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Center for Rural Health
School of Medicine & Health Sciences
University of North Dakota

Fact Sheet

Expanding the Dental Team in North Dakota

This fact sheet is Number 6 in a series of analyses regarding oral health in North Dakota.

North Dakota has a lower dentist (DDS) to population ratio than the national average with dentists also disproportionately located in urban communities. Poor access to dental care, and lower utilization rates, have a significant impact on the oral health status of rural, poor, Medicaid, and American Indian residents in North Dakota.[1-3]

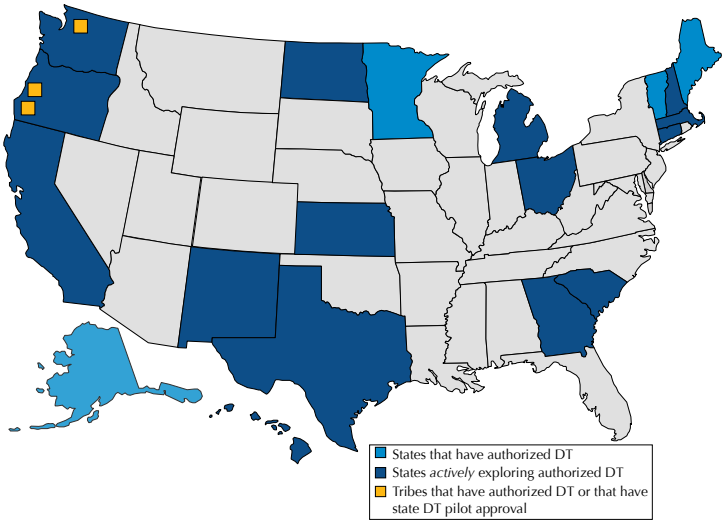
In 2015, North Dakota legislation proposed expanding the dental team in North Dakota by licensing another type of provider, often referred to as a dental therapist (DT). Senate Concurrent Resolution 4004 called for further research on the topic, intending to inform the 2017 session. This fact sheet outlines the current legislative efforts of other states implementing dental mid-level providers, and lists the infrastructure needed in North Dakota to pursue similar dental workforce expansion models.

The Center for Rural Health neither supports nor opposes the development of another type of oral health provider. The Center strives to "strengthen the health of people in rural and tribal communities" through research, evaluation, information dissemination, and community engagement.

States Implementing Dental Therapy

More than 50 countries have improved access to dental care by allowing dentists to incorporate DTs into their teams to provide routine preventive and restorative care. In all but one country, the DT works under supervision of a dentist. As of July 2016, 19 states had either passed or were exploring this type of oral health workforce model. See Figure 1.

Figure 1. Dental Therapy in the United States



Definition of Dental Therapy

Though there are varying models of DT in the United States, all of these providers serve as a member of the existing dental team. Under supervision of a providing dentist, a DT may provide preventive and routine restorative care for patients, providing this care with or without the dentist physically present. Utilizing a DT to provide routine and common restorative care has allowed dentists to accept more underserved and Medicaid patients and provide more complex care to those who need it. A mid-level oral health provider is one that has graduated from an accredited program, provides primary oral healthcare directly to patients to promote and restore oral health through assessment, diagnosis, treatment, evaluation, and referral services.[4] In comparison to dentists, these midlevel providers perform fewer procedures, require less education, and command lower salaries.[6]

The Dental Team	
Dentist:	Provides advanced restorative care, leads the dental team
Dental Therapist:	Primarily provides preventive and routine restorative care
Dental Hygienist:	Primarily provides preventive care
Dental Assistant:	Assists members of the dental team as the team member provides direct patient care

Commission on Dental Accreditation (CODA)

CODA is responsible for reviewing all dental related educational programs to ensure quality dental training, and patient care. They are responsible for accrediting all oral health professional schools. In August, 2015 CODA approved and implemented national standards for DT. For more details, or specific accreditation standards, visit www.ada.org/en/coda.

Policy, Law, & Licensing in North Dakota

For DTs to practice in North Dakota, the state would need to pass legislation permitting it. As in Minnesota, Maine, and Vermont statutes, such legislation could establish:

- Education/training requirements
- Scope of practice
- Supervision, including whether dentists would be permitted to supervise DTs from another location through telehealth or other means
- Licensing body (currently, the North Dakota Board of Dental Examiners licenses other oral health professionals)

- Restrictions on practice, such as limiting to primarily low-income, uninsured or underserved patients or entities/communities with workforce shortages
- Reciprocity with other states

Training & Education in North Dakota

As with dentists and other oral health providers, North Dakota may allow reciprocity for DTs from other states. Given CODA's implementation of educational standards in 2015, it is likely that the parameters around DTs will become more consistent as additional states allow them. North Dakota may explore coordinating with other institutions that already have training programs and collaborate with bordering states to reserve slots for interested North Dakota students.

North Dakota may also create a program for training DTs at in-state colleges that currently educate dental providers. This would require hiring DT faculty, creating a program, and applying for CODA accreditation. These existing dental education programs may also explore articulation agreements with existing DT programs. An articulation agreement allows a student to apply credits earned in specific programs at one institution toward advanced standing, entry, or transfer into a specific program at the other institution.

In Minnesota, DT program completion ranges between 16-32 months. This does not include the time necessary to complete pre-requisite courses or degrees. The programs may cost students between $35,000 and $60,000, depending on the program. Dental school graduates typically see debt at, or over, $200,000.

Reimbursement for Care in North Dakota

Expanding the dental team enables dental practices to increase the number of patients served in a cost-efficient and patient-centered manner.[7] DTs are able to provide reimbursable care, at a lower overhead cost to the dental clinic.

In Minnesota, services provided by DTs are billed at the same rate as the dentist, but in order to be eligible for Medicaid payments, they must: be licensed by the MN Board of Dentistry; have a board-approved collaborative management agreement (CMA) with a supervising dentist; and, be employed by a provider enrolled in Medicaid. CMAs are developed by the supervising dentists and establish the practice relationship. They set both the scope of practice and the supervision requirements for a DT. The CMA may limit a DTs scope and level of supervision, but cannot expand beyond what is identified in State law or by the Licensing Board.

Patients Served through Dental Therapy

DTs have been utilized to provide preventive and routine restorative care for Medicaid patients and the underserved. Three tribes, outside of Alaska, are also working to use DTs to address the oral health crisis nationally in Indian country. Though Minnesota DTs are not working in any tribal community at this time, 43% are providing care in rural Minnesota.[7] Private practice dentists have also reported increased revenue for their clinics.

In North Dakota, 50% of residents live in rural communities; 22% of those are in isolated rural communities. Roughly 30% of the counties are designated as dental health professional shortage areas, and the dentists per population ratio (55.4/100,000) is lower than the national average (60.9/100,000).

American Indian youth have significantly worse oral health outcomes when compared to their Caucasian peers, and low-income and Medicaid patients significantly lack both preventive and restorative oral healthcare access.[1-3] As a result of dental therapists being integrated into the dental team, clinics in Minnesota and Alaska have collectively increased oral healthcare access and utilization for these same patient demographics offering care for a larger number of Medicaid, under/uninsured, poor, high-risk, and American Indian patients, and it is one of many oral health initiatives under consideration by the North Dakota legislature.

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For more information

Visit the CRH webpage for additional oral health publications and information. ruralhealth.und.edu/what-we-do/oral-health

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