



Policy Brief
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Enchanting and Affordable Smiles: Why Dental Therapy is Right for New Mexico

By D. Dowd Muska

Introduction

In a 2000 report, the U.S. Surgeon General warned of “profound and consequential disparities in the oral health of our citizens” – a “silent epidemic” that “restricts activities in school, work, and home, and often significantly diminishes the quality of life. Those who suffer the worst oral health are found among the poor of all ages, with poor children and poor older Americans particularly vulnerable. Members of racial and ethnic minority groups also experience a disproportionate level of oral health problems. Individuals who are medically compromised or who have disabilities are at greater risk for oral diseases, and, in turn, oral diseases further jeopardize their health.”¹

Over a decade and a half later, oral health remains a significant problem for many Americans. More than 17 percent of those between the ages of 5 to 19 have untreated tooth decay. For adults between the ages of 20 and 44, the portion is 27.4 percent.² In New Mexico, 32 percent of residents report that they experience mouth and teeth pain “very often” or “occasionally.” Over 40 percent of those living in the state’s low-income households describe the overall condition of their mouth and teeth as “poor” or “fair.”³

There are several reasons why oral health is not what it should be in the nation and New Mexico, but a prime cause of the crisis is inadequate access to providers. The U.S. Department of Health & Human Services estimates that there are 5,381 dental Health Professional Shortage Areas in

¹ U.S. Public Health Service, “Oral Health in America: A Report of the Surgeon General,” 2000.

² National Center for Health Statistics, “Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities,” 2016.

³ Health Policy Institute, American Dental Association, “Oral Health and Well-Being in New Mexico,” n.d., accessed October 17, 2016.

the country.⁴ A Bloomberg analysis found that the Land of Enchantment had “the third worst dental care professional shortage in the nation following Mississippi and Louisiana. Almost 40 percent of New Mexicans live in a Dental Desert; an area where there is a shortage of dental health care professionals.”⁵ The latest annual report of the New Mexico Health Care Workforce Committee found that 18 of the state’s 33 counties have shortages of dentists – and four counties have no dentists at all.⁶ As the graphic below indicates, while the Albuquerque-Santa Fe-Las Vegas combined statistical area enjoys adequate coverage; that is not the case in most rural counties.

County	Population	Practice County	Mailing County	Estimated Total	Surplus (+) / Shortage (-)
Bernalillo	675,551	269	211	480	210
Catron	3,556	1	0	1	0
Chaves	65,878	12	9	21	-5
Cibola	27,349	4	4	8	-3
Colfax	12,680	2	2	4	-1
Curry	50,969	13	12	25	5
De Baca	1,825	0	0	0	-1
Doña Ana	213,676	58	37	95	10
Eddy	56,395	10	5	15	-8
Grant	29,096	7	6	13	1
Guadalupe	4,468	0	1	1	-1
Harding	683	0	0	0	0
Hidalgo	4,560	0	0	0	-2
Lea	69,999	11	8	19	-9
Lincoln	19,706	5	3	8	0
Los Alamos	17,682	9	7	16	9
Luna	24,673	2	5	7	-3
McKinley	74,098	21	11	32	2
Mora	4,592	1	0	1	-1
Otero	65,082	8	11	19	-7
Quay	8,501	0	1	1	-2
Rio Arriba	39,777	9	1	10	-6
Roosevelt	19,536	3	0	3	-5
Sandoval	137,608	31	29	60	5
San Juan	123,785	46	25	71	21
San Miguel	28,239	6	6	12	1
Santa Fe	148,164	59	53	112	53
Sierra	11,325	4	2	6	1
Socorro	17,310	3	1	4	-3
Taos	33,084	11	4	15	2
Torrance	15,611	2	0	2	-4
Union	4,297	0	0	0	-2
Valencia	75,817	10	10	20	-10
State Total	2,085,572	617	464	1,081	247

Source: 2015 Annual Report, New Mexico Health Care Workforce Committee

⁴ Kaiser Family Foundation, “Dental Care Health Professional Shortage Areas (HPSAs); Timeframe: as of September 8, 2016,” accessed October 7, 2016.

⁵ Simon Thompson, “NM Dental Health Care Professional Shortage Third Greatest in Nation,” KRWG, April 21, 2015.

⁶ New Mexico Health Care Workforce Committee, “2015 Annual Report,” October 1, 2015.

Nationally, the “uneven distribution of dentists” means that “access to care is constrained for people ... regardless of income or insurance coverage.” In addition, the “relatively small number of dentists who participate in Medicaid means that many low-income people are not receiving dental care.”⁷

But a simple reform could help alleviate the dental-access problem. Deregulation of the dental workforce is increasingly seen by the left and right as a promising way to boost oral care. Mid-level practitioners, usually called dental therapists, “work under the supervision of a dentists and provide basic, preventative and restorative care such as fillings and certain tooth extractions. Mid-level practitioners also enable dentists to expand the geographic reach of their practices by offering care in schools, nursing homes ... and other community settings.”⁸

Unfortunately, in the states where lawmakers have considered legalization of dental therapy, the reform has encountered stiff resistance. Dentists have used the good will they rightfully receive from the public – and powerful lobbying muscle – to block attempts to legitimize mid-level practitioners. Seeing change as a threat, rather than an opportunity, dentists have successfully blocked dental therapy in all but three state legislatures.

Yet the need for better oral healthcare in the nation is not going away, and proponents of dental therapy are not likely to abandon their commitment to solving the uneven-distribution problem. Herewith, an examination of the history of, as well as the myths and facts about, dental therapy, and an exploration of how the profession would benefit New Mexico.

A Success Abroad

Dental therapists’ “duties include functions that, in the Untired States, until recently have been reserved for dentists alone. In sharp distinction to the United States, dental therapy has been established in many other countries for many decades.”⁹

New Zealand created the first dental therapists, nearly a century ago. They are

*authorized to perform a small set of procedures, particularly cleanings, fillings, and application of dental sealants, without a dentist being on-site or examining the patient first, but a dentist is on call to consult if needed. This system ensures that children receive care without the delays that can result from requiring that a dentist be present. Today, dental therapists provide care for children from infancy through age 18; they must have a written agreement with a dentist that allows them to seek advice and refer patients with needs outside their scope of practice. They may practice in both public and private settings, but most continue to work in elementary schools.*¹⁰

⁷ Pew Charitable Trusts, “In Search of Dental Care: Two Types of Dentist Shortages Limit Children’s Access to Care,” June 2013.

⁸ John Davidson, “Dental Workforce Reform in Texas,” Center for Health Care Policy, Texas Public Policy Foundation, March 2016.

⁹ Burton L. Edelstein, DDS, MPH, “Examining Whether Dental Therapists Constitute a Disruptive Innovation in US Dentistry,” *American Journal of Public Health*, October 2011.

¹⁰ Pew Charitable Trusts, “Dental Therapists in New Zealand: What the Evidence Shows,” May 2013.

From New Zealand, dental therapists have “spread to more than 50 other countries and territories.” Canada, Australia, Belize, Hong Kong, Gabon, Thailand, the Netherlands, Vietnam, Zimbabwe, Laos, Costa Rica, Singapore, South Africa, Nepal, Sri Lanka, Malaysia, and the United Kingdom permit the practice, with many allowing the practitioners to serve adults as well as children.¹¹

In America’s neighbor to the north, where the “national system of health insurance ... does not include dental care,”¹² dental therapists were first trained at the University of Toronto in the early 1970s. Graduates were “hired by the federal government to work in the Yukon and the Northwest Territories.” Now, dental therapists “work all across Canada.”¹³ They are “trained to perform basic clinical dental treatment and preventive services within a variety of practice settings.”¹⁴

In the United Kingdom, dental therapy became a profession in the 1960s. The practitioners are allowed to perform a range of procedures, including oral assessments, periodontal treatments, routine restorations of “both deciduous and permanent teeth, on adults and children, from Class 1-V cavity preparations,” and extractions of “deciduous teeth under local infiltration analgesia.”¹⁵

Researchers have consistently found that dental therapists abroad provide quality, affordable services. In 2012, a sweeping monograph written by 17 “academics or public health officials who are knowledgeable about dental workforce issues in their respective countries” surveyed the “literature relating to the practice of dental therapists in their respective countries.” The authors concluded that dental therapists “improve access to care, specifically for children,” are “effective in providing oral health care within their scope of practice,” “have a record of providing oral health care safely,” and “have the potential to decrease the cost of care, specifically for children.”¹⁶

Alaska Sets the Precedent

In the early 2000s, the Alaska Native Tribal Health Consortium (ANTHC), working with local tribal-health entities, founded the Alaska Dental Health Aide Initiative. With oral-health issues rampant in the native population, particularly in remote villages accessible only by air, sea, and snow machine, the dental-therapist model working so well in so many countries attracted the

¹¹ David A. Nash et al., “A Review of the Global Literature on Dental Therapists: In the Context of the Movement to Add Dental Therapists to the Oral Health Workforce in the United States,” W.K. Kellogg Foundation, April 2012.

¹² Carlos Quiñonez, “Why was dental care excluded from Canadian Medicare?,” Working Paper, Network for Canadian Oral Health Research, 2013.

¹³ Sajiev Thomas, “A Brief History of Dental Therapy In Canada,” Canadian Dental Therapists Association, February 20, 2012.

¹⁴ Canadian Dental Therapists Association, *Handbook: Scope of Professional Practice/Competencies & Code of Ethics*, August 2004.

¹⁵ British Association of Dental Therapists, “What Can Dental Therapists Do?,” website, n.d., accessed October 17, 2016.

¹⁶ David A. Nash et al., “A Review of the Global Literature on Dental Therapists: In the Context of the Movement to Add Dental Therapists to the Oral Health Workforce in the United States,” W.K. Kellogg Foundation, April 2012.

¹⁶ Sajiev Thomas, “A Brief History of Dental Therapy In Canada,” Canadian Dental Therapists Association, February 20, 2012.

attention of the initiative's officials.¹⁷ The ANTHC received funding from the Rasmuson Foundation to send "the first class of dental therapy students to New Zealand for training After two years of rigorous training and education, the new dental therapists returned to practice in their villages."¹⁸

Formally known as dental health aide therapists, the practitioners work with dentists and hygienists "to provide prevention, basic restorative, and urgent care services" in a process similar to the "physician assistant model of medical care." Once training is complete, dental therapists

*complete a preceptorship under direct supervision of experienced dentists before being certified and placed in remote villages. Once in the villages, dentists provide general supervision using telephone or telehealth technology. The dentists visit the villages periodically. The supervising dentist provides care beyond the scope of practice of the dental health aides in the village or the patient can be referred to more sophisticated regional centers or the Alaska Native Medical Center as part of this integrated system. This collaboration between providers with different scopes of practice is a very efficient way to provide care, and one which allows each provider to work up to the highest level of their education and certification or licensure. The dentist supervisor can spend his or her time on the more complicated patients for which they have more education to treat. The dental health aides provide the more basic services and pre-screen patients to insure the time the dentist spends with each patient can be maximized. The patients benefit from increased access to higher level services which previously the dentists could not provide since they were providing less complicated services.*¹⁹

In 2010, a lengthy evaluation of dental therapists in Alaska concluded that they were "performing well and operating safely within their scope of practice," operating "under the general supervision of the dentists to whom they are assigned," are "well accepted in the villages and serve as role models," and are "in compliance with the Community Health Aide Program Certification Standards and Procedures."²⁰

Lower costs are another desirable outcome from Alaska's experiment: "The average dental therapist salary in Alaska is about half that of a dentist – \$60,000 per year versus 120,000 – so the savings are very real."²¹

In 2015, the ANTHC's dental-therapy program won the Indian Health Service's National Director's Award, which "recognizes service significantly advancing the IHS mission and goals through enhancements supporting IHS priorities."²² The service's executive director praised

¹⁷ Scott Wetterhall et al., "Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska: Final Report," W.K. Kellogg Foundation, Rasmuson Foundation, and Bethel Community Services Foundation, October 2010.

¹⁸ W.K. Kellogg Foundation, "In Alaska, Better Dental Care," February 7, 2013.

¹⁹ Sarah Shoffstall-Cone and Mary Williard, "Alaska Dental Health Aide Program," *International Journal of Circumpolar Health*, Volume 72, 2013.

²⁰ Scott Wetterhall et al., "Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska: Final Report," W.K. Kellogg Foundation, Rasmuson Foundation, and Bethel Community Services Foundation, October 2010.

²¹ W.K. Kellogg Foundation, "In Alaska, Better Dental Care," February 7, 2013.

²² "IHS Director's Award," Indian Health Service website, n.d., accessed November 4, 2016.

Alaska’s native communities for creating “a model that ... provides a solution to the problem of access for their own Tribal citizens” and demonstrating “the incredible potential of [dental therapists] for other Tribal Nations and underserved communities across the United States.”²³

But the legitimization of dental therapy in the Last Frontier was not the result of a state law. Funded by the federal government, and thus not subject to Alaska’s licensing regulations, the ANTHC was able to circumvent approval by the governor and legislators in Juneau.

Minnesota: Progress at the State Level

The first successful state-level authorization of dental therapy began as an effort to address “significant disparities” for “low-income residents, people of color and the elderly,” since the cohorts suffered “disproportionately from oral diseases.”²⁴ The Minnesota Safety Net Coalition “took the lead” in lobbying for legislation. It assembled a coalition of “more than 50 organizations,” including, most prominently, the Minnesota Dental Hygienists’ Association and Minnesota State Colleges and Universities System. National entities lending support included the American Public Health Association and American Association of Public Health Dentistry.²⁵

In 2009, a legislative compromise was reached that created two types of providers: dental therapists and advanced dental therapists. Training, scope of practice, and levels of dentist supervision for the two positions are described below.

	Educational/ credential requirements	Scope of practice	Level of supervision
<i>Dental therapist</i>	<ul style="list-style-type: none"> ▪ Bachelor’s degree in dental therapy. ▪ Competency and licensure exam. ▪ Jurisprudence examination. 	<p>A licensed dental therapist may perform certain dental services under “indirect supervision.” See Appendix B for a full list of these services.</p> <p>A dental therapist may perform additional services under “general supervision” unless restricted or prohibited from doing so in the collaborative management agreement. See Appendix B for a full list of these services.</p> <p>A dental therapist may also dispense certain medications and supervise up to 4 dental assistants.</p>	Practices under the supervision of a dentist, with whom they must have a collaborative management agreement. Some dental therapy services can be provided under “indirect supervision” (the dentist is on-site and authorizes procedures) and others under “general supervision” (the dentist is not necessarily on-site during procedure but does authorize its performance).
<i>Advanced dental therapist</i>	<ul style="list-style-type: none"> ▪ Dental therapist license. ▪ Master’s degree in advanced dental therapy. ▪ 2,000 hours of clinical practice. ▪ Certification exam for advanced practice. 	<p>An advanced dental therapist certified by the Board of Dentistry may perform the following services and procedures, pursuant to a written collaborative management agreement (and any limitations therein):</p> <ul style="list-style-type: none"> ▪ All services a dental therapist provides (see above). ▪ Oral evaluation and assessment. ▪ Treatment plan formulation. ▪ Routine, nonsurgical extractions of certain diseased teeth. 	Like a dental therapist, the advanced dental therapist practices under the supervision of a dentist, with whom they must have a collaborative management agreement, but all advanced dental therapy services can be provided under “general supervision.” The dentist does not need to see the patient first or be on-site during procedure.

Source: “Early Impacts of Dental Therapy in Minnesota,” Minnesota Department of Health and Minnesota Board of Dentistry

²³ April Hale, “ANTHC Receives Indian Health Service Director’s Award,” National Indian Health Board, June 3, 2015.

²⁴ Minnesota Department of Health and Minnesota Board of Dentistry, “Early Impacts of Dental Therapy in Minnesota,” February 2014.

²⁵ American Dental Hygienists’ Association, “The History of Introducing a New Provider in Minnesota: A Chronicle of Legislative Efforts 2008-2009,” September 2015.

Both types of therapists “must enter into a written collaborative management agreement (CMA) with a licensed, Minnesota dentist. A dentist may have a CMA with no more than five dental therapists or advanced dental therapists at a given time. The CMA can include limitations on services provided or supervision required as determined by the collaborating dentist. Also, the collaborating dentist accepts responsibility for all services authorized and performed.”²⁶

In 2012, Christy Jo Fogarty, Minnesota’s first advanced dental therapist, testified before Congress that “the acceptance level of dental therapy is nothing short of amazing. Every patient I see I explain to them that I am not a dentist and that I am a dental therapist. Once I explain to them that dental therapist is much like a nurse practitioner in medicine they are comfortable with me treating their children. I have never once had anyone say they would prefer to see a dentist.”²⁷

A 2014 assessment of the initial impacts of dental therapists in the Gopher State found:

- reduced wait times, with 77 percent of “patients who reported it had taken at least two months to get a previous appointment ... getting the current appointment in less than one month”
- decreased travel time for patients – for “93 percent of respondents, it took less than one hour to travel to the current dental appointment with the dental therapist, compared to 74 percent who traveled less than an hour to their last appointment”
- while it was “too early to definitively answer how many dental therapists may affect the use of emergency rooms for treatment,” interviews and surveys “suggest dental therapists may be helping to serve patients who have visited the ER in the past for dental issues”
- two-thirds of “clinics interviewed noted the significant savings in personnel costs that come with employing a dental therapist compared to a dentist”²⁸

The final finding, according to Leon Assael, a professor at the University of Minnesota’s School of Dentistry, contributes to more low-income patients being served: “Due to low reimbursement rates, dentists cannot afford to treat tooth decay in most practices in Minnesota for patients on public assistance for whom the reimbursement is just 38 percent of usual fees. Dental therapists reduce the unit cost of care by treating patients with dental decay on public assistance who would not otherwise be seen in the dental practice.”²⁹

A case study of the first dental therapist hired by a federally qualified health center found that “the estimated revenue she generated more than covered the costs of her employment.” The practitioner was hired by People’s Center Health Services, “which serves a low-income and heavily immigrant population in Minneapolis.” In her first year, she conducted 1,756 patient

²⁶ Minnesota Dental Association, “Dental Therapy in Minnesota,” Issue Brief, July 2013.

²⁷ Christy Jo Fogarty, Testimony, “Hearing on Dental Crisis in America: The Need to Expand Access,” U.S. Senate Committee on Health, Education, Labor, and Pensions, Subcommittee on Primary Health and Aging, February 29, 2012.

²⁸ Minnesota Department of Health and Minnesota Board of Dentistry, “Early Impacts of Dental Therapy in Minnesota,” February 2014.

²⁹ David Borenstein, “Looking a Dangerous Disease in the Mouth,” *The New York Times*, October 30, 2014.

visits, incurring costs – compensation and supplies – of \$136,070. The center “collected an estimated \$166,920 from Medicaid for the dental therapist’s procedures,” and thus, “the estimated Medicaid revenue that she generated exceeded the cost of her employment by more than \$30,000.”³⁰

Maine and Vermont: Starting a Trend?

Minnesota enacted its dental-therapy legislation in 2009, but it would be five years before another state followed suit. In 2014, Maine’s governor signed LD 1230, “An Act To Improve Access to Oral Health Care.” The legislation established a new type of provider, the dental hygiene therapist.

Once again, a broad coalition of supporting organizations was necessary to overcome strenuous opposition from dentists. The Maine Children’s Alliance, Maine Head Start Directors Association, Roman Catholic Diocese of Portland, Maine Hospital Association, Disability Rights Center, Maine Association of Interdependent Neighborhoods, Maine Association of School Nurses, and Maine Equal Justice Partners were among the groups backing dental therapy in the Pine Tree State.

Endorsements from prominent legislators aided the effort. The speaker of Maine’s House of Representatives stressed that more than half of the children on the state’s Medicaid rolls “don’t see a dentist,” his state had the sixth highest “percentage of Medicaid children without access to care in the United States,” and “15 of 16 Maine counties ... have designated dentist shortage areas.”³¹ Rep. Stephen Stanley and Rep. Jeffery Gifford, speaking for the legislature’s Rural Caucus, noted that over two-thirds of the state’s population lives in “a rural area, but only 13.5 percent of dentists practice in those areas. To make matters worse, a Maine Dental Association funded study found that within the next five years 23.7 percent of dentists in Maine plan to retire and an additional 16.1 percent expect to reduce their hours.”³²

A strong interest in growing the dental-therapy profession in Maine likely had an impact. The Maine Dental Hygienists Association cited a survey that found that 70 percent hygienists in the state were “interested in more training to become some form of an advanced dental practitioner.”³³ To allay concerns about education, Assael, of the University of Minnesota’s School of Dentistry, came to Maine to testify that his students are “well-trained, fully understand the limited but essential scope of services they are authorized to provide, and provide high quality dental services under the supervision of a dentist. Indeed, at the University of Minnesota they are educated in exactly the same courses that educated dentists with regard to these services. Their devotion to a limited area of practice makes them very effective in that specific area. As

³⁰ The Pew Charitable Trusts, “Expanding the Dental Team: Increasing Access to Care in Public Settings,” June 2014.

³¹ Rep. Mark W. Eves, Testimony, Hearing on LD 1230, “An Act to Improve Access to Oral Health Care,” Committee on Labor, Commerce, Research and Economic Development, Maine State Legislature, April 11, 2013.

³² Rep. Stephen Stanley and Rep. Jeffery Gifford, Testimony, Hearing on LD 1230, “An Act to Improve Access to Oral Health Care,” Committee on Labor, Commerce, Research and Economic Development, Maine State Legislature, April 11, 2013.

³³ Pat Jones, Testimony, Hearing on LD 1230, “An Act to Improve Access to Oral Health Care,” Committee on Labor, Commerce, Research and Economic Development, Maine State Legislature, April 11, 2013.

pioneers of this field in America, they are particularly devoted to their patients and to the importance of their work.”³⁴

LD 1230 passed both chambers of Maine’s legislature and was signed by the governor in May 2014. It permitted dental hygiene therapists to perform “oral health assessments, pulpal disease assessments for primary and young teeth, simple cavity preparations and restorations and simple extractions.” In addition, they can “prepare and place stainless steel crowns and aesthetic anterior crowns for primary incisors and prepare, place and remove space maintainers,” make referrals, “administer local anesthesia and nitrous oxide analgesia,” and conduct “urgent management of dental trauma, perform minor surgical care and suturing and extract primary and permanent teeth.”³⁵

Two years after dental therapy’s victory in Maine, Vermont became the third state to legalize dental therapy. By now, the narrative was familiar. The Vermont Oral Health Care for All Coalition spearheaded lobbying. Its membership included the Vermont Developmental Disabilities Council, Vermont Early Childhood Alliance, Hunger Free Vermont, Vermont Low Income Advocacy Council, Vermont Migrant Workers Coalition, Vermont Coalition of Runaway & Homeless Youth, Vermont Nurse Practitioners Association, Vermont Parent Child Center Network, Rutland Free Clinic, Vermont Public Interest Research Group, Vermont State Nurses’ Association, and Voices for Vermont’s Children. (Many other organizations, such as the League of Women Voters of Vermont, were not officially members of the coalition, but endorsed the legislation.) The Vermont State Dental Society stood in opposition, making the now-familiar claim that the training dental therapists would receive would not be “sufficient for the kind of patient care we would like to deliver.”³⁶

Once again, Assael made the trip from Minnesota, telling legislators and Vermont’s media that dental therapists had practiced “in the U.S. for more than 10 years with no adverse patient events or complaints, and no reports of patient safety being compromised.” The professor expressed confidence that Vermont Technical College’s program to educate mid-level practitioners “will meet the Commission on Dental Accreditation standards for dental therapy education programs,” with students undergoing “the same blind test and [exams] in the same process as dental students.”³⁷

In June, Vermont’s governor became the first Democratic chief executive to sign dental-therapy legislation into law, praising the measure’s ability to “improve access to high-quality, cost-effective dental care for Vermonters in all parts of the state. This is important because there’s a direct connection between oral health and overall health. Having dental therapists available to work with dentists and hygienists will make it easier for Vermonters to get the care they need, closer to home and no matter what type of insurance they have.”³⁸

³⁴ Leon A. Assael, Testimony, Hearing on LD 1230, “An Act to Improve Access to Oral Health Care,” Committee on Labor, Commerce, Research and Economic Development, Maine State Legislature, April 11, 2013.

³⁵ LD #1230, “An Act To Improve Access to Oral Health Care,” 126th Maine Legislature, Second Regular Session.

³⁶ Peter Hirschfeld, “Dentists Push Back Against Bill That Would Allow ‘Dental Therapists’ To Practice,” Vermont Public Radio, April 3, 2015.

³⁷ Kati Gallagher, “Dean of MN dental school visits VT to advocate for dental therapy,” Vermont Public Radio, March 2, 2016.

³⁸ “Gov. Shumlin Celebrates Law to Expand Dental Services to More Vermonters,” press release, June 20, 2016.

The Need in New Mexico

With only two states suffering from worse dental-professional shortages, New Mexico desperately needs to expand its oral-care workforce. Fortunately, interest in establishing dental therapy has been building in recent years. Since 2013, the New Mexico Legislature has drafted several bills to legalize the profession in the Land of Enchantment.

The most recent attempt was H.B. 191, a bill drafted during the 2016 regular legislative session. It incorporated many provisions similar to dental-therapy legalizations in other states, such as:

- in order to practice, dental therapists would be required to provide “evidence of having graduated and received a degree from a dental therapy school accredited” by the Commission on Dental Accreditation, pass “a written examination covering the statutes and rules relating to the practice of dental therapy in the state,” pass “a practical or clinical examination on the practice of dental therapy administered by the [New Mexico Board of Dental Health Care] or its agent that reasonable tests the individual’s skill,” and pay “any requisite fees and complied with any other reasonable requirements for licensure”
- dental therapists would be under the supervision of a dentist with whom they would be required to sign a “collaborative dental therapy agreement”
- dental therapists’ practice would be limited to 16 tasks under “general supervision,” including “oral evaluation and assessment,” the crafting of “an individualized treatment plan,” the placement and shaping of “direct restorations without mechanical preparation,” extraction of “primary teeth without radiological evidence of roots,” palliative treatment, “fabrication and placement of temporary crowns,” and the dispensing of “analgesics, anti-inflammatory substances and antibiotics” prescribed by a dentist
- under the “indirect supervision” of a dentist, dental therapists could prepare and direct “restoration of prepared cavities in primary and permanent teeth,” and fit, shape, and cement “stainless steel crowns on teeth prepared by a dentist”
- as it does for dentists, the New Mexico Board of Dental Health Care would regulate working dental therapists, with the power to “grant, deny, review, suspend and revoke” the practitioners’ licenses
- similar to restrictions adopted in Minnesota and Maine, dental therapists were required to offer their services only in rural counties, health services provided by the Indian Health Service, federally qualified health centers, “private residences and facilities “in which an individual receives long-term community-based services” under Medicaid, private residences with individuals who are “unable to receive care in a dental facility,” and schools “engaged in the training of dental therapists accredited by the commission on dental accreditation”³⁹

³⁹ H.B. 191, “Dental Health Act Changes and Therapists,” 52nd Legislature, State of New Mexico, Second Session 2016.

As was the case in previous states, a lengthy list of organizations has endorsed dental therapy in New Mexico, with Health Action New Mexico coordinating a coalition that includes the New Mexico Public Health Association, New Mexico Dental Hygienists' Association, AARP New Mexico, Rio Arriba Community Health Council, New Mexico League of United Latin American Citizens, Lutheran Advocacy Ministry of New Mexico, Navajo Nation, New Mexico Alliance for Retired Americans, Albuquerque Area Indian Health Board, New Mexico Center on Law & Poverty, Pueblo of Tesuque, New Mexico Conference of Churches, New Mexico Intertribal Community Services Council, New Mexico Telehealth Alliance, New Mexico Voices for Children, Southwest Women's Law Center, and Union County Health & Wellness Network. While no action was taken on H.B. 191 during the 2016, regular session, it is expected that a dental-therapy bill will be drafted in 2017, and it is likely that such legislation will again draw bipartisan support. With sessions in odd-numbered years lasting 60 calendar days, rather than 30, proponents hope that dental therapy will be able to garner more attention in 2017.

Conclusion

Dental therapists have proven their worth abroad, and have begun to make significant contributions to better and more-affordable oral health in the United States. The criticisms leveled at the practitioners have been shown to be specious – a substantial body of research shows “no difference between care provided by mid-levels and care provided by dentists.”⁴⁰ As a result, liberals and conservatives, Democrats and Republicans, have embraced dental therapy. While the profession is no panacea for the nation's oral-healthcare challenge, its ability in expand access and cut costs is no longer in doubt.

New Mexico has serious dental-access issues. The crisis is unlikely to be surmounted without expanding the state's dental workforce. Dental therapy has conclusively demonstrated its value elsewhere, and would surely boost oral healthcare in the Land of Enchantment.

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⁴⁰ John Davidson, “Dental Workforce Reform in Texas,” Center for Health Care Policy, Texas Public Policy Foundation, March 2016.