



Protecting, Maintaining and Improving the Health of All Minnesotans

January 31, 2018

TO:

Senator David Craig
Senator Chris Kapenga
Representative Paul Tittel
Representative Nancy VanderMeer

Representative Mary Felzkowski
Representative Romaine Quinn
Representative Rob Swearingen

CC:

Senator Leah Vukmir
Secretary Linda Seemeyer

Representative Joe Sanfelippo
Liz Portz

The Minnesota Department of Health (MDH) recently had the opportunity to review the Wisconsin Dental Association's (WDA) materials on dental therapy (DT) in Minnesota and beyond. This letter is to clarify the claims noted with respect to the dental therapy profession in Minnesota, based on our experience providing information and technical assistance to community stakeholders and legislators on this topic, working with providers who have employed or are seeking to employ DTs, and evaluating the impact of DTs in Minnesota.

As background, MDH has had oral public health responsibilities since 1872. Our oral health staff includes dental health professionals, epidemiologists and health workforce researchers, and the department is accredited by the Public Health Accreditation Board.

The WDA material is imprecise on the start of dental therapy in Minnesota. The first Minnesota legislation on DT passed in 2009; the first DT in MN was licensed and employed in 2011; and in Sept 2011, the state's Medicaid agency enrolled the first DT as a billable provider. By 2014, when MDH published the first evaluation of the access impacts of DTs, there were 32 licensed DTs practicing in 15 dental clinics in MN as compared to 4,027 licensed dentists and 5,542 licensed dental hygienists statewide.¹ Currently, there are 79 DTs practicing in Minnesota, roughly one DT for every 70,000 Minnesotans. To get to this level of adoption of a new profession in such a short time, Minnesota's oral health community came together to assemble the basic foundation needed to support these workers and the clinics in which they practice, including developing educational programs, licensing and certification procedures, reimbursement policies, and helping interested dental practices to understand the new role and integrate it into their operations.

The 2014 evaluation offered our first look at the impact of these newly licensed professionals on access to and quality of oral health. The evaluation, which was based on patient data and interviews with oral health providers and clinic administrators, found that DT patients reported decreased travel and appointment wait times, and employers reported an increase in the number

of new Medicaid patients to the clinic in addition to increased productivity among the dental team providers, increased efficiency and flexibility with scheduling, and reduced clinic operating costs. Between 2011-2013, in their first few years of existence, DTs saw 6,338 new patients.ⁱⁱ

It is important to put the contributions of DTs into the broader context of long-standing oral health access challenges in Minnesota. Like many states, Minnesota struggles with providing consistent access to oral health care across the state, especially for Medicaid patients despite a dental Medicaid benefit. An aging dental workforce, historically low reimbursement rates for oral health services by public programs, and complex administrative and payment structures have resulted in low participation of dentists in Medicaid, thereby decreasing access and increasing oral health disparities for Medicaid populations. It was because of these long-standing access challenges that Minnesota's oral health community came together to explore, research and ultimately advocate for DT legislation. This was only one of a number of strategies for improving access that were advocated for and ultimately enacted by the Minnesota Legislature.

But because these access problems are caused by multiple complex factors, the responsibility for solving them cannot lie solely with DTs. While we know that DTs are opening up additional access points and expanding access, in particular for underserved populations, a cohort of less than 80 practitioners which is growing but still less than one percent of Minnesota's workforce cannot yet produce statistically valid changes in statewide or regional access and utilization data and even in the future will not be the entire solution to the longstanding, multi-faceted access problem. DTs must be part of a comprehensive package of strategies to support access to high-quality oral health services, including sufficient reimbursement across payers; administrative streamlining; and incentives to attract, recruit and retain all dental provider types to serve in urban and rural underserved areas.

As part of our oral health program's overall mission to promote, protect, and improve oral health, because it is critical to the health of all Minnesotans, MDH monitors the oral health workforce in Minnesota, including DTs. As part of this tracking, we know that DTs are now distributed throughout Minnesota's rural and urban areas in proportion to the distribution of the population at large. DTs are also one of the more diverse licensed health care providers in the state—a third of the providers are people of color, and they are serving an equally diverse patient base. DTs are also more likely to work in community based or non-profit settings or clinics as compared to any other dental profession (24 percent). About 35 percent of DTs work in community-based, nonprofit, faith-based clinics or community health centers/federally qualified health centers.ⁱⁱⁱ

We also know that the number of patients receiving care from DTs is growing. In 2016 alone, DTs provided dental care in an estimated 94,392 patient visits. DTs still account for roughly less than one percent of the state's licensed oral health workforce of approximately 17,000 providers as compared to 23 percent who are dentists.^{iv}

The WDA handout mentioned the lack of CODA-accredited dental therapy education programs in the U.S. The handout failed to point out that CODA only recently adopted accreditation standards and has not yet commenced accreditation activities. Existing training programs in

Alaska and Minnesota were established prior to CODA's accreditation program and have the authority to continue to operate without CODA accreditation. However, CODA's development of an accreditation program was initiated at the request of the University of Minnesota Dental School's education program and all three of the existing education institutions contributed significantly to the development of CODA's standards and would meet be able to meet CODA's standards if they pursued accreditation.

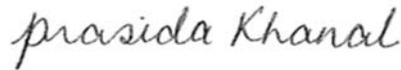
The body of evidence supporting dental therapy shows that dental therapists are a lower-cost provider that can improve access while providing safe, high-quality care. The evidence continues to grow as this workforce expands. In Minnesota like in other states, a multi-pronged approach is needed to solve the oral health crises but from our experience, dental therapists are opening access, welcoming new patients and addressing the needs of the underserved.

Thanks for the opportunity to review this material. If you have any questions, please do not hesitate to contact us for more information.

Sincerely,



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Enclosures:

Dental Therapy in Minnesota – Fact Sheet
Minnesota's Dental Therapist Workforce - 2016

ⁱ See <http://www.health.state.mn.us/divs/orhpc/workforce/oral/dtlegisrpt.pdf>

ⁱⁱ See <http://www.health.state.mn.us/divs/orhpc/workforce/oral/dtlegisrpt.pdf>

ⁱⁱⁱ Figures as of December 2016. See <http://www.health.state.mn.us/divs/orhpc/workforce/oral/2016dtb.pdf>

^{iv} See <http://www.health.state.mn.us/divs/orhpc/workforce/oral/ohchartbook052016.pdf> for Minnesota's oral health workforce composition