Promoting public policy that enhances the lives of children and youth in Vermont

Michelle Fay
Associate Director, Voices for Vermont's Children
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As an independent children's research and policy advocacy organization, Voices advocates for our most vulnerable and disadvantaged children and youth, including around issues of health disparities. Because oral health is integral to overall health, the lack of access to dental care in Vermont undermines the health and well being of children and adults alike. We know that when parents don't access dental care, their kids are less likely to as well.

That's why Voices leads an oral health coalition of more than 40 organizations that represent thousands of people across Vermont, including: clinics for the uninsured, health care providers, community action programs, seniors, low-income adults, and children. These organizations are all saying there is a dental care access problem for Vermonters of all ages, and one of the most promising strategies to counter this is expanding the dental team to include a dental therapists.

OPR questions

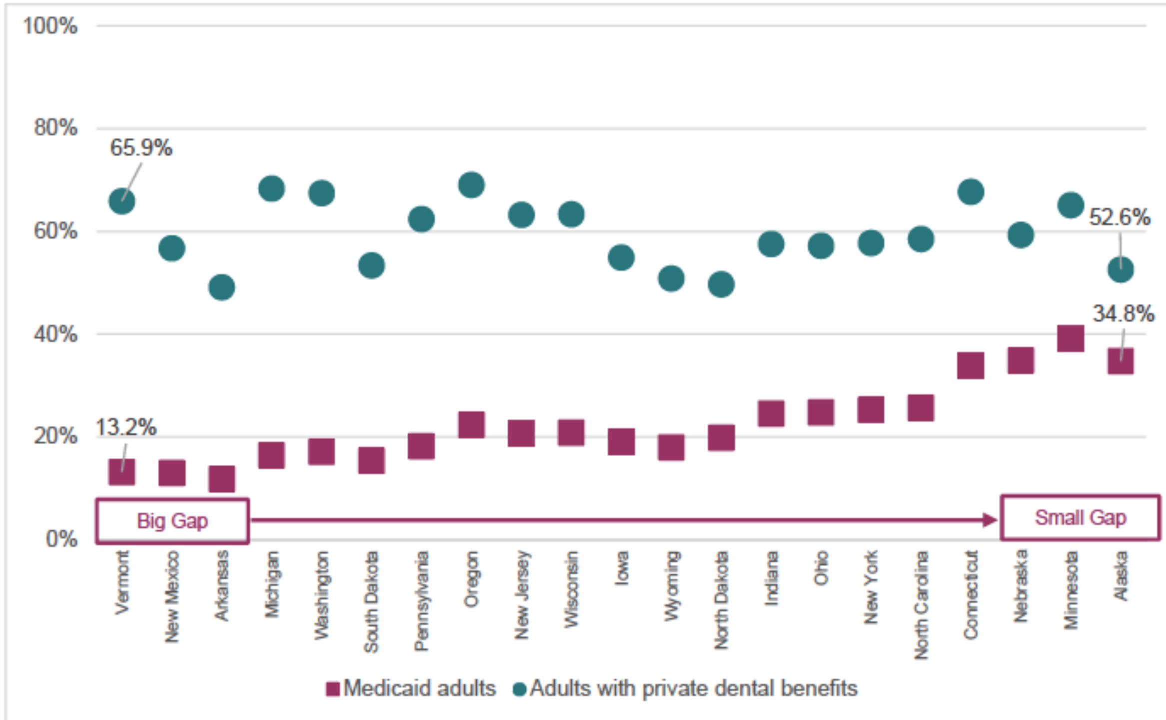
The nature of the problem:

1. **Is there a lack of access to dental care in Vermont?**

- Yes. Every year, tens of thousands of Vermonters are not accessing needed dental care. Going without dental care can mean suffering in pain, missing work and school, not being able to eat well, and living with the effects of poor oral health.[i]
- The system is not working when in just one year, over 6000 emergency department visits are for dental care at a cost of $3.4 million – of which $1.8 million is Medicaid funded (2013 VT DOH Compilation of ED Data).
- Children ages 0-5 are hospitalized for early childhood caries treatment at a cost of 2.7 million dollars. (2009 Two is Too Late, Dr. Steve Arthur).
- 40% of children with Dr. Dynasaur coverage do not get needed dental care. This amounted to more than 22,500 children ages 1-18 in 2013.

- Vermont has the utilization highest gap in the nation between Medicaid enrolled adults and those with private dental insurance.

Figure 6: Relative Gap in Dental Care Utilization between Medicaid-Enrolled Adults and Adults with Private Dental Benefits, 2013



Source: HPI analysis of Truven Health Analytics MarketScan® Research Databases and Medicaid data from Medicaid Statistical Information System provided by CMS. **Notes:** States are ordered from left to right according to the relative gap between Medicaid-insured adults and adults with private dental benefits. Population is based on adults continuously enrolled in Medicaid or a private dental plan for 90 days. The states plotted provide adult Medicaid dental benefits.

(from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0915_1.ashx)

2. **What types of dental services are identified as being inaccessible? Specialized care, routine basic preventive services?**

   The 2013 VT Dentist Survey makes it clear that all areas of dentistry are at facing workforce attrition though retirement, and that access varies by geographic region in the state. dentists accept more than a handful of Medicaid patients. Both preventive and routine care is inaccessible for Vermonters of all ages. The Office of Oral Health in the Department of Health has also collected extensive evidence that confirms the above points.

   Vermont is often held up as a leader in health access, but some of the statistics used to tout Vermont's relatively good dental care access are misleading. While 85% of VT dentists are *enrolled* as Medicaid providers, only 29% bill any substantial

amount ($50k or more annually) to Medicaid or accept more than 5 new Medicaid patients per month. That means only about 100 dentists are serving most of the Medicaid recipients who seek treatment in Vermont, and they are not distributed proportionately throughout the state. Pediatric dentists in particular are clustered in Chittenden County.

3. **Which Vermonters are at risk from inadequate access to dental care?**

See above

4. **How great is the problem?**

See above

5. **Is lack of access based on geographic or other non-economic factors?**

   There are several reasons people do not have access to dental care. On such reason is geographic limitation. The data from the Department of Health, Dental Landscape Study, 2013 VT Dentist Survey, story collection from the Coalition, VHHIS, and other sources show people cannot find a dentist willing to treat them in their area. Many towns also fall outside the catchment area of a Federally Qualified Health Center, limiting their accessing to sliding scale fees based on income. Voices for Vermont's Children also conducted outreach to New American communities in Chittenden County and found that cultural differences contribute to access challenges as well. In both AK and MN, dental therapists are recruited from diverse communities to be able to address these cultural barriers.

6. **Is lack of access due to patient/family's inability to afford dental services?**
7. **How many existing dental practices accept Medicaid enrolled patients?**

   One barrier to accessing dental care is cost of services. The 2012 VHHIS indicates that nearly 68,000 adults did not see a dentist in 2012 due to cost. One challenge impacting affordability is the relatively low number of dentists accepting meaningful numbers of patients on Medicaid.

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8. **How many dental practices are there in the state?**

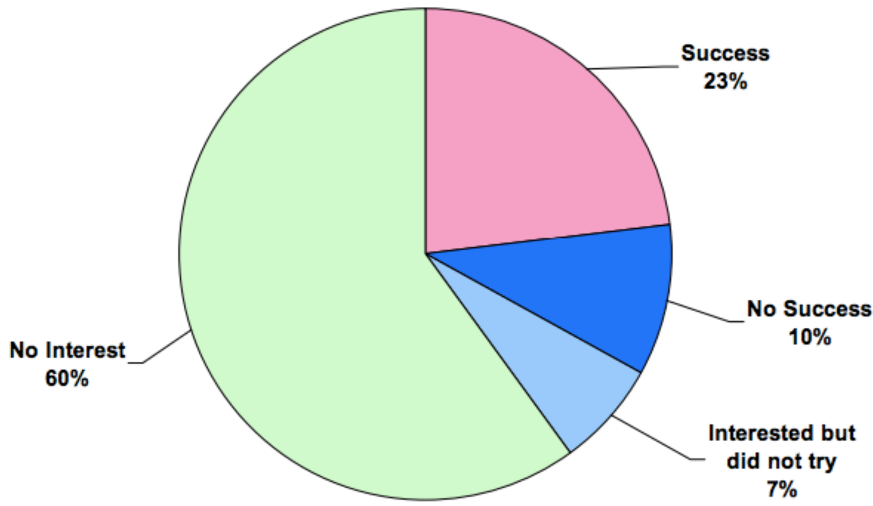
   According to the Vermont Department of Health's Office of Oral Health, there are currently 264 active dental practices, with 360+ licensed dentists. (in 2013 there were 298 active primary care dentists – general and pediatric). More detailed information can be found in the biennial Survey of Dentists conducted by the Oral Health Division of the DOH. (2013 report here:

http://www.healthvermont.gov/research/HlthCarePrvSrvys/documents/DDS13ppt.pdf) 2015 figures still being analyzed.

9. **Is lack of access due to an insufficient number of licensed dentists? If so, what accounts for the insufficient number of dentists? Demographics of the profession? The cost of a dental school education? Is this unique to dental practice or part of a larger problem with other primary care providers?**
   Vermont has the oldest population of dentists in the United States. Data from the 2013 Dentist Survey shows that at the time of the survey 62% of dentists are 50 or over, 48% were 55 or older, and 35% were age 60 or older. Not only are there not enough dentists, there are not enough dentists willing to accept patients with Medicaid or no insurance. The state and the VT Dental Society have been trying to address this issue for years, with little progress. Between 2011 and 2013 the net number of primary care dentists in VT increased by 1. The Vermont Dental residency program brings in just a handful of residents per year, with an estimated retention rate of 50%. Of the dental residents who stay in Vermont, most locate in Chittenden County.

10. **Is lack of access due to an insufficient number of dental practices?**
    There are both an insufficient number of dental practices and an insufficient number of practices willing to take the patients that need dental care. (again, refer to the VDH survey for more detail)

INTERESTED IN ADDING AN ASSOCIATE



2013 Dentist Census 27

The nature of the solution:

1. **Can lack of access be remedied without creating a new profession?**
   The Dental Landscape Study (http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/House%20Human%20Services/Bills/S.20/Testimony/S.20~GMCB~Vermont's%20Dental%20Landscape~3-23-2016.pdf) concluded that even if we increase Medicaid reimbursement for dentists, remove or raise the Medicaid dental cap, and added more dentists, we would still have an access problem. The study recommended innovative workforce solutions like adding a midlevel dental provider to the dental team.

2. **Can more comprehensive funding for dental care resolve the problem now and for the near or far future?**
   Additional dental coverage will help to make dental care more affordable for Vermonters but still would not address the shortage of dentists or the lack of dentists willing to accept patients with Medicaid or who are uninsured. There is also a political reality at play – the likelihood of lifting the cap on adult Medicaid dental care or improving reimbursement rates in the current budget climate is extremely low.

3. **Can currently available dental human resources provided in a different manner meet access needs?**
   No. The lack of an appropriate number of dentists and the limitations of current providers such as dental hygienists or expanded function dental assistants (EFDAs) make increasing access through the use of current dental human resources insufficient to meet access needs. EFDAs, for example, must practice under the direct supervision of a dentist in an office setting, have very little clinical treatment capacity, and would not be able to reduce barriers that a Dental Therapist could address by providing the most common and needed procedures at times and locations that are more accessible to underserved Vermonters. What's more, several of the alternate options proposed by the VSDS carry significant and unknown costs to the state.

4. **Can economic changes or incentives remedy the problem?**
5. **Is there a way to attract already trained professionals (dentists, dental hygienists) to provide access to needed dental services?**
   Again, there have been efforts to attract dentists to Vermont through incentives, with only marginal success after years of trying. We need more providers who can treat patients and do so in settings that reduce barriers for Vermonters.

6. **Are there other means, e.g. advanced dental hygiene practitioners to meet dental health needs?**
   There is no single cure-all for the access problem in the state. The solution must be multi-faceted and sustained. Dental therapists have been shown to improve access in Minnesota, Alaska, and in the 50+ countries around the world where they practice. We need only look to the primary care medical field to see how moving toward a team-based model of care was an absolute necessity in order to address access and workforce shortages.

7. **Can Community Dental Health Coordinators help patients navigate the dental health care system and find an appropriate provider? Can they themselves provide limited dental services?**
CHDC have the potential to help with care coordination and would work best in a dental team, which included a provider like a DT who can provide clinical treatment. There must be providers willing to take patients that need care for a CDHC to be successful. The dental therapist is the only proposed provider in VT that has the training and education to do clinical treatment in a way that addresses barriers Vermonters face.

<u>If dental practitioners are seen as *a solution* to lack of access:</u>

1. **Can dental practitioners provide safe dental services meeting expected professional standards?**

   For over 90 years, mid-level dental practitioners have provided safe, quality care in over 50 countries. Most recently, an American Dental Association Study published in the January 2013 edition of the Journal of the American Dental Association found that *"A variety of studies indicate that appropriately trained midlevel providers are capable of providing high quality services."*
   Additionally, a 2012 Global Literature review, http://www.wkkf.org/news-and-media/article/2012/04/nash-report-is-evidence-that-dental-therapists-expand-access, examined more than 1,100 reports regarding dental therapists and their clinical outcomes worldwide found that mid-level dental providers offer safe, effective dental care.

2. **What kind of track record for safety do dental practitioners have in other U.S. or foreign jurisdictions?**

   Mid-level dental practitioners have an excellent track record of providing safe, quality care. There have been no malpractice claims filed against a dental therapist in Alaska or Minnesota. Sarah Wovcha, JD – director of Children's Dental Services in Minnesota testified to the following in House Human Services (see her entire testimony here http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/House%20Human%20Services/Bills/S.20/Testimony/S.20~Sarah%20Wovcha,%20JD,%20MPH~Dental%20Therapy%20in%20Minnesota~1-20-2016.pdf):
   - Since December of 2011, CDS' ADTs combined have provided care to over 7,000 patients.
   - There have been 3 requests to see a dentist instead of a dental therapist.
   - There have been no complaints of poor quality by ADTs; during the same period there were 3 complaints of poor quality against a dentist and 1 complaint against a hygienist.
   - Overall appointment wait time has decreased by 2 weeks; overall patient time with provider has increased by 10 minutes.
   - 97% of survey respondents state that they are satisfied or very satisfied with the quality of care received by an ADT, compared with 92% satisfaction with dentists and 97% satisfaction with hygienists

3. **Will the number of dental practitioners decrease without assured funding?**

   Not sure what this means.

4. **Will there be a two-tiered expectations of standards of practice; one for dentists, the other for dental practitioners?**

   Experience and evidence clearly demonstrates that dental therapists provide safe, high quality care. Dental therapists, like dentists, will complete a rigorous education training program accredited by the Commission on Dental Accreditation. But whereas dentists are trained in hundreds of procedures during their 4 years of dental school, dental therapists focus on 34 routine preventive and restorative procedures during their 3+ years of dental education. Then, they will pass a board exam and will be licensed by the state dental board just as dentists are in Vermont. Clinical board exams are conducted "blind" – meaning that examiners do not know which education program the students completed. There is only one set of standards that anyone practicing must meet. Additionally, dental practitioners will practice under the supervision and in coordination with their supervising dentist.

5. **Is the scope of practice for dental practitioners sufficiently defined? Is it too narrow or too broad for the access need to be identified?**
6. **Does the scope of practice include a realistic mix of skills?**

   The scope of practice for dental therapy is sufficiently defined based on the practice of dental therapists in over 50 countries for over 90 years and the evidence detailed in over 1100 studies. The scope is between that of a hygienist (preventive care) and dentist (all aspects of restorative care). The purpose of the new provider is to provide all preventive and limited restorative procedures and refer to a specializing dentist when indicated. As written, the scope of practice will adequately address the majority of needs of a large segment of the population unable to access care at this time. In addition, the introduction of the new provider will allow more to enter the dental system and find a dental home for their specialized needs.

7. **What education is needed to properly train an individual to become a dental practitioner?**
8. **Which institution, existing or one to be created, is best able to house and provide the necessary administration, faculty/staff, and facilities for dental practitioner education?**
9. **Is the education suggested in the proposal sufficient to permit dental practitioners to perform all the functions specified in the proposal (400 hours to competently perform 30 plus different procedures)?**

   In August of last year, dentistry's own accrediting body the Commission on Dental Accreditation (CODA) voted to implement educational standards for dental therapy programs. In doing so, they effectively codified the profession and laid the groundwork for portable licenses as states specify that 'graduation from CODA-accredited education programs' is the standard for professional licensing. Witnesses from the education community will address the implications of the CODA ruling in more detail, but generally speaking the standards:

- Ensure training institutions will have national standards to shape their programs.
- Give students from underserved communities the ability to enter accredited programs, be eligible for financial aid, and graduate equipped to meet the unmet needs of their community.
- Provide a pathway for dental hygienists to continue their professional development and advance in their careers.

Vermont Technical College's program will be accredited as the program has been designed to exceed CODA standards. By the time DTs begin practicing, they will have as much clinical experience in the procedures they are trained and licensed to perform, as a dental school graduate. VTC has been providing high quality, accredited dental hygiene education to Vermonters for more than a decade, and is well positioned to help Vermonters advance professionally while serving their communities. What's more, VTC will be well positioned to attract DT students from around the region as other states implement dental therapy legislation (as Maine did in 2013).

Dr. Ellen Grimes will be testifying and can provide more detail on this question.

10. **How will an education program determine how many clinical hours of training are needed for each of the various procedures taught?**
11. **Who is qualified to provide dental therapist education?**
12. **Does the training program have a properly qualified administration?**
13. **Do didactic faculty have necessary teaching credentials? Are they properly qualified to teach? How is that determination made, and by whom? See, for example, Administrative Rules of the Vermont Board of Nursing for criteria by which it approves nursing education program in Vermont.**
14. **Do the clinical faculty have the necessary clinical and teaching experience? How is that determination made, and by whom?**
15. **Who is qualified to accredit the dental practitioner training program? Will be the Council on Dental Accreditation? If not, who determines which accrediting body is proper? How is that determination made?**

All of these questions were resolved with the adoption and implementation of CODA standards.

16. **Where will dental practitioners practice? WIC offices, Head Start Programs, Schools, Churches nursing homes, FQHC's private dental practices, other location?**

Dental therapists will be authorized to practice under the general supervision of dentists in clinics and practices of all kinds, as well as community-based settings like schools and nursing homes, determined by their supervising dentist and the needs of the community.

17. How many dental practitioners will be needed?

Vermont has significant unmet dental needs. Nearly 40% of the Vermont children on Dr. Dynasaur go without care – more than 22,500 children in 2013. The coming retirement bubble will compound the problem. In other jurisdictions dental therapists are able to see 1,000 or more patients per year, so even a small number of dental therapists will significantly improve access.

18. How will dental practitioners fit in with current dental practices?

DTs can work in settings that currently have empty dental chairs in a cost-effective way. Dental services are billed by the procedure, not the provider. This means that a dental practice is paid the same amount to restore a tooth whether a dentist or DT does the work. DT's are paid at a lower rate to reflect their limited scope of practice, which is focused on the most common restorative and preventive procedures.

19. Will private dental practices lure dental practitioners from providing public services in needed areas?

In Minnesota and Alaska, dental therapists have proven to help private practice and safety-net practices expand access to low-income, uninsured, and rural populations. We expect to work with stakeholders to ensure this is the case in Vermont. (see graphic)

20. Will dental practitioners in remote areas receive adequate supervision when there no dentist nearby?

Dental practitioners will be properly trained to practice under the general supervision of dentists in remote locations. Additionally, the supervising dentist will work to develop standing orders/collaborative practice agreement to help guide the dental practitioner they are supervising. As noted above, dental therapists have a track-record of providing high quality care.

21. Who will treat patients with emergency condition arising during treatment?

Like dentists and other medical professionals, dental practitioners will be properly trained to handle emergency conditions, stabilize patients and refer them to appropriate providers if needed. The quality of care provided by mid-level dental practitioners is well-documented.

Financial Considerations:

1. Where will dental practitioners practice? New dental practices or facilities? Existing dental practices?

Answered previously

2. What are the economic realities to an existing practice of adding a dental practitioner to the dental team?
3. What will be the cost of building/renting and furnishing dental practitioner practice facilities?
Mid-level dental providers are an economically viable and cost-effective dental provider. Dental providers are able to provide routine and preventive care to patients at a lower cost than dentists, which enables practices to add new patients to practices. A May 2013 Community Catalyst report highlighted that dental therapists in Alaska and Minnesota are providing care to traditionally underserved populations – Medicaid, uninsured, rural and tribal populations. Additionally, dental practices employing dental therapists are reporting an increase in the number of patients they are able to see, an increase in communication among the dental team as a result of the dental therapist, that dentists performing more complicated procedures and delegating routine care, and a cost benefit to the practices to help them deal with low Medicaid rates.

4. What will be the cost of creating a dental practitioner education program including faculty salaries? Is a "Vermont only" training program viable? Would a Vermont based regional training program achieve economies of scale beneficial to Vermont and other states?
5. Who will bear that cost?
Defer to Dr. Ellen Grimes.

6. Would such a program and the growing number of dental practitioners available make a traditional dental education undesirable?
7. Would creating dental practitioners as a regulated profession further reduce the number of dentists in Vermont?
Evidence in MN is that the expanded team allows entire practices to grow, including the addition of new dentists. Mid-level practitioners are an economically viable and cost-effective member of the dental team who will be supervised by dentists and often times employed by dentists. The practitioners will be an exciting innovation to the dental team that will help dentists see more patients and generate additional revenue. Ultimately, dental practitioners will help generate interest from prospective dentists.

8. Who will bear the cost of regulating the profession, adopting rules, etc. when there are no current members of the profession to pay for their own regulation? Current Vermont law requires that each OPR profession bear the costs of its own regulation.

(answered by OPR and Board of Dental Examiners)

9. What will be the cost of training and setting up a practice per dental practitioner?
Dental practitioners by employed by dentists and safety-net programs. They are economically viable providers that cost on average less than half the cost of employing a dentist in Alaska and help save a safety-net practice in Minnesota over $60,000 per year per provider, which is why employers are paying tuition to train dental therapists who return to work in their practice. We expect many dentists and safety-net programs to clamor for the opportunity to hire a dental practitioner once the profession is authorized.

10. Can that cost or a lesser amount be spent in other ways to more efficiently address the access problem?
n/a

11. What impact will the new profession and all its attendant costs have on amount spent to assure Vermonters have adequate access to dental care.
See fiscal note

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Conclusion

- For years we have tried to fix the current system. We have tried to increase Medicaid reimbursement rates for dentists. We have tried to lure dentists to the state by increasing the dollars that go into loan repayment. We have established providers such as the dental assistant. These are important components to addressing our dental access crisis.
- But clearly it is not enough. We need to increase our capacity, our workforce, our ability to treat the children and adults who year after year continue to suffer from the lack of access to needed dental care, and whose health and economic security is threatened as a result.
- It is time for dentistry to move toward a team-based approach that allows each member to practice at the top of his or her license for maximum efficiency and impact.
- Dentists who are interested in expanding access for Medicaid patients should be allowed to implement this proven solution, and those who aren't don't have to. Each dentist can assess whether dental therapists are a fit for their business model and mission
- Please support S.20 to add a proven, safe, effective solution to increasing oral health access for Vermont's most vulnerable and underserved people.

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[i] Vermont Department of Health, *Burden of Oral Disease in Vermont, 2013*, http://healthvermont.gov/family/dental/documents/burden_of_oral_disease.pdf