TESTIMONY OF CHRISTY JO FOGARTY, RDH, MSOHP
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HEARING ON DENTAL CRISIS IN AMERICA: THE NEED TO EXPAND ACCESS
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Introduction

Thank for this opportunity to share the Minnesota story on expanding access to dental care through the use of a new type of dental provider. My name is Christy Fogarty and I graduated in June 2011 with a Masters in Science from the Oral Health Practitioner Program administered jointly by Metropolitan State University in St. Paul and Normandale Community College in Bloomington, Minnesota. This program, which educates students who are licensed dental hygienists already holding a baccalaureate degree, to practice as Advanced Dental Therapists. Advanced Dental Therapists provide all of the services of a dental hygienist by virtue of dual dental hygiene and dental therapy licensure, all of the services of a basic dental therapist, and additional services including oral evaluation and assessment, formulation of an individualized treatment plan, extractions of permanent moderately to severely mobile or "loose" teeth and provision, dispensing and administering antibiotics, analgesics and anti-inflammatories. The Advanced Dental Therapist is a true mid-level provider – a provider between a dentist and a dental hygienist – and is similar to the nurse practitioner who works under general supervision but in the dental field. The Advanced Dental Therapist is not a replacement for a dentist but is intended to extend the reach of the oral health care delivery system so that it will be easier and more affordable for underserved populations, including children and the elderly, to obtain high quality oral health services. An estimated 60 percent of Minnesota dentists may retire in the next 15-20 years. (UMN-Academic Health Center, Educating Minnesota's future health professions Workforce:2008 Update)the dental workforce in rural areas has a larger percentage of dentists over the age of 59, magnifying the loss of dentists due to retirement in the near future. Twin Cities (Minneapolis/St. Paul metro area) emergency rooms reported 10,000 ER visits related to oral health problems at a cost of more than 4.7 million in 2005 (Davis, Deinard, and Maiga, 2005). In addition, only 42% of those on Minnesota's public health programs receive dental care, leaving low-income adults and children without needed dental care, even though every $1 spent on preventative care saves about $4 in dental costs (DHS, March 2007 and the National Institute of Dental Research). While Minnesota’s Advanced Dental Therapy program is the first of its kind in the United States, more than 50 other countries have educated and utilized mid-level dental providers safely and effectively for decades.

A Strong Foundation in Prevention

How did I begin my journey? I have been in dentistry for over 15 years, first entering the field as a dental assistant. Shortly after beginning dental assisting school I fell in love with the field of dentistry and knew I wanted to do more. Before completing dental

assisting school I applied for dental hygiene school. After competing with over 300 applicants for 30 spots, I was accepted at Normandale Community College's dental hygiene program. While in dental hygiene school, I took courses that included anatomy, physiology, biology, bio-chemistry, psychology, radiology, and pharmacology. In addition we spent hundreds of hours providing direct patient clinical care. We also spent time with patients teaching them how to prevent gum disease and tooth decay. After graduation I spent two years working with a private practice dentist who was very dedicated to giving back to the community and accepted a high percentage of public assistance patients. It was there I saw first hand the difficulty many people face in accessing dental care and learned how very challenging this population can be to treat. Although dental disease is almost 100% preventable, I saw patients with rampant untreated decay. In this practice I was able to hone my skills in prevention and disease treatment, collaborating with the dentist on treatment planning and realistic outcomes. I then moved forward with my career and began work as a temporary for hire hygienist. I was able to work in dozens of practices in the urban core of the Minneapolis/St. Paul metropolitan area, the suburbs, and the more rural areas of our state. For seven years I witnessed private practice offices unable or unwilling to serve people with public assistance insurance, the uninsured, and people with special needs and the homebound. I have often heard that the access issue has more to do with a maldistribution of dentists and not a lack of dentists. I have witnessed firsthand many areas where people cannot enter the dental system and receive care and I saw that it has nothing to do with the availability of dentists in the area. It was at this point in my career that I heard of the big push in Minnesota to create a mid-level practitioner to improve access to dental care, and I knew I had to be a part of this new program.

Minnesota Enacts Legislation to Improve Access to Dental Care Through the Creation of Two New Types Dental Providers:
The Dental Therapist and the Advanced Dental Therapist

Interestingly the push to create a dental mid-level did not come just from the dental community but from a large cohort of community groups including safety net programs, Health Partners, Regions Hospital, the United Way, and all of the major medical insures. In fact, over 45 organizations supported creating a mid-level point of entry practitioner.(appendix A). The opposition came only from organized dentistry. In 2009 the dental practice act in Minnesota was changed to include two mid-level practitioners, dental therapists and advanced dental therapists. Dental therapists work under the indirect supervision of a dentist, which means a dentist needs to be present in the office and aware of what procedures are being completed by the dental therapist, but the dentist does not need to be in the operatory with the dental therapist. This new provider, which in my opinion, doesn't do much to improve access to care for vulnerable populations because of the requirement for a dentist to be on-site, was included in the legislation largely at the urging of the Minnesota Dental Association and the University of Minnesota that educates dental therapists. The other mid-level practitioner created is the advanced dental therapist who after 2000 hour of working under indirect dentist supervision can work in alternative settings without a dentist present, but in collaboration with a dentist.

It is important to note that currently there is no requirement in the legislation that a dental therapist or an advanced dental therapist need to be a dental hygienist prior to licensure. However, the only advanced dental therapy program in Minnesota, which I graduated from, requires that all applicants be licensed dental hygienists with extensive dental hygiene work experience. I chose to attend Metropolitan's program because I feel the foundation in preventive care afforded by a dental hygiene education is critically important for treating this vulnerable population. By virtue of their dual dental hygiene and dental therapy licensure, graduated from Metropolitan State's program work as Advanced Dental Therapist to provide a full range of preventive oral health care services in addition to administering restorative services, performing extractions of "baby" teeth and very mobile permanent teeth and having limited prescriptive authority. This broad range of primary care services will enable me to improve access to care for rural and underserved populations and increase entry points into the oral health care delivery system. Working with a collaborative management agreement with a dentist, I will also refer patients to a dentist when they need the services that only a dentist can provide.

Becoming an Advanced Dental Therapist

I was in the first class of advanced dental therapists but getting there wasn't as easy as it may seem. I learned that despite having over a dozen years of experience as a dental hygienist I still needed more training to even be accepted into the program. While I had the required 2000 hours of dental hygiene experience, I also had to be licensed to administer both local anesthetic and nitrous oxide, and be certified as an REF or restorative expanded function hygienist. This certification allows licensed dental hygienists to place both silver and tooth colored fillings, and place stainless steel crowns after a dentist has removed the decay and prepared the tooth to be restored. Note that fourteen other states allow dental hygienists to provide these types of restorative services, illustrating that many states are expanding the role of non-dentist providers to increase access to dental care.(appendix B). I then had to go through an extensive application and interview process. Once accepted into the accredited, 27 month, full-time masters program I started very challenging coursework. This included clinical coursework that taught us the new skills we would be performing.

We were taught these skills, within the scope of our practice, to the same level as a dentist. In other words our training to prepare teeth, remove decay and fill teeth was taught in the same matter dental students learn it across the country everyday. In addition, we took coursework in advanced pharmacology, epidemiology, managing patients with special needs, and pediatric dentistry.(appendix C) While learning new skills is always challenging my background was very useful in learning treatment planning, assessments, and prevention education as these were critical thinking skills I had used for over a decade as a dental hygienist. In our clinical training I was able to see dozens of uninsured patients in our home clinic allowing me to restore hundreds of teeth before ever officially entering the field of dental therapy. We also were able to do rotations through Community Dental Clinic, Hennepin County Medical Center in their pediatric and oral surgery departments, the VA nursing home and Children's Dental Services. These experiences allowed us not only more clinical time with patients but allowed us to work directly with experts in the field to expand our critical thinking skills.

While completion of this master's level education was the most significant requirement for licensure in Minnesota there were still several additional requirements I had to complete prior to being allowed to practice dental therapy in Minnesota. I had to complete a clinical exam on both a typodont or " fake" teeth, and I had to complete two fillings on actual patients. The patient portion of the exam was taken with dental students from the University of Minnesota and other dental students from across the country. The evaluators in this process did not know which patients were being treated by a dental student or an advanced dental therapy student, again this shows that in our scope of practice, we are trained to the level of a dentist. After passing the dental boards I then had to find employment in order to gain the 2000 hours of experience as a dental therapist before being eligible to take the certification exam that will certify me as an Advanced Dental Therapist. Finding work was not challenging as Children's Dental Services was eager to hire an advanced dental therapist. In fact, they have another licensed hygienist currently in the program they intend to hire.

Children's Dental Services is a non-profit dental clinic that sees children from birth to age 21. And because education of new mothers on how to take care of their children's gums and teeth is so critically important, we also see pregnant women to not only improve their oral health, affecting their overall health, but to educate them on preventive care for their children. Children's Dental Services also does mobile dentistry, bringing care to over 150 metro site including schools, community centers and hospitals. Statewide we have over 200 sites allowing us to bring much needed dentistry directly to the children who most need care. We also see children with special needs, having taken our mobile units over an hour and a half away to treat deaf and blind children in their schools. We also offer translators in almost a dozen languages. This helps to remove language as a barrier to dental care, and increases our ability to educate patients and parents on preventive oral care. The final piece to being able to practice dental therapy in Minnesota was to find a dentist to collaborate with. Again this was not as challenging as I thought it might be. The dentists I work with at Children's Dental Services were very supportive quite frankly because they knew and trusted me because of my work as a dental hygienist. As a result I have not just one but five dentists I am in collaboration with, with several more willing to sign with me.

Effects on Access Dental Therapy is Having Today

As a practicing dental therapist, I see firsthand every day the difference I make in opening access to dental care. As a full time dental therapist I see anywhere from 6-10 patients a day. For example, in the month of January alone I saw 57 patients who needed numerous restorative procedures. In addition to referrals and triaging I did 4 space maintainers, 5 pulpotomies (root canals on baby teeth), 11 stainless steel crowns, 17 extractions and 47 fillings. I also saw 12 emergency patients that could have otherwise ended up in the emergency room where they would have been given antibiotics and pain medications and told to find a dentist. There really is no dental emergency room. A medical emergency room simply isn't able to provide oral health care services but only to administer palliative treatment to alleviate the pain and prevent infection.

On one occasion I saw a two year old l boy who had fallen and hit his front tooth. After a week had gone by without dental care, the tooth had turned dark and was causing him

pain, making it difficult for him to sleep. By the time I saw him, the tooth was traumatized beyond repair and I performed the necessary extraction to relieve the pain and eliminate the infection. The boy's mother told me she had called around for hours before she was able to get an appointment with our clinic. She did not have insurance for her little boy and dental office after dental office turned her away because of the lack of dental insurance and because her little boy was under the age of 3, which is the standard age most private dental practices in Minnesota begin to see children. She said we were the last call she was going to make before she just brought him to the emergency room. This would have been a huge expense on the public health system, with no conclusive treatment. When I become an advanced dental therapist, after completing 2000 hours as a dental therapist, I will become even more effective as a point of entry into dental care. I will have the ability to work in schools, community centers, nursing homes, virtually anywhere that dental needs are going unmet.

Public Acceptance in Minnesota of New Dental Providers

From my vantage point, the acceptance level of dental therapy is nothing short of amazing. Every patient I see I explain to them that I am not a dentist and that I am a dental therapist. Once I explain to them that a dental therapist is much like a nurse practitioner in medicine they are comfortable with me treating their children. I have never once had anyone say they would prefer to see a dentist. In many cases, because I am a licensed dental hygienist, I have also cleaned their teeth so the parents are already comfortable with me, and I have developed trust with them. In fact, there was an eight year old boy I saw recently who had never been to the dentist before for several reasons including struggling with finding a dental office who would take their public assistance insurance. Unfortunately, as is the case with the vast majority of the population I see, this little boy needed extensive dental work. He needed four hour and a half appointments to complete 8 stainless steel crowns and several baby root canals, or pulpotomies. After the first appointment with me the mother said, "I don't care if you're a dentist or not I want my son to see only you." After completing all of this restorative work, I also was able to clean his teeth and place sealants as a part of completing his treatment. This little boy was not only pain free but he and his mother were well educated in how to prevent future dental decay.

What Can Be Learned from Minnesota

Minnesota is the first state to take the mid-level practitioner and fully integrate it into dentistry and many things can be learned from what we are doing. First, mid-levels are offering safe, cost-effective care to people across the state, opening up access to dental care to people who otherwise would have struggled to find care. I myself am seeing over 50 patients a month. Second, no longer will seeing a dentist be the only means to entering the dental system. Traditionally the only way a patient could seek dental treatment was to first see a dentist but with Minnesota's legislative changes it is now possible for advanced dental therapists to assess and treat dental pain without the patient first having to see a dentist. This means schools, nursing homes, community centers, really anywhere with a power source can become a place to receive dental care. Advanced Dental Therapists are also able to assess and refer not only to our

collaborating dentist but also to specialists if the needed treatment is outside our scope of practice. This enables the patient to get needed treatment faster and more efficiently. Third, utilizing an already trained workforce of dental hygienists means getting a dental therapist workforce can be achieved in a relatively short amount of time. In fact in Minnesota there are over 5300 licensed dental hygienists. This is an incredible and largely untapped resource that can help open access to dental care not only in Minnesota but across the country. At the same time we have this large dental hygiene work force we are looking at a shortage if dentists in the very near future with nearly 18% of the 3300 practicing dentists in Minnesota planning to retire in the next five years in the state of Minnesota .(appendix D).

Conclusion

For over 50 years nurse practitioners have provided quality, safe, effective medical care to people across the country, opening up a new entry point into the medical care delivery system. It is time to do the same for dentistry. Too many people struggle to enter the dental system and mid-level providers can be that additional entry point and help access desperately needed dental care. In addition to opening access, mid-level dental providers can also help decrease costs. Mid-level advanced dental therapists are paid far less than dentists therefore employment at places like Children's Dental Services can decrease costs and provide safe, quality, effective dental care for those most in need.

Frankly, it has been tough slugging in Minnesota. I have faced delays in credentialing, struggles with processing insurance claims, and as a I work towards my 2000 hours needed to become an ADT, the Minnesota Board of Dentistry is still is still working a process to test dental therapists to allow licensure as ADT's. Despite the challenges in becoming and working as a mid-level dental provider but I am proud to be persevering and so gratified to see the result of our work with patients suffering from the pain of untreated dental decay and look forward to continuing to serve those who would likely not have had access to needed dental care without me. Please do whatever you can to make it easier to improve access to care through the exploration and utilization of new types of dental providers in Minnesota and across the nation.