

This report explains how children's and public health advocates in Minnesota campaigned successfully for a law to increase children's access to dental care. The new law is likely to ensure that dental care will reach many kids who are underserved.



The Minnesota Story

How Advocates Secured the First State Law of Its Kind Expanding Children's Access to Dental Care

In May 2009, the Minnesota legislature became the first in the nation to approve the licensing of a new oral health practitioner called a dental therapist—the dental equivalent of a nurse practitioner. A dental therapist is licensed to perform such duties as filling cavities and extracting teeth. Policy makers in other states are viewing Minnesota's law as one of several potential solutions to the lack of access to dental care for millions of Americans, particularly the poor and uninsured.

Advocates rallied support for creating new types of dental providers in Minnesota by sharing the growing evidence that too many children were not receiving basic care. In the United States, dental cavities, or caries (Latin for “decay”), are the most common chronic disease of childhood, affecting 59 percent of children ages five to 17.¹ Tooth decay is five times more common than asthma.² In addition, one in four Americans ages six to 19 suffers from untreated decay.³ Yet many children often go years without seeing a dentist due to lack of insurance or an available practitioner.

TO LEARN ABOUT OTHER INNOVATIVE PRACTICES IN STATES AND COMMUNITIES, VISIT:

From 1993 to 2000, Minnesota suffered the greatest percentage decline of all 50 states in the dentist-to-population ratio, which fell to only one dentist per 1,670 residents.⁴ In 2008, a state health official reported that roughly 350,000 low-income Minnesotans see a dentist less often than they should or not at all.⁵

Dr. Colleen Brickle, an oral health educator and dean of Normandale Community College, spent a year-long sabbatical researching dental care workforce issues. The sabbatical's focus was driven by her frustration with encountering many Minnesotans, especially children, who were going without needed dental care.

Brickle's research confirmed that the evidence was real, not anecdotal. Thousands of state residents did not have access to a dental provider, due to geography, low-income status or other factors. Given the shortage of dentists, she realized that part of the solution to this access problem was the creation of new types of practitioners.⁶

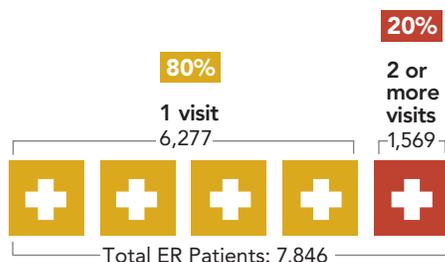
“From 2003 to 2007, dental hygiene students performing oral assessments on school children in Bloomington [Minn.]—a community just south of Minneapolis—found that roughly one out of four students showed visible dental health needs that required direct referral to a dentist,” said Brickle. “Out of those with identified needs, approximately half had urgent needs due to toothaches or other oral pain.”⁷

Dr. Amos Deinard, an adjunct associate professor at the University of Minnesota's School of Public Health, also provided information that strengthened the case for new types of providers. Deinard co-led a year-long study of seven hospitals in the Minneapolis-St. Paul metropolitan area and found that patients made more than 10,000 trips to the emergency room for dental-related problems, such as toothaches or abscesses.⁸

Untreated Dental Problems Drive Up Emergency Room Visits

A year-long study of seven hospitals in the Minneapolis-St. Paul area traced 10,325 emergency room visits to toothaches, abscesses or other untreated dental problems. The cost for these visits exceeded \$4.7 million.

Thousands of patients took their dental problems to the hospital ER



SOURCE: Journal of Public Health Dentistry, 2010.

The total cost of these emergency room visits was staggering: more than \$4.7 million. In addition, of those who went to the emergency room for dental-related

problems, nearly 20 percent went more than once.⁹

Children who are taken to hospital emergency departments for severe dental pain can end up in a revolving door that costs Medicaid—and taxpayers—significantly more than preventive and primary care. Hospitals are generally not equipped to provide dental treatment for toothaches and abscesses. “Unless the hospital has a dental program, they give [the child] an antibiotic and send him on his way,” said Dr. Paul Casamassimo, chief of dentistry for Nationwide Children’s Hospital in Ohio. The antibiotic may suppress the infection, but it does not address the underlying problem.¹⁰

Advocates for new types of providers were also armed with data showing that people in rural Minnesota had significant problems with access to dentists—and because of projected retirements of dentists, the situation would soon worsen.¹¹

Although dental therapists are not well-known in the lower 48 states, they have been employed by Alaska Native tribes since 2004, and in Great Britain, Canada, New Zealand and many other countries for decades.

This lack of access disproportionately punishes the poor. Children ages two to 11 whose families live below the federal poverty level are twice as likely to have untreated decay as their more affluent peers.¹²

The Focus of the Law

Minnesota’s law allows the creation of two new types of licensed oral health professionals: a **dental therapist** who will work with a dentist on-site and an **advanced dental therapist** who will work under a collaborative practice agreement with an off-site dentist.¹³ The first class of new providers is slated to graduate by 2011 and will work in low-income and underserved communities.¹⁴ Dental therapists will hold bachelor’s degrees, and advanced dental therapists will have master’s degrees.¹⁵

Although dental therapists are not well-known in the lower 48 states, they have been employed by Alaska Native tribes since 2004, and in Great Britain, Canada, New Zealand and many other countries for decades. In these nations and Alaska, such providers flourish and enjoy widespread support and patient acceptance.¹⁶

The Minnesota law was passed in a relatively quick two years, aided by the work of a state health care reform commission that documented the lack of dental care access and called for using more alternative health care

professionals. But the legislative journey was a test of endurance. The proposal attracted tremendous opposition from the Minnesota Dental Association, which engaged in both lobbying and—in its own words—an “aggressive statewide advertising campaign” to try to prevent the creation of new types of licensed dental professionals.¹⁷

The opposition of dentists had helped defeat similar proposals in other states during the 1950s and 1970s,



THE UNMET NEED

Dental care is the greatest unmet need for health services among children.²⁸ An estimated 17 million U.S. children—one in five between the ages of one and 18—go without a dental visit each year.²⁹

The costs of dental disease are severe: impaired nutrition and health, missed school days, worsened job prospects as an adult and—in extreme cases—even death.

but the dynamics began to change a few years ago. Most significantly, in 2008 Minnesota advocates built a broad coalition composed of persistent lawmakers, public health dentists, hospitals, health care providers, oral health educators and nonprofit groups assisting children and the poor.

The coalition was strengthened by the involvement of organizations that advocate for people with disabilities and for seniors. These organizations recognized that new types of dental professionals also could expand access for the disabled and elderly, many of whom reside in group homes, nursing homes or other facilities with limited access to a dentist.¹⁸

As this coalition began its advocacy for new types of dental providers, the cause was made more urgent by the story of a Maryland boy whose death exposed the tragic consequences of children not having access to dental care.¹⁹

In February 2007, 12-year-old Deamonte Driver of Maryland died after bacteria from an untreated tooth abscess spread to his brain. The family’s Medicaid insurance had lapsed during a period in which they were homeless. Even before their coverage expired, Deamonte’s mother had struggled unsuccessfully for months to find a dentist who would see her children in a timely manner and accept Medicaid’s

low reimbursement levels.²⁰ During the same week, six-year-old Alexander Callendar of Mississippi collapsed on his school bus and died from an infection caused by two abscessed teeth that had been recently removed.²¹

These tragedies haunted Minnesota state Sen. Ann Lynch. She first considered authoring a bill to create the dental therapist as a new type of licensed dental professional in 2007, after hearing at a health conference about the work of dental therapists in Alaska. Lynch met with a core group of early supporters, including the Minnesota Safety Net Coalition, and then approached state Sen. Linda Berglin—who chaired a subcommittee overseeing health finance issues—to encourage Berglin’s support. The next year, 2008, Lynch introduced a bill in the state Senate, and Rep. Cy Thao did the same in the state House of Representatives. Yet Lynch said she never imagined how difficult the legislative process would become—or how contentious.²²

The first bill to create a new type of dental provider in Minnesota would have allowed new practitioners to perform dental procedures without onsite supervision. Some dentists supported the idea, but others contended that allowing anyone but a dentist to conduct procedures such as fillings and tooth extractions would lower the standards of patient care in

Minnesota. Some opponents implied that the new class of providers could be a danger to patients.²³

Backed by focus groups and a survey funded by the American Dental Association, the Minnesota Dental Association sponsored newspaper ads in 2008 attacking the idea—and took aim at Lynch with radio ads that aired in her hometown of Rochester, Minn. Meanwhile, Lynch’s bill stalled. “It was like having the ball at the goal line without being able to get it across,” she said.²⁴

Work Group Examines New Models

In a compromise, the legislature approved a skeletal framework for a new type of dental care provider and created a 13-member work group to conduct more research. This work group was charged with studying new dental workforce models and making specific recommendations for legislation that would be introduced in 2009. The work group included Michael Scandrett, staff director of the Minnesota Safety Net Coalition, and Dr. Colleen Brickle, dean

A 13-member work group was charged with studying new types of dental providers and making specific recommendations for the legislation that was introduced in 2009.

of Normandale Community College. Both had helped organize the initial coalition in support of creating new providers.²⁵

Also serving on the work group was Dr. Patricia Tarren, a pediatric dentist who knew from personal experience the value of having a workforce that includes dental therapists. Although she practices in Minneapolis, she grew up in and was trained in Great Britain, where dental therapists have provided care for decades.²⁶

Members of the work group traveled—sometimes at their own expense—to see how dental therapists work in other countries. The trips helped many work group members recognize how the model of an alternative provider functioned in these nations and how it enhanced dental practices rather than competed with them. Such professionals have worked in New Zealand since 1921 and in Canada since 1972.²⁷

After these international visits, the work group engaged in vigorous debate, voted on proposals and finally released its recommendations. Out of more than 50 votes taken by the work group on the creation of new types of providers, nearly half of the votes were unanimous. Most of the remaining decisions were approved by 10 of the body's 13 members. Members appointed by the Minnesota Dental Association wrote a letter criticizing the final report draft.

Their reservations, as well as those of Dean Patrick Lloyd of the University of Minnesota School of Dentistry, were included in the report.³⁰

Type of new provider:

Dental Therapists

Where they will be deployed:

Will work on-site with a dentist

Education required:

Bachelor's degree



Type of new provider:

Advanced Dental Therapists

Where they will be deployed:

Will work in community settings under a collaborative practice agreement with a dentist

Education required:

Master's degree

The work group's recommendations were refined by legislators, and a detailed proposal for new types of provider picked up momentum as the 2009 session of the Minnesota Legislature convened.

Heading into the session, the Pew Center on the States supported frontline advocates by providing research, funding and policy experts. Shelly Gehshan, director of the Pew Children's Dental Campaign, testified before the state legislature about the need for new approaches to address the problem of access.³¹

The Pew Children's Dental Campaign also identified dentists who had worked with dental therapists in Alaska and Canada, and arranged for these dentists to testify before Minnesota legislators to share their observations and insights. The W.K. Kellogg Foundation provided significant funding to the Minnesota Safety Net Coalition, which was a leading voice in the coalition supporting new dental providers. The Kellogg Foundation's contribution reflected its vigorous promotion of Alaska's successful use of dental health aide therapists.³²

The evidence-based campaign by advocates overcame the opponents' strategy, which included a misleading advertisement urging Minnesotans to tell legislators they want to allow only "supervised, dental school trained professionals" to perform "surgery."³³ This ad stoked fears by disregarding a key

fact—the new providers would receive extensive training in a limited set of primary care services.

During the 2009 debate, Tarren spoke in support of new types of providers at public forums. She also testified on the issue before the U.S. Senate. "I would stake my reputation on the quality of care that well-educated dental therapists can give," Tarren declared in an interview. "I would have them treat me, and I would have them treat my family."³⁴

As the debate played out in the Minnesota Senate during its 2009 session, the tragedy of Deamonte Driver's death helped to keep Sen. Lynch focused during the often heated discussion among legislators. "I had to bring the conversation back to why we were having the conversation," she said. "A 12-year-old died because of an abscessed tooth."³⁵ Advocates cited the Driver story as one consequence of the difficulty that Medicaid-eligible children encounter trying to find a dentist.

Since the law's passage in 2009, the University of Minnesota's dental school and a Metropolitan State University–Normandale Community College partnership have each developed a curriculum to train the new dental providers. Students are currently enrolled, and each institution plans to graduate about a dozen new providers in 2011. Based on the example of

general practice dentists, each dental therapist could provide at least 2,000 dental visits per year.³⁶ Such an infusion of new professionals could increase the impact of health centers such as Mankato's Open Door Health Center, which routinely turned away 100 dental patients a month in 2009 because of a lack of staff.³⁷

Minnesota's reform is still a work in progress. The Minnesota Safety Net Coalition and other supporters of the law are committed to ensuring that the intent of the law is respected by the rule-making process. If the bold vision behind this law is fulfilled, thousands of children in Minnesota will have a much healthier and brighter future.

EIGHT LESSONS FROM MINNESOTA

Conversations with the leading advocates for Minnesota's landmark law reveal key lessons for those in other states who are striving to expand access for children by creating new types of dental providers:

1 A broad coalition demonstrated widespread support for new oral health practitioners and also helped bridge differences among key constituencies.

2 The focus was on the data. Advocates addressed concerns and questions by sharing key research findings with legislators, the media and the public.

3 The law was written to improve access for a range of state residents, including seniors and people with disabilities.

4 Advocates identified supportive dentists and encouraged them to attest to the quality and safety of the new types of providers.

5 The historical success of new dental providers in Alaska and 53 countries helped convince lawmakers of the value of creating new providers.

6 The coalition worked with legislators and knowledgeable advocates who understood legislative rules, process, strategy and the political landscape. This helped to overcome legislative hurdles.



7 The Minnesota legislation was comprehensive. Advocates carefully assessed the policy options and covered all the necessary components, including licensing, scope of practice, educational programs, patients to be served and other details. They addressed the issues that could become points of contention, especially the level of supervision and the scope of practice.

8 Advocates continued their work after the law's passage, monitoring regulation and reimbursement policies to ensure successful implementation.

Endnotes

- 1 The data are from Figure 4.1 in the report, *Oral Health in America: A Report of the Surgeon General*, (Washington, DC: National Institute of Dental and Craniofacial Research, May 2000) 63; accessed June 29, 2010, <http://silk.nih.gov/public/hck1ocv.@www.surgeon.fullrpt.pdf>.
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- 13 See the section “Patients of a Dental Therapist” in the report: Patricia Glasrud, Carol Embertson, Tom Day, and Richard W. Diercks, *A History of Minnesota’s Dental Therapist Legislation: Or ... What the Heck Happened Up There?*, Minnesota Dental Association (2009):13–14; http://www.mndental.org/client_files/documents/DENTAL_THERAPIST_FINAL.pdf.
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- 15 See Minnesota Statutes 2009:150A.105 and 2009:150A.106, available in Glasrud et al., *A History of Minnesota’s Dental Therapist Legislation*, 2009.
- 16 This information from the Minnesota Safety Net Coalition was included in the following report: “Oral Health Practitioner Recommendations: Report to the Minnesota Legislature 2009” Minnesota Department of Health and the Minnesota Board of Dentistry (January 15, 2009):51–53 (Appendix F); accessed May 12, 2010, http://www.health.state.mn.us/healthreform/oralhealth/FinalReport_OHP.pdf. See also David A. Nash, Jay W. Friedman, T. B. Kardos, R. L. Kardos, E. Schwarz, J. Satur, et al., “Dental Therapists: A Global Perspective,” *International Dental Journal* 58 (2008):64, Table 2.

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22 Pew Center on the States interview with Sen. Ann Lynch, November 12, 2009.

23 Glasrud et al., *A History of Minnesota's Dental Therapist Legislation*, 2009, 16–17, Appendix B.

24 Pew Center on the States interview with Sen. Ann Lynch, November 12, 2009.

25 For a list of the members of Minnesota's Oral Health Practitioner Work Group, see “Oral Health Practitioner Recommendations,” 2009, 45.

26 Pew Center on the States interview with Patricia Tarren, pediatric dentist, December 8, 2009.

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29 The estimate of the number of low-income children without dental care comes from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, “Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit—State Agency Responsibilities” (CMS-416); accessed July 8, 2009, http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp. The CMS-416 report collects data on the statewide performance of states' Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for all children from birth through age 20. In this report, we chose to examine a subset of that population, children ages one to 18. We chose the lower bound of age one because professional organizations such as the American Academy of Pediatric Dentistry recommend that a child have his or her first dental visit by age one. We chose the upper bound of 18 because not all state Medicaid programs offer coverage to low-income 19- and 20-year-olds. Data are drawn from lines 12a and 1 of the CMS-416 state and national reports; the sum of children ages one to 18 receiving dental services was divided by the sum of all children ages one to 18 enrolled in the program. The denominator (line 1) includes any child enrolled for one month or more during the year. It is estimated that in July 2007 the civilian population of children ages one to 18 was 73,813,044, meaning that about 22.8 percent, or one in five, were enrolled in Medicaid and did not receive dental services. Additional data from U.S. Bureau of the Census, Monthly Postcensal Civilian Population by Single Year of Age, Sex, Race, and Hispanic Origin: 7/1/2007 to 12/1/2007; accessed January 5, 2010, <http://www.census.gov/popest/national/asrh/2008-nat-civ.html>.

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33 Glasrud et al., *A History of Minnesota’s Dental Therapist Legislation*, 2009, 16, Appendix B.

34 Pew Center on the States interview with Patricia Tarren, December 8, 2009.

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36 This estimate is based on national data showing that a general-practice independent dentist had an average of 3,755 patient visits (including hygienist visits), and 2,346 patient visits (excluding hygienist visits) in 2005. The estimate of 2,000 annual visits reflects the fact that dental therapists will offer the kind of preventive care that some hygienists provide as well as the basic, restorative procedures that dentists provide. See the relevant chart of dental visits at: “Key Dental Facts,” American Dental Association, (September 2008) 4; accessed July 27, 2010, http://www.ada.org/sections/professionalResources/pdfs/08_kdf.pdf.

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Contact Us

We welcome your comments and questions about this report, new dental workforce models and other policy strategies to improve children's dental health. Please contact:

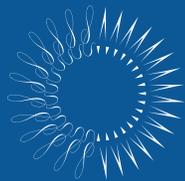
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