F I S C A L I M P A C T R E P O R T

SPONSOR Shendo **ORIGINAL DATE** 1/21/15 **LAST UPDATED** **HB**

SHORT TITLE Dental Therapist Licensure and Regulation **SB** 6

ANALYST Elkins

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY15	FY16	FY17		
	TBD	TBD	Recurring	Dental Board

(Parenthesis ( ) Indicate Revenue Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY15	FY16	FY17	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$25.0	$25.0	$50.0	Recurring	Dental Board

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Regulation and Licensing Department (RLD)
Department of Health (DOH)

SUMMARY

Synopsis of Bill

Senate Bill 6 amends the New Mexico Dental Health Care Act to create a new midlevel dental health care provider. The new provider position would be entitled "dental therapist." SB6 would also amend the New Mexico Gross Receipts and Compensating Tax Act, the New Mexico Drug, Device and Cosmetic Act, the Public Assistance Act, the Health Maintenance Organization Law, and the Nonprofit Health Care Plan Law. The legislation:

- Establishes a new dental provider entitled, "dental therapist," providing for licensure and scope of practice, supervisory requirements and agreement guidelines with a sponsoring dentist in order to practice as a dental therapist. Scope of practice includes: (1) behavioral management, oral health instruction and disease prevention

education, including nutritional counseling and dietary analysis; (2) diagnosis of dental disease and the formulation of an individualized treatment plan, including caries risk assessment; (3) preliminary charting of the oral cavity; (4) prescribing, exposing and interpreting radiographs; (5) mechanical polishing of teeth and restorations; (6) application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants; (7) pulp vitality testing; (8) application of desensitizing medication or resin; (9) fabrication of athletic mouth guards; (10) placement of temporary restoration; (11) tissue conditioning and soft reline; (12) traumatic restorative therapy; (13) dressing changes; (14) emergency replacement and stabilization of an avulsed or dislodged tooth to prevent the unintended loss of a tooth or teeth; (15) administration of local anesthetic; (16) extractions of primary teeth; (17) extractions of permanent teeth that are not impacted and that do not need sectioning or an incision for removal; (18) emergency palliative treatment of dental pain; (19) placement and removal of space maintainers; (20) cavity preparation; (21) restoration of primary and permanent teeth; (22) placement of temporary crowns; (23) preparation and placement of pre-formed crowns; (24) pulpotomy of primary teeth; (25) indirect and direct pulp capping on primary and permanent teeth; (26) suture removal; (27) brush biopsies; (28) simple repairs and adjustments to removable prosthetic appliances; (29) re-cementing of permanent crowns; (30) prevention of potential orthodontic problems by early identification and appropriate referral; (31) prevention, identification and management of dental and medical emergencies and maintenance of current basic life-support certification; (32) dispensing and administration of analgesics, anti-inflammatory medications and antibiotics only within the parameters of a dental therapist management agreement; and (33) other related services as permitted by board rules.

- Establishes overall training and licensing requirements, supervisory authority, disciplinary actions and procedures. To be licensed as a dental therapist, an applicant shall: (1) be licensed as a dental hygienist; (2) have passed a written examination covering the laws and rules for practice in the state; and (3) have submitted, to the joint committee for its approval and recommendation, proof: (a) of graduation and receipt of a degree from a dental therapy education program that provides a competency-based curriculum, developed in partnership with an accredited institution of higher education; (b) of passage of a competency-based examination given by a nationally recognized regional testing agency if available or, if not available, by an institution of higher education with a dental therapy education program; and (c) after graduation from a dental therapist competency-based education program, of having completed a minimum of four hundred additional clinical hours under the indirect supervision of a dentist.
- Establishes guidelines for temporary licensure of a dental therapist practicing and in good standing from another state to practice in New Mexico.
- Establishes general administrative guidelines for the licensing fees, renewal of licenses and other general procedures relating to dental therapists.
- Establishes a joint committee and membership requirements to include a dental therapist representative, five dentists from the Dental Health Care Board, five dental hygienists of the Dental Hygiene Committee, and two members of the public. The committee is to develop regulations for licenses and discipline for licensed and unlicensed dental therapists.

- Establishes time frames for the committee to establish rules relating to the practice of dental therapy and for the NM Dental Health Care Board to ratify, adopt, and promulgate the rules.
- Amends the NM Gross Receipts and Compensating Tax Act to allow the dental therapist to be eligible to participate in the program;
- Establishes prescription authority.
- Amends the New Mexico Dental Health Care Act by including the dental therapist in the policies and procedures governing the Dental Health Care Board.
- Includes the dental therapist in the provisions of the Uniform Licensing Act, the Public Health Assistance Act, and the Nonprofit Health Care Plan Act Law and the Impaired Dentists and Dental Hygienists Act.

FISCAL IMPLICATIONS

The creation of a joint committee that includes one new position will increase meeting cost. RLD estimates that the current reimbursement for member is $300 per day. Currently, the Dental Health Care Board meets four times a year. According to RLD the addition of a joint committee will increase the number of days that a board meeting lasts from one day to two days and that additional funds will be required for court reporters and advertising of rule changes. LFC staff estimates the addition of four members, member reimbursements for additional days, and other costs will require approximately $25 thousand in additional funds.

This bill does allow for reasonable fees that may offset some or all of the expenses. However, the number of potential applicants and practitioners is uncertain.

SIGNIFICANT ISSUES

RLD offers the following commentary:

There are many concerns with the bill including;

- There are currently no dental therapy education programs. The education program is just one year more than an associate's degree in hygiene. The Minnesota program requires at least a Master's degree in hygiene. The education of a dental hygienist which is aimed at prevention and scaling and prophylaxis and an additional year may not be sufficient to prepare one for this scope of practice as proposed. Many of these areas require exhaustive diagnosis considerations and judgments to be made in mid-treatment that the hygienist/therapist education will not prepare the hygienist/therapist for.
- The competency exam to certify this hygienist-therapist would have to be the regular regional board exam taken by dentists since that is what their scope suggests.
- The Legislature passed a new mid-level provider a few years ago, called a "Community Dental Health Coordinator". We currently have a board-approved program that started at CNM this fall, and it will only be another 9-12 months before they could enter the community workforce. These providers are community health workers with dental skills (non-surgical) that will provide educational, diagnostic, preventive and limited restorative care. They will work in community health centers and institutions to help provide dental care and navigation to proper dental professionals for further care and follow-up. Access to care will increase.

- This bill reduces the current penalty for dentistry without a license from a 4th degree felony to only a misdemeanor.
- This bill removes the cost of disciplinary proceedings from the dental therapist. Right now, licensees shall bear the costs of disciplinary proceedings unless exonerated.
- This bill also removes this portion of the statute: "Any person filing a sworn complaint shall be immune from liability arising out of civil action if the complaint is filed in good faith and without actual malice." This deletion of this portion of the statute does not protect the public.
- Requiring an "advocate" on the board is opposed to the board's function of protecting the public.
- There are several areas in the scope of practice that are also of concern:
    - The definition and scope of practice includes diagnosis. One cannot perform diagnosis without the expanded scientific and clinical background that a dentist receives. One additional year and a 400 hour internship cannot prepare one to diagnose with all the myriad of considerations that must be considered.
    - Supervision of dental therapists would be very minimal. This bill allows them to work on patients without a dentist present. There are concerns that if a therapist gets in over their head and if no dentist were available on the premises, patients could be unnecessarily harmed.
    - Tooth implantation and stabilization: This requires management of trauma situations outside their abilities.
    - Administration of nitrous oxide: This requires a dentist to have an additional certificate due to systemic considerations.
    - Extractions sound simple to extract primary teeth but any dentist will tell you these can be some of the most difficult. Extraction of permanent teeth that "do not require surgical or sectioning" is a real problem because most of the time a dentist doesn't know if the tooth will have to be sectioned or surgically removed until after the procedure has been started.
    - Emergency palliative treatment of pain requires advanced diagnosis.
    - Space maintenance and orthodontic referral requires extensive knowledge of orthodontics and requires a specialty license.
    - Prescribing antibiotics and anti-inflammatory requires advanced pharmacology which these practitioners will not be prepared to know.
    - Diagnose and interpret radiographs- again this requires an extensive knowledge of dental pathology and radiology which this hygienist/therapist would not have.

According to DOH, The dental therapist model of care was established in rural Alaska where dental therapists provide dental care to rural Alaskan Natives. The States of Minnesota and Maine have implemented dental therapist provider models, and other states are studying various midlevel dental provider models. The American Dental Hygienist Association supports the midlevel provider concept and has established its own model wherein the midlevel dental care provider is entitled "advanced hygiene practitioner." Members of the New Mexico Dental Hygienists' Association have expressed support of the legislation.

State initiatives for low-income children enrolled in public programs have shown that progress can be made in improving access to and utilization of oral health services.
(http://www.nhpf.org/library/issue-briefs/IB836_OralHealthCheckup_03-29-2010.pdf)

The federal government has designated all or part of 32 counties of New Mexico as Dental Health Professional Shortage Areas. (http://hpsafind.hrsa.gov/HPSASearch.aspx)

New Mexico faces workforce challenges. More than 40% of the population lives in federally designated Dental Health Professional Shortage Areas. (http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2011/05/11/childrens-dental-health-new-mexico)

In the United States, children aged 5 to 17 years of age miss 1.6 million school days annually due to acute oral health problems (3.1 days per 100 students). Low income children have nearly 12 times as many missed school days as compared to children from families with higher incomes. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222359/)

Compared to the general population, American Indians and Alaska Natives (AI/AN) experience more oral disease including both tooth decay and periodontal diseases (http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/cnohr/Pages/AIANDemographics.aspx)

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