February 26, 2015

Members of the Senate Government Operations Committee;

Thank you for allowing me to speak with you today. My name is Sheila Bannister, and I am an Associate Professor at the Vermont Technical College (VTC) School of Dental Hygiene, and a Registered Dental Hygienist.

As an educator in the dental hygiene program I know from first-hand experience that the dental needs in our community are not being met for a significant number of people. As national research has shown, there are profound oral health disparities within the United States and, consequently, within our state. I personally see the evidence of this on a daily basis, much more so than someone working in a traditional dental office might, because the patients that the dental hygiene students at VTC treat are usually the patients that cannot access a traditional dental office for care.

Today, I would like to address some questions that have been asked about S. 20 and the Licensed Dental Practitioner.

First, how do we know the target population would be accepting of a new provider? In 2013, research was conducted in Vermont of patients at health clinics in Plainfield, Richford, and Rutland to determine perceived need and public acceptance of the Licensed Dental Practitioner. Of 287 study participants, 91% reported they would receive services, restorative and/or preventive, from an LDP. Of those surveyed, 64% answered affirmatively that they have delayed dental care due to unaffordability.

Will the proposed education in Vermont be adequate to train this provider? Yes. In 2010, the American Association of Public Health Dentistry (AAPHD) convened a panel of national dental educators and experts that reviewed the education and training programs for Alaska Dental Health Aid Therapists and other successful international midlevel dental provider models. The panel then created an evidence-based framework for dental therapy education in the U.S. and recommended a two-year dental therapy curriculum that culminates with an Associate's degree, or a one-year curriculum for already licensed dental hygienists to be trained in the additional procedures needed to become a dental therapist. Additionally, the AAPHD developed a national model curriculum; the proposed curriculum at VTC meets or, in several areas, exceeds recommendations put forth by the AAPHD panel, and the amount of education for the provider at VTC will exceed the amount recommended by the AAPHD. Although accreditation standards have not yet been confirmed by the Commission on Dental Accreditation (CODA), the curriculum will be revised, if it is necessary, to meet or exceed all finalized CODA standards.

Does evidence indicate the provider will competently and safely treat the public? Yes. In Minnesota, providers carry their own liability insurance and in Vermont they would be required to do the same. The insurance for the Minnesota provider costs less than a dentists'

liability insurance partly due to the fact that since licensing began no complaints related to patient safety issues have been filed against dental therapists.

What services will the LDP provide? The scope of practice in Vermont will consist of all preventive services a licensed dental hygienist already performs or can be legally trained to perform (20 and 6 respectively), and 8 new procedures that would be limited to the LDP scope of practice and parallel the scope of practice in Minnesota and Alaska. The number of procedures proposed for the Vermont provider is significantly lower than procedures performed by the Minnesota Advanced Dental Hygienist (at 82 procedures), or the Alaskan dental health therapist (at 46 procedures), yet the education proposed for the LDP is significantly more than the education required of the Alaskan therapist, and only 59 hours less than the Minnesota provider.

Is there a need for a provider in Vermont that can practice under general supervision both in and outside a traditional dental office, and go directly to the populations most in need? Yes. For example, the elderly; older adults develop dental decay at a higher rate than children, and develop higher rates of severe periodontal (gum) disease than the general public. Bacterial infections of the oral cavity, compounded by medical conditions and medications, often lead to tooth loss, oral cancer and systemic illness. As of 2010, approximately 1.6 million people resided in long term care facilities and over 1 million in assisted living facilities. State and federal regulations mandate the provision of oral health care to institutionalized residents, but a significant portion of patients in these facilities receive only emergency and palliative services, or minimal oral hygiene care delivered by an untrained and overworked health aide.

Another example of the necessity for general supervision would be the addition of the LDP in an emergency room. In Rutland this summer I met with a physician's assistant who showed me the unstaffed dental unit in the ER and then explained the palliative treatment and referral to nowhere he provides for patients in pain. He would like to have an oral health expert on the medical team to provide some restorative care, but can't find a dentist to fill the position. An LDP on the ER medical team would reduce the number of repeat ER visits, save taxpayer money, and increase patients' knowledge of preventative oral care.

These examples illustrate the absolute need for this provider to work under general supervision rules as they safely do in Alaska, Minnesota, and throughout the world. Without this ability, a huge portion of the underserved will remain without any care. Because the education proposed for the VTC program is close to equivalent to the education required for the Minnesota program, exceeds the education for the Alaskan therapist, and exceeds the framework created by the American Association of Public Health Dentistry, I urge the committee to strike the amendment requiring the practitioner to work under direct supervision and instead suggest the number of hours under direct supervision after licensure be increased. This increase, combined with the necessity for the supervising dentist to sign off on the provider's ability to work under general supervision, will more than

adequately assure the provider is prepared to safely and competently practice under a collaborative agreement with a dentist.

I have been a dental hygienist for 16 years and a dental hygiene educator for 11 years, and I am convinced that a Licensed Dental Practitioner in Vermont could treat early decay and disease thoroughly and competently as they have done in other countries and other states. This provider will fill a void in our current dental system and reduce the need for more invasive and expensive treatment further on down the road, thereby reducing the risk of the medical problems that can often accompany untreated decay. Because the Licensed Dental Practitioner will be based on a dental hygienist, disease will be prevented, not just treated, and prevention is the way out of the cycle we find ourselves in today. Dental disease is almost 100% preventable, and effective measures now exist to prevent the most common dental diseases. It is time that everyone had access to these methods. Through the creation of the LDP in Vermont, I am confident that we will be taking a step toward assuring that all members of our state have an equal chance for a healthy life.

Again, thank you for allowing me to speak with you today.