The nature of the problem:

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

Yes. There is significant evidence that tens of thousands of Vermonters of all ages lack access to affordable dental care. The Dental Landscape Study to the Green Mountain Care Board, the VT Household Health Insurance Survey (VHHIS) conducted by the state, over 200 stories collected by the Oral Health Care for All Coalition, and Pew Foundation reports all have information about the lack of access to dental care. There has been testimony on each source and we will provide copies if requested by the committee.

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

Preventive, routine and specialized care is inaccessible to Vermonters of all ages. The 2011 VT Dentist Survey indicates that many primary care and specialized care dentists are nearing retirement age. The report also indicates regional disparities. For example, five of the nine pediatric dentists practice in Chittenden County. Eight of the fourteen counties do not have a pediatric dental practice. Rutland County is the only other Vermont county with at least one FTE pediatric dentist. Some regions of the state only have one dentist who accepts Medicaid patients. Only 29% of general dentists accept 5 or more new Medicaid patients per month. The Office of Oral Health in the Department of Health has collected extensive evidence that confirms the above points.

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

Access is limited for Vermonters of all ages. In 2011 over 23,000 children with Dr. Dynasaur coverage did not receive dental care. In 2012, 68,000 adults went without care, saying they could not afford it.

4. How great is the problem?

Oral health is vital to overall health yet the data reveals that access to affordable dental care is limited in the state of Vermont. In 2011, there were over 6,000 visits to the emergency room for dental services. Over 2.5 million dollars in avoidable procedures are performed on Vermont children. We are relying upon a system of cobbled together care where people do not have access to preventive and basic restorative care, resulting in more expensive care and often times result in the extraction of teeth. The Green Mountain Care Board's Dental Landscape Study further clarifies how great the problem is.

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. One cause is geographic. The data from the Dental Landscape Study, 2011 VT Dentist Survey, and story collection from the Coalition all show that across the state people cannot find a dentist willing to treat them within their geographic area. Many towns also fall outside the catchment area of a Federally Qualified Health Center. These clinics offer sliding fees scales based on income.

6. Is lack of access due to patient/family's inability to afford dental services?

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.

7. How many existing dental practices accept Medicaid enrolled patients?
Another significant barrier is the number of dentists willing to accept patients on Medicaid. Data from the 2011 VT Dentist survey indicates that only 29% of dentists accepts five or more new Medicaid patients a month, compared to 68% new non-Medicaid patients. While 80% of dentists do accept at least one Medicaid patient a year, two-thirds of those dentists had fewer than $50,000 in claims, indicating a small percentage of overall claims collected for services in one year.

8. How many dental practices are there in the state?
According to the 2011 Dentist Survey, there are 368 dentists providing patient care in Vermont. This represents 281.2 full-time equivalents, of which 229.0 are in primary care. More detailed information can be found in the report and through the Oral Health Division of the DOH.

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 2011 Dentist Survey shows that at the time of the survey 63% of dentists are 50 or over, 49% were 55 or older, and 34% 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. This is true across the country. More dentists are retiring, fewer students are graduating from dental school, and most of those students will practice in more urban settings. In his testimony before the Senate Government Operations Committee, Dr. Steve Arthur, DDS, Director of the Oral Health Office in the DOH discussed demographics and cost of dental school education as reasons for the insufficient number of licensed dentists.

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. Data from the 2011 Dentist Survey shows the number of dentists by county and service area.

<u>The nature of the solution:</u>

1. Can lack of access be remedied without creating a new profession?
No. The Dental Landscape Study 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. It went further to say that we need 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. See the testimony of Dr. Steve Arthur and Craig Stevens.

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 LDP could address.

4. **Can economic changes or incentives remedy the problem?**
   Economic changes or incentives cannot remedy the problem alone. We need more providers who can treat patients and do so in settings that reduce barriers for Vermonters.

5. **Is there a way to attract already trained professionals (dentists, dental hygienists) to provide access to needed dental services?**
   There are several efforts in place to attract current dental providers both to the state and to provide access to needed dental services. However, it has not resolved the access problem. For more information on current programs, please refer to Dr. Steve Arthur's testimony in front of the Senate Government Operations Committee.

6. **Are there other means, e.g. advanced dental hygiene practitioners to meet dental health needs?**
   Significant increasing access to dental care requires a comprehensive solution. No one solution is a magic bullet but the LDP is a necessary and critical component to meeting Vermonters dental health needs.

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 LDP who can provide clinical treatment. There must be providers willing to take patients for a CDHC to be successful. The LDP 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 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.

   In 2011, Darren Berg, a dental therapist, reported on behalf of the Saskatchewan Dental Therapists Association, "With respect to Professional Liability Insurance (malpractice), we have offered this directly to our members for about 13 years and to date not one single claim has been made against a member's policy for a liability issue. Additionally, no claim has ever been made against an employer of a dental therapist for services provided by the dental therapist while under their employ."

3. **Will the number of dental practitioners decrease without assured funding? See, "On the Pediatric Oral Health Therapist: Lessons from Canada, J. Public Health, Winter 2008.**
   The funding structure referred to in the above article from Canada is not applicable to Vermont. The conclusion of the study, however, is applicable. "It is clear that the pediatric oral health therapist provides a long term, sustainable option to responsibly meeting the needs of America's socially marginalized groups" (page 55 - 56).

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 there will not be two-tiers of care delivered by the dental practitioners. Evidence clearly shows that dental practitioners provide safe, quality care. Dental practitioners, like dentists, will complete a rigorous education-training program. Then, they will pass a board exam and will be licensed by the state dental board just as dentists are in Vermont. Dental therapists in Minnesota took their exams side by side with dental students. Examiners did not know which education program the students completed and graduates of both programs were held to the same standards. 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?**
   The scope of practice of Licensed Dental Practitioners 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. Furthermore, in May 2014 Community Catalyst released a report titled, *Economic Viability of Dental Therapists*, http://www.communitycatalyst.org/doc-store/publications/economic-viability-dental-therapists.pdf, which found that dental therapists practicing in Alaska and Minnesota, have expanded access to routine and preventive oral health care for low-income adults, children, and people living in tribal communities.

Sheila Bannister's (Vermont Dental Hygiene Association) response: Yes, it is sufficient. The scope of practice mirrors that of the Alaskan and Minnesota providers. The scope, in combination with a referral system for specialized procedures, has been determined to be adequate for needs of the general public. The scope as written is at a level 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.

6. **Does the scope of practice include a realistic mix of skills?**

Licensed dental practitioners, like dental therapists, are highly trained to provide routine and preventive care. By being able to practice under the general supervision of dentists and being trained to diagnose and plan treatment, dental practitioners will be able to provide community-based care in new settings where no dentists currently practice, thereby increasing access to care for underserved Vermonters. Additionally, mid-level dental providers are culturally competent providers who have been trained to be highly skilled motivational interviewers.

Sheila Bannister's (Vermont Dental Hygiene Association) response: Yes. Prevention and limited restorative skills with the ultimate goal of referral to a specialist when indicated. Scope of practice between that of a hygienist and a dentist. Education and clinical training for the prevention portion of scope of practice has been proven to be safely and competently accomplished with a minimum of 18 months of education and training (RDH). The restorative scope of practice has been proven to be safely and competently accomplished with a minimum of 18 months of education and training (DHAT).

7. **What education is needed to properly train an individual to become a dental practitioner?**

In Vermont, dental practitioners will be licensed as dental hygienists and dental therapy. Two national panels of dental experts concluded that three years is sufficient training to practice both scopes of practice. Below you will find additional details.

In 2010, the American Association of Public Health Dentistry (AAPHD) convened a panel of dental educators that reviewed the Alaska DHAT program and other international models. The panel outlined the principles, competencies and curriculum to

educate dental therapists. The panel's findings were published in a special edition of the Journal of Public Health Dentistry and detail the framework for a two-year dental therapy curriculum that culminates with an Associate's degree. The panel recommended a one-year curriculum for dental hygienists to be trained in the additional scope of practice needed to become a dental therapist, or in Vermont, a dental practitioner.
As follow-up to the AAPHD panel, Community Catalyst convened a panel of academic and program experts comprising representatives from all three of the existing U.S. educational programs for dental therapists, as well as experts in dental therapy practice in the U.S. and Canada and educational standards experts. The panel researched accreditation models, standards and competencies for existing health professions to address critical issues such as curricula, faculty credentials, basic program length, and the level of financial support and type of setting needed to offer quality education programs. The panel recommended:

- Dental therapists should be trained to practice under the supervision of a dentist and to work collaboratively as part of a dental care team.
- Dental therapy curricula must include at least two calendar years of full-time instruction or its equivalent at the post-secondary level, and graduates must receive an Associate's degree. If a student is to be jointly trained in dental therapy and dental hygiene, the curriculum must include at least three years of full-time instruction or its equivalent.
- Graduates from dental therapy programs must be able to competently provide care within a scope of practice that includes assessing patients' oral health needs, providing preventive care and treatment for basic oral health problems and recognizing and managing complications, while adhering to all recognized community and professional standards.
- Dental therapy education program leaders must be qualified to administer the program, but do not need to be dentists. However, if a program is not dentist-led it must employ a dental director—a licensed dentist who is continually involved in the program.

Sheila Bannister's (Vermont Dental Hygiene Association) response: A: As proven, minimum of 18 months (didactic and clinical) at an accredited institution to safely and competently train a dental therapist (DHAT). Vermont proposing a 30-39 month combined (RDH/LDP) educational program. Draft curriculum based on successful educational programs in Alaska and Minnesota.

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?

Vermont Technical College, an accredited institution, is equipped to train dental practitioners. Currently, dental schools, dental hygiene programs and a joint education initiative of the University of Washington MEDEX program and the Alaska Native Tribal Health Consortium are training practicing dental therapists in the United States. Under the legislation, there is reciprocity for providers trained and licensed in other states.

Sheila Bannister's (Vermont Dental Hygiene Association) response: Vermont Technical College (VTC) will be the accredited institution to provide the initial LDP educational program. Administration, faculty, supervising dentist, staff, and facilities in the form of the 22 chair dental hygiene clinic are already in place. Adjunct part time/full time faculty will be added when necessary. The LDP will graduate with a BS degree which VTC is able to confer.

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)?**
   As noted above, expert panels of dental educators convened by the American Association of Public Health Dentistry and Community Catalyst developed national model curriculums and education standards. The model curriculum developed by the American Association of Public Health recommends a three-year training program for a combined dental therapy/dental hygiene practitioner.

   The education standards report recommends, "If a student is to be jointly trained in dental therapy and dental hygiene, the curriculum must include at least three years of full-time instruction or its equivalent.

   The Vermont Technical College training program for dental practitioners builds on the recommendations made by both expert panels by requiring four years of training and completion of a Bachelor's degree to become a dental practitioner.

   Sheila Bannister's (Vermont Dental Hygiene Association) response: Yes. See above answers. In addition, of the 34 procedures listed, 26 can be performed by an already licensed dental hygienist and the LDP will be based on a dental hygienist only. This leaves 8 procedures to be mastered over the course of 12 months of education and training. The 400 hours will be completed under the direct supervision of a dentist after the LDP has already obtained their license.

10. **How will an education program determine how many clinical hours of training are needed for each of the various procedures taught?**
    The American Association of Public Health Dentistry model curriculum includes five sections of clinical training and an additional clinical preceptorship. The Vermont program will incorporate national model curriculum and best practices from the programs in Minnesota and Alaska. Additionally, the state's dental board and educational agencies will oversee the educational program. Then graduates will undergo a preceptorship, a licensing process, and then develop a collaborative management practice with their supervising dentist who will establish their scope of practice based on their assessments of the practitioner's competencies.

Sheila Bannister's (Vermont Dental Hygiene Association) response: Through data compiled from existing programs with input from educators.

11. Who is qualified to provide dental therapist education?

Vermont Technical College is an accredited institution that will employ properly credentialed instructors for each of the courses. The school expects to employ dentists to teach clinical courses and other coursework.

Sheila Bannister's (Vermont Dental Hygiene Association) response: Dentists or dental therapists for the clinical portion and some didactic courses. Dental hygiene educators for didactic course content in their area of expertise (for example; Medical Emergencies, Pharmacology, Practice Management).

12. Does the training program have a properly qualified administration?

Yes. The program at Vermont Technical College has an administrator who has been in the position for 8 years and a dental educator for over 30 years. She has experience with budgeting, curriculum design, scheduling, and faculty recruitment.

It also important to note that the expert panel that developed national standards explicitly highlighted that the administrator of the training program does not need to be a dentist.

Sheila Bannister's (Vermont Dental Hygiene Association) response: The program has an administrator that has been in the position for 8 years and a dental educator for over 30 years. She has experience with budgeting, curriculum design, scheduling, and faculty recruitment.

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.

Yes. Vermont Technical College is an accredited institution and all faculty teaching in the program will be appropriately credentialed. Additionally, all programs will work with the Vermont Dental Board on criteria.

Sheila Bannister's (Vermont Dental Hygiene Association) response: All faculty teaching in the program will have a Master's degree or higher with courses in educational methodology. All full-time faculty at Vermont Tech must have at least a Master's degree. Clinical faculty must have a minimum BS degree for the dental hygiene portion of the curriculum. Clinical faculty for the dental therapist portion of the LDP degree must be a licensed dentist or dental therapist. The determination on whether didactic and/or clinical faculty is properly qualified to teach will be made by the program director.

14. Do the clinical faculty have the necessary clinical and teaching experience? How is that determination made, and by whom?

Vermont Technical College is an accredited institution. It will employ faculty with proper credentials and clinical experience as required.

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?**
    There are several entities developing standards for dental therapy education programs including the Council on Dental Accreditation. At this point, no organization including the Council on Dental Accreditation is planning to accredit dental therapy training programs. The legislation, as required in Minnesota, calls for the Vermont State Dental Board to oversee dental therapy training programs and the practice of dental therapists in the state.

16. **Where will dental practitioners practice? WIC offices, Head Start Programs, Schools, Churches nursing homes, FQHC's private dental practices, other location?**
    Licensed dental practitioners will be authorized to practice under the general supervision of dentists in remote locations. They will be able to diagnose, treatment plan, provide preventive and restorative services. Because dental practitioners will be able to practice under the general supervision of dentists they can expand the reach of dental offices to community based settings 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. Over 40% of the state's children go without care. There are a growing number of dentists who are retiring, which will compound the problem. Dental Practitioners can be employed by dentists and safety-net providers to be deployed to meet the state's growing dental needs.

18. **How will dental practitioners fit in with current dental practices?**
    Dental practitioners will be employed by existing dental practices - either private practices or safety-net practices. Dental practitioners will help dental practices increase their capacity to expand care to previously underserved populations. Additionally, dental practitioners have proven to be cost-effective – for every dollar they generate they cost less than $.30 to employ.

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.

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 conditions 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?

As noted, dental therapists are an economically viable provider. They are cost-effective to employ because they can provide preventive and routine care to underserved populations in a variety of settings. In Minnesota and Alaska, dental therapists have been incorporated into existing dental practices – both public and private. We expect dental practitioners will expand access to services by practicing in currently underserved communities in new settings under the supervision of dentists.

2. What are the economic realities to an existing practice of adding a dental practitioner to the dental team?

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 the following: 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; the fact that dentists are performing more complicated procedures and delegating routine care; and a cost benefit to the practices to help them deal with low Medicaid rates.

Dental therapists have helped increase the capacity of these providers to serve previously underserved populations.

3. Who will bear the cost of building/renting and furnishing dental practitioner practice facilities?
As noted above, mid-level dental practitioners are cost-effective members of the dental team to employ. We expect safety-net and private practices will incorporate them into their practices in a variety of ways. Ultimately, the dentists and program administers who employ dental practitioners will determine where they practice and how to appropriately integrate the practitioners into their practice. Again, the Community Catalyst report demonstrated that dental therapists practicing in a variety of settings – tribal, non-profit safety-net, school based, and large-group – were economically viable.

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?
Vermont Technical College is positioned to host the training program. It is a well-established program. Training providers to provide additional services will benefit the economy and consumers.

Sheila Bannister's (Vermont Dental Hygiene Association) response: Costs already accounted for in dental hygiene program. Additional costs will come from addition faculty hires and restorative supplies. All costs will be paid through student tuition and no costs will be incurred by the state.
See the testimony of Dr. Ellen Grimes.

5. Who will bear that cost?
The cost of the program will be covered by student tuition.

6. Would such a program and the growing number of dental practitioners available make a traditional dental education undesirable?
No, the dentist continues to head the dental team, receive the highest salary and perform the most complex procedures.

7. Would creating dental practitioners as a regulated profession further reduce the number of dentists in Vermont?
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.
Ultimately, dental practitioners will cover the costs of regulating their profession.

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.

10. Can that cost or a lesser amount be spent in other ways to more efficiently address the access problem?
First, the current dental system is ill-equipped to meet the state's unmet needs. In fact, 4 out of 10 children receiving Medicaid went without dental care in 2011, as well as tens of thousands of adults. This is costing both private patients and the Medicaid program money because they are going without routine and preventive care.

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.
The LDP is budget neutral to the state.