Approved:March 23, 2011
Date

MINUTES OF THE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Vicki Schmidt at 1:30 p.m. on March 9, 2011, in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Carolyn Long, Committee Assistant

Conferees appearing before the Committee:
Jason Wesco, Community Health Center of Southeast Kansas
Heidi Foster, Rawlins County Dental Clinic
Maggie Smet, Kansas Dental Hygienists Association
Kevin J. Robertson, Kansas Dental Association
Dr. Paul Kittle, DDS, Leavenworth
Dr. John Fales, DDS, Olathe
Dr. Mark Herzog, DDS Ellsworth
Dr. Dave Hamel, DDS, Marysville
Dr. Cindi Sherwood, DDS, Independence

Others attending:
See attached list.

The Chair continued the hearing on **SB 192—Kansas Dental Board; licensure of registered dental practitioners** and welcomed Jason Wesco, Community Health Center of Southeast Kansas. Mr. Wesco said that for them it would mean the ability to greatly expand access to quality dental care, in the same way that they use medical mid-levels to extend the reach of their physicians. He stated that the RDP is the best tool they have at their disposal to help eliminate numerous barriers that many Kansans face today in accessing oral health care (Attachment #1)

Heidi Foster, Rawlins County Dental Clinic which is a non-profit safety net dental clinic serving 18 counties in Northwest Kansas stated in her work she sees a persistent lack of dental care access. With the help of RDP, young people and adults in Northwest and Central Kansas could access the expanded spectrum of dental care they need. Their most vulnerable patients are children who are developmentally disabled, and frail elderly could receive services where they live and study, eliminating barriers to full dental care (Attachment #2).

Maggie Smet, Kansas Dental Hygienists Association President said she loves being able to give quality dental care to every Kansan. However she feels that those without dental insurance and those Kansans who qualify for federal poverty levels are at a great disadvantage (Attachment #3).

Presenting written testimony in favor of the legislation was Janette Delinger, KDHA Legislative Chair (Attachment #4), Denise Maus, KDHA past president (Attachment #5), Dave Sanford, CEO and Executive Director of GraceMed Health Clinic in Wichita (Attachment #6), Cathy Harding, Executive Director, Kansas Association for the Medically Underserved (Attachment #7), Tanya Dorf Brunner, Oral Health Kansas (Attachment #8), Katherine Weno, Director, Bureau of Oral Health, KDHE Attachment #9), Michael J. Hammond, Executive Director, Association of CMHCs of Kansas, Inc. (Attachment #10), and Georges C. Benjamin, Executive Director, American Public Health Association (Attachment #11).

The Chair recognized Kevin J. Robertson, Executive Director of the Kansas Dental Association (KDA), who spoke in opposition to **SB 192**. The KDA believes that all Kansans deserve access to safe and quality oral health care and to a dentist to provide for their diagnostic, restorative, and surgical dental needs. Dentists across Kansas believe that **SB 192** jeopardizes patient health and safety. Though not financially or politically feasible at this time, dental Medicaid for adults is a critical component to truly improving oral health in Kansas. The KDA supports the expansion of services for dental hygienists and worked toward the agreement that became the Extended Care Permit (ECP) Dental Hygienist. They endorse further expansion to the law to create an ECP III. They would have the same infrastructure, practice

locations/populations and dental supervision that the current ECP I and II have and as such would not create the bureaucracy of an entirely new practitioner (Attachment #12).

Dr. Paul Kittle has been in private practice in pediatric dentistry since 1994 and does accept Medicaid. He states Kansas has exceptional dentists who care for children. He has participated in Kansas Mission of Mercy (KMOM) projects in nine different areas through the State. He states the problem is not that there are insufficient Kansas dentists to treat those with a dental need, the problem is that even when and where care is available, the value and the importance of oral health is not understood (Attachment #13).

Also in opposition to **SB 192**, Dr. John Fales, President of the Kansas Association of Pediatric Dentists, believes that Kansas does not have an access to care issue but rather a barrier to care problem. He suggests some of the reasons are lack of understanding of the importance of good oral health on the part of the parents, inability to get to the dentist providing the free care because of transportation issues, fear of discovery by undocumented parents or not being able to take time off or not being allowed time off by employers (Attachment #14)

Dr. Mark Herzog, DDS from Ellsworth, told the committee that right now Medicaid is only for children and many come from economically and/or socially depressed households. He wonders if the majority of those who are in dire need of dental treatment are adult patients, how is the midlevel going to be able to treat them? There is no reimbursement other than extractions of permanent teeth which, under their guidelines, only allows them to do the very non-complicated (Attachment #15).

Dr. Cindi Sherwood, DDS, Independence told the committee that she has had both educations—that of a dental hygienist and a dentist, and that there is no comparison between the two curriculums. The breadth and depth of the dental curriculum is much more rigorous than the dental hygiene courses. The dental hygiene curriculum does not teach diagnosis. She does not feel that you can teach someone to do everything a general dentist does except root canals with 18 months of education on top of a superficial understanding of dentistry. A dental hygienist is not a dentist in training and she feels there are clear safety concerns based on a lack of adequate education for the proposed scope of practice of the dental practitioner (Attachment #16)

Dr. David Hamel, President of the Kansas Dental Association, stated that the location of dentists across the state follows the distribution of the population as a whole. Only the most remote farmers are not within 30 miles of a dentist. He acknowledged there are communities in Kansas without a dentist but also stated that it would be cost prohibitive and unnecessary to put dentists in each of those communities or call them underserved (Attachment #17).

Submitting written testimony in opposition to **SB 192** was Christy Gunter (Attachment #18), Dr. Jeffrey Stasch, DDS, Garden City (Attachment #19), Jessica Rogers, dental hygienist from Garden City (Attachment #20), Ric Crowder, DDS, President, Kansas Academy of General Dentistry (Attachment #21), Glenn Hemberger, DDS, President of Kansas Dental Board (Attachment #22), and Julie C. Swift, DDS, Topeka (Attachment #23).

There being no further conferees, the Chair closed the hearing on **SB 192**.

The next meeting is scheduled for March 10, 2011.

The meeting was adjourned at 2:30 p.m.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: March 9, 2011

NAME	REPRESENTING
Ron Nagel DDS	Those w/o Access
Kendra Poole	KAMU
Heidi S. Foster	Rawlins County Dental Clinic
Jason Wesco	Community Health Center of SEK
Jan Minnis	CHC/SEK
Maggie Smet RDH	Kansas Dental Hygienists Assoc.
Tom Gaches	KDHA
Cathy Harding	KAMU
Anna Lambertson	KS Health Consumer Coalition
Dawn Downes	Reach Foundation
Tanya Dorf Brunner	Oral Health Kansas
Bill Brady	KDA.
Robert Wood	KDA
Cynthia Sherwood	KDA
Christopher Jordan	Sen. Morris
Lana Cotsoradis	KAC
Chad Moore	CMFHP
Zac Kohl	Federico Cons.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: March 9, 2011

NAME	REPRESENTING
Paige Moore	Children's Mercy
Robert Stiles	KDHE
Benjamin Anderson	Ashland Health Center
Kari Presley	Kearney & Associates Inc.
LeAnn Bell	KHI
Betty Wright	Ks Dental Board
Paul Kittle	Private Practice, Leavenworth

Community Health Center of Southeast Kansas

Testimony – SB 192

Senate Public Health and Welfare Committee – March 8, 2011

Jason Wesco, Chief Operations Officer

Madam Chairwoman and members of the committee, thank you for allowing me to provide testimony in support of SB 192.

My organization provides access to medical, behavioral and dental care services to all individuals regardless of their ability to pay. Last year we cared for more than 23,000 patients during nearly 80,000 visits to clinics located in Pittsburg, Columbus and Iola. Our dental program employs five full-time dentists and ten dental hygienists (all with Extended Care Permits) that offer services in four clinical locations and on-site in schools, Head Starts and long-term care facilities across Southeast Kansas. The growth in our dental services has been significant since the inception of the program in 2006. Last year we cared for 12,000 dental patients during more than 21,000 visits.

In my work at CHC/SEK, I am responsible for all aspects of our dental program, from new program development and strategic planning to recruiting dentists and dental hygienists. In this capacity, I have seen first-hand the critical lack of access to dental care that exists in rural Kansas, not just for the underserved, but for entire communities. As a Community Health Center, we concern ourselves with access to care for everyone, not just the underserved. And we are very concerned about the current and especially the future of access to oral health care in Kansas.

Since inception, our dental clinics have cared for patients from twenty-six Kansas counties and we regularly see patients that drive from 75 miles away to obtain affordable dental care. This demand has been the impetus for the rapid expansion of our dental program, but even with our expansion we are still hopelessly understaffed. In Southeast Kansas alone, there are almost 70,000 low-income individuals in the nine county region – nearly 40% of the total population. But the problem doesn't stop here. There are about 175,000 individuals in our region and, at my last count, 44 general practice dentists (and no pediatric dentists, no endontists and just one oral surgeon). That's one dentist for every 3,977 residents. By my calculations, the ratio in Kansas is about 1:2,500, and in the nation about 1:1,100. By any measure we are underserved.

To further compound the problem, we have an aging dental workforce. According to KDHE's Bureau of Oral Health's recent workforce survey, the average age of a dentist practicing in rural Kansas is about 55. With the increasing demand for care and the decreasing supply of dentists, we are facing a crisis in access to dental care of increasing severity over the next 10 years – assuming attrition in providers that tends to come with an aging workforce. In some of our counties over that time, I anticipate that we may be the only source of dental care available for anyone, insured or not, wealthy or poor. This reality will strain our resources tremendously. In fact, there is no way, given the current environment, we would be able to provide adequate access to care to additional patients.

P.O. Box 1832, 3011 N. Michigan, Pittsburg, KS 66762-1832 *Phone: 620.231.*

Community Health Center of Southeast Kansas

SB 192 proposes the creation of a Registered Dental Practitioner, a mid-level provider that would function much the same way as Advanced Registered Nurse Practitioners and Physician's Assistants do in the medical field. The RDP would work under the supervision of a dentist through a collaborative agreement, an agreement that could restrict the RDP's scope of practice beyond the proposed legislation. The RDP could work under direct or general supervision, essentially freeing them much as medical mid-levels are freed, to practice without a doctor on-site.

For us, the RDP would mean the ability to greatly expand access to quality dental care, in the same way that we use medical mid-levels to extend the reach of our physicians. In our medical practice, we employ six full-time physicians and six full-time nurse practitioners. I expect the same kind of ratio in our dental practice if we were to have access to RDPs. If we were to hire six dental mid-levels, we estimate that an additional 8,000 patients could be cared for during 15,000 visits each year.

The RDP would mean an increased provider pool for us to recruit from. Currently, of the five dentists we employ, only one is a Southeast Kansas native, a fact that could lead to long-term retention issues. Expanding the dental provider pool to include RDPs would increase the likelihood of finding regional natives that would choose to practice (and remain long-term) in the area. This increased provider pool would allow us to increase capacity at our current clinical sites and to more readily expand into communities where CHC/SEK does not currently have a physical presence.

In short, the RDP is the best tool we have at our disposal to help eliminate numerous barriers that many Kansans face today in accessing oral health care. Over the next decade, the conjoined problems of access to care and the declining dental workforce, problems that have traditionally affected the uninsured and those with public health benefits, threaten to make most Kansans "underserved."

This legislation before you appeals to, as Lincoln said, "the better angels of our nature." It says "yes" to our fellow Kansans in need who are so accustomed to being told "no." It illustrates our heritage as a people who seek out, find and implement unique solutions to complex challenges. It carries on the proud Kansas tradition of passing progressive legislation in the public's interest.

We, as a state, can lead on this issue.

On behalf of our board, staff, patients and most importantly those we are as yet unable to serve, I ask that you support this important piece of legislation.

Thank you for considering my testimony. Best wishes as you deliberate on this matter.

P.O. Box 1832, 3011 N. Michigan, Pittsburg, KS 66762-1832 Phone: 620.231.9873 Fax: 620.231.5062

Testimony in Support of SB 192

Senate Public Health and Welfare Committee

Heidi Foster, Chief Executive Officer, Rawlins County Dental Clinic

March 8, 2011

Madam Chair and Members of the Committee,

I appreciate the opportunity to speak before you today in support of Senate Bill 192.

My name is Heidi Foster and I am the chief executive officer of the Rawlins County Dental Clinic, a nonprofit safety net dental clinic serving 18 counties in Northwest Kansas.

It took nearly 6 years for the community to establish a dental clinic for Rawlins County, but our clinic has grown exponentially in its first 18 months of operation. Due to continued growth we expanded to a new building in November 2010 and added a full-time dentist. We have also expanded our work to students in area schools, nursing homes residents, and patrons of developmentally disabled centers, by providing services such as cleanings, sealants, patient education, and fluoride varnishes.

In my work, I see a persistent lack of dental care access. Our clinic staff provides an array of services to students in area schools, but our hygienists cannot diagnose decay under current practice acts. Our staff makes an effort to send letters home with students, alerting parents to potential problems with their children's teeth. However, many students' parents cannot provide transit to a clinic for themselves or their children due to the prohibitive distance. Consequentially then when we returned the following school year to perform preventative services over 60% of these children with noted concerns have more areas of potential decay and the existing areas are much larger. So students qualifying for free or reduced cost lunches at public schools in Northwest Kansas receive semi-regular cleanings, but still don't have access to the regular care they need.

This is where the Registered Dental Practitioner could fill the void. With the help of Registered Dental Practitioners, young people and adults in Northwest and Central Kansas could access the expanded spectrum of dental care they need. Our most vulnerable patients' children, developmentally disabled, and frail elderly could receive services where they live and study, eliminating barriers to full dental care.

Registered Dental Practitioners are necessary to fill the gap in Kansas because it seems as though we have exhausted other options for bringing care to people in rural areas. Even though Rawlins County Dental Clinic did recruit a second full time dentist, she only plans on staying until her loans are repaid through the state loan repayment. Upon completion of her obligation she plans to return to Omaha and open her own practice. Our second dentist that works three days per week is in his upper 70's. It's time to try something different.

Thank you. I'm happy to stand for questions.

Senate Public Health & Welfare Committee
Testimony of Maggie Smet, RDH
KDHA President 2010-2011
In support of SB 192: Registered Dental Practitioner
Tuesday March 8, 2011

Chairwoman Schmidt and Committee Members:

Thank you for allowing me to speak on behalf of Kansans who can not afford private practice dental care.

I currently hold the very first Extended Care Permit granted in the state of Kansas and worked with many underserved Kansans from 2004 until 2009. I carried a mobile dental chair and other dental equipment to 8 nursing homes In Harvey, Butler, Sedgwick and McPherson counties to perform dental cleanings for elders who could not easily access a dentist. I also worked at the Health Ministries Clinic in Newton giving preventive dental care to many children and adults from Harvey and surrounding counties.

I heard many stories from the patients related to their prolonged absence from a dental office-most of the time, it was due to cost. Safety net dental clinics use a sliding fee scale based on a person's income to pay for dental procedures. For example, a simple filling to repair a cavity in private practice can cost from $152 to over $200. At a safety net dental clinic the same filling would be $70. If a tooth needed a full coverage crown (also known as a cap) the cost is $950 in private practice vs. $360 in a safety net clinic!

As a dental hygienist, I love being able to give quality dental care to every Kansan. However, I feel those with out dental insurance and those Kansans who qualify for federal poverty levels are at a great disadvantage. They can receive wonderful dental care at a safety net dental clinic, but the waiting list is long. Safety net dental clinics have difficulty employing and retaining a dentist. Theses clinics need help! A Registered Dental Practitioner (RDP) can positively impact the needed dental care for thousands of Kansans. Our state has an abundance of dental hygienists that can be trained in further dental procedures that will help accomplish the dental need.

I do not subscribe to the scare tactics cited by other organizations related to patient safety under the care of a RDP. I feel that Kansas can create a program to appropriately educate RDPs to deliver quality care. This proposed legislation has many safety features built in such as having a licensed dentist available for both consultation and referral, related to patient care by a RDP. The collaborating dentist will oversee the RDP for at least 500 hours of direct supervision to allow for a RDP to hone dental skills in their scope of practice. Additionally the sponsoring dentist can, by written agreement with the RDP, limit the procedures due to comfort level.

As President of the Kansas Dental Hygienists Association, I have visited Garden City Kansas, UMKC dental hygiene students from Kansas and the Manhattan area discussing this topic. In each crowd many dental hygienists are interested in pursing this additional training and providing the needed dental care to

people in their areas. I have also received many emails from dental hygienists in other parts of our state asking when and where they can take this training. A lot of excitement is being generated.

Kansas has 19 safety net dental clinics. They are the answer to delivering needed dental care, but they need help! Please support SB 192. Please help the thousands of Kansans who will be able to receive the needed dental care and dental education to promote total health.

Respectfully submitted,

Maggie Smet, RDH

Te. ony of Janette Delinger, RDH, BSDH
Supporting SB 192: Creating the Registered Dental Practitioner
Public Health and Welfare Committee
Tuesday, March 8, 2011

Chairwoman Schmidt and members of the committee, I am asking for your support of the enactment of SB 192, a proposal to increase access to basic and preventive dental services for the underserved and unserved populations through the development of the Registered Dental Practitioner (RDP). Kansans have been suffering for many years due to the shortage of dentists in our state. Currently 91 of 105 counties are without enough dentists to take care of the population (as well as the lack of Medicaid providers) and are designated by the state as Health Professional Shortage Areas (HPSA).

Development of a mid level dental provider, such as the Registered Dental Practitioner (RDP), is very comparable to the medical profession's nurse practitioner. A registered dental hygienist (RDH) has a minimum of an Associate Degree with at least 3 years of college, passed a national board exam, clinical exam and a state ethics and jurisprudence test given by the Kansas Dental Board (KDB) before becoming licensed to practice in the state of Kansas. Every dental hygiene program and dental school program in the U.S. are accredited by the same organization, the Commission on Dental Accreditation (CODA). There are competencies ("Section 2-Curriculum, Patient Care Competencies, and Curriculum Management" attached to this testimony) required for each dental hygiene student to complete in order to graduate from the program. If you review the attached section, you will see what a demanding and challenging program dental hygiene students have to complete for graduation. To review the full 42 page document of the Accreditation for Dental Hygiene Education Programs, please visit http://www.ada.org/sections/educationAndCareers/pdfs/dh.pdf . Accepting a RDH as the starting point for the RDP program is exactly where a mid level provider should begin. The RDH would become a RDP by completing curriculum of at least 12 months, but not more than 18 months at an accredited institution, completing a clinical examination and then be licensed as an RDP (also retaining their RDH license). The RDP education will continue to build on the RDH's dental knowledge by further expanding their clinical skills to include basic dental services alongside their full preventive services to provide care for specific target populations in specific practice settings.

The KDA opposition to the RDP based on the registered dental hygienist because they don't have sufficient level of training seems like a hypocritical argument to me. The KDA developed the legislation authorizing the scaling assistants to do the job of dental hygienists including cleaning and scaling teeth and they have no accreditation standards at all – None! They have no minimum education requirements and have no more than 90 hours of education and training. Not 90 college hours; just 90 hours. They also have no continuing education or licensure requirements at all. The Registered Dental Practitioner will be a highly qualified and experienced mid-level provider with education and clinical training substantially greater than a dental hygienist allowing them to meet the preventive and basic dental needs of the underserved and unserved Kansans.

Now is the time to be proactive for the underserved and unserved populations that cannot speak for themselves. Let's do what is right for Kansas and give those in need good, basic and preventive care dental services that will have a huge impact in improving their overall health. I urge you to approve SB 192 and create the Registered Dental Practitioner.

Respectfully submitted,

Janette Delinger, RDH, BSDH
KDHA Legislative Chair
janettedelinger@yahoo.com

Senate Public Health & Welfare
Date 3-9-2011
Attachment 4

Dental Hygiene Standards

Curriculum

2-6 The dental hygiene program must define and list the competencies needed for graduation. The dental hygiene program must employ student evaluation methods that measure all defined program competencies. These competencies and evaluation methods must be written and communicated to the enrolled students.

2-7 Written course descriptions, content outlines, including topics to be presented, specific instructional objectives, learning experiences, and evaluation procedures must be provided to students at the initiation of each dental hygiene course.

2-8 The curriculum must include content in the following four areas: general education, biomedical sciences, dental sciences and dental hygiene science. This content must be integrated and of sufficient depth, scope, sequence of instruction, quality and emphasis to ensure achievement of the curriculum's defined competencies. A curriculum document must be submitted for each course included in the dental hygiene program for all four content areas. Intent:

2-9 General education content must include oral and written communications, psychology, and sociology.

2-10 Biomedical science content must include content in anatomy, physiology, chemistry, biochemistry, microbiology, immunology, general pathology and/or pathophysiology, nutrition and pharmacology

2-11 Dental sciences content must include tooth morphology, head, neck and oral anatomy, oral embryology and histology, oral pathology, radiography, periodontology, pain management, and dental materials. Intent:

2-12 Dental hygiene science content must include oral health education and preventive counseling, health promotion, patient management, clinical dental hygiene, provision of services for and management of patients with special needs, community dental/oral health, medical and dental emergencies, legal and ethical aspects of dental hygiene practice, infection and hazard control management, and the provision of oral health care services to patients with bloodborne infectious diseases

2-13 The basic clinical education aspect of the curriculum must include a formal course sequence in scientific principles of dental hygiene practice, which extends throughout the curriculum and is coordinated and integrated with clinical experience in providing dental hygiene services.

2-14 The number of hours of clinical practice scheduled must ensure that students attain clinical competence and develop appropriate judgment. Clinical practice must be distributed throughout the curriculum.
Intent: *Sufficient practice time and learning experiences should be provided during preclinical and clinical courses to ensure that students attain clinical competence. The number of hours devoted to clinical practice time should increase as the students progress toward the attainment of clinical competence. The preclinical course should have at least six hours of clinical practice per week. As the first-year students begin providing dental hygiene services for patients, each student should be scheduled for at least eight to twelve hours of clinical practice time per week. In the final prelicensure year of the curriculum, each second-year student should be scheduled for at least twelve to sixteen hours of practice with patients per week in the dental hygiene clinic.*

Example: WSU translates to the following:

Preclinic hours	105
1st Year clinic	244
2nd Year clinic	480
	829 hour Total

2-15 The dental hygiene program must have established mechanisms to ensure a sufficient number of patient experiences that afford all students the opportunity to achieve stated competencies.

Patient Care Competencies

2-16 Graduates must be competent in providing dental hygiene care for the child, adolescent, adult and geriatric patient. Graduates must be competent in assessing the treatment needs of patients with special needs.

2-17 Graduated must be competent in providing the dental hygiene process of care which includes:
a) comprehensive collection of patient data to identify the physical and oral health status;
b) analysis of assessment findings and use of critical thinking in order to address the patient's dental hygiene treatment needs;
c) establishment of a dental hygiene care plan that reflects the realistic goals and treatment strategies to facilitate optimal oral health;
d) provision of patient-centered treatment and evidence-based care in a manner minimizing risk and optimizing oral health;
e) measurement of the extent to which goals identified in the dental hygiene care plan are achieved;
f) complete and accurate recording of all documentation relevant to patient care.

2-18 Graduates must be competent in providing dental hygiene care for all types of classifications of periodontal disease including patients who exhibit moderate to severe periodontal disease.

2-19 Graduates must be competent in interpersonal and communication skills to effectively interact with diverse population groups.

2-20 Graduates must be competent in assessing, planning, implementing and evaluating community-based oral health programs including, health promotion and disease prevention activities.

2-21 Graduates must be competent in providing appropriate life support measures for medical emergencies that may be encountered in dental hygiene practice.

2-22 Graduates must be competent in applying ethical, legal and regulatory concepts to the provision and/or support of oral health care services

2-23 Graduates must be competent in the application of self-assessment skills to prepare them for life-long learning

2-24 Graduates must be competent in the evaluation of current scientific literature

2-25 Graduates must be competent in problem solving strategies related to comprehensive patient care and management of patients.

Curriculum Management

2-26 The dental hygiene program must have a formal, written curriculum management plan, which includes:
a) an ongoing curriculum review and evaluation process with input from faculty, students, administration and other appropriate sources;
b) evaluation of the effectiveness of all courses as they support the program's goals and competencies;
c) a defined mechanism for coordinating instruction among dental hygiene program faculty.

For the complete CODA standards on Dental Hygiene Programs visit:
http://www.ada.org/sections/educationAndCareers/pdfs/dh.pdf

Senate Public Health and Welfare Committee
Testimony of Denise Maus, RDH, BS
KDHA Past President
In support of SB 192: Registered Dental Practitioner
Tuesday, March 8, 2011

Chairwoman Schmidt and Committee Members:

Thank you for providing this time to discuss with you the important issue of access to dental care for all Kansans and how the Registered Dental Provider (RDP) could help in the future to provide greater access to dental care throughout the state. I have been actively involved in dental hygiene for nearly 30 years serving on many different boards in varying capacities. I have held numerous officer positions in my local and state dental hygiene associations. I am a clinical dental hygiene examiner for 2 different regional testing agencies (Central Regional Testing Agency and Western Regional Examing Board) and have participated on committees within each organization. I am a member of the Kansas Dental Board and a past president. I have also been involved in dental hygiene education as an adjunct clinical faculty and was the lead hygienist organizing patient education at the past five Kansas Mission of Mercy's as well as attending all ten.

Several years ago I was before you discussing what was then a perceived shortage of dental hygienists. The solution provided by the Kansas Dental Association at that time was to create scaling assistants who could perform many of the same oral health services as a dental hygienist until we could educate enough dental hygienists to fill the perceived shortages across the state. Since that time several dental hygiene schools opened throughout the state (increasing from two to five the number of hygiene schools in Kansas) which now provide us with approximately 100 graduates each year. In just the last three years alone, we have seen the number of actively practicing dental hygienists with practice locations in Kansas go from 1529 to 1750, an increase of 221 dental hygienists. In the same time frame, we have seen the numbers of actively practicing dentists with practice locations in Kansas increase only from 1413 to 1425, an increase of only 12 dentists. Although the state has licensed 2112 dentists and 2403 dental hygienists, keep in mind that these numbers only tell you who holds a license and not their practice situation or what state they may reside in. Kansas has no dental school and it appears quite likely that there will never be one. Other options must be considered to increase the productivity of dentists especially as we see much of our dentist population retiring in the near future. It is evident that there is no shortage of dental hygienists and as time passes there will be fewer and fewer dentists to work for, making the employment situation for hygienists even more difficult.

Another significant development related to access to care is the numbers of dental hygienists practicing with extended care permits. Dental hygienists with this special certificate may go into many different locations outside the dental practice to provide care to children and the elderly who are unable to acquire or access a dental home of their own at that time. To date, there have been 43 ECP I's and 81 ECP II's issued to dental hygienists. Dental hygienists want to reach out and help provide care to these people but are limited by their scope of practice. The ECP III being proposed by the dental association is certainly one more step forward but still lacks many of the provisions provided for in this bill.

The concept of increasing the scope of practice of dental hygienists to include some of the simpler duties that a dentist can only provide at the current time has been around for many years. This year alone, there are several states looking at these very same issues about how citizens could better access

and receive dental care. States as varied as Washington, Oregon, New Mexico and Connecticut and many in between are looking at practice issues and how to best provide dental care in their state.

Over the past several years, I have closely watched the progress that Minnesota has made in regard to "their new provider- the dental therapist" who performs services nearly, if not identical, to the list of service you see contained within this bill. In fact, the first class of students is set to graduate this spring. I believe that the new provider contained within this bill today has been done before just not in Kansas. Countless hours and great care was placed into the formation of a curriculum to ensure the appropriate education for the dental therapist to perform these procedures that are listed. In fact, in Minnesota, dental therapist students are trained alongside dental students and are held to the same standards as the dental students in regard to these procedures.

This spring, these new providers will be taking a clinical exam designed for them and implemented by CRDTS (Central Regional Testing Service, Inc.). CRDTS is the third party regional clinical testing agency that currently examines dentists and dental hygienists on the proficiency of their skills in order to gain licensure. In order to practice in Kansas, all licensees are required to have passed a regional clinical test such as CRDTS. CRDTS has no opinion on new providers but is there to help state boards with their requests in clinical testing of dentists, dental hygienists and most recently dental therapists. They will be testing the dental therapists on the more difficult procedures that would be performed just as they do for other dental professionals ensuring proficiency of those skills. Areas that are being tested for the dental therapist include cavity preparation and restoration (fillings), stainless steel crown preparation and placement, and tooth pulpotomy. Much time and expense has gone into the development and implementation of this test that we should take advantage of what has been accomplished using it here in Kansas.

I strongly feel that we should not reinvent the wheel with the Registered Dental Practitioner. We should take advantage of the work that has been completed before us by dental educators and the board of regents, state dental and dental hygiene associations, clinical exam testing services and by legislators such as you. So much effort and care has been placed into the development and implementation of the curriculum and clinical testing of these services that are before you today, I hope that you will consider keeping all the services as listed knowing that this can work for Kansas as well! By doing so, much time and expense can be saved yet ending up with well educated and trained providers who would be able to provide quality dental care contained within their scope of practice.

Kansas is considering a great choice when we choose to use a dental hygienist who already has a vast amount of knowledge about dental hygiene, prevention of dental diseases and general dental knowledge to become a Registered Dental Practitioner.

Thank you for your time and careful consideration of these important issues related to the Registered Dental Practitioner. Please support passage of SB 192.

Denise A. Maus, RDH, BS
Wichita, KS
KS DH Lic. #1499

GraceMed

A Health Ministry of the United Methodist Church
Kansas West Conference

Corporate Office
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March 8, 2011

Good afternoon Madam Chair and members of the Senate Public Health and Welfare Committee.

My name is Dave Sanford, CEO and Executive Director of GraceMed Health Clinic in Wichita. I also currently serve as President of the Board of the Kansas Association for the Medically Underserved, (KAMU), one of the partners in the Kansas Dental Project.

On behalf of KAMU and the 39 safety net clinics in Kansas, I am here to speak in support of SB 192. Eighteen of our member clinics provide dental services and maintaining an affordable and adequate work force is an ongoing challenge.
Not a day goes by at GraceMed's main dental clinic that we don't see a person who desperately needs dental care. For example, Shawna M., an 8-year old elementary school student from a small south central town had missed a number of school days because of pain associated with poor oral health. She was screened at school by one of our dental hygienists and found to have several cavities needing immediate attention. With no local dentist available, the uninsured mother did not know where to turn for care. The family qualified for HealthWave coverage and was referred to our main dental clinic for follow up care. As with many families in underserved areas, the mother was not aware of any local dental resources and, at the same time, felt that without insurance, her family was excluded from accessing private services in neighboring communities. If SB 192 is passed, perhaps in a few years, this family and others in that community will have access to some level of oral health care services provided by a competent, caring professional working under the supervision of a dentist in a neighboring town.

Registered Dental Practitioners (RDP) in Kansas are Registered Dental Hygienists who choose to obtain advanced training beyond their hygiene degree. This training for RDP's will be intensive, hands-on experience to master the approved scope of practice. By approving this legislation, you will be addressing the oral health care needs of thousands of Kansans who currently lack access to quality care in a more affordable system.

You have already heard the major concern this proposed bill addresses is access to dental care for underserved Kansans. It is a significant issue in the rural areas of the state, but I also want to share that access to dental care is a concern in some urban areas as well. In Wichita, we have a wonderful, engaged dental community. Many of

our local dentists participate in the annual KDA sponsored *Mission of Mercy*, several local dentists participate annually in our *Give Kids a Smile Day* (free care for low-income, uninsured children), a number of dentists volunteer at the Sedgwick County Health Department's Children's Dental Clinic and a number of dentists do provide some pro bono or reduced fee services for patients. Yet, even with these valiant local efforts, the demand for oral health care services exceeds supply. In 2010, GraceMed provided care for 13,705 unduplicated dental patients through 21,989 patient visits. This demonstrates, even in Wichita, that the current and projected number of dentists is simply inadequate to meet the demand for care.

The creation of a Registered Dental Practitioner in Kansas will not only make dental care more accessible, but more affordable as well. The opportunity for dentists to hire and supervise RDP's with a well-defined scope of practice will lead to the provision of cost-effective oral health care services. Since we are unable to meet the current demand for services in the State of Kansas, the passage of SB 192 will allow private practices and community health centers to hire RDP's and close the gap between demand and supply. The passage of this bill fits perfectly with the State's current emphasis on trimming costs while providing needed services. Ultimately, improving the overall health of patients is the long term objective of the Registered Dental Practitioner. As you deliberate this important, new opportunity for Kansas, may I provide an analogy from our past. Several years ago, many physicians opposed the creation of the Physician Assistant and the Advanced Registered Nurse Practitioner (ARNP) models for some of the very same reasons you may hear. Today, though, most physician practices have employed mid-level providers and have increased access to quality medical care for their patients. This model has proven successful in addressing many of the same issues we are discussing today in the oral health care field.
Medical mid-levels are now recognized as such an important component of the medical team that physician practices are required to employ at least a part time mid-level to be federally designated as a Rural Health Clinic.

System changes are always difficult to implement. Often, change is perceived as being either frightening or threatening because it's never been tried before. It is easier to stick with the 'status quo'. However, in this case, the current system is not sufficiently addressing the needs of all Kansans. There are simply too many real-life examples, like the ones I mentioned earlier, that focus on access and affordability. Change can be challenging – but sometimes it's simply the right thing to do. As with the medical mid-level example, we will one day look back on the passage of SB 192 and rejoice in the fact that more Kansans have access to quality oral health care services.

KAMU
THE PRIMARY CARE ASSOCIATION OF KANSAS
strength
unity
advocacy

Testimony on:

Senate Bill 192

Presented to:

Senate Public Health and Welfare Committee

By:

Cathy Harding, Executive Director
Kansas Association for the Medically Underserved

March 8, 2011

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Good afternoon, Madam Chair and members of the committee. I am Cathy Harding, Executive Director of the Kansas Association for the Medically Underserved (KAMU). Our association represents 39 safety net clinics in Kansas, 18 of which provide dental services.

Years ago I served as the Executive Director at the Flint Hills Community Health Center in Emporia when they established their dental clinic, and will never forget a phone call I took just before the clinic opened. A soft-spoken gentleman called to schedule an appointment for his nine-year-old daughter. When I responded that I'd take their names but that there was already a three-month waiting list, he said that was fine. He explained that his daughter was having trouble sleeping at night because of the pain and was beginning to have trouble eating solid food, but he understood that others needed care more than she did. "Just put us on your list," he said.

Our clinics receive calls like this all the time. Although 2010 clinic data is still being reported now so I don't have it available, in 2009 our clinics provided dental services for 54,116 people. This is a drop in the bucket compared to the unmet need. During the fall of last year KAMU partnered with SRS on a short-term dental program that provided just over $1 million in dental care for Kansans that qualified for TANF. Many private dental practices and safety net clinics participated in this program, which lasted for about two months. One of my staff members decided to tally the number of phone calls she took about this program for two weeks, which numbered 74 people. Keep in mind that this staff member only took incoming phone calls after our two main receptionists were unavailable, so I can only surmise that the volume likely well exceeded 300 calls during that two weeks. We're still taking calls from people now that have heard of the program, which ended in September. Just last week I answered one of these calls myself.

An effective plan to improve the oral health of Kansans – and particularly our most vulnerable citizens – must be multi-faceted. It must include education and prevention, along with increased access to needed care. The bill you have before you will address all these things. Dental hygienists are trained to focus on patient education, so this new provider built upon existing dental hygiene training will achieve the education and prevention component, but also will increase the number of professionals that can treat patients that need more care.

Tomorrow you will hear testimony designed to scare you, to make you believe that your support of this legislation will jeopardize the public's health and welfare. This testimony is based solely on emotion, without any evidence or research to support it. The bill before you today is not about emotion, but about one thing only: Workforce. The U.S. Health and Human Services produced a report earlier this year about the number of dentists each state was short. According to this report, Kansas now needs an additional 94 dentists to meet the needs of the population. The Kansas Department of Labor projects that by 2016 our state will be short 279 dentists. In 2016, calls like the one I described earlier in this testimony will be made by people like you and me.

As you listen to opponent's testimony tomorrow I ask you to remember the conversation I had a few years ago with a father trying to relieve his nine-year-old daughter's pain, and who said that it was "okay" to wait another three months. This is ***not*** "okay." By your support of this legislation, you can take the steps needed to ensure calls like this are history.

Thank you for your time today. I'm happy to stand for questions.

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ORAL HEALTH KANSAS

Public Health and Welfare Committee
March 8, 2011

Madam Chair and members of the Committee, thank you for the opportunity to testify about SB 192. My name is Tanya Dorf Brunner, and I am the Executive Director of Oral Health Kansas, Inc. We are the statewide advocacy organization dedicated to promoting the importance of lifelong dental health by shaping policy and educating the public so Kansans know that all mouths matter. We achieve our mission through advocacy, public awareness, and education. Oral Health Kansas has over 1,100 supporters, including dentists, dental hygienists, educators, safety net clinics, charitable foundations, and advocates for children, people with disabilities and older Kansans.

We see three types of barriers to accessing oral health in our state: access to a payment source; access to a provider; and willingness to access services. A variety of approaches to all three types of access must be present in order for all people to have adequate access to oral health care. With our partners in the oral health field, we are working to address each of these through a variety of means.

Oral Health Kansas recognizes the need to expand and strengthen the dental workforce in Kansas. We believe access to both a provider and a payment source need to be strengthened in order to ensure all Kansans have access to good oral health care. Without a funding source, people do not have access to dental services. Likewise, without a dental provider, people do not have access to dental services. Both are critical, and one of our key priorities is to strengthen the Kansas Medicaid program by ensuring all people eligible for the program have access to dental services.

Our board supports the efforts being undertaken to address dental workforce issues through SB 132 and SB 192. This Committee will hear testimony from lots of the experts on the specific components of this bill. They will help you determine the best public policy for the state related to oral health providers. I am here on behalf of Oral Health Kansas, representing an objective, third party advocacy organization, that encourages you to support SB 192 to address the general, statewide interest in expanding and strengthening access to oral health services.

Oral Health Kansas is dedicated to collaboration; as such, we encourage the parties working on dental workforce models to collaborate on a model that works best to meet the oral health needs of all Kansans.

Thank you for the opportunity to provide this testimony.

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Senate Public Health & Welfare
Date 3-9-2011
Attachment 8

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Kansas

Robert Moser, MD, Acting Secretary | Department of Health & Environment | Sam Brownback, Governor

Testimony on SB 192

Presented to
Senate Public Health and Welfare Committee

By
Katherine Weno, DDS, JD
Director, Bureau of Oral Health
Kansas Department of Health and Environment

March 8, 2011

Chairperson Schmidt and members of the committee, I am Dr. Kathy Weno, the Director of the Bureau of Oral Health at the Kansas Department of Health and Environment, the State Dental Director. Thank you for the opportunity to provide you with written testimony about Kansas' oral health workforce and SB 192.

The Bureau of Oral Health is the state's public health section dedicated to oral health. We collect data on the oral health of Kansans, administer a Dental Recruitment program and provide funds for community based oral health improvement projects.

The sufficiency of Kansas' dental providers to meet the oral health needs of Kansans is an issue the Bureau of Oral Health has been working on for several years. In 2009 the Bureau completed a workforce research project, the "*2009 Kansas Oral Health Workforce Assessment*"[1]. Utilizing this research, we were able to secure a federal grant to create the Kansas Dental Recruitment Program. The program employs a full time workforce specialist to assist rural dentists and safety net clinics in dental professional recruitment and offers workforce incentives like student loan re-payment and provider grants to subsidize community based projects like school sealant and nursing home programs. We also created "Dental Club", a program for high school students to interest them in dental careers. Dental Club provides students with work/study and mentoring opportunities as well as college scholarships for students willing to commit to a dental career. Lastly, the grant includes an on-going task group, the Dental Workforce Cabinet, where a diverse group of stakeholders work together on workforce issues.

Kansas currently has 1,425 active licensed dentists that practice mainly in population centers across the state. Thirteen counties in Kansas have no dentist, and 80% of these counties are in sparsely populated parts of Western Kansas. The average age of a Kansas dentist is 50, but as the population of a Kansas county decreases, the age of their dentist increases. The average age

[1] http://www.kdheks.gov/ohi/download/2009_Oral_Health_Workforce_Assessment.pdf

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of a dentist increases to 57 in a frontier county. 54.3% of these dentists plan to retire in the next 3-5 years. Recruiting dentists to work in Kansas is difficult. For dentists who reported their practice was for sale, 75% indicated the practice had been for sale for a year or more. Among those looking to hire an additional dentist to their practice, 48.5% reported that recruitment had been difficult.

Currently the Bureau is working with researchers at the University of Kansas Medical Center on a new dental workforce research project using population data and geo-coding to identify areas in Kansas that are without convenient access to dental care. The project is on-going but as it is particularly relevant to this hearing, I have included two maps from this research with this testimony. Figure One is a map of all of the dental practices in Kansas, placed on a background indicating the county's dentist to population ratio. The dot on the map indicates a dental practice location, and the white box is the total number of dentists located within the county. The more darkly colored counties indicate counties with fewer dentists practicing in a county with a significant population density. Based on this information, it appears that Kansas dentists are relatively well situated to meet the needs of the state's population. Counties with low population densities may have few or no dentists, but looking at the map as a whole, a dental practice is usually located nearby. If the Bureau utilized this map to determine where new access points should be created, we would concentrate our efforts in north central and south western Kansas where the dentists are few and the population is sufficient to support a new dental practice or a community based dental program.

The plotting of dental practices on a map in relation to population density is a useful tool, but the Bureau of Oral Health realizes that it does not tell the whole story. The presence of a dental practice in a county does not guarantee access to dental services for all sections of the population. Most dentists limit their practices to those with dental insurance or the ability to pay. For uninsured populations and children on Medicaid, access is much more challenging. Kansas Medicaid provides only children with a full dental benefit; dental services for adults on Medicaid are limited to emergency services only. Kansas Medicaid pays dentists around 60.5% of their median retail fees, and the majority of Kansas dentists do not participate. Last year, only 412 dentists filed a Medicaid claim. Even fewer dentists see a significant number of Medicaid patients on a regular basis. Figure Two maps the number of dentists who received $10,000 in Medicaid claims payment in FY 2010. This includes only 222 dental providers. In 2007, only 41.2% of Kansas Medicaid enrolled children received a dental service.

The Bureau of Local and Rural Health applies for federal designation of Dental Health Professional Shortage Areas (HPSAs). HPSAs exist in areas that have a high ratio of population to dentists or a high ratio of certain populations to dentists, such as low-income or those enrolled in Medicaid. This designation is used to identify these areas to support the most effective targeting of resources by federal programs, such as the National Health Service Corps. There are currently 27 full county-dental HPSAs in Kansas; meaning that there exists a high ratio of population to the total dentists in these areas and that there is not reasonable access to dentists in other areas. There are also 62 full-county designations for the low-income or Medicaid populations along with the cities of Wichita and Topeka, meaning that there exists a high ratio of the indicated population to dentists that serve the population in these areas and there is not reasonable access to dentists in other areas serving the population.

SB 192 would create a new dental provider (called a Registered Dental Practitioner) that is intended to treat Medicaid and other underserved populations. The Bureau of Oral Health supports innovative proposals that could increase access to dental care. The new proposed practitioner is a registered dental hygienist with additional training in restorative and surgical procedures. A community based dental hygienist model is not unprecedented in Kansas. In 2003 the Kansas Dental Practice Act was amended to allow a dental hygienist to practice relatively independently in community sites if they received an Extended Care Permit (ECP). These ECP hygienists are able to work in community sites (schools, nursing homes, senior centers) although they do not have an expanded scope of practice and can only do hygiene services. The proposed Registered Dental Practitioner (RDP) would be allowed to do more, including restorative and surgical procedures in federally designated shortage areas and other community sites. This provision is meant to restrict a RDP's practice to underserved populations, but as mentioned in the previous paragraph, with 91 out of 105 counties designated, they could practice almost anywhere.

SB 192's Registered Dental Practitioner would be unique to Kansas. No other state has yet implemented this type of model, so there is no data to estimate what (if any) impact a RDP would have on dental access. It is important to note that the Extended Care Permit has not been well utilized by hygienists. Only 124 out of a total of 1750 hygienists currently have ECPs, and most do not use the permit in their day to day dental hygiene practice. The new RDP training curriculum is much more rigorous and expensive than the ECP requirements. Based on the state's history with the ECP, it may be difficult to recruit dental hygienists to this new practitioner model. It is also unclear how many dentists would be willing to be RDP supervisors or train hygienists to be RDPs.

The Bureau of Oral Health is committed to improving the oral health of all Kansans. This includes improving dental access for underserved populations, including those without dental insurance and on Medicaid. The Bureau encourages innovative workforce solutions, like the one proposed in SB 192. Thank you for the opportunity to provide these written comments.

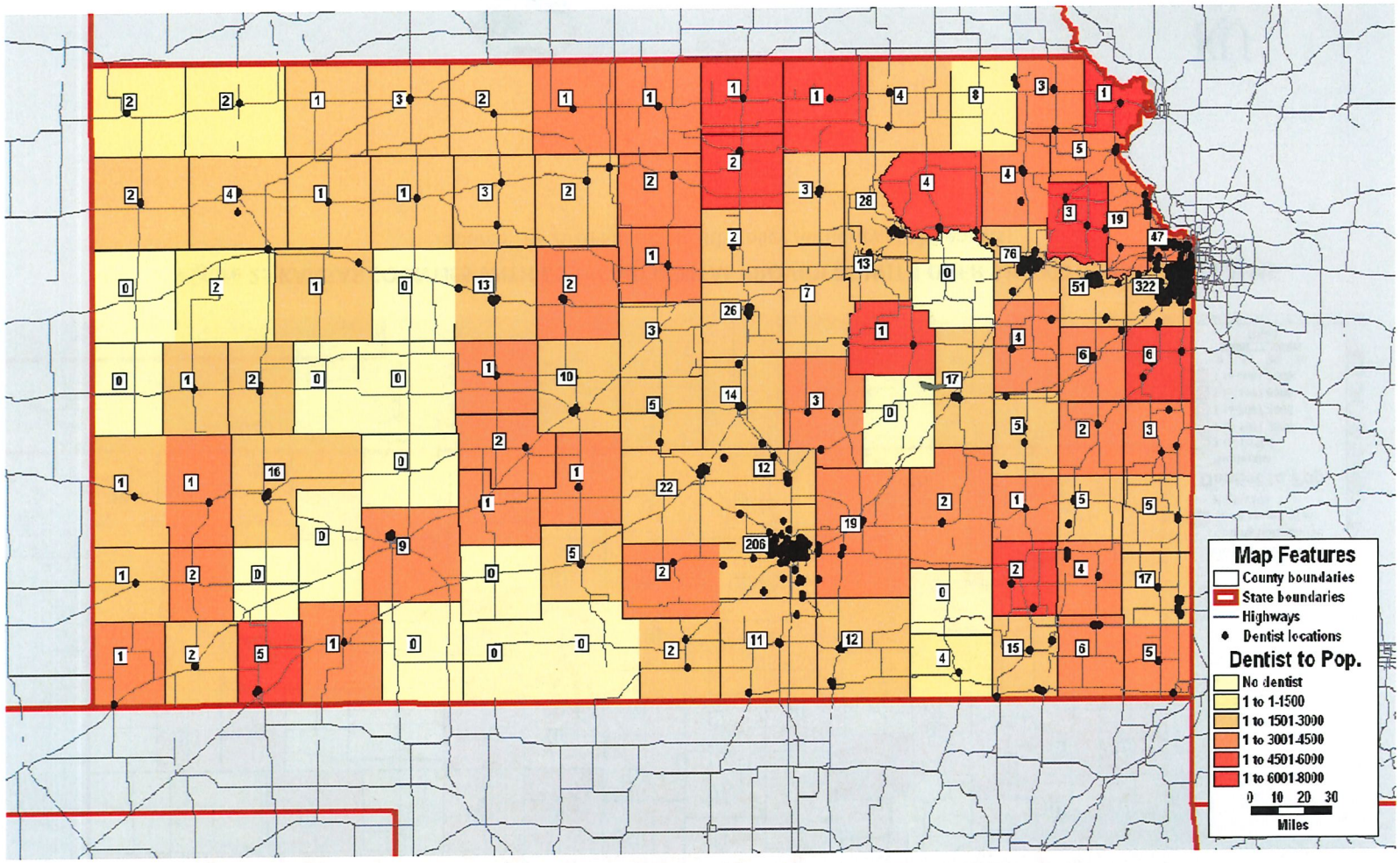

Figure 1: KANSAS DENTAL PRACTICE LOCATIONS WITH COUNTY-LEVEL DENTIST TO POPULATION RATIOS

Source: 2010 Kansas Dental Board Licensure Data (1,179 Dentists) and 2009 U.S. Census

Kansas Department of Health and Environment
Katherine Weno, DDS, JD Bureau of Oral Health

University of Kansas Medical Center
Kim Kimminau PhD, Department of Family Medicine

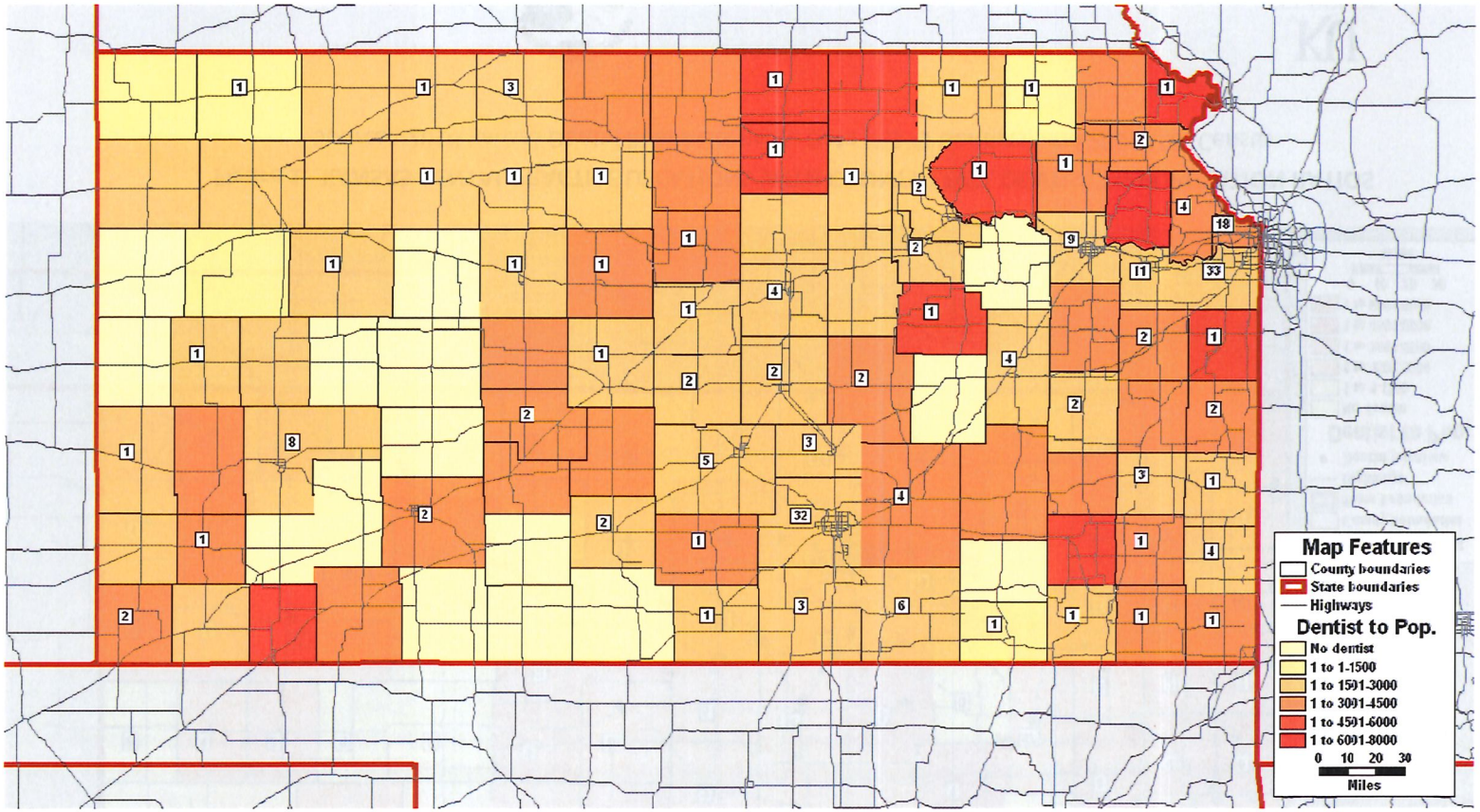

Figure 2: KANSAS COUNTIES WITH MEDICAID DENTAL PROVIDERS WITH OVER $10,000 IN ANNUAL CLAIMS

Source: FY 2010 Kansas Health Policy Authority (222 Dentists)

Kansas Department of Health and Environment
Katherine Weno, DDS, JD Bureau of Oral Health

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Kim Kimminau PhD, Department of Family Medicine

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Senate Public Health and Welfare Committee

Testimony on Senate Bill 192

March 08, 2011

Presented by:

Michael J. Hammond, Executive Director
Association of CMHCs of Kansas, Inc.

(written only)

Madame Chairman and members of the Committee, thank you for the opportunity to appear before you to testify on Senate Bill 192. My name is Mike Hammond, I am the Executive Director of the Association of Community Mental Health Centers (CMHCs) of Kansas, Inc.

The Association represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,500 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems.

Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs, collectively serving over 115,000 Kansans with mental illness.

It is important to note that one in four adults—approximately 57.7 million Americans—experience a mental health disorder in a given year.[1] Evidence suggests that individuals with mental illness are at a greater risk of oral disease and have greater oral treatment needs[2].

Numerous factors influence oral health, mitigate against self-care, and affect routine access and provision of oral health care in adults with psychiatric conditions. Cost of the care and dental phobia are the mostly reported barriers to dental care in psychiatric patients. Poor access to dental services is another significant factor as well[3]. We know that of those served by the CMHC system who are non-Medicaid, and reporting income information, 69% earn less than $20,000 a year. Creation of a Registered Dental Practitioner would be a cost-effective solution to increase access to dental services for all Kansans with mental illness.

Additionally, increased preventive dental access for individuals with mental illness that are on Medicaid, would save the State money as fewer individuals would show up in emergency rooms and community hospitals with dental-related problems. In an era of higher medical spending across the health care spectrum, the State should explore opportunities that would ultimately bend the cost curve.

Thank you for your support of mental health care and treatment for all Kansas, and the adoption of Senate Bill 192, which would enhance dental care access.

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[1] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999, pp. 408, 409, 411.

[2] Dicks JL. Outpatient dental services for individuals with mental illness: a program description. Spec Care Dentist. 1995 Nov-Dec;15(6):239-42.

[3] Matevosyan NR. Oral health of adults with serious mental illnesses: a review. Community Ment Health J. 2010 Dec;46(6):553-62. Epub 2009 Dec 29.

American
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Association

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Protect, Prevent, Live Well

March 2, 2011

Kansas State Capitol
300 SW 10th St.
Topeka, Kansas 66612

Dear members of the Kansas Legislature:

On behalf of the American Public Health Association, the oldest and most diverse organization of public health professionals and advocates in the world dedicated to promoting and protecting the health of the public and our communities, I write in support of Senate Bill 192 and House Bill 2280, legislation concerning the Kansas dental board relating to licensure of registered dental practitioners.

It is our understanding that the Kansas Registered Dental Practitioner (RDP) has been modeled after the Alaska Dental Health Aid Therapists (DHAT). It differs essentially in that the RDP is also a dental hygienist and thus will be serving in both capacities. The Act specifies that "Registered dental practitioners shall practice in federally-designated professional workforce shortage areas, indigent health care clinics, nursing homes, head start, federal and state correctional institutions or in private practice where at least 20% of total patient revenues are derived from Medicaid."

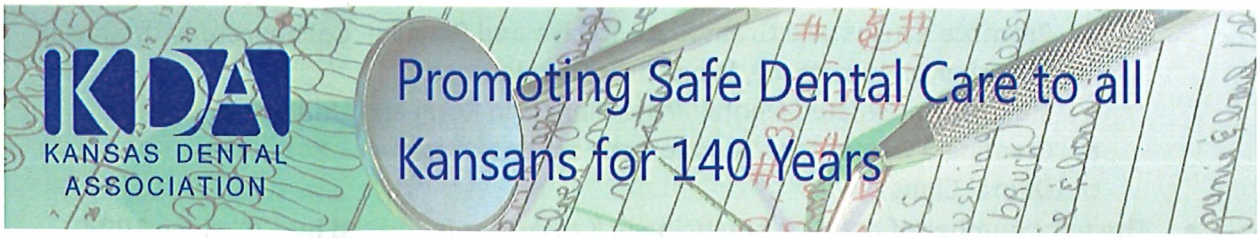
The proposed legislation is consistent with the policy of the American Public Health Association in support of the DHAT and similar innovative dental care providers aimed at improving access to preventive and therapeutic oral health services for underserved populations.

Accordingly, the American Public Health Association is pleased to offer its endorsement of Senate Bill 192 and House Bill 2280 for the development of Registered Dental Practitioners to serve the underserved populations in Kansas.

Sincerely,

Georges C. Benjamin, MD, FACP, FACEP (E)
Executive Director

Senate Public Health & Welfare
Date 3-9-2011
Attachment 11



Date: March 9, 2011

To: Senate Committee on Public Health and Welfare

From: Kevin J. Robertson, CAE
Executive Director

RE: Opposition to SB 192 – Registered Dental Practitioners

Chairman Schmidt and members of the committee I am Kevin Robertson, executive director of the Kansas Dental Association representing 1,250, or some 77% of the state's licensed dentists. Thanks for the opportunity to discuss with you the Kansas Dental Associations' thoughts on HB 2280.

The Kansas Dental Association (KDA) believes that all Kansans deserve access to safe quality oral health care and to a DENTIST to provide for their diagnostic, restorative, and surgical dental needs. As such, the **KDA is STRONGLY OPPOSED TO SB 192.**

With me today to discuss concerns on SB 192 are a few of the OVERWHELMING majority of dentists across Kansas that believe SB 192 jeopardizes patient health and safety. First, let me take a minute to discuss the dental workforce and dental access in Kansas. The dental workforce is improving in Kansas. In fact there are exciting things going on in Kansas!

- As recently as 2004, Kansas had only **NINE** dental students graduate from UMKC School of Dentistry. The past five classes at UMKC have graduated 19, 19, 21, 23 and 27 Kansas students respectively!
- In the past five years 374 (81, 80, 80, 57 and 76) new dentists have been licensed in Kansas.
- The new Advanced Education in General Dentistry residency program that began in Fall 2009 at Wichita State University graduated its first class of residents last summer and will house around 10 dental students in each class of a two-year residency program that will include a rural rotation during the second year once it is fully operational.
- The KDHE Bureau of Oral Health Workforce Cabinet was created in Kansas and is exploring innovative ways to increase the dental workforce in Kansas including :
    - Assist with Dental Recruitment Efforts by Networking with Dental and Dental Hygiene Programs, working with Dentists and Safety Net Clinics.

    - Promote Kansas as a Great Place to Live and Practice- Collaborate with Kansas Chamber of Commerce, Workforce Development
    - Support for Isolated Dental Professionals in Rural and Underserved Areas
    - Creating a Dental Job Website and Facebook Page
    - Dental Clubs
- The total number of dentists practicing in Kansas has increased by 17% since 1997 according to Kansas Dental Board licensure numbers.
- The statewide full time equivalency of general dentists increased by 7% in an eight year span from 2000 to 2008 according the Kansas Department of Health and Environment.
- The statewide full time equivalency of dental hygienists increased by 43% in a nine year span from 2000 to 2009 according the Kansas Department of Health and Environment increasing the productivity of dentists.
- The growth in the number of dentists and dental hygienists both outpaced the population growth of the state of Kansas which grew by only 6.1% from 2000 to 2010 according to the U.S. Census Bureau,
- In 2002 the KDA worked with the Kansas Dental Hygienists' Association to create a new Extended Care Permit dental hygienist that could to dental hygiene procedures without direct dental supervision with underserved populations.
- Kansas' own "Keep Kansas Smiling" oral health report card gave the state a "B" in 2009.
- The Kaiser Family Foundation ranks Kansas 17th in dental and medical Medicaid access for children 0-17. Missouri ranks 41st, Oklahoma ranks 37th, Nebraska ranks 34th, and Colorado ranks 31$^{st.}$
- Nationally, after a low of 3,810 dental graduates in 1996 there has been a steady increase of dental graduates as new schools have opened and others are increasing the size of their classes and in 2008 4,796 students graduated from U. S. dental schools – a 26% increase in 13 years.
- The number of dental indigent clinics in Kansas (including CHCs and FQHCs) number18 and growing...a short time ago it was only five.
- Eventual Passage of HB 2241 will allow dental franchisors like Comfort Dental to do business in Kansas who will help to recruit dentists to our state.
- The Governor's Rural Opportunity Zone legislations promises to provide an incentive for dentist to locate in the state most depressed counties.
- The KDA and other stakeholders will be meeting on Friday to explore options for the UMKC Dental Student service agreement in SB 132.

It's interesting to note that even with PAs and ARNPs there are actually more Primary Care Health Professional shortage areas (94) and Mental Health Professional Shortage Areas (106) than there are Dental shortage areas.

Let me be clear that the improvements I've cited does not mean there are not barriers to dental care that prevent Kansans from receiving dental care that should be addressed. As you know the KDA has introduced a comprehensive oral health initiative that is in this committee and stands behind all of its provisions or similar alternatives.

Though not financially or politically feasible at this time, dental Medicaid for adults is a critical component to truly improving oral health in Kansas. For each of the past 10 years the Kansas Dental Charitable Foundation (KDCF) has treated thousands through its Kansas Mission of Mercy (KMOM) free dental clinic. As a result of KMOM, dentists have been applauded for the care they provide at KMOM and scolded for not doing more. People ask, *"how can that many Kansans be without a dentist!?"* In an effort to answer that question the KDCF received grant funding to conduct an exit survey of patients at each of the first six KMOM events. An average of 8% of the patients said they didn't like to go to the dentist or didn't think they needed care, less than 3% said there was no dentist in their area and an overwhelming majority of **87%** said they did not have insurance or other means to pay for a dentist. Simply creating a lower class of dental practitioner will not solve a significant barrier to care for these people.

The KDA also supports the expansion of services for dental hygienists. As I mentioned previously, in 2002, the KDA and Kansas Dental Hygienist Association hammered out the agreement that became the Extended Care Permit (ECP) Dental Hygienist. Our concept creates a further expansion to the Dental Hygienist Extended Care Permit law to create an ECP III. An ECP III would have the same infrastructure, practice locations/populations and dental supervision that the current ECP I and II have and as such would not create the bureaucracy of an entirely new practitioner. At this time ECP II practice locations/populations include nursing homes, prisons, indigent health clinics, head start programs and children in schools, but we are amenable to the possibility of expanding it to more practice locations. The ECP III Dental Hygienist would be allowed to use additional procedures that would assist them in treating these patients – but DO NOT include surgical procedures.

These new procedures that the ECP III dental hygienist could perform are:

- (A) Removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci;
- (B) the application of topical anesthetic if the dental hygienist has completed the required course of instruction approved by the dental board;
- (C) the application of fluoride;
- (D) dental hygiene instruction;
- (E) assessment of the patient's apparent need for further evaluation by a dentist to diagnose the presence of dental caries and other abnormalities;
- (F) identification and removal of decay using hand instrumentation and placing a temporary filling, including glass ionomer and other palliative materials;
- (G) adjustment of dentures, placing soft reline in dentures, checking partial dentures for sore spots and placing permanent identification labeling in dentures;
- (H) Smooth a sharp tooth with a slow speed dental handpiece;
- (I) Use of local anesthetic, including topical, infiltration and block anesthesia, when appropriate to assist with procedures where medical services are available in a nursing

home, health clinic, or any other settings. If the dental hygienist has completed a course on local anesthesia and nitrous oxide as required in this act

- (J) Extract deciduous (baby) teeth that are partially exfoliated with class 4 mobility;
- (K) prescription of fluoride, chlorhexidine, antibiotics and antifungal as directed by a standing order from sponsoring dentist,

I hope you will consider this alternative to the registered dental practitioner.

Thank you for the opportunity to appear before you today. I would be happy to answer any questions at the appropriate time.

Dr. Paul Kittle, DDS

Senate Committee on Public Health and Welfare (SB 192)

Madame Chair and Committee Members,

My name is Paul Kittle. I am a retired United States Army Colonel, I directed the Army Residency Program in Pediatric Dentistry, and I have been in private practice in pediatric dentistry in Leavenworth since 1994....so, 40 years of practicing dentistry. And I DO accept Medicaid. And yes, if I look familiar,...I am the one who practically begged you to mandate general anesthesia operating room coverage for young children with extensive dental needs, who could not be treated in a dental office. And thank you. You have helped a significant number of children not become adult dental phobics by passing that legislation. You did....what was right for Kansas children!

I am now here to ask you to again do what is right for our Kansas children! You have a proposed bill before you that would significantly alter how dental care would be provided in the State of Kansas. I am here to ask you to vote **against** this proposal and I am passionate about my opposition to it, especially as to how it affects children!

Kansas has exceptional dentists who CARE for our children. My pediatric dental colleagues and I have participated in Kansas Mission of Mercy (KMOM) projects in 9 different areas throughout the State. **My** time away from my business and my family, **my** materials, **my** paid staff, **my** transportation costs, **my** hotel costs. Don't tell me we don't CARE! ..... Why are these children there at KMOM? It is NOT because the dentists are too busy to treat them or because no dentist takes the Medicaid card...(and in fact, 80% of Kansas pediatric dentists accept Medicaid)...NO... it is because the parent does not have transportation, or the Medicaid card has not been renewed (the State is currently 3-4 months behind in issuing renewals), or the parent cannot afford dental treatment, or oral health care is not important until an emergency arises. (See the copy of the letter

submitted with my written testimony)..... Children.....We just treated over a hundred children at the KMOM in Hutchinson a month ago. Is there an access to care a problem for children in Hutchison? **NO**...there are 2 exceptional pediatric dentists in Hutchinson and they DO accept the Medicaid card. .....ADULTS.....Why are there hundreds of adults, and why do we end up doing thousands of extractions of adult teeth, at KMOM?? Same answer with 1 BIG ADDITION...[no transportation, no money, no value to oral health]...There is, **NO** ADULT Medicaid card in Kansas. There is **no** State benefit. So, if you are an adult and you do not have money.....and the State does not provide dental benefits for you .....and you do have dental problems...you go to KMOM! And..yes...only 25% of Kansas dentists accept Medicaid in Kansas. Why...because, just like where you work, or the business you own,....dentistry, is a business. Last year my practice submitted $45000 in Medicaid claims to the State...and we were paid $19350...that's 43% of what I billed. Now...I, like any business have to pay for equipment, materials, staff salaries, rent, utilities, etc, etc. [and that costs me 60 cents of every dollar] and, I provide **jobs** to **20 Kansans** [everything is about jobs] in my practice...so...I lost over $7500 treating the children on Medicaid. But I am fortunate...the practice is successful...and I (we) made a decision to care for these children! That does not work as a business model in the United States!

SAFETY

What is the real issue in creating a mid level dental provider that would treat children and adults? I submit to you that the answer is **SAFETY**! I spent 4 years of college and 7 years of graduate and postgraduate education in learning how to become a dental specialist for treating children. Thousands of hours learning not only the surgical skills required of a dentist, but, of equal importance, hours and hours and hours of growth and development in children, the psychological development of children, behavior management of children [2 years, in fact, of advanced education learning how to treat just children]....and yet, the proposal before you allows a disproportionate number of dental surgical procedures to be performed on children by someone with little education in these most important

areas. This bill proposes to lower the standards of dental care for Kansas children. That is NOT ACCEPTABLE! We are not a third world country! We CANNOT allow a dental hygienist, no matter how well intentioned, to drill into the nerve on a primary tooth, to extract a solidly embedded primary molar. These are surgical treatments that I always am cautious with every time I perform them, but yet we are going to allow someone with little training and even less experience to perform on a child...talk about creating **phobic adults**!!! Would you want your grandchild or your child to be treated by a person who is not a dentist???

"THE PROBLEM"

Chair and Committee Members, it is a known and accepted fact that persons of low socioeconomic status have more dental problems than the rest of the population. The problem is NOT that there are insufficient Kansas dentists to treat those with a dental need, the problem is NOT that there is NO dentist CLOSE BY, ...the problem IS (with children) that even when and where care is available..., the value and the importance of oral health is not understood and/or THE APPOINTMENTS ARE NOT KEPT, or the patient waits until the pain is intolerable before seeking care. I have kept meticulous stats since the first of January in anticipation of having to give this testimony...and, do you know how many appointments children on Medicaid failed at my office, children needing exams or had actual treatment scheduled??? 38%!!!

EDUCATION

This is a problem of **education**, this is a problem of transportation (even when the office is only several miles away), this is a problem of lack of understanding and valuing oral health until an emergency occurs. And, yes, this is a problem of not being able to afford dental care....What is the solution to these problems??? I strongly suggest to you that it is a problem in EDUCATION. NO KID IS BORN WITH CAVITIES! Cavities are preventable! Cavities are an infectious disease! Mom...or dad...or adult patient...Do you have hundreds or thousands of dollars to spend on your dental care? The disease is preventable! So...here's what you don't do...you

do not share spit with your kid...because it's full of cavity causing bacteria...you do not put your child to bed, or down for a nap, with a bottle of milk or formula...you do not fill a sippy cup with apple juice and allow them to sip on it all day long! I spend 1 hour almost every month giving a prenatal class to couples at St John's Hospital in Leavenworth telling these same things to all the parents about to have their first baby. I have been giving this class monthly for 15 years! Only **1** kid that I know whose parents attended these classes has brought me a child with cavities! The problem is EDUCATION!

The Kellogg Foundation wants to spend money on dentistry?, the Pew Foundation wants to spend money on dentistry?...don't socialize dentistry...EDUCATE the socioeconomically disadvantaged! Use the $15 million dollars poured into the effort to create 2 standards of dental care...1 level for the poor... and the better level for the not poor, **to educate.** Or, better yet, the Kellogg Foundation is estimated to have a corpus of $8 BILLION, generating over $250 million dollars in interest yearly. The Kellogg Foundation or the Pew Foundation wants to help? KAMU wants to help? The United Methodist Ministry wants to help? Oral Health Kansas wants to help...? Kansas Action for Children wants to help...dentistry...**DON'T** lower the standard of care!! Kansas wants to be innovative and make a difference?...then let's be the first state in the nation to really attempt to educate the population. (we are **NOT** going to drill and fill our way out of the problem...we have to **PREVENT** the problem!!!). The opposition has hired a great PR firm (wonderful ads)...get them to use their talents to EDUCATE! Let's take the Kellogg and Pew money and use it to do repeated media blasts to EDUCATE. Every TV, every day. Every radio station, every day!! Or, here's a second idea.... petition the Kellogg and Pew Foundations to donate money, for a finite time period, to implement adult Medicaid and to assist the State of Kansas in funding an adequate Medicaid payment rate to treat Kansas children **and** adults. (And you think it doesn't work...Michigan and South Carolina adjusted their State reimbursement fees to match the level close to what Delta Dental pays...and guess what...75% of the dentists in those states now treat Medicaid patients!) Do NOT LOWER our standards of care! Do NOT subject

children to a less educated dental practitioner...a mid level! Do NOT create the next generation of dental phobics....**EDUCATE** the poor. AGGRESSIVELY PURSUE permanent, private funding from those philanthropic organizations who say they want to help. THE DENTISTS OF KANSAS CARE about taking care of our own! I ask you please to **NOT SUPPORT** this misguided legislation.

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Testimony of Dr. John Fales, DDS in Opposition to SB 192

Madame Chair and Committee Members,

My name is John Fales and I am a pediatric dentist with a practice in Olathe, Kansas. I am currently the President of the Kansas Association of Pediatric Dentists and I am here representing that organization and myself. I have practiced dentistry in Kansas since 1982 and have specialized in pediatric dentistry since 1989. I have been an active Medicaid provider since 1982 and I am here today because I am opposed to Senate Bill 192.

The road I took to becoming a pediatric dentist was greatly influenced by other pediatric dentists who encouraged me to follow that path of study only if I was doing it for the children. I believe that is the reason that I changed my direction and began the rigorous course of study that resulted in my becoming a specialist in this wonderful practice of pediatric dentistry. I have always felt that as a pediatric dentist I have a responsibility to be a child advocate particularly in the area of oral health. Another part of my practice that I feel very strongly about is the area of oral health care for patients with special health care needs.

Hubert Humphrey said in one of his last speeches, "...the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped."
It is my belief that Senate Bill 192 would not demonstrate that our government desires the best level of care for the children, the elderly or those in the shadows of life.

Those supporting Senate Bill 192 have stated that we have an access to care problem in Kansas. I suspect that since I practice in Olathe, there are those who would say that I have no idea what access to care issues are. I respectfully disagree. I have participated in 9 Kansas Mission of Mercy projects and two MOM projects in other states, New Mexico and Colorado. I am also a volunteer dentist in the Donated Dental Services program. I serve on the American Academy of Pediatric Dentistry's Advocacy team. I have conducted many free dental clinic days in my office in conjunction with the American Dental Association's Give Kids a Smile program, I have participated in annual Team Smile events and in Olathe I participate in several programs with the Olathe School District to provide dental care for children in need. Just this past weekend, my team and I participated in the Give Kids a Smile event at GraceMed in Wichita providing free dental care to kids. I understand there is need and with my amazing team at my office we do much to help children needing dental care. Last year alone my team and I provided around $100,000 worth of free dental care to patients in Kansas with no financial help from any government agency.

I am not alone. There are dentists all across this great state who do exactly what I do and they ask for no pat on the back because they are doing something from their heart. Most of the pediatric dentists accept Medicaid patients. I tell you this because I think it is important to understand that dentists in Kansas want to help those less able to help themselves. You have already heard the numbers that state that Kansas dentists provide over $46 million dollars in free dental care. The state of Kansas only provides around $30 million dollars through the Kansas Medicaid program for dental care. I just received a Form 1099 from the State of Kansas indicating that I was paid over $153,000 for providing dental care through the Medicaid program. The total amount my office billed for those services was over $390,000. As many of the pediatric dentists in Kansas do, I choose to absorb this tremendous loss because providing care for kids is the right thing to do. Many dentists are unable to absorb this kind of loss and

still keep their doors open. I do believe Kansas dentists know about charitable giving and that a need exists.

What can we do to change that need? I believe that we do not have an access to care issue but rather a barrier to care problem. I base that opinion on my experiences in Olathe and stories I have heard from parents at the many Mission of Mercy projects I have participated in and in my office. I have heard from parents that they are working two, sometimes three jobs to provide for their kids and are not able to take time off or are not allowed by employers to take time off from work for fear of losing their job! Many times these parents have a Medical card for their children or other insurance but can't afford the risk of losing their job. I have heard from parents who wait over 3 months just to have their Medical card applications processed! These are not access to care issues but rather, they are 'barriers to care!'

As an example, the Olathe School District, with help from nearly 30 Olathe dentists started a program 4 years ago designed to provide free dental care for young students in need of oral health care. Dentists volunteered to see patients at no cost to the school district or to the parents. In the first year of the program, only 5% of the children identified as needing care made it to a dentist for the free care. The second year, we got 16% of the kids to that free care and the third year we got to 19%. That to me is not a great success. Free care was available less than 5 miles from where these kids live but they didn't get care. Why? I can suggest some reasons; lack of understanding of the importance of good oral health on the part of the parents, inability to get to the dentist providing the free care because of transportation issues, fear of discovery by undocumented parents, fear of losing a job? I could go on and on with ideas and I will be honest in saying I do not know the exact reasons. I do know that when there are over 30 dentists with the desire to provide free care to these kids and less than 1 in 5 children make it to the dentist's office that are less than five miles from their homes, this is not an access problem.

This year we have a program where kids identified as needing care are brought to my office by the school district and I provide free care. The parents only need to agree to the care and provide consent. They go to work, or whatever other responsibilities they have and every child gets dental care at the highest level available. We have 100% of the children identified as needing care and scheduled for an appointment receiving that care.

Restorative dental care, surgical dental care and diagnosis of oral and dental disease conditions are parts of dental care that make it a complex science. The training and experience that a licensed dentist brings to the table in Kansas is unmatched anywhere in the world. To lower the training and experience required for a non-dentist practitioner to treat Kansas citizens is not a responsible act.

Senate Bill 192 would allow a non-dentist practitioner to perform extractions of primary teeth as well as permanent teeth. I can tell you that the last 'simple' extraction of a primary tooth, I performed, was only 'simple' after the tooth was lying on a piece of gauze sponge. The number of possible untoward outcomes from extraction of any tooth is dizzying. I can only begin to imagine the scenario in a distant location somewhere in western Kansas with a small 3 year old child, terrified and in extreme pain due to a dental abscess enduring the most excruciating experience of his young life while a young, minimally trained, non-dentist practitioner attempts to manage the behavior of this screaming child and the parents who are also terrified watching their child have a primary tooth extracted. Managing a situation like this requires training, education and experience that a non-dentist provider will not have.

Senate Bill 192 also would allow the restoration of primary and permanent teeth. Unfortunately, this too would lower the standard of care in our state for those people treated by a non-dentist practitioner.

Most people do not understand and would, quite frankly, be bored to death with trying to understand the thought process that goes into making a decision about what material or method to use to restore a tooth. The understanding of dental materials and their use is not something to be taken lightly. Use the wrong material and you risk failure of the restoration. This leads to a return visit and, additional expense, for repair of the failed restoration. I do not believe that a child deserves to be put through two or more procedures just because the non-dentist practitioner didn't have the full understanding of the materials and the processes being used. Again, picture if you will, the young patient being seen by the non-dentist provider, crying, uncooperative, scared, tired and all of this because the non-dentist practitioner is ill-equipped and not as qualified to manage the situation as a licensed dentist would be able to do.

We have an opportunity to do the right thing for those unable to provide for themselves. These are your constituents. They are the people we as a society are charged with caring for. I see myself and all dentists as their advocates and I ask that you not allow Senate Bill 192 to become a law of the State of Kansas. The weak, the small, the unable deserve better than a second tier of dental care that you and I would not choose for ourselves. As my dental team says every morning before we start our day, 'do the right thing' and the right thing in this instance is to not allow a non-dentist practitioner to be allowed to provide care for the people of Kansas.

Mahatma Ghandi said, "A nation's greatness is measured by how it treats its weakest members." Kansas should demonstrate that we are a great state and we will always treat our weakest members with the greatest respect and not settle for inferior care for those people.

Thank you for this opportunity to share my concerns about Senate Bill 192.

John T. Fales, Jr., D.D.S., M.S.
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Testimony of Dr. Mark Herzog, DDS, Ellsworth
In Opposition to SB 192

Good afternoon Members of the committee, I am Dr. Mark A. Herzog, a private solo practicing Dentist in Ellsworth Kansas. I have been in practice in Ellsworth for going on 25 years and have accepted Medicaid all 25 years. I have endured the bureaucracy of Medicaid and the other frustration that many of my colleagues have endured. Many a time I have wondered why I continued to accept Medicaid patients and continue to endure the difficulties. These difficulties ranged from who is eligible and when. What am I going to get paid per procedure? When am I going to get paid? What supporting documents do I need to send along with each procedure? Am I doing too much at one appointment? Who authorizes the procedure and who pays for the procedure and when there are discrepancies, who do you call to clear it up? Are the patients going to show up on time or even at all? And once I correct their dental needs are they going to follow up with the needed home care to sustain a healthy mouth..

Right now Medicaid is only for children and many come from economically and or socially depressed households. There was a time when each Medicaid enrollee was given an ID card each and every month so we had to verify every time If they were still eligible for the treatment scheduled for that day. If it happened to be that the appointment was on the first of the month they may not of received their new card for that month so do we take a chance that they are eligible or not or do you error on the side of safety and reschedule? Either way we would lose, in that we treated them and they were not eligible or we have an unproductive hole in our schedule. Time is money and we just got burned again. Now as to what we were going to get paid? Some preventative procedures we would get close to breaking even. But the problem was that they got the same procedures done at a different office 5.6 months ago and therefore they were not eligible for those procedures because the full 6 month had not past. Or they needed an emergency root canal and we couldn't get it done because we had to send it in on a predetermination. Pain and suffering on the patient's part and a scheduling and pain management issue on our part. We also could not get reimbursed for posterior composite restorations ,white fillings, but had to settle for the reimbursement rate of a silver filling. If a Dental sealant came off that was placed at another office I could not get paid for replacing it. I have done thousands of reseals knowing that I would never get paid for it but, couldn't morally not do it when I am doing other sealants for the patient. I had a patient in the other day that amazingly had outstanding home care no fillings and no decay. He had trauma to his upper front left tooth and had a porcelain crown present. The sad thing was that he had fractured it. Good looking kid and polite but was self conscious of his chipped tooth. We called Medicaid and that said they would pay for it but certainly not at my usual and customary fee. Well the lab fee will usually run about $150 and my chair time a little over one and a half hours. Even if I get paid at 50% of my fee I still lose money on the deal. So like many of my colleagues we will suck it up and do the crown anyway. These are just some of the examples us Medicaid providers have endured. Then to whom, what and where do we send everything in to. There was a time when EDS and Doral dental both administered the Medicaid program. You talk about a bureaucratic nightmare. The

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only way I could get anything looked at that they denied was a family relative worked for one of the entities and we earmarked everything to their attention. I am sure many of my colleagues threw in the towel as far as being a Medicaid provider. Then we have the problems of how best to schedule our Medicaid patients? Do we just schedule them all at once and treat on a first come first serve bases, and if we don't have time to see them tell them to try again on another day? Do we schedule them into our regular schedule and hope and pray that they show up on time or at all? Medicaid patients are on average less reliable the non Medicaid patient. As for if we will ever see them again once we get all their treatment completed will we ever see them again for follow up maintenance which is critical to maintain optimal dental health. They are often a transient population who move and leave no forwarding address and no way of finding out if they intend to keep their 6 month recare appointment. Or their phone numbers have changed and we have no way of notifying them of their up coming appointment. Do we take them off the schedule? Leave them and again hope and pray that they show up? Or do you double book them and tick off the whole staff because they showed up and we are really behind schedule for the day. Then we have the issue of having our reimbursement rate cut another 10 percent to help with the states overall budget. Talk about being taxed to death for trying to do the right thing. Then we have the left out in the cold adults who are qualified for Medicaid a lot who are the frail and elderly who are on so many medications that their mouths are as dry as the desert. They have rampant decay, ill fitting dentures and/or partials and they are having a hard time eating thus compromising the overall health. The only coverage they have thru Medicaid is extractions. So it leaves them with few dental options. That brings us to the over 21 adult Medicaid patient. Here again the only treatment Medicaid allows for them is extractions. That is why 85% of the treatment perform at the Kansas Missions of Mercy is on adult patients. Only 15% of the treatment at KMOM is on children because most of them can get treatment on their medical cards. Today Medicaid is much improved from a bureaucracy standpoint. It is now web based so that we know what the patient is eligible for prior to treating. There is only one entity to deal with and payment is usually received in 2 weeks.

So where does this all fit in with the midlevel proposal? If the majority of those who are in dire need of Dental treatment are adult patients How is the midlevel going to be able to treat them when there is no reimbursement other than extractions of permanent teeth which, under their guidelines does not allow them to do only the very non-complicated(what ever that is). If they are to serve in underserved areas like Ellsworth Co. or Lincoln Co. or Lyons Co. all counties surrounding my practice why aren't the Dentist in these Counties completely booked with Medicaid patients. (I was paid over $76,000 last year by the State of Kansas, I don't even want to know what percentage I wrote off?)We don't turn away Medicaid patients and yet my practice is not booked out months at a time. We take care of our area of Kansas and sometimes beyond our area. If they are having an access to care problem in our area they are not doing their part to solve the equation. So even if we were inundated with Medicaid patients how could a midlevel help me to alleviate the problem? Well like most practices in Western Kansas we own our own buildings with just enough room for me and my Hygienist to practice. We don't have extra room, extra equipment, extra staff and extra payroll to pay these individuals. And since they are limited to what I think they could do (the supervising doctor

determines the scope of practice within the guidelines of the bill) How can I justify hiring a midlevel? Well they could work unsupervised after 3 months of direct supervision (Who in a busy practice has time to look over there shoulders for 3 straight months to see if they were adequately trained) off site in a satellite office. Well here again who is going to build or buy an office at, lets be conservative $150,000, Equipment 3 operatories at $250,000. 2 staff at $40,000 per year, $50,000 general supplies and $50,000 to payroll the Midlevel. That comes to an initial total of $540,000 to be bank rolled in the first year. Granted the building and the equipment could be put on a bank note, but who in their right mind would fork out that kind of money only to break even (not even likely to break even) because Medicaid only pays roughly 50 cents on the dollar. So what do we do? My solution is to entice more Dentists to locate in these rural areas. Now not all counties can support a Dentist but we already have a Dentist within a 30 mile radius of every part of Kansas. Do they all take a medical card, not at the present but give them an incentive (loan reimbursement for education, state tax relief for the portion of their write off, Increase the reimbursement rate. increase the number of Dental seats at Dental schools. Nothing will solve the problems of "access to care" better than good old healthy competition in areas that need better access and a financial incentives. Much like when KAMU received a Federal Grant for treating a qualifying population, they tried to use it strictly though FQHC clinics. When they realize they were not going to be able to spend all of the grant money they turned to Private Practicing Dentist to do the Job. We basically had 1 month to treat a lot of people in a short time. They had to limit the number of Dentist willing to help for fear of overspending their grant allotment. Kansas Dentist have been stepping up to the plate to help alleviate the Dental crisis in our state. Look at the millions of dollars of treatment we have provided to our fellow Kansans with the KMOM programs. A Kansas Dentist also on the average does $33,000 of free dentistry in their practices a year $33000 X's 1428 practicing Dentist that comes to over $47 MILLION DOLLARS of free treatment to our Kansas underserved. You will find very few Kansas Dentist in this State who supports the midlevel model. We understand we have issues with an aging population of Dentists in rural Kansas. But the solution is not an undertrained midlevel. The solution is incentives to get more Dentists in the rural areas. A trend that has already started happening in the last few years. Don't let opinions from the East Coast tell Kansans how to take care of our underserved population. They deserve to be treated by a REAL DENTIST and nothing less. I thank you for your time and consideration.

Dr. Cindi Sherwood, DDS, Independence
Senate Committee on Public Health and Welfare (SB 192)

My name is Cindi Sherwood and I am a registered dental hygienist and a general dentist from Independence. I went to Wichita State and then later attended the University of Missouri –Kansas City. I am not unique, there are a number of dental hygienists who have continued their education to become dentists. I want to tell you about my experience having had both educations – that of a dental hygienist and a dentist.

First, let me say that there is no comparison between the two curriculums. The breadth and depth of the dental curriculum is much more rigorous than the dental hygiene courses. While the titles of many of the classes are similar – for example, periodontics (the treatment of gum disease) or pharmacology, the basic assumptions are completely different. The dental hygiene classes are based on the concept that the dental hygienist will work as a member of the dental team under the supervision of the dentist.

The dental hygiene curriculum does not teach diagnosis. The diagnosis of dental disease requires knowledge of the underlying science that is not taught to dental hygienists. This includes post graduate classes in cell biology, human anatomy, physiology, histology, biochemistry, microbiology, pathology, pharmacology, oral diagnosis and oral medicine. Dentists must manage patients with complex health situations that take numerous medications. A seemingly simple procedure can become problematic if there is no understanding of a patients health history or medications. There could be complications including bleeding, infection, cross reactions of medications with local anesthetic, pain and anxiety control problems.

The pre-requisites for dental school are also more advanced than those for dental hygiene school. In order to be accepted into dental school, most students have a bachelors degree in either biology or chemistry. In Kansas, we have dental hygiene programs that accept students immediately out of high school and therefore can become licensed as a registered dental hygienist with two years of college. In the dark ages when I decided to go to dental school, I had to take two

more years of chemistry, physics and math courses to be able to apply for dental school, and that was after I had a bachelors degree in dental hygiene. While no one has provided information on the exact curriculum the further 18 months of education that the dental practitioner would have, it can't compare to the 4 years that dental students have.

I looked at the American Dental Association Commission on Dental Accreditation standards for both professions. The Commission on Dental Accreditation was established in 1975 and is the recognized group by the United States Department of Education to accredit dental education programs. The CODA standards document says, " The dental hygienist functions as a member of the dental team and plays a significant role in the delivery of comprehensive patient health care. The dental hygiene process of care is an integral component of total patient care and preventive strategies. The dental hygiene process of care is recognized as part of the overall treatment plan developed BY THE DENTIST for complete dental care." This again verifies that the underlying premise of dental hygiene education is that they will be supervised by a dentist

I also looked at the current outline of the curriculum for both the doctoral program and the dental hygiene program at UMKC to evaluate current information. The classes which teach dental students to diagnose, drill and fill, pull teeth, make orthodontic appliances, and crowns - all procedures which the proposed dental practitioner could do – take place all four years of dental school. First year dental students take dental morphology, clinical assisting, clinical decision making, operative dentistry lecture and lab, oral diagnosis, and dental occlusion in addition to their general sciences. Second year students take preventive periodontics, operative dentistry lecture and lab, anesthesiology, pathology, orthodontics, fixed prosthodontics (crown and bridge), medical emergencies, oral surgery, advanced periodontics, principles of medical and physical diagnosis, dental pharmacology and pediatric dentistry. These are all classes required to learn what the dental practitioner would be allowed to do. I did not include the classes on root canals implants and dentures and partial dentures that are not included in the dental practitioner scope of practice.

I will continue – third year dental students take oral oncology, dental biomaterials, oral diagnosis and oral medicine, periodontics II, oral surgery II, orthodontics II, treatment planning, review of preclinical dentistry, operative dentistry III, oral surgery III, therapeutics,dental behavioral science, diagnosis and management of orofacial pain and extramural clinical rotations. Third year students have 24 credit hours worth of clinic time treating patients. Fourth year students have dental behavioral science II, pathology III, anxiety and pain control, periodontal treatment planning, dentistry for special patients, pediatric dental seminar, practice management, extramural clinical rotations II, review of clinical dentistry, jurisprudence, practice management II and 26 credit hours of clinical treatment of patients.

My point is that you cannot teach someone to extract teeth, drill and fill teeth, perform pulpotomies, make appliances to treat TMJ, reimplant and stabilize knocked out teeth, numb and sedate patients with nitrous oxide, diagnose oral disease and formulate treatment plans , make orthodontic appliances, place crowns, - basically do everything a general dentist does except root canals – with 18 months of education on top of a superficial understanding of dentistry which is what you get with an associates or bachelors degree in dental hygiene.

While we are on the subject of education, I want to also mention that the comparison between a nurse practitioner and the proposed dental practitioner is not valid. Nurse practitioners have a Bachelor of Science in health sciences or nursing, then work 3-5 years in either emergency or acute care in a hospital and then have at least two more years of training - culminating in at least a Masters degree. Many programs result in a Doctoral degree and they have recently made the requirement that all new nurse practitioners will have a Doctoral degree by 2015. Nurse practitioners are valuable members of the medical team; yet they do not provide surgical or irreversible procedures on their patients. The regulation that governs their practice allows the following :

All functions defined for basic nursing practice

Evaluation of the patient with health history, physical exam and diagnostic tests

Assess finding from the history, physical exam and lab reports

Manage the medical plan of care prescribed for the client, based on protocols or guidelines adopted jointly by the ARNP and the physician (this most often involves prescribing medications and follow up evaluations)

Initiate and manage accurate records

The proposed dental practitioner has also been compared to a physician's assistant. A physicians assistant can do some of the procedures that the ARNP performs such as taking a history, performing a physical, ordering tests, etc... but under more direct supervision of a physician. They can ASSIST a surgical procedure but can not perform any irreversible procedures on a patient. A PA takes a curriculum that takes 26.5 months after at least two years of college. Some PA's receive a Bachelors degree at the end of their education and some have a curriculum that awards a Masters degree

I have one other point that I wanted to briefly discuss. On pages 4 and 5 of the bill, it lists 34 tasks that the dental practitioner can perform. While some of the procedures listed are vague and difficult to know exactly what is meant, I believe that 12 of the listed tasks are currently allowed for dental hygienists. I thought it might be helpful to explain what is involved in some of the remaining procedures.

12. atraumatic restorative therapy – I think this can mean anything done to restore teeth like fillings, crowns or bridges; without causing trauma to the patient. This appears to be a very broad ill-defined statement.

14. tooth reimplantation and stabilization – This refers to when someone gets a permanent tooth knocked out and we try to reimplant the tooth to save it. This is a very complex process that requires a lot of decision making – sometimes the tooth needs a root canal before it is reimplanted, the socket the tooth came out of could be broken, it may need to be stabilized with braces, etc.. the list goes on and on. I have done this only 4 or 5 times in my 28 years of dental practice.

15. local anesthetic – There are many possible complications with the anesthetics we use – heart attack, reactions with other drugs the patient is taking, some

ingredients in certain anesthetics should not be used in medically frail patients, especially the elderly. The most concerning complication would be an overdose, which is possible especially in children, and they could die. That is why we recommend that when anesthetic is used it either be in the presence of a dentist or in another health setting such as a nursing home or health clinic where medical attention is available.

16. Nitrous oxide (laughing gas) – This is a potent drug that can be used to put people completely under. It causes respiratory depression and in combination with local anesthetics and other meds, could result in a medical emergency.

17 and 18.- Diagnosis of dental disease and formulation of an individualized treatment plan. As we discussed, diagnosis is the most difficult part of a dentist's job. It takes all the background science and extensive dental classes to establish the exact problem, what caused it, how can we fix it so it doesn't come back again. If a dental practitioner has minimal education in the options available – TMJ treatments, implants, root canals, crown and bridgework, removable partial dentures, how can they put them in a treatment plan?

19. Extractions of primary teeth – already discussed by Paul and John

20. Extraction of a loose permanent tooth – As has been said, it is impossible to know if this will be simple. A fractured root often cannot be seen on an x-ray. I have had to section (cut into pieces) many a loose tooth with dense bone or a hook on the end of the root that didn't appear to be there on the x-ray.

21. Emergency palliative treatment of dental pain – I'm not sure where this varies from 9 – placement of a temporary filling.

22. Space maintainers – These dental appliances are cemented into a child's mouth that has to have baby teeth removed early. They can be simple and they can be complex depending on the position of the erupting permanent teeth. An orthodontic complication can occur if they are not placed correctly and removed at the appropriate time.

23. Cavity preparation – Drilling on teeth.

24. Restoration of primary and permanent teeth – By definition to restore means to return to form and function. So it appears that this could mean almost anything. Restoring can be filling, placing crowns, and doing root canals. Restoring a missing tooth can involve bridges, implants or removable partial dentures. This is one of the many procedures on the list that need a lot more explanation.

26. Preparation and placement of preformed crowns. – In order to put any kind of crown on a tooth there must be extensive drilling to make the whole tooth smaller in all dimensions. The only difference in preformed crowns is that you don't take an impression. We try to fit an "already made" metal crown to a tooth without leaving gaps where it would leak or not fit tightly against the teeth next door. Many times, this is harder to do than making a custom crown where the dental dental lab constructs a well-fitting crown from a model we sent them.

27. Pulpotomies – A pulpotomie is a root canal on a baby tooth or the first step of a root canal on an adult tooth. Again, not a simple procedure, especially on a child.

28. Pulp capping – The need for this procedure can occur when decay is removed from the tooth and we are very close, or have exposed, the nerve. There is a lot of judgment required at this stage. We ask ourselves , "Is the nerve so exposed that they need a root canal? Was it a pinpoint exposure and the surrounding dentin hard? Which material should I use for the case?" Again, a seemingly simple procedure that requires much background information to make the correct decision

30. Brush biopsies – This is a relatively simple procedure with complex variables. Does the dental practitioner have the training to counsel the patient on their options concerning oral cancer? If the biopsy comes back inconclusive, what is the next step? Can they evaluate all the patient's risk factors to help them?

32. Recementing a permanent crown – Again, sometimes a simple procedure, sometimes not. There can be decay present that needs to be removed and a judgement made if the crown can be recemented. Frequently if the crown has been off for a while, the teeth shift and extensive drilling of the crown or the

adjacent teeth can be required. If the crown is recemented and doesn't go down all the way, it could need to be removed again (not always simple) or the bit adjusted in the patient's mouth.

33. Identifying and referring patients for orthodontic problems – Orthodontic issues are extremely complex and varied. Some kids need referral at age 4 and some not until age 12. Some could need referral for speech and breathing issues related to the position of their teeth. This is not something that can be taught in a short class.

I want to make clear that this list of procedures is totally unacceptable based on the amount of education that is suggested for a dental practitioner and that you understand some of the reasons we are concerned about a poorly trained person performing these procedures.

I apologize for my passion if I seem a little overwrought. But this "solution " to the barriers to dental care is Kansas is no solution at all. I hope that I have helped you understand that a dental hygienist is not a dentist in training. There is clear safety concerns based on a lack of adequate education for the proposed scope of practice of the dental practitioner. The underserved do not deserve poor quality dental treatment – or a two tiered system of care – we must find answers that protect the public and help them receive safe, quality dental care.

Dr. David Hamel, DDS, President KDA

Written Comments in opposition to SB 192

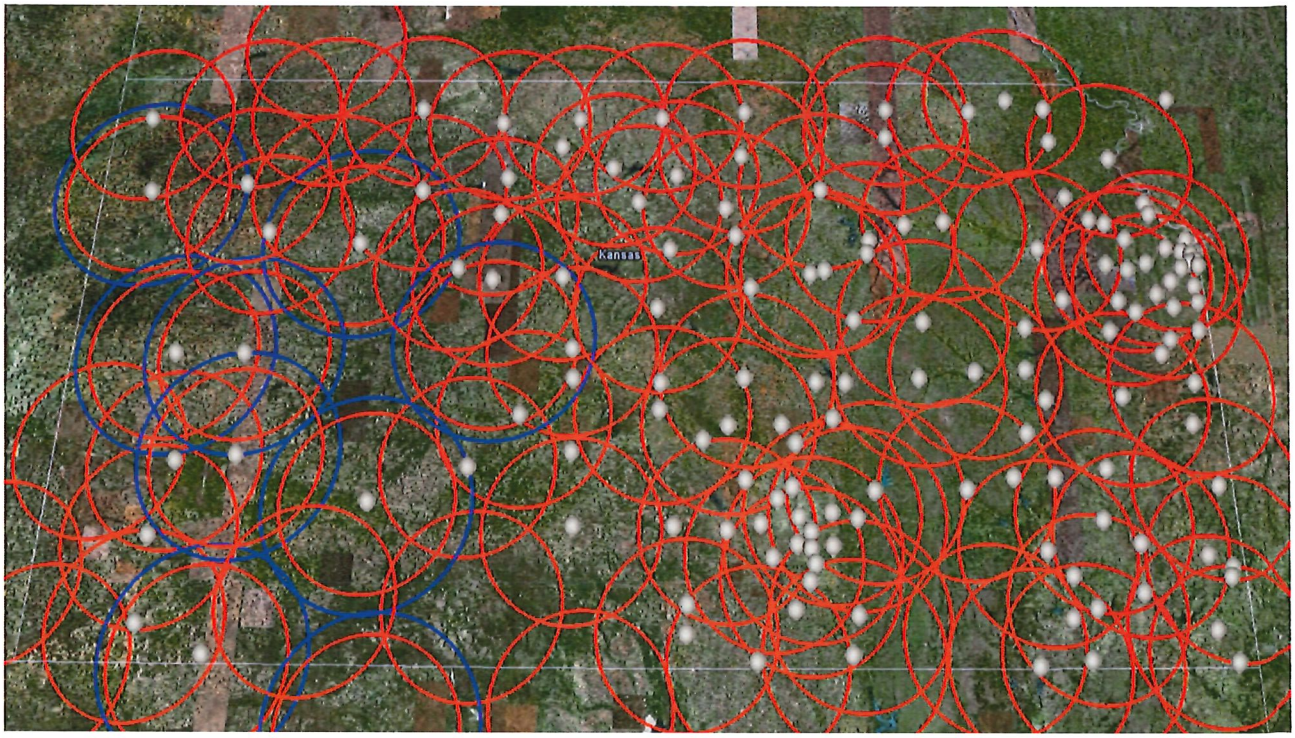
Members of the House Health and Human Services Committee:

Thank-you for allowing me to testify in written form, I regret I cannot make it in person. Having grown up in small town Kansas, lived my entire life there and began my dental practice life in a town of 400, I believe I can relate to many of the wonderful opportunities and challenges that exist here. As a rural dentist I have a unique perspective to understand the reasons, barriers and limits to the real life journey of first preserving and when needed recapturing oral health through appropriate treatment.

My objection to the establishment of a non-dentist practitioner in this bill is as much from the perspective of a taxpayer and a rural resident that wishes to see rural Kansans be given the best opportunity to maintain or attract new dentists to their communities.

Many of you have heard or read articles stating there are shortages of dentists and dental workforce in Kansas. It is possible for a midlevel to actually help cause a shortage of dentists in areas of rural Kansas. I've enclosed a letter sent to me by a dentist looking to rural areas to settle and he expresses a concern that I share about rural Kansas communities facing additional barriers to attract dentists to live and work in their community.

Is there an uneven distribution of dentists in Kansas? Well, a little bit. About 73% of dentists practice in areas that contain 65% of the population. However, the location of dentists across the state pretty much follows the distribution of the population as a whole. Sure, there are areas in Kansas with no dentist. Specifically but not verified, by my unofficial count there are over 500 communities in Kansas without a dentist. But we are not going to put dentists in every one of those communities nor call them underserved. They are just too small. It is cost prohibitive and unnecessary. People in those areas do travel some to receive care and almost all other services. Fortunately all those areas have dentists in nearby communities. Only the most remote farmers are not within 30 miles of a dentist. I've included a map for you to see. The red circles indicate a 30-mile radius around a dental office, blue is 35 miles.



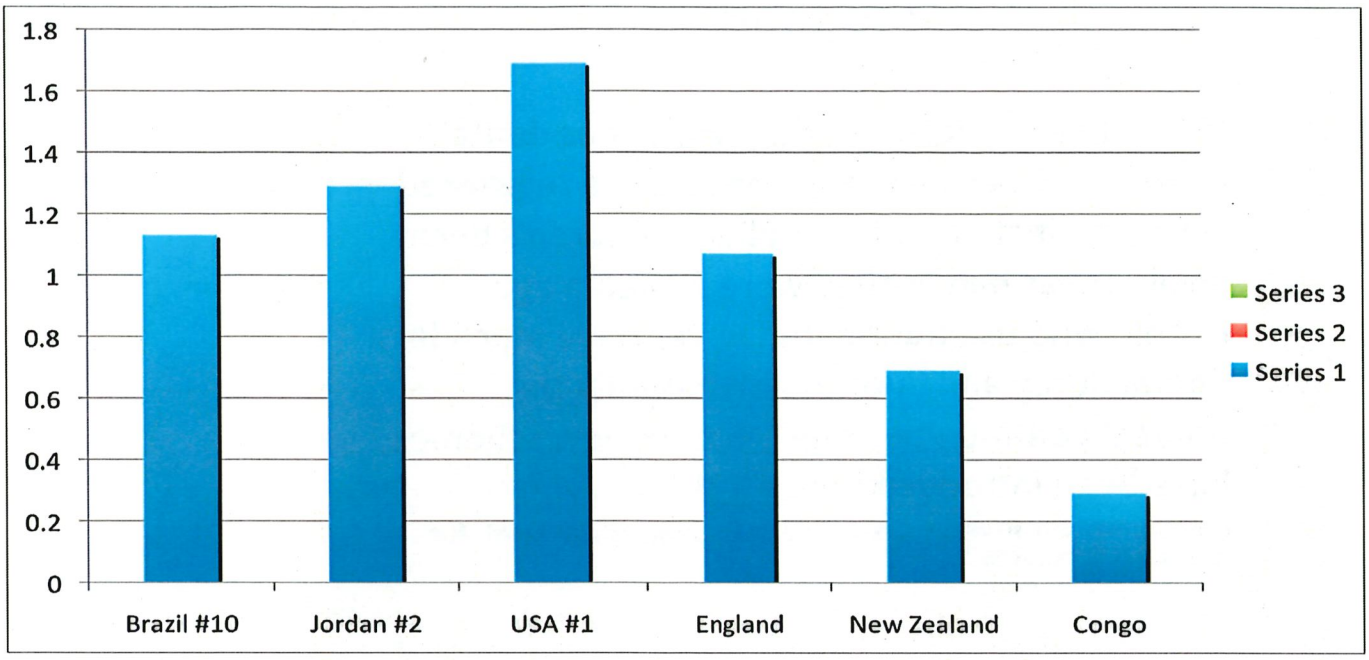
There are many convolutions that happen on paper for an area to receive a HPSA designation. It is a policy designation, not a measurement of reality. For instance, how far can you drive in 40 minutes, in western Kansas, on a primary highway? Most of us can drive 40 miles but for a HPSA designation, HRSA uses the idea you can only drive 25 miles in 40 minutes. HRSA also does not count all dentists and I found out I am no longer considered a whole dentist but am now only .8 of a dentist because I am over age 56. There are other convolutions, but I hope you see the point.

HHS says that a HPSA designation is a "first screening" for determining need. RuPRI (Rural Policy Research Institute) states only that a HPSA designation "may" indicate a shortage and KS Oral Health Officials concur with HHS in the statement that the designation means an area can apply for grants. Policy designation does not necessarily coincide with reality.

Another thing you will hear is that a non-dentist model exists and works well in other countries. I hope you realize the USA is different in many ways than other countries. That includes dentistry.

Below is a graph illustrating World Health Organization information on dentist per capita compared to these other countries. The USA is number one in the world, Jordan is second and Brazil is 10th. England is in the top 25 and New Zealand is not even close.

World Health Organization- dentists per capita



The USA has 1 ½ times the number of dentists per capita as England and Europe
The USA has 2 ½ times the number of dentists per capita as New Zealand

The USA has far more dentists than other countries and does not need a non-dentist practitioner. We also have the least amount of dental care purchased by the taxpayer. Observation shows that these other countries use the non-dentist practitioner as a building block for their nationalized or government subsidized systems for dental care. In the USA, about 6% of dentistry is purchased by the taxpayer, in Australia that rises to about 21%. In Europe it is higher but the information is combined with their national medical care.

17-3

England

- Inequalities in health In deprived areas dental health is worse, and fewer people are registered with a dentist. In some localities children's decay levels are as bad as they were 15 years ago. People who use fluoridated water have much less dental decay and fluoridation benefits the poorest communities most, but no new schemes have been introduced since 1985.
- Primary dental care services in England and Wales | **Inequalities in health, National Audit Commission 2006**

Therapists do not fix the problem in countries that have them

The New Zealand oral health therapist program is touted as the model for this country's foray into a mid-level provider system, yet in 2004, the DHBNZ (Ministry of Health) declared the School Dental Service to be "in strategic crisis" and that inequities continue to exist, notably with low income, minorities, and rural populations. It further concluded that facilities were run down, not suited to modern practice, and non-compliant with health and safety standards.

acknowledgement for information to James Crall DDS MPH former PEW Foundation Consultant

I have included a letter from a local partnering community group to share a success for an alternative to this bill.

I ask that you vote against SB 192!

17-4

Thank-you,

David Hamel DDS
1200 Broadway
Marysville, KS 66508
Kansas Dental Association President 2010-2011

17-5

Dear Dr. Hamel,

I see you are the president of the Kansas Dental Association and I have been following the dental news in Kansas.

I am currently a dentist located in rural Colorado. I have a private practice that is primarily geared towards treating children with Medicaid. It has been a very successful practice, but my family and I are ready to explore new options. We prefer the rural lifestyle and are looking at establishing a new practice in the Sublette / Satanta / Liberal area.

Your effort with the KDA to establish some incentives for dentist to begin practice in rural areas caught my eye. I hope you are successful with that as I can see how it could make a difference in where a dentist chooses to practice. I also had some concerns that maybe you can help me answer.

My first concern is the proliferation of publicly funded health centers throughout the rural Midwest right now. These centers claim to serve only the patients that private practice dentists won't see, but that has definitely not been the case in my area. One public health center in my area went as far as obtaining a grant to provide transportation 5 hours away for patients that needed treatment in the hospital setting to avoid referring patients to local dentists. I am the only dentist in the area with hospital privileges and they were finding that families they referred to my office chose to remain at my office instead of returning to the health center.

My second concern is the intense push I see in Kansas for a mid-level provider. The areas I am looking at are barely capable of supporting a single dentist and the addition of a mid-level provider in one of these areas (with or without government funding) would absolutely cripple the ability of a small private practice to remain profitable.

I appreciate the efforts you are making with the KDA. Good luck with your initiatives. If there is anything I can do to help, please let me know.

Thanks,

Jared Staples, DMD

17-6

February 9, 2011

To Whom It May Concern:

Marshall County Community Resource and Education Center, a family resource center, in Marysville, Kansas, has partnered with Dr. Dave Hamel, who has sponsored Dental Access days during which individuals receive dental services at no cost to them.

We assist Dr. Hamel by recruiting families and individuals who need dental care and are unable to afford the cost of the service. We work closely with the patients regarding their appointment time, do follow-up calls to remind them of their appointment, and we provide transportation if necessary.

While the population that we serve tends to be low-income, we have not limited the program based upon income restricted, so individuals from other income levels may participate. However, I see no reason it could not carry income limitations. In addition, the program serves all age groups.

This Dental Access Days pilot project has provided an opportunity for a variety of agencies to collaborate by identifying potential clients and informing them of the services through the public schools, the GED program, and all the home-visitation programs such as Parents as Teachers.

In our rural community this program has proven to be an efficient and effective method of providing dental care to a population that otherwise would not have been able to access care. The services of Dr. Hamel are essential for this program to be successful, and the cooperation of other entities in the community – makes it work. This cooperative effort results in a seamless support system for families that is convenient and affordable. The long-term effects on families, especially children, are important for the future of the participants, as well as a positive impact on the health of the community.

I encourage you to develop methods of funding or adapt existing funding programs to help this be an ongoing and widespread opportunity for our at risk populations to receive dental care.

Sincerely,

Charles Friedrichs,
Administrator
Marshall County Community Resource and Education Center
405 N 4th
Marysville, KS 66508

Madame Chair and Committee Members,

My name is Christy Gunter. I am a survivor of domestic violence and currently working on my doctorate in global health and wholeness. This means I am dreadfully poor as I try to stand up on my feet again following an experience with abuse. Since this is the backdrop of my life, I am educated and passionate about issues pertaining to what happens to the poor, of which circumstances caused me to be a part.

There are two things about the Senate Bill 192 which cause concern. First, those who are proponents of this bill believe there is a lack of quality care available for the number of people who need assistance and thus propose non-dentist practitioners be made available to those who need to participate in the Kansas Medicaid program. This is simply untrue. I live in Wichita, the largest city in Kansas, and there are a great number of dentists available in my area. Anyone who lives in the city of Wichita should be able to access a dentist. But I could not.

Even though I am located in an area with multiple dentists, I still could not find dental care for my four year old son. This was not from a lack of effort on my part. One day I called a local clinic eight times. Another day I left a message for a pediatrician recommended dentist. No one returned my calls. No one could see me. The dentists are physically present but I could not access them.

I waited 8 ½ hours in a free dental clinic in Hutchinson Kansas and fortunately receive care from a dentist who practices in Olathe Kansas. This is surely indicative of a more serious problem than a lack of quality care available for the number of people who need assistance.

Therefore, the issue is *not* access to a large enough population of licensed dentists. The issue is found in the obstructions of access to the available dentists. In my case, simply being poor and having Kansas Medicaid as my insurance was my obstruction, nothing more than this.

The second thing that causes concern about this bill is that if it passes, because I am poor, my son would not have access to qualified persons for dental work. He would be forced to have major dental surgery performed by a non-dentist practitioner. My adorable, energy-filled child would be forced to see someone with less experience and less training to handle emergency situations. He could quite possibly suffer greatly because of my poverty.

Why should I not have access to the same care in my poverty as the person with the finances to pay a qualified licensed dentist? Does my time in poverty, induced by running away from abuse, mean I do not deserve a licensed dentist? To allow the wealthy access to qualified dental surgeons while denying access to the poor or those with disabilities is simply dehumanizing. This is not who we are as a country. We were meant for something better than this.

Hear the voice from the oppressed and poor—we deserve better care. We need better care. Thank you.

With all respect,

Christy Gunter

Dr. Jeffrey Stasch, DDS, Garden City
Senate Committee on Public Health and Welfare (SB 192)

Good Afternoon, Madam chairperson, and members of the committee. My name is Jeff Stasch, and I have maintained a general dental practice in Garden City for 27 years. I have served on the dean's advisory board at the University of Nebraska Medical Center College of Dentistry, and Target: Rural Access; a consortium made up of dental leaders from South Dakota, Wyoming, Nebraska, and Kansas. For the past 4 years, I have served on the ADA's Council on Access, Prevention, and Interprofessional Relations—specifically tasked with looking for answers to the problems we are addressing here today. I am a cofounder of the Kansas Mission of Mercy, and the founder of America's Dentists Care Foundation, which to date, has provided 28 million dollars in care to over 60,000 patients in 14 states. I have worked at mission projects and seen the scope of the problem, in towns both large and small, in Connecticut, Wisconsin, Illinois, Iowa, Nebraska, and Oregon to name a few---as well as 10 projects here in Kansas.

It is generally accepted that 50% of Americans do not see the dentist regularly, and mission work has shown that these 50% have significantly more than half of the dental need. But it is the type of need that is so shocking --not simple little fillings but what in the profession we call "bombed out teeth". We pull on average 3,500 teeth at a project; to give you an idea, that's two five gallon buckets full of teeth. Simple and easy are not words we use---we have 4th year dental students, after 7 and a half years of college, mind you, that can find precious little clinical dentistry to do inside their comfort zone.

In dental school, we had an Endodontics professor, who said that he could teach a 13 year old how to do a root canal. But the point that he made to us was that it was the combination of anatomy, physiology, biochemistry, histology, patient management, and a myriad other factors, that tell us what needs to be done, how best to do it, and predict potential outcomes.

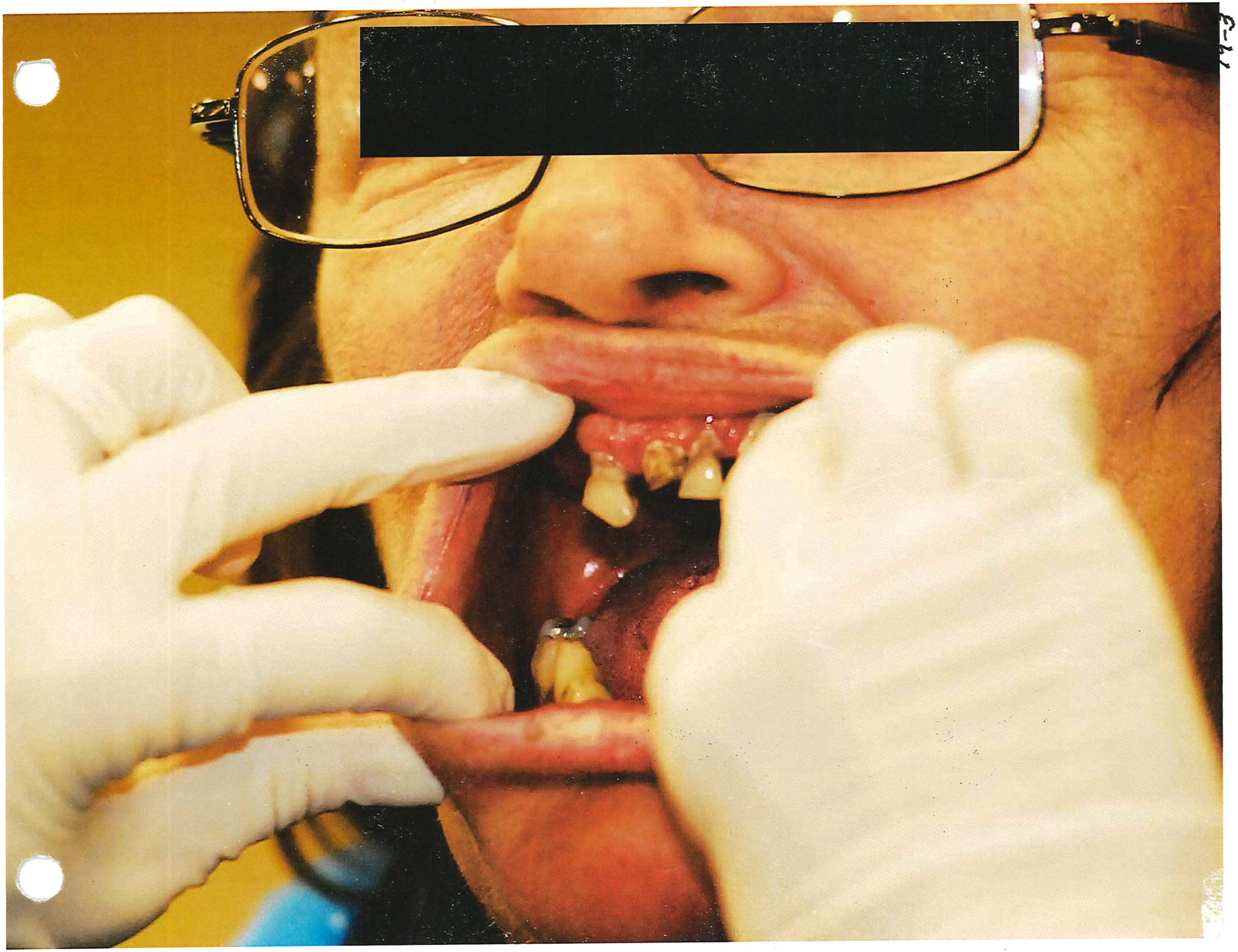
I live so far out in rural Kansas that we don't walk around at night without flashlights, for fear of falling off the edge....it is a lonely place to be when something goes wrong, and you are the only game in town! People ask "what is a simple extraction"? The answer is, "one that came out easi

with the emphasis on the past tense—after the procedure is over. No x-rays can reliably show all the shapes and irregularities of the roots, or the bone density of the patient, the 'brittleness' of the tooth, the proximity of blood vessels and a host of other important variables. I personally, within the last year, have scheduled a patient for what appeared to be a simple extraction, only to spend the next 2 hours sweating and praying for divine intervention!

Much has been said about access to care in rural areas, so we did a Zip code search of our patients, and found that they came from 17 counties. If they had trouble getting in to see us, friends, neighbors, or family always brought them, and many of these people have to drive a significant distance just to buy a loaf of bread. We hear about long waits for appointments, but if you call my office, or many of my peers, you will get in this week, or next....that number again, is 275-4782.

The proponents of this bill say that here in Kansas, the RDP would be just like nurse practitioners, or physician's assistants. I think it is a very great leap from sending a high school graduate to a vocational / technical school for two years and getting their associates degree, then sending them back for 18 months of additional training, to comparing them to a PA. And make no mistake.....PA's do not pick up a scalpel.....which is used to cut human tissue, just like the dental drill. What is interesting is that if you cut soft tissue, it will heal, even if you ignore it, in most cases. But if you cut a tooth, it is gone forever.....the very definition of an irreversible procedure.

It is my firm belief, that if we doubled the number of dentists in the United States, we could not service all the need that exists.....if there was a way to pay for it. We cannot drill our way out of this situation. The only solution lies in education and prevention. If we start educating parents before the baby comes, and carry it into the preschools and K through 12....healthy choices, fluoridation, proper nutrition, good hygiene ..... will turn the tide. This registered dental practitioner can be likened to giving a person a fish—they are fine for today, but will be hungry again tomorrow. Education.....Prevention....is the only thing that will pay dividends to the citizens and tax-payers of the state of Kansas.



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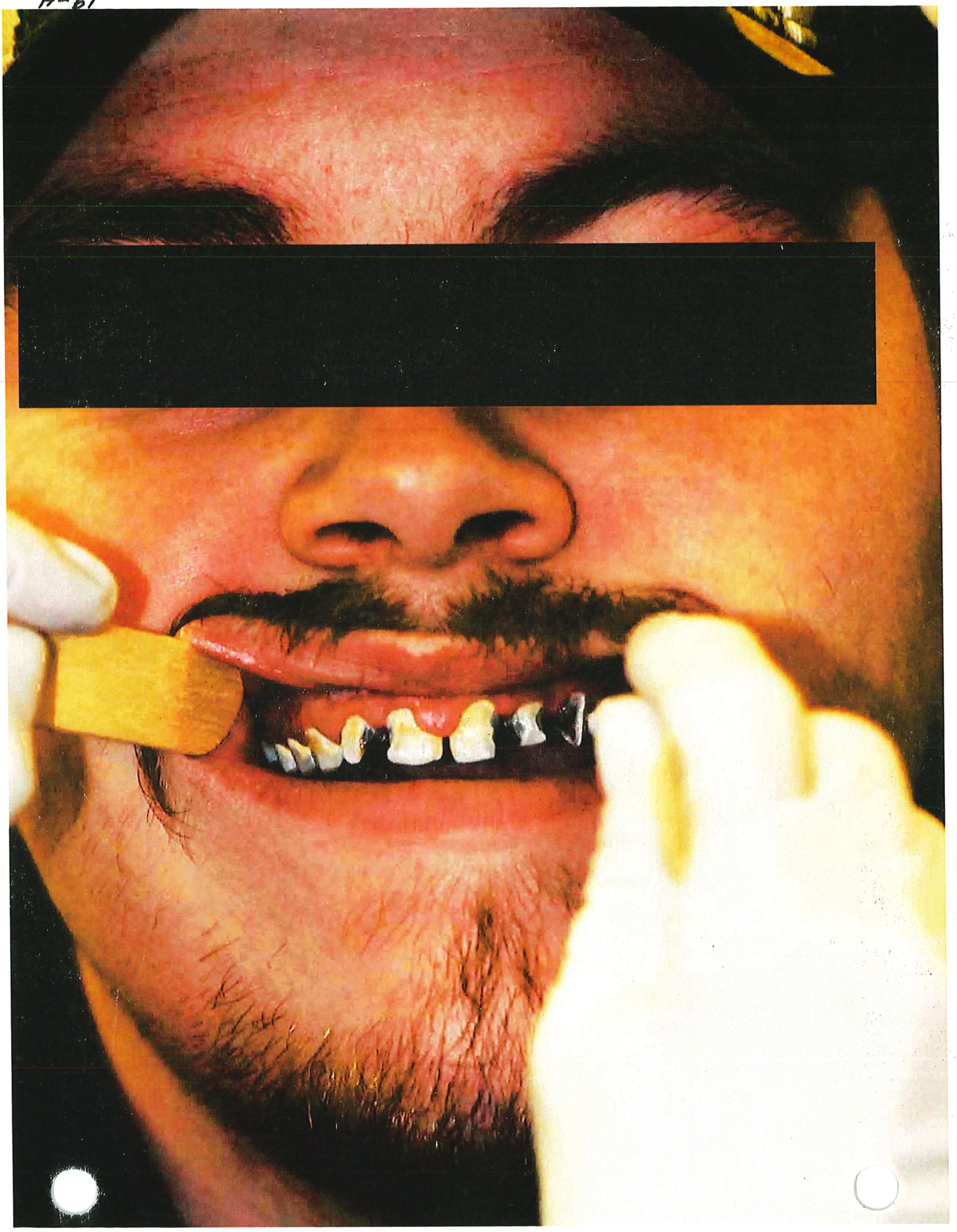

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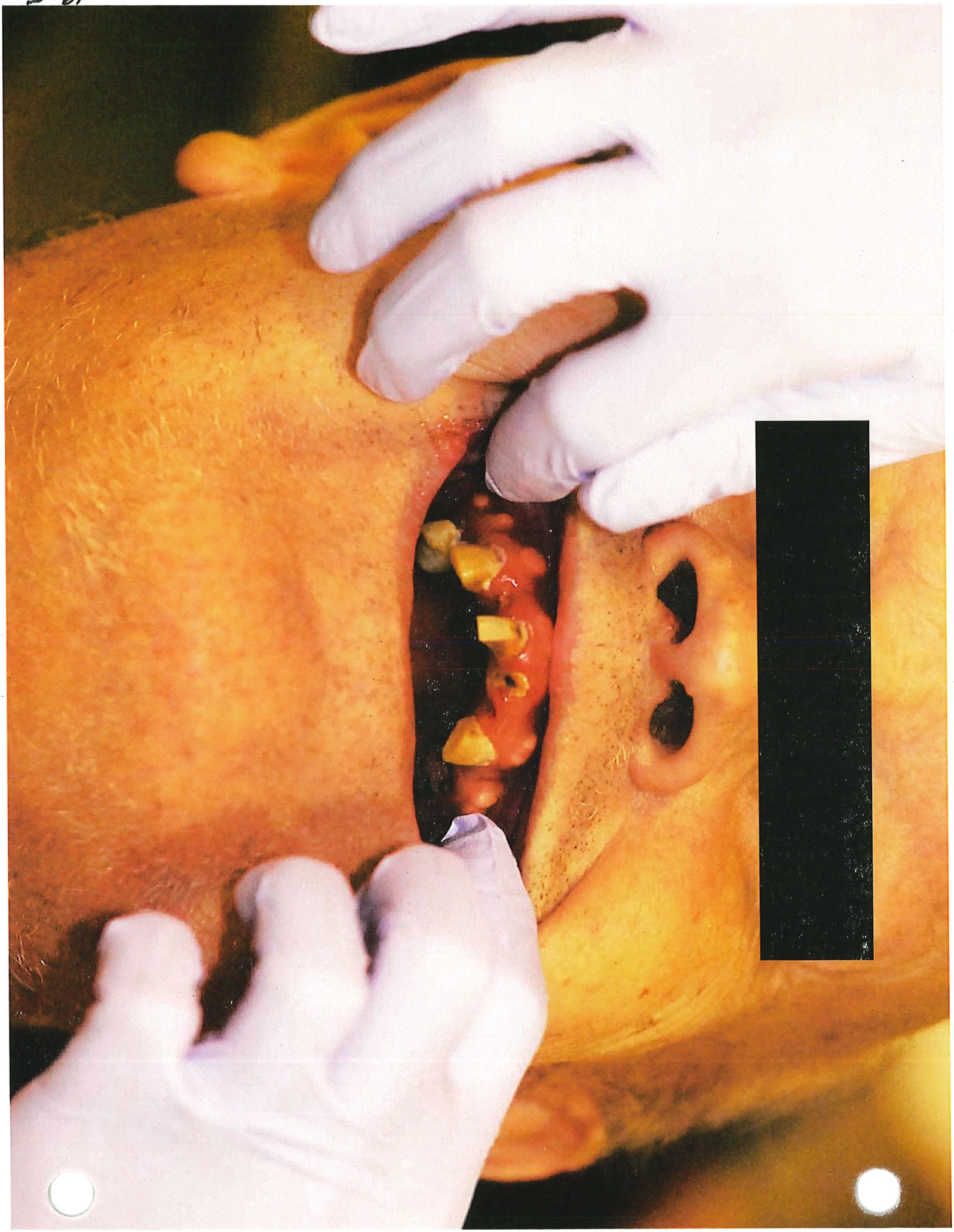

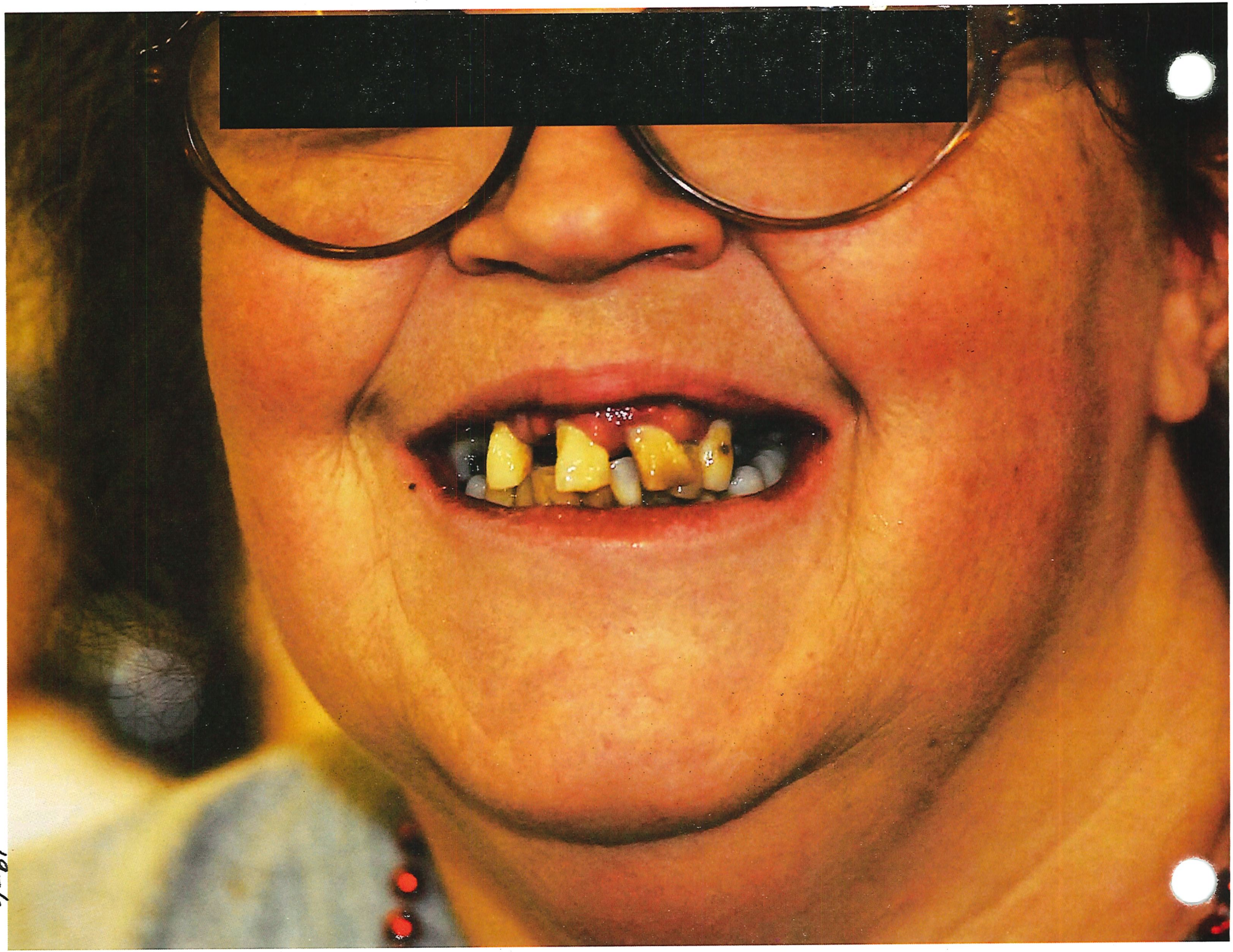

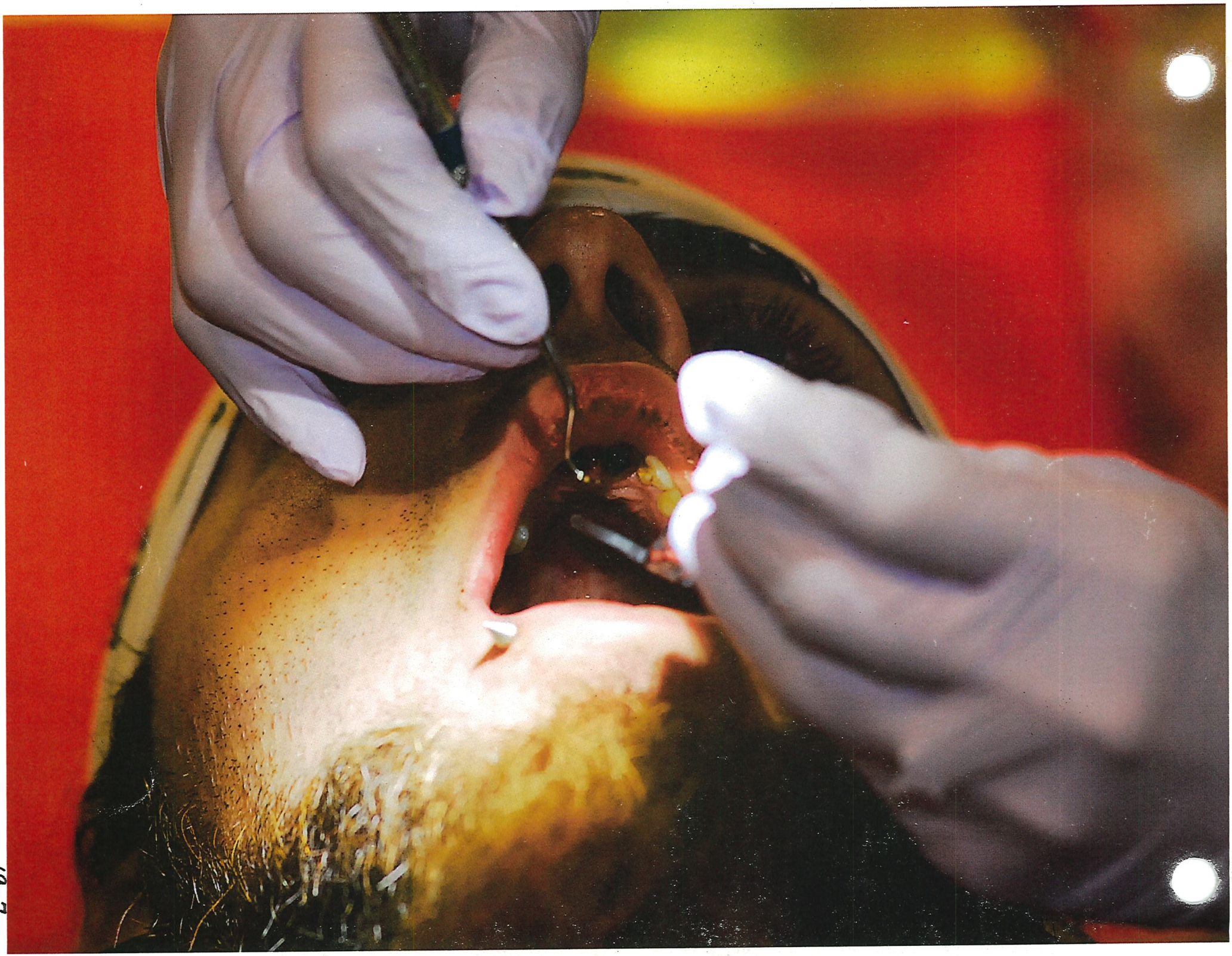

19-7

March 9, 2011

Dear Committee Members,

Thank you for taking the time to consider SB 192 regarding the licensure of registered dental practitioners. I am a registered dental hygienist from Garden City, KS and have worked in private practice for the last five and a half years. I received my bachelors in dental hygiene from the University of Nebraska in May of 2005. I am proud to be part of the dental profession and truly enjoy making a difference in people's lives. After considering the proposed bill, I have several concerns.

The first thing we need to consider is patient care. Dentists have 8 years of intense education and training, and the RDP program will be an additional 18 months of training for hygienists who may only have a 2 year education. While they may be able to learn basic skills in this training period, there are so many other components to consider… will they be capable of properly diagnosing? what about treating medically compromised patients? I know from working in a dental office that sometimes a "simple" extraction can turn difficult in a hurry, or a "simple" filling can be deeper than anticipated and go to a root canal in a matter of minutes. These are situations that will arise and without the presence of a dentist, they are going to be real problems.

I know that there is a dental need across our state. I have been humbled by volunteering at five mission of mercy projects where I have seen some of this need first hand. Much of the need is what would be considered severe dental problems, often times it is a full mouth of infection and disease. The problem is not access to care. The majority of people could get to a dentist if they needed to. Many of them choose not to for reasons including fear, finances, and just not being educated in their dental health. I'm not convinced that by having registered dental practitioners, it will make a difference in the needs that are out there.

I serve patients in a rural area. Many of them drive a great distance to get dental care. However, they have lived in these areas all of their lives, and know that they don't have a dentist next door. They choose to live in these areas and driving an hour for them is generally not an issue, it is a way of life. They drive that far to buy groceries, shop, see their medical doctor, and do other business. I grew up in rural Nebraska and can relate to this way of life. We drove 40 miles, to a dentist in another county, but we didn't think twice about it. Again, I don't think RDPs are the answer to solving dental need. I hope that somehow we can reach out to help people with needs. We need to do everything we can to educate people on the importance of prevention.

Thank you again for taking the time to consider this issue.

Sincerely,

Jessica Rogers, B.S. RDH

March 9, 2011

Dear Members of the Committee,

I am writing as President of the Kansas Academy of General Dentistry to oppose Senate Bill 192. The Academy of General Dentistry is 35,000 member organization of general dentists that promotes lifelong learning with required continuing education, provides public education on dental issues and advocates for general dentistry.

The Academy of General Dentistry believes that :

- Only dentists should diagnose disease and develop treatment plans
- Only dentists should perform irreversible procedures such as extractions, fillings, pulpotomies, crown placement, tooth reimplantation
- Dentists should be present when local anesthesia and nitrous oxide are used by allied personnel
- Patient safety is at risk if this proposal goes forward
- The training of any new dental team member should occur through programs accredited by the ADA Commission on Dental Accreditation, which is recognized by the U.S. Department of Education
- The education of a dentist and a dental hygienist are not comparable. A dentist has minimally 8 years of post high school education and the proposed dental practitioner could have as few as 3 ½ years of post high school education
- Barriers to dental care in Kansas are many and complex, however proposing that a new dental provider will significantly reduce these barriers is at the least, naïve and suspect in origin.

The Kansas Academy of General Dentistry is strongly opposed to SB 192 and asks that you vote to defeat this ill-conceived proposal on the basis of patient safety.

Ric Crowder, D.D.S. President, Kansas Academy of General Dentistry

14922 W. 87th St., Lenexa, KS 66215

Kansas Dental Board
Landon State Office Building
900 SW Jackson, Room 564-S
Topeka, KS 66612

phone: 785-296-6400
fax: 785-296-3116
www.ks.gov/kdb

Betty Wright, Executive Director

Kansas Dental Board

Sam Brownback, Governor

Testimony re: SB 192
Senate Public Health and Welfare Committee
Presented by Glenn Hemberger, DDS President of Kansas Dental Board
March 9, 2011

Madame Chair and Members of the Committee:

Thank you, Madame Chair and members of the Public Health and Welfare Committee for the opportunity to testify on Senate Bill 192.

My name is Glenn Hemberger. I am a pediatric dentist and President of the Kansas Dental Board. The Board consists of nine members: six dentists, two hygienists and one public member. The mission of the Dental Board is to protect the public. Our protection process involves licensure, regulation, and investigative oversight of the dental profession.

The Kansas Dental Board is in opposition to Senate Bill 192 due to the Board's concern for patient safety and appropriate patient care.

The Kansas Dental Board is particularly concerned about the registered dental practitioner's duties listed under Section b, page 1,(line 22-33) of SB 192, i.e., working under general supervision. Direct supervision is where there is a dentist present to oversee the treatment rendered and to provide direct and immediate assistance when necessary. Under general supervision, there may be no dentist present. Why is general supervision such a concern? If there is one consistency in the practice of dentistry it is that procedures frequently do not go as planned. Frequently, complications occur when finding more disease or structural damage than anticipated. These problems, in part, are due to the limitations of our diagnostic aids available including X-ray and visual exams. When problems are encountered, the dentist has to rely on his/her extensive training and experience to complete the treatment. The duties listed for the registered dental practitioner allows such person to encounter these complications, but their training does not allow them an avenue for proper completion. Although SB 192 Section 1 (b) requires the supervising dentist to provide or arrange with another dentist to provide the necessary treatment when treatment requirements are more than the register dental practitioner can provide, the proposed bill permits this to be done through "distance technology". Let me give you just two examples that give the dental board concern:

Item (c) (27):

The registered dental practitioner is allowed to perform a pulpotomy on primary (baby) teeth. This procedure involves the removal of the upper portion of the nerve (or pulp) of the tooth when decay has infected it. Many instances, however, the infection goes beyond the upper portion of the pulp and extends down the roots. This requires a pulpectomy or "baby tooth root canal" treatment which the therapist is untrained to perform. The tooth must then be temporized and referred to a dentist for treatment to be completed.

Item (c) (19):

The registered dental practitioner is allowed to perform extractions of primary teeth. The removal of primary teeth can be a very complicated procedure sometimes requiring the *sectioning* of the tooth to prevent breaking the roots off and causing undue post-treatment discomfort for the patient. The therapist is untrained and prohibited from performing any sectioning of the tooth (item (c) 20) or the removal of root fragments if and when the roots are fractured. Again the patient will have to be sent for another appointment with a dentist to reopen the area and complete the root removal. In both of the above examples, the child patient will have to be

reanesthetized and subjected to unnecessary second appointment. This may not seem that significant to an adult, but to the child patient, being reanesthetized (getting another shot) and having the same procedure redone can have a lasting negative impression.

If any of the above two examples were routinely done today by a practicing dentist, the dental board would consider this *below* standard of care.

The Dental Board also speaks in opposition of this proposed Bill because the education process a written is not clear.

- It does not define education as full time or part time, nor does it address content, classroom or clinic hours
- While the proposed Bill states that, in order to practice, the registered dental practitioner must also be a licensed dental hygienist, it does not require completion of dental hygiene school or licensure as a dental hygienist prior to enrollment.
- Unlike the training for dentists and dental hygienists, there is no provision for approval of the training program for dental practitioners by the Kansas Dental Board – either by independent evaluation or through an accepted entity like the Commission on Dental Accreditation.
- Because the proposed professional does not exist at this time, no educational institution in the state of Kansas has developed a curriculum for training yet. The Board has concerns that this time limit will place undesired restrictions on the educational institutions that provide the proposed dental practitioner education (July 1, 2013).
- The bill also specifically prohibits extending the education program beyond the stated number of months (18). The college or university must be permitted to act if it is determined that additional training is necessary for an individual or group of students to gain competency.

It is the Dental Board's position that this presents a risk to the public.

Senate Bill 192 requires 2 new and additional members be appointed to the Kansas Dental Board. The proposed registered dental practitioner is required to also be a licensed dental hygienist. Licensed dental hygienists are currently members of the board. The requirement of 2 registered dental practitioners is disproportionate to the anticipated numbers of providers.

I am glad to stand for questions by the Committee.

Sincerely,

Glenn Hemberger, DDS
President, Kansas Dental Board

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-------- Original Message --------
Subject: Thoughts on HB 2280
From: <drswift@topekaperio.com>
Date: Mon, February 14, 2011 1:26 pm
To: ann.mah@house.ks.gov

Dear Representative Mah,

As you can see from the information below, I am a board certified periodontist practicing here in Topeka and I would like to express my concern regarding the bill to create a Registered Dental Practitioner mid-level (HB 2280).

First of all, I am quite concerned about the lack of education and training for this potential mid-level practitioner. From what I've read on this matter, this potential RDPs would only have a 18-month training program with no hands on experience. My clinical training itself was much longer than this, just to become a "dentist", not to mention all the education I had to do prior to putting my hands in anyone's mouth.

I do not feel like the public at large would understand how "under-trained" these individuals are since a "registered dental practitioner" sounds like a nurse practitioner or PA to borrow examples from the medical community. Both of those typically work in a setting where they are "over-seen" by a physician. My understanding is that the RDPs would be able to do numerous procedures including nonsurgical extractions (with stipulations in regards to mobility and what not - the mobility scale is not even anything I have ever encountered), cavity preparation, restoration of primary and permanent teeth, etc. Without supervision and no clinical experience, these procedures could quickly become problematic. In other words, a tooth that is mobile and non-impacted can still fracture during extraction and would therefore need to be surgically removed. If these people are not practicing with a dentist, who is going to handle that "emergency"? Would the patient have to then be referred to a real dentist? Who is going to pay for the extraction at that point? How will these patients get worked in to the real dentist's schedules?

I'm offended that the state would even consider creating such a position and putting the citizens of this state at such a risk. When I came back from my residency to practice in this state, I had to pass the WREB exam and also an additional test since I was planning to practice as a specialist. I think anyone that is going to be diagnosing and treating oral disease should be held to the same standard so that no one is "accidentally" hurt.

I understand the state is under a lot of pressure from the Kellogg Foundation to create this position supposedly because we are having a shortage of dentists for our population. This simply isn't true. I've seen their advertisements and while they are convincing they are false. The total number of dentists has increased 17% since 1997 and the growth in number of dentists and dental hygienists both outpaced the population growth of the state of Kansas which grew by only 6.1% from 2000 to 2010 according to the US Census Bureau.

If you, as a representative, are concerned about the access to dental care problem that is presented by this group, allowing the creation of such a sub-standard der
will only turn potential dentists away from practicing in our state. If I we

uate considering whether or not to return to my home state to practice and knew the state had passed a measure to allow RDPs to begin practicing, I would keep looking for a state that valued my education and services as well as the citizens that I would be treating. I would not want my reputation as a dentist to be at risk because of these practitioners that lack both education and training.

As you can already tell, I most definitely am opposed to the creation of a Registered Dental Practitioner mid-level. I hope you will keep this in mind when meeting with the House Committee on Health and Human Services this Thursday.

<sigimg1.png>;
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