VERMONT TESTIMONY

INTRODUCTION- Long time dental educator;

former dean of UFCD and past president of ADEA.

Have been a Committee member of CODA and a consultant/site visitor for accreditation.

Most of my research and advocacy work since 2002 has focused on access to oral health care. Have been actively involved in Dental Therapist issues for about a decade and was an early supporter. Have been to Alaska several times and also Minnesota. Have testified before other legislative committees, New Mexico, or consulted about DTs- Kansas, Massachusetts, and others.

WHY ARE WE RECOMMENDING DENTAL THERAPY AS AN ADDITION TO THE ORAL HEALTH WORKFORCE?

The plain and simple answer is ACCESS. For a variety of reasons- financial being a key issue- there are many people in this country who cannot access routine dental care in dentists' offices the way most of us can. We either have the financial resources to pay for dental care, or we have dental insurance. We also have a certain amount of oral health literacy- we know routine dental care is important. We know that oral health is linked to overall health. We have a car or can pay for

transportation to a dental office; many truly underserved patients have transportation problems, especially in rural areas of the state.

The data I have seen about your state is frankly chilling to me.

- 2014, (37%) 1-18 (enrolled 90 continuous days) received zero dental services. (EPSDT -Early Periodic Screening, Diagnosis, and Treatment -2014 data)
- Less than 50% of people eligible for Medicaid have received any oral health care in 2010
- From BRFSS (Behavioral Risk Factor Surveillance System) data: that ~146,000 adults/seniors didn't see a dentist in 2012
- From HCUP (HealthCare Cost and Utilization Project) data: Emergency room visits for dental care doubled between 2003 and 2011. And I would bet that if your are similar to Florida, you have had big increases over the past few years.

Let me give you an example from my state of Florida to illustrate the costs involved with ED visits. In 2014, over 168,000 Florida patients had to go to hospital emergency departments for a preventable dental problem that resulted in pain and infection and that was potentially life threatening.

This cost our state over $250,000,000. Think about that, over $250,000,000 wasted dollars!!

Many of these patients had Medicaid but in our state, only about 25% of Medicaid patients actually get dental care and adult get virtually no care. Many of these patients are what we call self pay. These generally are children not eligible for Medicaid, senior citizens who reach Medicare age of 65 and suddenly find out that Medicare does not cover dental care, and other folks who are generally low income.

One other factor is that there is a maldistribution of dentists and many would argue, a shortage of dentists in some areas of the country. This may be particularly true in your state with more than 50% of dentists are over the age of 55. Where are your new dentists going to come from?

The Bottom Line is that these kinds of access problems are found all over the country and they exist in Vermont!

So, how can dental therapists help? First of all, they are less expensive to educate than dentists- 2-3 years versus a minimum of 8 years for dentistry.

Second, they are less expensive to employ. And I will say more about employment in a few minutes.

Third, they frequently come from the underserved communities they eventually serve and they are very employable and willing to work in what I call access settings such as FQHCs and CHDs and rural, underserved areas.

WHAT IS THE COMMISSION ON DENTAL ACCREDITATION OR CODA?

All dental educational programs are accredited by CODA which is made up of representatives of organized dentistry, educational programs, licensure groups, specialty organizations and the public. CODA is authorized by the US Department of Education.

The fact that CODA has now recognized dental therapy as a legitimate dental educational program by developing and implanting accreditation standards is critical and really gives legitimacy to dental therapy.

Just as CODA accreditation ensures that dentists graduate at the highest standards possible, CODA accreditation assures that dental therapists will also graduate with the highest standards of quality. It is a recognition of the safety and efficacy of dental therapists in taking care of patients.

It will be a year or two before the first programs are actually accredited but we know that the Alaska program is starting to prepare for the process.

GENERAL EDUCATION ISSUES-

CODA's accreditation standards stipulate three academic years of education but I would point out to you that this could be condensed or accomplished in only two full calendar years, as is done in the Alaska model of dental therapy.

One of the important questions we are frequently asked about dental therapists is how can be educated in only 2-3 years while it takes 8 years for dental education- four years of college and four years of dental school. The answer is very straightforward. As a dentist, I learn about 500 or so skills or what we call competencies. But a DT only learns about 50-60 depending on the nature of the program. In other words, DT only perform a small fraction of the procedures that a dentist performs. For example, dentists learn how to do root canal therapy. A DT does not learn this because it is not in their scope of practice. Dentists learn how to remove teeth that are buried in bone- we call that an impacted tooth- DT do not do this.

More importantly, for those procedures within their scope of practice, DTs frequently do more of those procedures while in school than dental students do. A great example is SSCs.

DTs are trained to do what are the routine, what some might call the “bread and butter” of dental practices, fillings, preventive treatments, extractions, SSCs and pulpotomies/nerve treatments.

DENTAL THERAPISTS ARE NOT A THREAT TO DENTISTS- In fact, some limited data from Minnesota shows that when a private practitioner hires a dental therapist (who in that state is required to see a minimum of 50% Medicaid patients), that the dentist is freed up to work at the top of his or her scope of practice, doing more complex procedures, and can increase practice income and profitability. We can get those studies to you if you would like to have them.

I wanted to address the issue of employability of dental therapists. You may know that when dental therapy was implemented in MN, there were strong objections from organized dentistry. Well, the reality of what happened after implementation is remarkable to me. MN has now graduated 47 therapists. 46 are fully employed with only 1 not employed because she does not want to work right now. But where they are employed will really excite you. 20 are employed in private

dental practices and the others are in non profit clinics, FQHCs, and other similar facilities. And you should be very interested in this number – 15 of them work in HRSA designated rural areas which is a major issue here in Vermont. So, would I be concerned about dentists hiring them in Vermont- absolutely NOT.

The other thing I would point out relates to quality of care. In an evaluation of the world literature where DT has been used in over 50 modern industrialized countries for about 100 years, there is no evidence of poor quality, in fact, just the opposite. A 2013 paper in the Journal of the ADA reported good quality of care. There is absolutely NO ISSUE about quality of care. My favorite question to ask an opponent of DT who raises quality concerns is- I appreciate your personal opinion about safety and quality but can you point out just one study which has demonstrated your concerns. The response is usually SILENCE. There is no literature that can demonstrate problems with therapists care of patients.

In MN and Alaska, therapists have been shown to be very effective in reducing wait times at safety net clinics, work well in collaboration with dentists, decreased use of hospital EDs, and other good indicators of improved access.

LICENSURE- The other issue I wanted to mention is licensure. Because the therapists in Alaska work for the Native American corporations and have their own "licensure" thru the Indian Health Service, there is not much we can learn from them. BUT in MN, the therapists take the same exam as the dental students, limited to those procedures within their scope of practice. They take both the MN exam plus the larger regional exam called CRDTS; they only perform the procedures in their scope of practice and use the same examiners that use identical grading criteria.

So, whatever exam your dentists and dental hygienists take for licensure in Vermont will suffice for the therapists. You should have no concerns about licensure.

BOTTOM LINE- DTs HAVE THE POTENTIAL TO SIGNIFICANTLY IMPROVE ACCESS TO CARE AND REALLY TRANSFORM HOW DENTAL CARE IS DELIVERED AND MANAGED.

If time, talk about Motivational Interviewing.