchanged since 2013. North Dakota's failure rate in this category ranks as third-worst in the country.

Almost as many Medicaid children – 32, 999, or 65 percent of those enrolled – "went without any dental or oral health service" in 2015, the Center states.

An especially interesting note for lawmakers hesitant to embrace dental therapy is that 25 percent of Medicaid children received oral health care services from a "non-dentist provider" – i.e., a qualified health care practitioner such as a nurse or medical aide who is not a dentist or dental hygienist, assistant, or therapist. Those who fear authorizing the profession of dental therapy in North Dakota will diminish the quality of care should consider the quality of oral care one in four Medicaid children already receive from non-dentist providers.

Leading Medicaid from Behind

Access to dental health services is an acute problem for North Dakota's Medicaid population, especially enrolled children, despite three factors that, on the surface, might lead one to expect better results from the state.

Access to dental health services is an acute problem for North Dakota's Medicaid population, especially enrolled children.

First, 83 percent of North Dakota dentists signed up to participate in Medicaid for children in 2014 – almost twice the national rate of 42 percent, according to the American Dental Association. In 2015, dentists in the state self-reported a lower Medicaid participation rate, 56 percent, which nevertheless also surpasses the national average, according to the Center. (The share of dentists accepting "any and all Medicaid patients," as opposed to only patients with emergencies, was 17 percent.) [11]

Second, North Dakota's reimbursement rate for dentists was among the highest in the country in 2014. Medicaid reimbursed North Dakota dentists for 63 percent of what the dentists billed Medicaid, compared to a national Medicaid reimbursement rate averaging 49 percent, according to the Center.

Third, North Dakota had the second-highest ratio of Medicaid reimbursements for adult dental care services compared to commercial insurance reimbursements. The American Dental Association uses this ratio to measure how well Medicaid reimbursements are keeping up with market rates. Although Medicaid pays dentists less than insurers do, North Dakota's 60.2 percent

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http://www.legis.nd.gov/files/committees/63-2013nma/appendices/2012-2017_Oral_Health_State_Plan.pdf. Accessed December 30, 2016.

[10] Center for Rural Health, "Oral Health among North Dakota Medicaid Recipients." *Fact Sheet* 8. School of Medicine & Health Sciences, University of North Dakota, December 2016, https://ruralhealth.und.edu/pdf/oral-health-nd-medicaid-recipients.pdf. Accessed December 30, 2016.

[11] *Ibid*.

reimbursement rate compared to insurers was second only to Arkansas' (60.5 percent) and ahead of Alaska's (58.4 percent).[12]

High provider participation rates, high Medicaid reimbursement rates, and a high Medicaid-to-commercial insurance ratio have not solved North Dakota's oral care shortage.

Gender and Tribe

Oral disease is no respecter of gender, tribe, or urban-rural divisions in North Dakota.

Although periodontal disease presents more frequently in men than women nationally, "[o]ral disease is associated with chronic disease among all populations and may cause birth complications for pregnant women," according to NDDoH's 2012–2017 report.[13]

During their last pregnancy, more than half of North Dakota women did not visit a dentist or dental clinic, and only one-third spoke with a dental or heath care professional about oral care, NDDoH reported. This share dropped to 16 percent among American Indian women, who "were three times more likely not to visit a dentist or dental clinic" while pregnant than white women.

North Dakota's oral care shortage is ubiquitous. Approximately 66,663 North Dakotans live in 35 areas designated as having a dental health professional shortage.

Rural and Urban Areas

North Dakota's oral care shortage is ubiquitous. Approximately 66,663 North Dakotans live in 35 areas designated as having a dental health professional shortage, according to HHS's Health Resources & Services Administration's (HRSA) Data Warehouse.[14] Of these 35 health professional shortage areas (HPSAs), 14 are geographic regions with population-to-provider ratios of at least 5,000:1. Two are population groups outnumbering providers at least 4,000:1. The remaining 19 HPSAs are federally qualified health facilities or correctional facilities.[15]

Despite having fewer HPSAs than every other state in the region besides Wyoming (29), North Dakota has one of the lowest "Percentage of Need Met"[16] scores, at 33 percent. Only South

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[12] Kamyar Nasseh, Marko Vujicic, and Cassandra Yarbrough, *A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services*. Health Policy Institute, American Dental Association, October 2014, http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_3.ashx. Accessed December 30, 2016.

[13] North Dakota Department of Health, *supra* note 9.

[14] U.S. Department of Health and Human Services. Health Resources & Services Administration. Data Warehouse, "Shortage Areas." http://datawarehouse.hrsa.gov/topics/shortageAreas.aspx, 2016. Accessed November 22, 2016.

[15] U.S. Department of Health and Human Services. Health Resources & Services Administration. Data Warehouse, "Designated Health Professional Shortage Areas Statistics," 2016, https://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=PDF. Accessed November 22, 2016.

[16] "The percentage of need met is computed by dividing the number of dentists available to serve the population of the area, group, or facility by the number of dentists that would be necessary to reduce the population to provider ratio below the threshold for designation so that it would eliminate the designation as a dental HPSA." *Ibid.*

Dakota has a lower "Need Met" percentage (26 percent), among 63 shortage areas. Montana's need is 34 percent met despite having 84 HPSAs; Colorado's need is 36 percent met despite having 97 HPSAs; Utah's need is 60 percent met despite having 52 HPSAs; and Wyoming's need is 63 percent met despite having 29 HPSAs.[17]

North Dakota's oral care shortage restricts the access of both rural and urban residents. Rural residents sometimes bear the brunt of these shortages, such as pregnant women who were less likely to visit a dentist or dental clinic than pregnant women living in urban areas in 2002.

North Dakota's oral care shortage restricts the access of both rural and urban residents.

In other cases, such as North Dakota's nursing home population, the incidence of oral health needs was basically equal in urban and rural settings, the Center for Rural Health found in 2016.

In still other cases, urban areas evince greater shortages than rural communities. Residents of urban LTC facilities, for instance, had longer wait times to see dentists than rural LTC residents, the Center found. Only 59 percent of urban LTC facilities surveyed could offer residents a list of area dentists for referral, compared to 80 percent of rural LTC facilities.[18]

Solution Within Reach

Fortunately, North Dakota beats four out of five states in the region in the most important dental health professional shortage area category: the minimum number of new practitioners mathematically required for the state to eliminate all 35 of its HSPAs and meet 100 percent of its need.

Based on HRSA's projections – which are inaccurately low – North Dakota would need eight more practitioners at present, and 34 practitioners by 2025, to eliminate its oral health care shortages, because of overlap among its shortage area populations. (Wyoming would require at least six at present; South Dakota 25; Montana 27; Utah 59; and Colorado 99.)[19]

Unfortunately, the actual numbers of shortage areas and dentists needed are likely much higher than HRSA estimates. The patient/dentist ratios HRSA uses to calculate area shortages (4,000:1 and 5,000:1) are higher than a typical dentist's patient load of 1,500 to 2,500 patients per year, and HRSA's numbers are based on current utilization rates, not the number of people who should be obtaining oral care.

Even if North Dakota had a supply of new dentists willing to open up practices or take jobs under other dentists in the state tomorrow, perfectly placing these dentists would be impossible for a government, organization, or any force other than a free market.

Instead, lawmakers can and should free dentists to expand their practices by hiring dental therapists: high-skilled midlevel practitioners currently authorized in four states. This would

[17] *Ibid*.

[18] Schroeder, *supra* note 5.

[19] U.S. Department of Health and Human Services, *supra* note 15.

accelerate fulfillment of North Dakota's oral care shortage, increasing patient access to high-quality oral care.

2. Dental Therapy: What It Is, How It Works

Licensing dental therapists to practice in North Dakota would give dentists the option to hire them as members of a dental team equipped to meet scores of oral care needs, under the supervision of a dentist located onsite or offsite.

Dentists who want to grow their practices by employing and supervising dental therapists would be free to do so. Dentists who do not want to hire dental therapists would not be required to.

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Team Players

A dental therapist is "a licensed oral health professional who practices as part of the dental team to provide educational, clinical and therapeutic patient services. Dental therapists provide basic preventive and restorative treatment to children and adults, and extractions of primary (baby) teeth under the supervision of a dentist," according to the University of Minnesota School of Dentistry.[20] All states with dental therapists allow them to extract adult teeth extremely loosened by disease.

Dental therapists treat patients in conjunction with a dental team, which in most settings also includes a supervising dentist and at least one dental hygienist and dental assistant. In extremely rural regions, a team may consist of only a dental therapist and supervising dentist. The therapist/dentist relationship resembles the relationship between physician assistants or advanced practice registered nurses and supervising doctors.

Like every other aspect of a dentist's practice, the practice's owner – typically the supervising dentist – determines the specific role dental therapists play on the team, the kinds of patients they treat, and the range of services they provide within their legally defined scope of practice.

Dentists dictate these and other terms for dental therapists using "collaborative care agreements" (Alaska),[21] "written practice agreements" (Maine),[22] "collaborative management agreements" (Minnesota),[23] or "collaborative agreements" (Vermont).[24]

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[20] University of Minnesota School of Dentistry, "Dental Therapy: Our Division," 2016, https://www.dentistry.umn.edu/degrees-programs/dental-therapy/our-division. Accessed December 30, 2016.

[21] Sarah Shoffstall-Cone and Mary Willard, "Alaska Dental Health Aide Program." *International Journal of Circumpolar Health* **72** (2013): 21198, http://dx.doi.org/10.3402/ijch.v72i0.21198. Accessed December 30, 2016.

[22] Maine Legislature, *An Act To Improve Access to Oral Health Care*. 126th Legislature, April 28, 2014, http://www.mainelegislature.org/legis/bills/bills_126th/billtexts/HP087001.asp.

[23] Minnesota Legislature. 2009. *Minnesota Session Laws, Chapter 95, Revisor of Statutes, Senate File 2083, Article 3*. 86th Legislature. https://mn.gov/boards/assets/enabling%20Legislation_tcm21-46113.pdf (January 2, 2017).

Education Requirements

The Commission on Dental Accreditation (CODA), the national body accrediting dental schools, released accreditation standards for dental therapy education programs in 2015.[25] Nevertheless, each state must determine the scope of practice, education prerequisites, and training requirements for its dental therapists.

Education and training requirements for dental therapists vary among states. Maine and Vermont, the states most recently to authorize "dental hygiene therapists" and "dental therapists," respectively, require applicants to be licensed dental hygienists. Once licensed, they need maintain only their dental therapy license, not their hygiene license, through a process involving reregistration, continuing education, and renewal fees.[26]

Minnesota's distinction between "dental therapists" and "advanced dental therapists" can help North Dakota lawmakers understand the value each profession offers patients and supervising dentists.

One of Minnesota's two higher education institutions with a master's program in dental therapy requires applicants to hold licenses as hygienists.[27] In 2016, the state's other institution converted its dental therapy program into a dual degree program for a Bachelor of Dental Hygiene/Master of Dental Therapy degree.[28] Like Maine and Vermont, Minnesota requires therapists seeking licensure to have graduated from a higher education dental therapy program approved by the state.

Alaska's educational requirements for "dental health aide therapists" primarily include completion of a two-year post-high school program culminating in certification by the Alaska Native Tribal Health Consortium. The program will award an associate degree starting in 2017.

Training, Scope of Practice

Although states set their own training requirements for dental therapists, Minnesota's distinction between "dental therapists" and "advanced dental therapists" (each of which meets CODA standards) can help North Dakota lawmakers understand the value each profession offers patients and supervising dentists.

Dental therapists in Minnesota are authorized to perform more than 70 services and procedures, including oral evaluations, disease prevention education, and consultation with the pediatricians

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[24] Vermont General Assembly. 2016. *An act relating to establishing and regulating dental therapists.* 2015–2016 Session, June 2. http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT161/ACT161%20As%20Enacted.pdf (January 2, 2017).

[25] Commission on Dental Accreditation, *Accreditation Standards for Dental Therapy Programs,* [2015] 2016, http://www.ada.org/~/media/CODA/Files/dt.ashx. Accessed January 3, 2017.

[26] Maine Legislature, *supra* note 22; Vermont General Assembly, *supra* note 24.

[27] Metropolitan State University, "Advanced Dental Therapy (MSADT)," 2015, http://www.metrostate.edu/msweb/explore/catalog/grad/index.cfm?lvl=G&section=1&page_name=master_science_advanced_dental_therapy.html. Accessed January 2, 2017.

[28] University of Minnesota School of Dentistry, "Dental Therapy," 2016, https://www.dentistry.umn.edu/degrees-programs/dental-therapy. Accessed January 2, 2017.

of patients aged three or younger. Dental therapists may also perform cementation and removal of space maintainers, crown implantation, anesthetization, replacing missing and broken teeth, and suture removal, according to a list of delegated duties of dental therapists posted online by the state Board of Dentistry.[29]

Contemporary dental therapy descends from a nearly century-long tradition of post-high-school vocational training programs.

The list grows to 80 services and procedures when counting those reserved for "advanced dental therapists," who gain this designation by graduating from a master's-level dental therapy program, completing more than 2,000 hours of directly or indirectly supervised clinical practice, and passing a board-approved exam for an advanced scope of practice.[30] The two-year Master of Science in Advance Dental Therapy program at Metropolitan State University in St. Paul, Minnesota, consists of 44 credits and includes courses on "Understanding health care needs and the incidence of disease across populations," 31 hours of clinical experience, and a "capstone project."[31]

Dental therapists without advanced degrees must have earned a baccalaureate degree from a dental therapy program, pass a clinical exam, and pass an exam on Minnesota's dentistry laws and rules.[32]

Tribal governments in Alaska introduced residents of the state to dental therapy in 2003 and 2004 with the profession "dental health aide therapist" (DHAT), which required a high school diploma, 3,160 hours of training and field work over two years, and certification renewal every two years.[33] The current version of the program remains two calendar years long and requires a preceptorship – essentially a medical apprenticeship – of at least 400 hours.[34] Dentists must supervise DHATs "in-person or remotely."[35]

Although a new concept to many in the United States, contemporary dental therapy descends from a nearly century-long tradition of post-high-school vocational training programs lasting two to four years, beginning with the graduation of the world's first "dental nurses" in New Zealand for the express purpose of serving the general public.[36] As of 2012, 54 countries were relying on

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[29] Minnesota Board of Dentistry, "Delegated Duties: Dental Therapists and Advanced Dental Therapists," April 24, 2010, https://mn.gov/boards/assets/Delegated%20Duties_tcm21-46116.pdf. Accessed January 2, 2017.

[30] Minnesota Legislature, *supra* note 23.

[31] Metropolitan State University, *supra* note 27.

[32] Minnesota Legislature, *supra* note 23.

[33] National Governors Association, *The Role of Dental Hygienists in Providing Access to Oral Health Care*, 2014, https://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf. Accessed January 2, 2017.

[34] Alaska Native Tribal Health Consortium, "DHAT Certification and Scope of Practice," 2016, http://anthc.org/dental-health-aide/dhat-certification-scope-of-practice/. Accessed January 2, 2017.

[35] National Governors Association, *supra* note 33.

[36] David A. Nash, Jay W. Friedman, *et al. A Review of the Global Literature of Dental Therapists.* W.K. Kellogg Foundation, 2012, p. 4, https://www.heartland.org/_template-

dental therapists to provide oral care, usually in connection with a school-related children's program.[37]

Midlevel, Top-Shelf

Within their narrower scope of practice, dental therapists' training equals that of licensed dentists, according to Alyssa Beaulieu, operations manager at Children's Dental Services in Minneapolis, Minnesota. "Advanced dental therapists and dental therapists undergo the same licensure tests [as dentists] for the services they provide," Beaulieu told researchers on a site visit to the University of Minnesota School of Dentistry in November 2016.[38]

In fact, dental therapists receive more training than dentists for certain procedures, Dr. Kevin Nakagaki, a dentist at the nonprofit health care organization HealthPartners, told researchers during the same site visit. "Dental therapists are actually doing more of the same kinds of procedures by the time they leave school than dental students, because the dental students spread out," Nakagaki said. "They have to do more kinds of procedures."

Within their scope of practice, dental therapists' training equals that of licensed dentists, and dental therapists receive more training than dentists for certain procedures.

The extensive list of preventative and restorative treatments dental therapists and advanced dental therapists provide reveals "midlevel practitioner" as a potentially misleading descriptor for dental therapists holding master's degrees, as it can be for midlevel practitioners in other fields of care, many of whom hold master's degrees and doctorates despite lacking the letters M.D., D.O., D.D.S., or D.M.D. after their names.[39] The U.S. Justice Department Drug Enforcement Agency uses the term *midlevel* practitioner to identify an "individual practitioner, other than a physician, dentist, veterinarian, or podiatrist" licensed "to dispense a controlled substance in the course of professional practice. Examples of midlevel practitioners include, but are not limited to, health-care providers such as nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists and physician assistants," federal regulations state.[40] (North Dakota lawmakers would not have to allow dental therapists to prescribe drugs or dispense narcotics for the profession to benefit patients and dentists.)

Dental therapists with or without advanced degrees provide "restorative services beyond the scope of preventive services traditionally provided by dental hygienists," states a paper published by the National Governors Association in 2014. In Minnesota, dentists must specifically authorize most dental therapy procedures and be present at the same facility. Advanced dental

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assets/documents/publications/Nash%20Dental%20Therapist%20Literature%20Review.pdf. Accessed January 2, 2017.

[37] *Ibid*., p. 3.

[38] Michael T. Hamilton, "'Dental Therapist' Teammates Enhance Practices Treating Low-Income Patients," *Health Care News,* The Heartland Institute, January 2016, https://www.heartland.org/news-opinion/news/dental-therapist-teammates-enhance-practices-treating-low-income-patients.

[39] Catherine S. Bishop, "Advanced Practitioners Are Not Mid-Level Providers." *Journal of the Advanced Practitioner in Oncology.* U.S. National Library of Medicine, National Institutes of Health. September 1, 2012, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4093350/. Accessed January 2, 2017.

[40] *Ibid*.

therapists have more leeway, but state law prohibits each from operating except under "a collaborative management agreement in place with a supervising dentist," the paper states.[41]

Patients have gained greater choice of care and easier, more affordable access to care when lawmakers in 50 states expanded the scope of practice of midlevel practitioners in pharmacies,[42] hospitals and clinics,[43] private practices,[44] elder and home care facilities,[45] and out-of-hospital labors and deliveries.[46] Oral care patients in North Dakota should be next in line to benefit from lawmakers' authorization of dental therapist licensure.

The rural nature of North Dakota and inclusion of Native American tribes in the community demand a nuanced solution to the state's oral care shortage.

3. Dental Therapy Expands Patient Access to Quality Care in Shortage Areas

The rural nature of North Dakota and inclusion of Native American tribes in the community demand a nuanced solution to the state's oral care shortage.

Care for Tribes

Alaska's dental therapy program illustrates benefits unique to states with Native American tribes. The Alaska Native Tribal Health Consortium (ANTHC) pinpointed DHATs as a remedy for underserved tribal communities when it established the first dental therapy program in the United States in 2003 and 2004.

In the early years of Alaska's program, dental therapists deployed to villages of at least 800 people to accomplish two specific priorities: (1) relieve oral pain exacerbated by insufficient access to care, and (2) implement preventive measures, including education and outreach, to

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[41] National Governors Association, *supra* note 33.

[42] Edward J. Timmons and Conor S. Norris, "CLIA Waiver Pharmacy Growth: How Does Broadening Scope of Practice Affect the Pharmacist Labor Market?" Mercatus Center, George Mason University. October 18, 2016, https://www.mercatus.org/publications/CLIA-waiver-pharmacy-growth. Accessed January 2, 2017.

[43] Victoria Garment, "Nurse Practitioners and Physician Assistants: Why You Should Hire One (or the Other)," *The Profitable Practice,* May 31, 2013, http://profitable-practice.softwareadvice.com/nurse-practitioners-and-physician-assistants-why-you-should-hire-one-or-the-other-0513/. Accessed January 2, 2017.

[44] Thomas Heath, "Local orthopedist now helps command the biggest practice of its kind in the U.S.," *The Washington Post,* November 6, 2016, https://www.washingtonpost.com/business/economy/local-orthopedist-now-helps-command-the-biggest-practice-of-its-kind-in-the-us/2016/11/06/4f193596-a142-11e6-8d63-3e0a660f1f04_story.html. Accessed January 2, 2017.

[45] Sue Webber, "North Memorial offers TotalCare program for Seniors," *Sun Current* [Minnesota], November 1, 2016, http://current.mnsun.com/2016/11/01/north-memorial-offers-totalcare-program-for-seniors/. Accessed January 2, 2017.

[46] Michael T. Hamilton, "State Laws Force Pregnant Mothers to Rely on Black Market to Find Midwives," *Consumer Power Report,* The Heartland Institute, October 13, 2016, https://www.heartland.org/news-opinion/news/pregnant-mothers-call-the-midwife-in-their-states-black-market. Accessed January 2, 2017.

reduce the incidence of oral disease. The first comprehensive study of the program's benefits was undertaken in 2010 by a team of one M.D., one Ph.D, and three dentists, two of whom also held Ph.Ds. The team found that while treating acute oral pain – the first objective – the dental therapists had earned the respect of the community as "role models." This was vital to creating the necessary inroads for the second objective, because "[e]ffecting change will take significant alterations in the oral health attitudes and behavior of Alaska Natives, and this will likely take years to accomplish. The therapists' cultural awareness and credibility in the villages can help shape changes in behaviors," the authors wrote.[47]

Lawmakers should consult the record of patient satisfaction, not merely the reservations of dentists, when evaluating the viability of dental therapy as a potential solution to oral care shortages.

The 28 DHATs practicing in Alaska as of February 2016 have "expanded much-needed access to dental care and prevention services for more than 40,000 Alaska Native people living in 81 rural Alaska communities" since 2004, ANTHC's website states.[48] An additional 14 individuals were graduates undergoing preceptorship training or students in their first or second year of DHAT schooling in February 2016.[49] Dr. Mary Willard, director of oral health promotion at ANTHC, estimates graduates of the current program will serve more than 80 communities and annually treat an average of 800 patients, *Alaska Dispatch News* reported on November 1, 2016.[50]

Local Problem, Local Solution

Lawmakers should consult the record of patient satisfaction, not merely the reservations of dentists, when evaluating the viability of dental therapy as a potential solution to oral care shortages. We suggest requiring dental therapists to earn their *patients'* trust is a higher standard than asking them to earn *dentists'* trust – and Alaska's DHATs, for example, are meeting that higher standard.

"Our dental therapy program really began as a local solution to a local problem. We just simply did not have access to oral health care," says Val Davidson, former senior director of intergovernmental and legal affairs at ANTHC, in the video *Dental Health Aide Therapists: Investing in Our People.*[51]

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[47] 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*, RTI International, October 2010, http://anthc.org/wp-content/uploads/2016/02/DHAT_2010EvaluationDHATWorkforce.pdf. Accessed January 2, 2017.

[48] Alaska Native Tribal Health Consortium, "Dental Health Aide," 2016, http://anthc.org/dental-health-aide/. Accessed November 9, 2016.

[49] Alaska Native Tribal Health Consortium, "2015–2016 DHAT Map," 2016, http://anthc.org/wp-content/uploads/2016/02/DHAT_Map_2016_v4.pdf. Accessed January 2, 2017.

[50] Alaska Native Tribal Health Consortium, "Bringing preventive dental care to rural Alaska," *Alaska Dispatch News,* November 1, 2016, https://www.adn.com/features/sponsored-content/2016/11/01/bringing-preventative-dental-care-to-rural-alaska/. Accessed January 2, 2017.

[51] Alaska Native Tribal Health Consortium, *Dental Health Aide Therapists: Investing in Our People*, Burness Communications, November 20, 2014, https://www.youtube.com/watch?v=uRzbK7jmSSw. Accessed January 2, 2017.

At least three Native American tribes are following ANTHC's dental therapist model. A Native American tribe in Washington state hired a dental therapist in January 2016, and Oregon authorized two Native American tribes to hire dental therapists in February 2016.[52]

Serving Suburban and Rural Residents

In addition to the state's expansive rural tracts, North Dakota has urban and suburban residents whom dental therapists could well serve.

The free market's dispersion of dental therapists in Minnesota since the program's authorization in 2009 shows dentists naturally tend to grow their practices with these midlevel providers where services are most needed.

Dentists naturally tend to grow their practices with dental therapists where services are most needed.

Minnesota had 63 licensed dental therapists practicing in August 2016, 27 of whom were advanced dental therapists and 22 of whom were dually licensed as hygienists and therapists. Of the 95 percent of these who were employed at that time, 52 percent worked in urban areas, where roughly 70 percent of Minnesotans live. Forty-eight percent of dental therapists were serving suburban and rural communities, where roughly 30 percent of Minnesotans live.

Instead of favoring urban centers with higher concentrations of dentists, dental therapists disproportionately practice in and benefit rural communities. This pattern demonstrates dental therapists are a natural way to expand access for the underserved.

Room for Therapists and Hygienists

Maine and Vermont's legal requirement that dental therapists be hygienists, and Minnesota's developing of that as an education requirement, may prompt lawmakers to ask, "Why not just let dentists expand their practices using dental hygienists?"

One opponent of legalizing dental therapists told North Dakota lawmakers the "high overhead cost of delivering dental services and the rural nature of the state" pose special challenges to solving the state's access problem.

The existence of challenges, however, is hardly an argument against trying new methods, such as licensing dental therapists, to overcome those challenges. The same opponent argued, "rather than untested dental therapist models, the best solutions utilize the current 1,450 dental hygienists and assistants" to reach underserved patients.[53]

Lawmakers should reject this faulty thinking. States don't have to choose whether to reach rural communities with therapists or hygienists. Dentists who think they will do better with hygienists are already free to do so. The continuing existence of an oral care shortage implies the benefits of expanding dental practices with hygienists do not always outweigh dentists' perceived costs of doing so.

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[52] Hamilton, *supra* note 38.

[53] North Dakota Legislative Assembly, *supra* note 1, p. 5.

Moreover, dental therapists and dental hygienists have separate scopes of practice. Dental hygienists are unable to perform extractions and fillings, the two procedures most likely to prevent serious oral health disease, which can lead to other serious health problems. If dental hygienists are a good idea, dental therapists are an improvement on it, because therapists are even better equipped to perform procedures that reduce oral health disease.

4. Dental Therapy's Potential to Increase Providers' Efficiency, Save Taxpayers' Money

Dental therapists can improve the bottom line of for-profit dental practices and increase savings in the state's Medicaid budget.

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Profit Despite Medicaid Shortcomings

Dental therapists' combination of advanced training for some procedures and wages lower than those of an associate dentist enables a for-profit practice such as Dental Associates of Minnesota to treat a higher volume of low-income patients with dental therapists than without them. The practice employs a dental therapist and two advanced dental therapists at its offices in St. Paul and Savage.

"Without dental therapists, our dentists would be booked out for weeks," Dental Director Dr. David Maki told researchers visiting the University of Minnesota School of Dentistry in November 2016.

Dental therapists have been shown to bring in revenue far exceeding the cost of their employment. "In 2012, two dental therapists provided care to 1,352 patients, many of whom received regular access to dental care for the first time," states a 2014 study by The Pew Charitable Trusts. "When compared to the reimbursement value of the care they delivered, the therapists exceeded their costs of employment by a combined $216,000."[54] The preventive care and early treatment of dental problems by one of these therapists stationed in a single village helped save $95,000 in Medicaid expenses in 2012.[55]

The shorter training period and narrower scope of dental therapists make them less expensive to employ than dentists. In low-income communities with large shares of the population enrolled in Medicaid, dental therapists have made it easier for their dentist-employers to profit despite Medicaid's notoriously low reimbursement rate, which varies by state.

A dental therapist in Minnesota who saw 1,756 patients in 2012 cost $136,070 to employ, including her compensation package, her dentist supervisor's time, and supplies, according to the Pew study.[56] The therapist generated $166,920 that year from Medicaid patients, who constituted

[54] The Pew Charitable Trusts, *Expanding the Dental Team Increasing Access to Care in Public Settings*, June 2014, p. 2, http://anthc.org/wp-content/uploads/2016/02/DHAT_ExpandingtheDentalTeam.pdf. Accessed January 2, 2017.

[55] *Ibid*.

[56] *Ibid.*, p. 5.

65 percent of her patient load, without a dental assistant. The $30,000 surplus she generated solely from treating Medicaid patients would almost have covered the $47,000 cost of hiring a dental assistant, the balance of which might easily be covered by the non-Medicaid revenue she generated serving the other 35 percent of her patients she treated, the study states.[57]

Increasing Efficiency, Retention, Scope

Using lower-wage dental providers has reduced care costs and increased the average productivity of the dental team employed by Children's Dental Services (CDS) in Minnesota, according to Executive Director Sarah Wovcha. Dental therapists earn average hourly wages of $39, advanced dental therapists $46, and dentists $75, Wovcha told North Dakota lawmakers on September 21, 2016. CDS has reinvested the savings from lower labor costs in expanding access by hiring additional providers.[58]

Despite earning just half the wages of a dentist, dental therapists are increasing dentists' retention of patients, *Health Care News*, published by The Heartland Institute, reported in January 2017.[59] Moreover, "[t]hey free dentists to operate at the top of their licenses," Beaulieu of CDS in Minnesota said. In other words, delegating services and procedures to dental therapists creates more time for dentists to perform tasks requiring a dentistry license.

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Markets Improve Medicaid

The demonstrated savings generated by dentists who delegate routine services and procedures to midlevel providers rebuts testimony given to North Dakota lawmakers in September 2016.[60] One opponent objected oral care provider shortages will persist as long as Medicaid reimbursements for dental work remain low. If North Dakota follows Minnesota's model, however, dentists who supervise and are in contract with dental therapists would receive the same Medicaid reimbursement rate for work done by therapists as if the dentists had done the work themselves. In such cases, the cost of care would decrease while the reimbursement stayed the same.

A second opponent, a Minnesota dentist, cited his experience employing a dental therapist whose training he eventually judged unsatisfactory to perform procedures the dentist had hoped to delegate.[61] Consequently, this dentist paid therapist wages for work he said was better left to dental assistants, whose wages are lower. Dr. John Powers, a dentist in Montevideo, Minnesota, countered this testimony in a revealing letter to state Sen. Judy Lee (R-West Fargo), chairman of the Health Services Committee, on November 1, 2016:

> The fact is that the dental therapist [the opponent] refers to is the same person I hired part time at my office. The therapist has done an excellent job in my practice, and I have the

[57] *Ibid*., p. 6.

[58] North Dakota Legislative Assembly, *supra* note 1.

[59] Hamilton, *supra* note 38.

[60] North Dakota Legislative Assembly, *supra* note 1.

[61] *Ibid.,* pp. 5–6.

> utmost confidence in his ability to effectively care for our patients. However, he has described to me a situation at [the opponent's] office where he is only allowed to do the most menial of tasks, resulting in an inefficient and ineffective use of his skills as a dental therapist. …[62]

The opponent's experience also conflicts with the positive experiences of other dentists who saved money by delegating routine services and procedures to dental therapists in nonprofit practices in Minnesota, as noted earlier.

It seems unwise for this opponent to hire a dental therapist in the future. It would be equally unwise to assume his management or hiring woes justify imposing his preference on all dentists in the state.

Not in Kansas … Yet

It is reasonable to expect that in most cases, delegating lower-skill tasks to less-skilled but well-trained individuals will free specialists to perform higher-skill tasks.

Blocking dental therapy undermines licensed dentists' liberty to treat patients to the best of their abilities as determined by the dentists' consciences and professional judgment.

Appreciating the savings likely to ensue from such an arrangement, three dentists in private practice have petitioned the Kansas legislature to license midlevel dental providers comparable to dental therapists, termed registered dental practitioners (RDPs).[63] "Lawmakers can help by passing the RDP legislation, allowing us to hire more Kansans, expand our practices and provide care to more patients," they wrote. "This system is working in the medical field between physicians and physician assistants and nurse practitioners."[64]

5. The Status Quo Diminishes Provider Liberty, Patient Access, and State Savings

Opposition to licensing of dental therapists in North Dakota does more than limit patient access to affordable care. Blocking dental therapy undermines licensed dentists' liberty to treat patients to the best of their abilities as determined by the dentists' consciences and professional judgment. Ironically, opponents of dental therapist licensing would also diminish licensed dentists' ability to grow their practices.

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[62] Powers, *supra* note 2.

[63] Kansas Dental Project, "Registered Dental Practitioner," 2016, http://www.oralhealthkansas.org/pdf/KAMU%20Advocacy%202.pdf. Accessed November 9, 2016.

[64] David Hart, Melinda Miner, Daniel Minnis, "Letter: Support dental practitioners," *The Topeka Capital-Journal,* December 11, 2012, http://cjonline.com/opinion/2012-12-11/letter-support-dental-practitioners. Accessed January 2, 2017.

Disruptive Innovation

Fear of change is a common malady, and those opposing dental therapist licensing are pressing lawmakers with their worries. "I believe the program has merit," one North Dakota lawmaker told us.[65] The same lawmaker, added, however, "My dentists do not want an additional layer of providers, which I guess is not surprising in the greater scheme of things. This reaction is common among the medical profession."

Such reactions by long-established players in the health care industry, however, are a common impediment to innovation. The conventional wisdom of entrenched interests is inadequate counsel for lawmakers who want to change the status quo and improve access to needed services.

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Fearing one's own service, product, or business model could become obsolete is an uncomfortable byproduct of progress. Established players who resist disruptive change introduced by risk-taking entrepreneurs are often motivated by fear of new competition, not concern for consumers. For example, after dentists complained to the North Carolina State Board of Dental Examiners that "nondentists were charging lower prices for [teeth whitening] services than dentists did, the Board issued at least 47 cease-and-desist letters to nondentist teeth whitening services providers and product manufacturers, often warning that the unlicensed practice of dentistry is a crime," writes United States Supreme Court Justice Anthony Kennedy in the Court's opinion of *North Carolina Board of Dental Examiners* v. *Federal Trade Commission* (2015).

The Board's fear and fear tactics were out of line. The Federal Trade Commission (FTC) filed a complaint against the Board for anticompetitive behavior. The Fourth Circuit Court of Appeals upheld the complaint, as did the U.S. Supreme Court.[66]

Beneficial to Dentists

Discrimination against dental therapy in North Dakota, like the North Carolina dentistry board's villainization of nondentist tooth whitening services, is ill-advised. The FTC urged the CODA director "to finalize and adopt accreditation standards for dental therapy education programs, which will likely benefit consumers," states a 2014 FTC press release.[67] CODA released its standards in 2015.[68]

Dentists would benefit from any competition introduced by licensing dental providers in North Dakota: Because therapists practice exclusively in the employment of supervising dentists, any competitive advantage gained by employing therapists would accrue to the dentists.

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[65] Bette Grande, personal correspondence, October 31, 2016.

[66] *North Carolina State Board of Dental Examiners* v. *Federal Trade Commission*, 574 U.S. 2015.

[67] Federal Trade Commission, "FTC Staff Urges Dental Accreditation Commission To Adopt Dental Therapy Accreditation Standards," December 1, 2014.

[68] Commission on Dental Accreditation, *supra* note 25.

Invisible Superiority?
Those who cite concerns about quality of care as justifying opposition to dental therapy assume ordinary patients are unable to distinguish superior care from inferior care.[69]

This line of argument actually undermines their opposition and affirms proponents' view: Any quality gap separating dentists from dental therapists would be virtually untraceable in the realm of care in which North Dakota dental therapists would treat patients. Moreover, dentists who employ dental therapists have a strong incentive to ensure those working in their practices are providing excellent care.

Dentists Retain Control
Some dental therapy opponents argue that because patients cannot discern the surpassing quality of dentistry over dental therapy, dentists must do so for them, not by proving their worth but through a government ban on dental therapy. This scorched-earth approach to promoting high-quality dental care is irrational and counterproductive.

A dentist who chose to hire dental therapists would retain complete freedom to direct the care given by each midlevel provider in his or her office, including care by dental therapists, just as dentists currently direct the work of dental hygienists.

Once licensed by the state, dental therapists would practice exclusively under the supervision of a licensed dentist. A dentist who chose to hire dental therapists would retain complete freedom to direct the care given by each midlevel provider in his or her office, including care by dental therapists, just as dentists currently direct the work of dental hygienists. The dentist's authority, responsibility, and autonomy would remain paramount. For this reason, as one Michigan state lawmaker told The Heartland Institute in September 2016, "I put the concern over quality right back in the dentists' laps."[70] Dentists would keep the full measure of quality assurance and responsibility they now have.

This fact exposes the greatest gaping cavity at the core of opponents' arguments against licensing dental therapists. Dentists who would block dental therapist licensure claim it would dilute care quality and raise care costs, even though these same dentists would maintain complete control over the spread of dental therapy in North Dakota if lawmakers authorize licensure. And although dental therapists would have to work under the supervision of and employment by a dentist, no dentist would be coerced into hiring a dental therapist.

Consequently, dental therapists will gain traction in North Dakota to the exact extent individual dentists allow. Only dentists who perceive the value dental therapists offer their businesses and patients would hire these midlevel providers. These entrepreneurial dentists deserve a voice and a choice. If opponents of dental therapy stake their credibility on the letters D.D.S. after their name, surely proponent dentists may do the same and expect lawmakers to respect their judgment equally.

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[69] North Dakota Legislative Assembly, *supra* note 3.
[70] Mary Tillotson, "States Consider Authorizing Dental Therapy to Expand Access," *Health Care News,* The Heartland Institute, November 2016.

Blockading dental therapy denies the rights of dentists confident they can serve North Dakota patients better than the entrenched model allows. After the state's thousands of underserved patients, dentists themselves will be the biggest losers if lawmakers allow North Dakota's *de facto* ban of dental therapists to continue.

Conclusion

The oral care shortage affecting North Dakotans of various ages and income levels warrants the entry of midlevel dental providers yet untried in the state. North Dakota lawmakers should act now to pass legislation authorizing the licensure of dental therapists.

Dental therapy is a 95-year-old profession with proven success at increasing oral care access for underserved patients in more than 50 countries, including the United States. Permitting dental therapists to obtain licenses in North Dakota would expand access for populations rural and urban, young and old, on Medicaid and off Medicaid. Dentists, who are currently obstructed from hiring dental therapists, would gain the freedom to grow their practices by building their dental dream teams.

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North Dakota lawmakers have excellent examples from which to draw in crafting dental therapy legislation. Requirements for dental therapist education, training, and scope of practice could resemble the laws of Maine, Minnesota, and Vermont. North Dakota's lawmakers could extend this flexibility to Native American tribes, encouraging them to adapt dental therapy licensure requirements similar to those adopted by the Alaska Native Tribal Health Consortium.

North Dakota should take advantage of the knowledge provided by other states' laboratories of democracy, making North Dakotans heirs and pioneers of the free market's successful experiments with dental therapy.

# # #

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