Sunrise Application

September 1, 2016

A request to provide statutory authority for the licensure of Dental Therapists in Arizona

Submitted by:

Pivotal Policy Consulting
for
Dental Care for AZ

Proposal:

This sunrise application, submitted by Dental Care for AZ, seeks consideration and recommendation, as required by A.R.S. 21-3105, to move forward in the development of legislation amending the Dental Practice Act (A.R.S. Chapter 11), establishing licensure and scope of practice for dental therapists.

The proposed dental therapist model builds on the use of dental therapists in 54 countries and territories worldwide (beginning in 1921[1]) and experience from states in the U.S. authorized to license dental therapists. Currently, this model is authorized in Maine, Vermont, and Minnesota; and on tribal lands in Oregon, Washington State and Alaska. We propose Arizona join these states and eliminate statutory restrictions that prevent dental therapists from practicing in our state. Eliminating these barriers would allow Arizona to begin addressing the significant need for dental care, implement an updated, cost-effective delivery model, and enhance workforce opportunities for new and existing dental health professionals.

Oral health is an essential part of overall health, with significant evidence-based links to acute and chronic diseases. Integrating highly skilled midlevel dental providers into a person-centered healthcare model, to work in primary care offices, Federally Qualified Health Clinics, dental offices, hospitals and mobile-based clinics, is necessary to improving the overall health and wellbeing of our citizens.

Dental therapists are midlevel providers, similar to nurse practitioners and physician assistants in medicine. Dental therapists work with dentists to expand high-quality dental care to more patients, grow their practices, and provide treatment to underserved, at-risk populations, while also allowing dentists to focus their time and skills on the most complex and revenue-generating procedures. Dental therapists provide preventive and routine restorative care, such as filling cavities, placing temporary crowns, and extracting badly diseased or loose teeth.

Dental therapists receive rigorous training in a limited set of the most commonly needed routine procedures, as established by the Commission on Dental Accreditation's (CODA) national dental therapy education accreditation standards.[2] Evaluations in the United States and around the world consistently demonstrate

[1] David A. Nash, et al., *A Review of Global Literature on Dental Therapists*. Battle Creek, MI: W.K. Kellogg foundation. April 2012.

[2] Commission on Dental Accreditation. Accreditation Standards for Dental Therapy Education Programs [Internet]. 2015 . Accessed Sept 1, 2016 at : http://www.ada.org/~/media/CODA/Files/dt.pdf?la=en

that dental therapists provide safe, effective care, and expand access to the dental delivery system for individuals who otherwise would not receive dental care.[3]

Opening Arizona's statutes to permit dental therapy will directly benefit consumers and provide additional professional opportunities for Arizona's existing and future dental workforce. The Federal Trade Commission has endorsed the expansion of dental therapy as a way to *increase competition* in the dental market, concluding that "a greater supply of qualified providers would enhance competition, which can yield lower prices, additional service hours, shorter wait times, and innovations in care delivery.[4]" Dental therapy is a system-level reform to expand access and reduce cost per unit of care for dental practices, without creating a new government health care program.

Describing the Problem:

Millions of people throughout Arizona continue to face significant challenges to accessing dental care and treatment of dental disease. According to one study, more than half (52%) of our kindergarten children have a history of tooth decay, and by third grade, the rate of tooth decay experience increases to almost two-thirds (64%). The challenge of finding a dentist is particularly acute for children covered by Arizona Health Care Cost Containment System (AHCCCS); according to the American Dental Association, only 32% of dentists are enrolled to provide care.[5] In 2015, 49% of children enrolled in AHCCCS did not receive any dental services.[6] The problem continues into adulthood: in 2014, 41% of adults did not visit a dentist in the past year.[7] Even for adults and children with private dental insurance, the costs associated with poor oral hygiene, including caries, can add up quickly and are viewed as a barrier to care.[8]

Dental health education, along with proper assessment, screening and preventative measures, such as fluoride varnish, are critical to improving oral health. Good dental hygiene and preventative dentistry can reduce the risk of dental caries—a chronic,

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[3] Nash et. Al, "*A Review of Global Literature on Dental Therapists*.

[4] Lao, Marina, and Tara Isa Koslov. "A Need for Dental Therapists." Letter to New York Times. 1 June 2016.

[5] ADA Health Policy Institute, The Oral Health Care System: State-by-State Analysis, Dec 4, 2015. Accessed on Sept. 1, 2016 at http://www.ada.org/en/science-research/health-policy-institute/oral-health-care-system/Arizona-facts

[6] This figure counts children 1 through age 20 eligible 90 continuous days for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services (2016). Annual EPSDT participation report, Form CMS-416 (national) fiscal year 2015, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.

[7] Arizona Department of Health Services (December, 2015). *The Oral Health of Arizona's Kindergarten and Third Grade Children*. Healthy Smiles Healthy Bodies Survey-2015; Arizona Behaviorial Risk Factor Surveillance System, accessed via the CDC Oral Health Data by Location query tool http://www.cdc.gov/oralhealthdata/ September 1, 2016.

[8] Breaking Down Barriers to Oral Health for All Americans: The Role of Finance," Statement from the American Dental Association, April 2012, http://www.ada.org/~/media/ADA/Public%20Programs/Files/barriers-paper_role-of-finance.ashx.

infectious, and largely preventable disease commonly known as tooth decay—gingivitis, periodontitis and other dental problems. Poor oral health and dental disease can lead to persistent pain, malnutrition, childhood speech problems and serious, sometimes fatal, infections. Oral disease is of particular concern to pregnant women: risk of premature birth, low birth weight and the incidence of mothers transmitting dental disease to their babies can perpetuate a cycle of disease.[9]

Across the state, oral health education and prevention efforts are ongoing and increasing. However, given the size of the state, population distribution, shortage of dental providers, and the current rates of untreated dental disease in Arizona, education and prevention efforts alone are simply not enough. Currently, 2.3 million Arizonans live in a dental health professional shortage area.[10] Sizable portions of each of Arizona's 15 counties are so designated, including the entirety of Graham, Greenlee, La Paz, Santa Cruz and Yuma counties.[11]

Significant Needs in Rural Arizona: Arizona residents living in rural areas are at higher risk for poor oral health and more unmet needs than their urban counterparts.[12] Fewer dentists work in rural areas and smaller proportions of rural residents have dental coverage.[13] Regardless of financial resources, individuals in rural communities face access barriers to oral health care including geographic location and shortages of dental providers.[14] Both of these factors can lead to longer wait times and greater distances traveled to access the limited care available.[15] According to the Institute of Medicine and the National Research Council, an improved and responsive delivery model that allows dental professionals to deliver quality care to diverse populations in a variety of settings, using a variety of service-delivery mechanisms will be necessary to bridge the access gap between rural and urban areas.[16]

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[9] Committee on Oral Health Access to Services; Institution of Medicine and National Research Council (2011*). Improving Access to Oral Health Care for Vulnerable and Underserved Populations*. Washington, D.C.: National Academies Press. PDF available from: http://nap.edu/13116.

[10] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, "Designated Health Professional Shortage Area Statistics," (data as of July 18, 2016).

[11] Ibid.

[12] Committee on Oral Health Access to Services; Institution of Medicine and National Research Council (2011*). Improving Access to Oral Health Care for Vulnerable and Underserved Populations*. Washington, D.C.: National Academies Press. PDF available from: http://nap.edu/13116.

[13] Jihong Liu et al., "Disparities in Dental Insurance Coverage and Dental Care Among US Children: The National Survey of Children's Health," Pediatrics 119, Suppl. 1 (2007): S12–S21

[14] Susan Skillman et al., "The Challenge to Delivering Oral Health Services in Rural America," Journal of Public Health Dentistry 70 (2010) S49-S57; Anne Braswell and Nalo Johnson, "Rural America's Oral Health Needs," National Rural Health Association, Policy Brief, February 2013.

[15] Ibid**.**

[16] Committee on Oral Health Access to Services; Institute of Medicine and National Research Council (2011*). Improving Access to Oral Health Care for Vulnerable and Underserved Populations*. Washington, D.C.: National Academies Press. PDF available from: http://nap.edu/13116.

Systemic Challenges in Indian Country: Nowhere in Arizona is the gap in access to dental care more acute than on reservations. In Arizona, 76% of American Indian children have a history of tooth decay.[17] Nationwide two-thirds of American Indians aged 35 to 49 have untreated decay, more than twice the rate among all adults in the general U.S. population.[18] Nationwide, 2.4 million American Indians lived in counties with dental shortage areas, including half of all American Indian children.[19] American Indians suffer from the poorest oral health of any population in the United States.

Arizona is home to 22 individual sovereign nations with nearly 356,000 people residing on and off reservations. Tribes work collaboratively with Indian Health Service (IHS) to provide clinical, dental and behavioral health care to tribal members in their communities. Tribes must be allowed to develop innovative approaches to address provider shortages, geographically isolated locations, and long distances traveled to access care.

Tribal lands are generally located in rural areas and comprise 26% of the state. This population utilizes the IHS health system to access dental care, and is less likely than the general population to have private health insurance, and is more likely to be covered by Medicaid or remain uninsured. [20] Dentist recruitment continues to be a challenge for tribes,[21] and IHS consistently has a 20% vacancy rate in dental provider positions.[22] As a result of limited funding, geographic challenges, IHS funding and policy restrictions and limited workforce models, it is extremely difficult to recruit dentists to work on reservations.

Dental therapists have been delivering innovative, effective, and culturally competent dental care to Alaska Native people under the supervision of dentists

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[17] Arizona Early Childhood Development and Health Board (First Things First), "Taking a Bite Out of School Absences: Children's Oral Health Report 2016," 2016. Accessed from http://azftf.gov/WhoWeAre/Board/Documents/FTF_Oral_Health_Report_2016.pdf on September 1, 2016.

[18] Phipps KR and Ricks TL. The oral health of American Indian and Alaska Native adult dental patients: results of the 2015 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2016.

[19] Center for Native American Youth, the Aspen Center, "Oral Health and Native American Youth" (September 2014), http://www.aspeninstitute.org/sites/default/files/content/docs/cnay/Oral-Health-and-Native-American-Youth.pdf.

[20] Kaiser Family Foundation, "Health Coverage and Care for American Indians and Alaska Natives," Issue Brief, October 2013, accessed from https://kaiserfamilyfoundation.files.wordpress.com/2013/10/8502-health-coverage-and-care-for-american-indians-and-alaska-natives.pdf on September 1, 2016.

[21] The Commonwealth Fund, "States in Action: Innovations in Health Policy," 2010. Accessed from http://www.commonwealthfund.org/publications/newsletters/states-in-action/2010/mar/march-april-2010/snapshots/alaska-and-minnesota on September 1, 2016

[22] National Congress of American Indians letter to Dr. Sherin Tooks, Commission on Dental Accreditation, 2014. Accessed from http://www.communitycatalyst.org/blog/text/NCAI-Coda-Comments-Final-12-1-14.pdf on September 1, 2016.

since 2004. Alaska developed an innovative delivery model using Dental Health Aide Therapists (DHATs) to provide preventative and routine restorative care to the geographically isolated tribal communities. Since the program's inception, more than 40,000 Alaska Native people living in 81 previously unserved or underserved rural communities have regular access to care.[23] However, the 2010 reauthorization of the Indian Health Care Improvement Act (IHCIA)[24] banned other tribes from following Alaska's model, without state authorization, of dental therapists, even if those services are being provided in Indian Heath Service (IHS) or tribal facilities. This requirement has hampered the efforts of Arizona's tribes to develop options beyond licensed dentists to perform routine dental services so desperately needed in their communities. The need to reexamine the way oral health care is delivered in tribal and rural communities across the state is clear.

Other Underserved Populations:
Research indicates that regardless of their financial resources, people with disabilities, including those with developmental disabilities, and people in long-term care facilities confront access barriers, experience more oral disease and are less likely to have access to professional dental services than people without disabilities.[25] Long–term care residents are more susceptible to clinically significant oral health problems, infections, severe dry mouth (and other drug side effects), and/or loss of function from missing/diseased teeth and ill-fitting oral appliances.[26]

An Efficient and Effective Model for Dental Care and Treatment:
Over the last thirty years, Arizona's health care industry has undergone profound changes in technology, business models, insurance coverage, diagnosis and treatment. Dental care, however, has largely remained distinct and delivery models somewhat stagnant. Medical practices, hospitals and health clinics across the state have effectively enhanced their health care delivery models through the use of mid-level providers; nurse practitioners and physician assistants are regularly integrated into an expanded medical team.[27]

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[23] Mary Williard, Presentation to the National Indian Health Board 5th Annual National Tribal Public Health Summit, March 31-April 2, 2014. Accessed from http://www.nihb.org/docs/05212014/Dental%20Health%20Aide%20Therapists%20Presentation%201.pdf September 1, 2016.

[24] Indian Health Care Improvement Act (IHCIA) (2010) (25 U.S.C. Chapter 18).

[25] Centers for Disease Control and Prevention: Division of Human Development and Disability. *Oral Health and People with Disabilities A Tip Sheet for Public Health Professionals*. http://www.cdc.gov/ncbddd/disabilityandhealth/documents/oral-health-tip-sheet-_phpa_1.pdf

[26] The American Dental Hygienists Association (2014). *Executive Directors' Perceptions of Oral Health Care of Aging Adults in Long-Term Care Settings*

[27] Health Resources and Services Administration, Bureau of Health Professions National Center for Health Workforce Analysis, *Projecting the Supply and Demand for Primary Care Practitioners Through 2020,* November 2013, Accessed Sept. 1, 2016 at http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf

Despite debate about the impact of these practitioners when they were first introduced, these innovations and expanded services have proved highly effective, have increased access to care and have successfully integrated into medical teams.[28] Physicians and patients have come to rely on these highly-trained professionals to improve access to health care and provide a more efficient and cost-effective delivery model. Yet Arizona's current model of oral health care delivery and treatment has yet to benefit from midlevel dental providers. Arizona has made great strides in increasing the availability of primary health care, dental disease screening, prevention and oral health education, yet significant gaps in access to critical, routine treatment continue to exist.

Across the country, this is changing. Interest in oral health as a vital, integrated part of overall health and wellness is approaching the tipping point, and with it the need for greater access to dental care and new business models that expand the oral health workforce to meet the demand are emerging (see the table on the following page for a summary of dental procedures/scope of practice for each category, including dental therapist).

Since Alaska brought midlevel dental providers to the United States in 2004, three states have enacted legislation to authorize these providers and tribes in two additional states have begun utilizing these providers. Today, more than a dozen states are considering legislation to eliminate regulatory barriers to dental therapy in their states.

[28] Dill, M., Pankow, S., Erikson, C., & Shipman, S. (2013). Survey shows consumers open to a greater role for physician assistants and nurse practitioners. Health Affairs, 32(6), 1135–1142.

Category of Service	Dental Assistant	Expanded Function Dental Assistant	Dental Hygienist	Advanced Practice Dental Hygienist	Dental Therapist	Dentist
Diagnostic: Oral Evaluations					●	●
Image Capture (X-Rays)	●	●	●	●	●	●
Preventive: Dental Sealants, Fluoride Varnish	●	●	●	●	●	●
Dental Prophylaxis			●	●	●	●
Restorations: Silver and Tooth-Colored Fillings					●	●
Prefabricated Stainless Steel Crowns					●	●
Permanent Crowns						●
Extractions: Primary Teeth					●	●
Extraction: Badly Diseased Permanent Teeth					●	●
Extractions: Other Permanent Teeth						●
Endodontic treatment planning and clinical services on primary and permanent teeth						●
Prosthodontics/Dentures						●
Implants and other oral surgical services						●

Research has consistently confirmed that dental therapists provide high-quality, cost-effective, routine dental care while also improving access to treatment in areas where dentists are scarce.[29] More than 1,000 studies from around the world have

[29] David A. Nash et al., "A review of the global literature on dental therapists," Community Dentistry and Oral Epidemiology, 2013, Pages 1-10; Wetterhall, et al., *Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska*. Research Triangle Park, NC: W.K. Kellogg Foundation; Minnesota Department of Health and Minnesota Board of Dentistry, "Early Impacts of Dental Therapists in Minnesota" (February 2014),http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf

found dental therapists safely and effectively provide care.[30] The Minnesota Board of Dentistry and Department of Health reported that dental therapists have been delivering safe, high-quality care in rural and underserved communities, and that clinics employing them are expanding capacity and decreasing travel and wait times for patients.[31] Since dental therapists began seeing patients in Alaska in 2004 and in Minnesota in 2011, no malpractice or liability claims have ever been filed.[32] Actuaries have determined these providers are very low risk: it costs less than $100 per year to insure them in Minnesota.[33]

Benefits of New Licensure: Expanding the Dental Team

Expanding the availability of dental providers is a crucial component to bridging the gaps in availability of dental services throughout the state. The Dental Practice Act currently prohibits midlevel dental professionals from providing routine, critically necessary dental care.

As previously mentioned, dental therapists are midlevel dental providers, with training, education, and scope of practice between dental hygienists and dentists. Within the dental team as it exists in Arizona currently, dental hygienists provide crucial preventive dental care and cleanings that help promote oral health and prevent serious dental disease. Dentists are trained to provide extremely complicated and intensive dental surgery, but because of the public's dental needs, often find themselves spending much of their time on fairly routine fillings and extractions. Dental therapists fill a space between these providers. They complete intensive training to deliver the most commonly needed routine restorative procedures, including fillings and extractions, which had previously been the sole domain of the dentist. Dental therapists also extend much needed preventive services, including oral health education, oral health assessments, fluoride treatments, and dental sealants. By delegating these procedures to the therapist, the dentist is able to focus his or her time on the more complex, serious, and time consuming patients, while also lowering the per-unit cost of care and generating greater revenues for the practice. When each dental provider is able to work at the top of his or her license, it creates a more efficient practice, increases the number of

[30] David A. Nash et al., "A review of the global literature on dental therapists," Community Dentistry and Oral Epidemiology, 2013, Pages 1-10

[31] Minnesota Department of Health and Minnesota Board of Dentistry, "Early Impacts of Dental Therapists in Minnesota" (February 2014),http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf

[32] Email correspondence from Patrick Blahut, Indian Health Service Deputy Dental Director, to Jane Koppelman, Research Director, Pew Dental Campaign on February 25, 2016; Minnesota Department of Health and Minnesota Board of Dentistry, "Early Impacts of Dental Therapists in Minnesota" (February 2014),http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf

[33] Sarah Wovcha, "Dental Therapy in Minnesota: A Study of Quality and Efficiency Outcomes," Presentation given to the Arizona In-State Technical Assistance Meeting on Arizona Oral Health Workforce June 28, 2016.

patients who are able to receive dental care and results in greater revenues for the entire dental practice.

Because dental therapists perform only a small number of the most commonly needed procedures, they are able to complete their rigorous training more efficiently than dentists. In Arizona, dental therapists would perform 80 dental procedures, compared to the more than 400 procedures that general dentists are licensed to perform, and more than 600 procedures performed by dental specialists:

Provider	**Allowable procedures**
Dental specialist (e.g., oral surgeon)	657
Dentist	434
Dental therapist	80
Advanced practice dental hygienist	52
Dental hygienist	52
Expanded function dental assistant	28
Dental assistant	27

Analysis conducted by The Pew Charitable Trusts using the 2016 American Dental Association Code on Dental Procedures and Nomenclature, relevant statutes and regulations from the Arizona Board of Dental Examiners (BODEX), and the American Dental Association Commission on Dental Accreditation's Accreditation Standards for Dental Therapy Education Programs.

Dental therapists are highly trained and skilled professionals, able to enhance the dental team by providing evaluative, educational, preventative and routine restorative dental functions under the general supervision of a licensed dentist. Through proper education, competency examination and licensure, the safety and effectiveness of dental therapists in the U.S. and around the world has been consistently affirmed. A comprehensive review examining the literature and documenting dental care and clinical outcomes for children worldwide found dental therapists offer safe, effective dental care.[34]

Research shows that Alaska's DHATs are effective in treating dental disease (caries), performing uncomplicated extractions, providing dental health education and continuity of care.[35] The data show that DHATs are performing within their scope of practice, patients are satisfied with their care, and there is no significant difference between the quality of the treatment provided by the DHATs as compared with

[34] David A. Nash, et al., *A Review of Global Literature on Dental Therapists*. Battle Creek, MI: W.K. Kellogg foundation. April 2012.
[35] Wetterhall, et al., Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska. Research Triangle Park, NC: W.K. Kellogg Foundation.

dentists.[36] Additionally, no malpractice claims have ever been filed against a DHAT or dental therapy provider in Minnesota or Alaska.[37]

Dental therapists also earn lower salaries than dentists, so incorporating them into the dental team allows dentist practices to provide more cost-effective care. By delegating some of the routine procedures to these midlevel staff members, dentists can lower their per-unit costs, treat more patients, and generate higher revenue.

Myriad Benefits for Private Practices, Community Clinics and Hospitals:
Dental therapists can enhance capacity in both private and community health practices by expanding the personnel available to provide the most common restorative procedures at lower cost than that of a dentist. A lower cost per procedure can allow both private practice and community health dentists to serve more AHCCCS patients. By raising the number of patients served each day, allied providers can make it possible for existing private practices to care for more Medicaid-enrolled patients without sacrificing profitability.

Currently in Arizona, only 32% of dentists are enrolled with AHCCCS, well below the national average of 42%.[38] This number reflects dentists *enrolled* in Medicaid, but does not provide any information on the number of dentists who regularly see Medicaid patients or the number of Medicaid patients they serve. Medicaid reimbursement rates are often considerably below the practice's fee schedule. A lower cost provider of common, routine primary dental care services, can allow practices to treat more Medicaid patients, increase the volume of overall patients served and still remain profitable.

Benefits to Private Practice Dentists: A case study of two private practice dentists (including one in Minnesota) shows the impact of cost-of-care on both practice's ability to increase the number of Medicaid patients served while increasing the overall revenue of the practices.[39] In addition, early data from Minnesota reports that that patients experienced shorter wait times and were satisfied with the care they received.[40]

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[36] Wetterhall, et al., *Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska*. Research Triangle Park, NC: W.K. Kellogg Foundation.
[37] Minnesota Department of Health and Minnesota Board of Dentistry, "Early Impacts of Dental Therapists in Minnesota" (February 2014),http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf; Patrick Blahut, deputy director, U.S. Indian Health Service, Division of Oral Health, pers. comm., March 18, 2015.
[38] American Dental Association, "The Oral Health Care System: A State-by-state Analysis," 2016. Accessed from http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/OralHealthCare-StateFacts/Oral-Health-Care-System-Full-Report.pdf on September 1, 2016.
[39] The Pew Charitable Trusts (2014). *Expanding the Dental Team: Studies of Two Private Practices*. Available from: www.pewstates.org/dental.
[40] Minnesota Department of Health and Minnesota Board of Dentistry, "Early Impacts of Dental Therapists in Minnesota" (February 2014),http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf

In addition to reimbursements, dental practices often cite missed appointments as a cost to serving higher percentages of Medicaid patients. Oral health literacy is critical to increasing both the likelihood that a patient will seek dental care, and that patients will keep the dental appointments they schedule. It is important to note, however, that there may be significant challenges to keeping scheduled appointments for many lower-income patients, aside from oral health literacy issues.

It can be difficult for patients to take the time off work for dental appointments, as office hours are often limited. Arranging childcare and transportation to the dentist are often cited as reasons patients miss their appointments[41]. Because providers are prohibited from charging Medicaid for missed appointments, they are financially disadvantaged when patients miss appointments.

Early indications from Minnesota also point to extended hours as a way to reduce hospital emergency department use.[42] In 2013, there were 22,794 visits to Arizona emergency rooms due to dental complaints that could have been addressed in a dentist's office, such as dental pain.[43]

Benefits for Nonprofit Public Health Settings: Similar cost savings were shown in nonprofit public settings. While not profit driven, the goal of these clinics is to increase access to dental services for underserved populations and address as much of the unmet need as possible with the dollars they have available. A case study, similar to the private practice study above, involving three nonprofit public health clinics found the following: underserved populations had increased access to care, and the nonprofit practices were able to stretch their dollars to reach more underserved people[44].

Protecting the Public—Training, Licensure and Accreditation:
Requiring and maintaining high quality oral health care is imperative. Arizona's Dental Practice Act and the Arizona Board of Dental Examiners (BODEX) exist to ensure that the oral health, safety and welfare of Arizona's citizens are protected. By specifying examination, licensure and enforcement processes, Arizona can ensure a

[41] GAO, 2000; Greenberg et al., 2008; Mofidi et al., 2002; Shirk, 2010

[42] Minnesota Department of Health and Minnesota Board of Dentistry, "Early Impacts of Dental Therapists in Minnesota" (February 2014),http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf

[43] State statistics from HCUP State Inpatient Databases and State Emergency Department Databases 2013, Agency for Healthcare Research and Quality (AHRQ), based on data collected by the Arizona Department of Health Services and provided to AHRQ.

[44] The Pew Charitable Trusts (2014). *Expanding the Dental Team: Increasing Access to Care in Public Settings*. Available from: http://www.pewtrusts.org/en/research-and-analysis/reports/2014/06/30/expanding-the-dental-team.

scope of practice for dental therapists is appropriate for their education and training, and that these professionals are working within the requirements of their licenses.

Education: In August 2015, the Commission on Dental Accreditation (CODA) voted overwhelmingly to adopt and implement national training standards for dental therapy education, just as they have for dental, dental hygiene and dental assisting programs.[45] These standards are the product of five years of CODA research on standards, based on current and proposed dental therapy models across the nation and the world. The implementation of CODA standards demonstrates that dentistry's accrediting body understands it is in the best interest of the dental profession and the public to develop national standards for dental therapy education programs, and acknowledge the need for dental therapists throughout the country.

These standards are an important step forward for dental therapy programs and provide a blueprint for more states to establish dental therapy training programs. As a result of implementation of national CODA standards, training institutions will have national and streamlined standards to shape their programs, and accreditation will be overseen by a national body, instead of on a state by state basis. Further, students will be able to enter accredited programs and be eligible for federal financial aid.

CODA standards call for *three academic years of training*, in both didactic and clinical settings and with advanced standing granted to dental hygienists and dental assistants. This model provides a path of entry for new professionals entering the field, while creating expanded professional opportunities for Arizona's existing dental workforce. Dental hygienists wishing to enhance their professional skills and increase employability will have that option. New entrants to the profession should have the option of completing their dental therapy degree and deciding whether or not to complete training in dental hygiene. While establishing baseline requirements for dental therapists, CODA also ensures that states have the authority and flexibility to adopt a dental therapy scope of practice, supervision requirements and other standards to meet the state's specific needs and challenges.

Arizona currently has eight CODA accredited dental hygiene programs and two CODA accredited dental schools. With CODA standards in place, collaborative efforts between community college, university and dental school programs could provide

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[45] American Dental Association Commission on Dental Accreditation, "Accreditation Standards for Dental Therapy Education Programs," August 2015. Accessed from http://www.ada.org/en/~/media/CODA/Files/dt on September 1, 2016.

high-quality educational options and opportunities for rural communities to 'grow their own' dental therapy workforce and increase the likelihood that those students will remain in their communities. Barriers to accessing post-secondary education and professional growth can be high outside of the urban cores, however, with the availability of higher education options and opportunity for collaboration around education and training programs, many of the barriers could be eliminated. Creating career options and effectively training a geographically and culturally diverse workforce, representative of the communities most in need of greater access to dental care is critical.

High-Quality, Cost Effective Care: Dental therapists can increase the efficient delivery of care and can build capacity in dental practices by allowing them to increase the volume of patients served at a lower cost per unit of care.[46] In addition, dental therapists are uniquely positioned to deliver routine dental care in non-traditional settings such as nursing homes, schools, group settings for the developmentally disabled as well as offer extended and weekend hours in a dental practice or retail clinic.[47]

Regulatory structure: The dental therapy model and CODA accreditation standards require dental therapists to be highly trained in a small subset of the dental services provided by a dentist—as shown in the table on page. Dental therapists should be required to attend a program that meets CODA standards and pass a licensing exam commensurate with their education and training.

BODEX currently licenses Arizona's dentists, dental hygienists and dental assistants. Dentists and dental hygienists are required to graduate from a CODA accredited school and successfully pass the National Dental or Dental Hygiene Board examination and the Western Regional Examining Board examination. Dental therapists are trained to provide a subset of basic services currently only provided by dentists. In other states, because the dental therapist services are a subset of what dentists are trained to do, dentists and dental therapists are trained to the same standards for the overlapping scope of practice, including fillings and extractions. For example, at the University of Minnesota, dentists and dental therapists are educated and evaluated together for their shared competencies; the

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[46] Minnesota Department of Health and Minnesota Board of Dentistry, "Early Impacts of Dental Therapists in Minnesota" (February 2014),http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf; The Pew Charitable Trusts (2014). *Expanding the Dental Team: Studies of Two Private Practices*. Available from: www.pewstates.org/dental; The Pew Charitable Trusts (2014). *Expanding the Dental Team: Increasing Access to Care in Public Settings*. Available from: www.pewstates.org/dental.

[47] Ibid.

evaluators do not know which students are training to become dentists and which are training to become dental therapists.

The "Powers and Duties" section of Arizona's Dental Practice Act (A.R.S. 32-1207) grants BODEX the statutory authority to regulate "…the practice of dentists and *supervised personnel*…" consistent with the Act. This application anticipates that BODEX will serve as the regulatory body for dental therapists, thus eliminating the need for a new regulatory structure.

Potential Cost to the State and Public:
Expanding the types of dental providers in Arizona to include midlevel, dental therapists, is a common sense, free-market solution to address our oral health access challenges without creating a new government-run health care program. Dentists, regardless of practice setting, who wish to expand their practices to include dental therapists, should be granted that freedom by our State. This innovative solution has the potential to ensure more people get the dental care they need with negligible costs to the state or the general public.