Approved 3-31-92
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader
Chairperson
at

1:30 ~~a.m.~~/p.m. on March 18, , 1992 in room 423-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Brian Gilpin, Tobacco Free Kansas Coalition
John Holmgren, Executive Director, Catholic Health Association of Kansas
Denise Maseman, Dental Hygienist, and member of Kansas Dental Board
H. Philip Elwood, Attorney for Kansas Dental Board
Dr. Estel Landreth, President of Kansas Dental Board
Dr. Michael Reed, Dean of University of Kansas School of Dentistry
Marilyn Bradt, Kansans for Improvement of Nursing Homes
David Hanzlick, Kansas Dental Association
Dr. Charles A. Ritter, Jr., Dentist
Tom L. Barth, D.D.S. (Pediatric Dentistry)
Clifford W. VanBlarcom, D.D.S., M.S.D. (Specialist in prosthodontics)

Chair called meeting to order, drawing attention to conferees who did not have the opportunity to present testimony yesterday.

HEARINGS CONTINUED ON HB 3041, HB 3042, HB 3048.

Brian Gilpin offered hand-out, (Attachment No. 1), and commented on **HB 3042 and HB 3048.** He stated the National Institute for Occupational Safety/Health has recommended that ETS (Environmental Tobacco Smoke) be regarded as a potential occupational carcinogen and that all available preventive measures be used to minimize exposure. The best method for controlling worker exposure is to eliminate tobacco use from the workplace. He cited facts, i.e., ETS kills 53,000 Americans per year, making it the third leading preventable cause of death in America; 435,000 Americans die each year from tobacco related diseases; smoking costs the United States $65 billion in lost productivity and health care costs annually. He urged support of **HB 3042.** In regard to **HB 3048,** he noted the 10¢ tax on cigarette products for programs for the prevention of tobacco related diseases and to pay certain medical and health services costs is a nominal and insignificant price when compared to the $3 billion spent by the tobacco industry annually to promote tobacco use. In his view both bills are workable and reasonable. He urged support.

John H. Holmgren, Executive Director of Catholic Health Association of Kansas, offered hand-out (Attachment No. 2). He noted passage of **HB 3041** would provide rationale for hospitals to prohibit smoking. Signs will be placed throughout the hospital to cite the state law prohibition of smoking in hospitals, obtain uniformity throughout the hospital setting; provide for a smoke-free environment for hospital patients; help prevent risk from fire hazards. He urged support. He answered questions.

Chair drew attention to a hand-out distributed to members yesterday from Mr. John Peterson, Charter Medical Corporation. This hand-out indicates a proposed amendment on **HB 3041** and is recorded this date as (Attachment No. 3).

HEARINGS CLOSED ON HB 3041, HB 3042, HB 3048.

STAFF BRIEFING ON HB 3126.

Ms. Correll gave a comprehensive explanation of **HB 3126,** section by section, noting extensive changes proposed for the practice of dentistry and dental hygiene. She detailed new sections, what would be new authority, listed acts that could not be delegated, definition of terms. Ms. Correll then answered questions.

HEARINGS BEGAN ON HB 3126.

Denise Maseman, dental hygienist, and member of the Kansas Dental Board, (Attachment No. 4), stated her initial remarks are made as a Board member. The Dental Board had requested introduction of this legislation. There was a split vote on the endorsement of this proposal and she was one of those opposing. However, her opposition did not relate to the content of the bill as it currently stands. Her concern is the potential for modification to **HB 3126.** She urged members not to modify **HB 3126.** As a faculty member from Wichita State University, she presented an educator's viewpoint on **HB 3126.** She supports the suggested changes regarding dental hygiene practice, i.e., "general supervision" in particular. She detailed credit hours required for the dental hygiene programs; education; procedures; evaluation skills; local anesthesia and nitrous oxide administration; head/neck anatomy, and pharmacology. She noted general supervision and anesthesia administration for hygienists is a natural evolution in dental care. She answered questions.

Chair drew attention to a fiscal note on **HB 3126** that had been distributed. (See Attachment No. 5).

Mr. Phil Elwood, Attorney for the Kansas Dental Board, offered hand-out, (Attachment No. 6). He gave an overview of the process in development and introduction of **HB 3126**, the issue of what is the practice of dentistry, i.e., what control of delegation of functions does the practice of the public health, safety, and welfare require; what control can be enforced; what is the rural dentist to do. Proposed changes are significant, but simple. He detailed key changes in regard to dental hygienists; general supervision; administration of local anesthesia and nitrous oxide; work in alternative settings approved by the Board. He detailed key changes in regard to dental assistants: delegating under direct supervision can be done if the assistant is qualified/properly trained; if task is performed in customary manner; act does not violate limitations of statute; the assistant is not represented to be qualified to practice dentistry. He outlined procedures that can be performed by only a dentist. He noted the current law does not reflect the reality in today's marketplace. **HB 3126** has been determined by the Board to reflect the state of the art and science of dentistry today. These rules will protect the public health, safety, welfare. Rules can be enforced and will allow the Board to do its job.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on March 18, 19 92

HEARINGS CONTINUED ON HB 3126.

Dr. Estel Landreth, current President of the Kansas Dental Board, offered hand-out (Attachment No. 7), and stated the dentists of Kansas need a clear understanding of exactly what the law is in respect to dental practice. He explained the long process of coming up with a new Dental Practice Act. The premise of this act is, i.e., general supervision for hygienists; hygienists to be allowed to see home-bound patients or patients in care homes if they have been examined by a dentist during the previous seven months and the dentist has prescribed preventive care; administration of local anesthetic by hygienists; holds the dentist responsible for all acts delegated by the dentist. The purpose of **HB 3126** is to modernize the practice of dentistry. He urged support as submitted. He answered numerous questions.

Margaret Brietman, Director of Dental Hygiene Program at Johnson County Community College, (Attachment No. 8), spoke in support of **HB 3126.** She outlined the general educational curriculum; science based curriculum. After completion of these courses, students are enabled to perform clinical and health education functions as an integral member of the dental care team. She detailed requirements on written board exams and clinical dental hygiene board examinations. Upon completion of the two year dental program, students are awarded an Associate Degree and are eligible for licensure.

Note: Recorded as (Attachment No. 9) is written only testimony from Renee Arnett, a licensed dental hygienist.

Dr. Michael Reed, Dean of University of Kansas School of Dentistry, spoke in support of **HB 3126.** He noted his remarks are from an educator's point of view. He drew attention to new section 3, page 5, noting language "reasonable and prudent" and "sound dental judgment". He discussed this language, stating all the graduates of the school exibit these qualities. Administrative and staff of instructors are proud of the dental graduates, and of the education programs offered. He noted technology has advanced so much in the last few years. The user-friendly nature of materials used would allow those who are not trained as dentists to use these materials as would appear to be reasonable and prudent and in the sound dental judgment of the dentist. He supports the "direct supervision" of dental assistants to administer. He detailed the educational process, forms of training, and requirements. He noted, "general supervision" in his view, will become a part of the rules and regulations in Missouri for dental hygienists. He opposes a preceptorship form of training for dental hygienists.

Marilyn Bradt, Kansans for Improvement of Nursing Homes, provided hand-out (Attachment No. 10). There is often a serious lack of programs for dental/oral hygiene for patients in nursing homes. Most dentists are reluctant to extend their practice in this area. We realize that serious procedures cannot be done in this type of setting, however, this type of program is vitally important. Perhaps **HB 3126** is not a total answer, but it could become an avenue in which quality of general dental care for those in nursing homes could improve.

David Hanzlick, Assistant Director, Kansas Dental Association, introduced Dr. C. A. Ritter, Dr. Tom Barth, and Dr. Clifford VanBlarcom who would express their concerns in respect to **HB 3126.**

HEARINGS CONTINUED ON HB 3126.

Dr. C. A. Ritter, Jr., practicing dentist, offered hand-out (Attachment No. 11). He spoke in opposition to **HB 3126** noting this legislation will lower the quality of dental care for the people of Kansas. The Kansas Dental Association has carefully reviewed, and rejected the major changes proposed in **HB 3126.** The splinter group of dentists who are lobbying for this legislation want you to approve changes in the dental practices their fellow dentists have reviewed and consistently rejected. **HB 3126,** if passed, would permit dental assistants to perform procedures that only the dentist has the skill and judgment to perform. He detailed these practies, detailed the educational requirements for the dentists, hygienists, and dental assistants. He viewed "general supervision" as a dangerous idea. Dentists need to be on site and available for consultation with the hygienists. To permit hygienists to work in nursing homes without on-site supervision of a dentist would be unconscionable. He noted it is unfortunate that nursing home residents are being used to advance the cause of the hygiene group. **HB 3126** serves only the narrow interests of a small group of dentists who refuse to accept the judgment of their peers. He detailed the process of major policy changes that are proposed in **HB 3126**, noted a group of dentists whose self-interest outweighs (it appears) the protection of the public and prevents them from accepting the professional judgment of the majority of their peers. He drew attention to a letter from Dr. Ken Riley in his hand-out.

Dr. Tom Barth, a specialist in Pediatric Dentistry, and current Secretary of the Kansas Dental Association, offered hand-out (Attachment No. 12). He drew attention to a letter from Dr. John Carter, a practicing orthodontist and clinical professor of Orthodontics at the University of Mo. at Kansas City, and a letter from Dr. Don Thompson, an Overland Park Orthodontist, on the importance of the dentist personally placing bands and brackets on the teeth during orthodontics treatment. Dr. Barth then detailed why direct pulp caps and pulpotomies should not be performed by a dental assistant as **HB 3126** would allow, should it be passed.

Dr. Clifford VanBlarcom, licensed dentist and specialist in prosthodontics, offered hand-out (Attachment No. 13). He stated opposition to **HB 3126.** He is concerned with the extensive liberalization of the Dental Practice Act as indicated in **HB 3126.** He detailed the procedure of making impressions on a patient, and gave rationale on why this procedure should be done only by a qualified dentist. He detailed problems than can and do occur with patients during this procedure, and the importance of the dentist being on site. **HB 3126** will do nothing to enhance dental care in Kansas and he believes it will open a new avenue of citizen complaints to the already overworked State Dental Board. He stated Kansans seek quality dental cae by practitioners devoted to and working directly with their patients.

It was noted Dr. Sherwood will explain the balloon that is attached to Dr. Ritter's testimony tomorrow as Hearings will continue on **HB 3126** at that time. Other conferees are scheduled as well.

Chair adjourned the meeting at 3:05 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-18-92

NAME	ORGANIZATION	ADDRESS
David Hanson	Kansas Dental Assistants Assoc	Topeka
Barbara Gonzalez	Wichita State University	Wichita
Phillip Elwood	Ks Dental Bd - Woodell Tow Truck	Topeka
Carol Macdonald	Ks. Dental Board	Topeka
Denise Maseman	Ks Dental Board	Lawrence
C.A. Ritter J., D.P.S.	Kansas Dental Association	Salina Ks
Tom BARTH	Kansas Dental Association	Manhattan
Scott C Kennedy D.D.S.	Kansas Dental Assoc.	Topeka
Cliff VanBlaricom	KANSAS DENTAL ASSOCIATION	Prairie Village
Kevin Watens DDS	Kansas Dental Association	Olathe
Roger Fraedrich	Ks. Gov't Consulting	Topeka
JARY McLEAN DDS	Ks Dental Assoc.	Wichita, Ks
R. Wayne Thompson	Ks Dental Assoc	Shawnee Ks.
GARY Robbins	Ks Optometric Assn	Topeka
Polly Gister	Johnson County Com Colleg	Overland Park KS
Neil D Soder	Son of Chairperson	Overland Pk, KS
Marilyn Bradt	KNTH	Lawrence
Janey Purcell CDA	Ks. Dental Assistants Assoc.	Wichita
Brenda Long CDA	Ks. Dental Assistants Assoc	Topeka
Ruby Mercer, CDA	Wichita area Vocational Technical School	Wichita
Melanie Mitchell, CDA	Ks. Dental Assistants Assoc and Wichita Area Vo-Tech (D. Assisting Program)	Wichita
Pete Wiklund DDS	Ks Dental Assoc	Lawrence
Pam Pa Bumpurs RDH BHS	WSU Educator KDHA	Wichita

TESTIMONY IN SUPPORT OF HB 3041, HB 3042 AND HB 3048

Tobacco Free Kansas Coalition

Brian Gilpin

I bring evidence issued by the National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control, Atlanta Georgia. I also bring to you their recommendation for the control of death and disability caused by ETS.

In 1964, the Surgeon General issued the first report on smoking and health, which concluded that cigarette smoking causes lung cancer. Since then, research on the toxicity and carcinogen level of tobacco smoke has demonstrated that the health risks from inhaling tobacco smoke is not limited to the smoker, but also those who inhale environmental tobacco smoke (ETS).

Therefore, the National Institute for Occupational Safety and Health has recommended that ETS be regarded as a potential occupational carcinogen in conformance with the OSHA carcinogen policy, and that exposures to ETS be reduced to the lowest feasible concentration. Employers should minimize occupational exposure to ETS by using all available preventive measures.

Workers should not be involuntarily exposed to tobacco smoke. Therefore, the best method for controlling worker exposure to ETS is to eliminate tobacco use from the workplace and to implement a smoking cessation program.

The Environmental Protection Agency has classified ETS as a Class A carcinogen, a classification they reserve for the most dangerous cancer causers like benzyne, vinyl chloride and asbestos. The EPA also recommends that exposure to ETS be minimized wherever possible by restricitng smoking to separately ventilated areas that are directly exhausted to the outside, or preferably eliminating smoking in buildings all together.

The facts:

* Evironmental Tobacco Smoke kills 53,000 Americans every year (which is more than died of AIDS last year), which makes it the third leading preventable cause of death in America.

* 435,000 Americans die every year from tobacco related diseases.

* Smoking costs the United States $65 billion in lost productivity and health care costs annually.

Which leads me to also ask for your support for HB 3048. Our state's number one problem is not property taxes or school finance, but health care. Smoking is costing Kansas $65 million dollars in health care costs annually.

HB 3048 calls for a 10 cent tax on cigarette products for programs for the prevention of tobacco related diseases and to pay certain costs of medical care and health services for those afflicted with tobacco related diseases. Ten cents is nominal and insignificant when compared to the $3 billion dollars spent by the tobacco industry every year to promote tobacco use.

Once again, I ask you to support HB 3041, HB 3042 and HB 3048. These bills address our state's physical health and financial health. They are workable and reasonable. Thank you.

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Attm't 1.

Catholic Health Association of Kansas

John H. Holmgren • Executive Director
Jayhawk Tower, 700 Jackson, Suite 801 / Topeka, KS 66603 / (913) 232-6597

March 17, 1992

Catholic Health Association of Kansas
Topeka, Kansas, 66603

Testimony: House Public Health and Welfare Committee
Ref: Anti-Smoking Bill for general hospitals
H.B. 3041

Good Afternoon:

The Catholic Health Association, with membership including general hospitals, is pleased to go on record as supporting HK.B. 3041, prohibiting smoking in hospitals. The passage of this bill as a state law provides a basis and rationale for hospitals in Kansas to prohibit smoking and to:

1. Cite state law as a basis for this prohibition in signs throughout the hospital;

2. Otain uniformity throughout the hospital as regards this prohibition, by all hospitals, avoiding competition problems in this regard;

3. Provide for a smoke-free environment for patients while in the hospital, a major health measure in a public health facililty. and considering the effect of passive smoke, and the need for a smoke-free environment.

4. does help in reducing risk from Fire Hazards.

Again, our Association supports HB 2973, and urges your favorable consideration. Thank you

Contact:

John H. Holmgren,
Executive Director
Catholic Health Association of Kansas
Topeka, Kansas 66603
(913) 232-6597

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Attm # 2

Written only

HOUSE PUBLIC HEALTH & WELFARE
COMMITTEE
March 17, 1992

Proposed Amendment by
John Peterson
Charter Medical Corporation

Session of 1992

HOUSE BILL No. 3041

By Committee on Appropriations

2-14

AN ACT concerning smoking in medical care facilities; declaring certain acts to be unlawful and prescribing penalties for the violation thereof.

Be it enacted by the Legislature of the State of Kansas:

Section 1. As used in this act: (a) "Medical care facility" means a general hospital, special hospital ambulatory surgery center or recuperation center as defined by K.S.A. 65-425, and amendments thereto, and any psychiatric hospital licensed under K.S.A. 75-3307b, and amendments thereto; and

(b) "Smoking" means possession of a lighted cigarette, cigar, pipe or burning tobacco in any other form or device designed for the use of tobacco.

Sec. 2. Smoking in a medical care facility is hereby prohibited except when authorized for a patient by a physician's prescription, based on medical criteria that are defined by the medical staff. The chief administrative officer of each medical care facility shall cause to be posted in conspicuous places signs stating that smoking in the medical care facility is prohibited by state law.

Sec. 3. Any person found guilty of smoking in violation of this act is guilty of a misdemeanor punishable by a fine of not more than $20 for each violation. Any person found guilty of failing to post signs as required by this act, is guilty of a misdemeanor punishable by a fine of not more than $50. In addition, the department of health and environment, or local department of health, may institute an action in any court of competent jurisdiction to enjoin repeated violations of this act.

Sec. 4. This act shall take effect and be in force from and after its publication in the Kansas register.

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Briefs

Interpretations

Smoking Standard Clarified

Questions from the field have been raised about the interpretation and application of the new smoking standard. Therefore, the following interpretation is provided.

Effective January 1, 1992, organizations seeking accreditation under the Hospital Accreditation Program must comply with the new smoking standard developed in response to requests by a number of interest groups and the U.S. Secretary of Health and Human Services. The rationale for prohibiting the use of smoking materials in hospitals is based on such considerations as the potential adverse effects of smoking on a patient's treatment; the documented adverse effects of passive smoke on nonsmokers; the perception that hospitals should serve as role models for other environments; and the fire hazard created by smoking in hospitals. Thus this standard is perceived to be relevant to the quality of patient care and safety in hospitals. The standard and scoring guidelines are as follows:

Standard

MA.1.3 The chief executive officer, through the management and administrative staff, provides for the following:

MA.1.3.15 dissemination and enforcement of a hospitalwide smoking policy that prohibits the use of smoking materials throughout the hospital building(s).

MA.1.3.15.1 Any exceptions to the prohibition are authorized for a patient by a physician's prescription, based on medical criteria that are defined by the medical staff.

Scoring Guidelines

Intent

This standard is intended to restrict smoking to a minimum in hospitals, with the eventual goal of establishing a smoke-free environment. The restriction on smoking is intended to

1. reduce the risk of smoking to the patient, including its possible adverse effects on the patient's treatment;
2. reduce the risk to other patients

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Interpretations

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and staff associated with passive smoking; and
3. reduce the risk of a fire safety hazard.

Score 1
The hospital has developed and implemented a policy to prohibit smoking. Any exceptions to the prohibition are defined in written criteria that are developed and approved by the medical staff and authorized for individual patients by physician order.

Score 2
The hospital has developed a plan to implement a policy to prohibit smoking within the hospital building(s) by a specified date before December 31, 1993. The plan outlines the steps the hospital will take to become smoke free. The plan was implemented January 1, 1992.

During the transition, smoking is restricted to a designated location(s) that is separate from all inpatient and outpatient care areas. If smoking is permitted in such a designated location(s), a healthy environment is maintained for other patients, staff, and visitors.

Score 3
The hospital has a plan to implement a policy to prohibit smoking by a specified date before December 31, 1993.

Score 4
While the hospital shows some evidence of a plan to prohibit smoking at some time in the future, little or no progress has been made, and no target date has been established. Smoking is permitted in areas that are not separated from both inpatient and outpatient care areas.

Score 5
The hospital has no policies or plans to address the prohibition of smoking in the hospital building(s).

Applicability
Long term care and mental health care programs, surveyed under the *Consolidated Standards Manual* or the *Accreditation Manual for Long Term Care* and housed in the same building as a hospital surveyed under the *Accreditation Manual for Hospitals (AMH), are* subject to the new standard that calls for the prohibition of smoking.

The Joint Commission recognizes that the transition to a smoke-free environment will require time. Therefore, the scoring guidelines indicate that effective January 1, 1992, all hospitals desiring to be in at least "significant" compliance with this standard should have a plan to be smoke free by December 31, 1993, not within 24 months of the "date of survey" as incorrectly reported in the 1992 *AMH, Volume II: Scoring Guidelines.* A hospital that has implemented a plan to achieve a smoke-free status by December 31, 1993, and has in the interim restricted smoking to designated areas will be judged to be adequately compliant with the standard. Thus the scoring guidelines allow for the fact that some hospitals cannot implement the smoking policy by January 1, 1992, for various valid reasons.

The plan should outline the steps the hospital will take to become smoke free. For example, the plan could include the hospital's offer to conduct a smoking-cessation support program for staff members and employees who wish to stop smoking. It could also provide for public relations or promotional efforts to inform local community members of the hospital's new smoking policy. During this transition period, smoking should be restricted to a designated location(s) separate from all inpatient and outpatient care areas in order to maintain a smoke-free environment for nonsmoking patients, staff, and visitors.

The hospital must show evidence of a track record, such as activities initiated to implement the actual smoking policy or a plan to implement the policy on or around January 1, 1992.

Medical Criteria
An important step in implementing this standard is for the hospital's medical staff to develop and approve (with the chief executive officer's concurrence) a list of medical criteria under which a patient in the hospital building(s) will be allowed to smoke. These criteria should be integrated into the hospitalwide smoking policy.

It is important to note that the smoking policy should be a *hospitalwide policy,* not department or program specific. The medical criteria must be specific in nature. For example, they may relate to specific diagnoses or major disease categories. The criteria development process should also reflect the fact that consideration was given to the potential ill or adverse effects on the patient's condition or the effectiveness of the treatment were he or she to be prohibited from smoking. Essentially, the medical criteria should weigh the "pros and cons" of allowing a patient to smoke, as defined by the hospital's medical staff. For example, medical criteria for patients who could be allowed to smoke might apply to those who are terminally ill or who are undergoing treatment for alcohol or chemical dependency. The rationale for allowing terminally ill patients to smoke is that these individuals are nearing the end of their lives and it is desirable to make them as comfortable as possible in their final days. As for the patient undergoing

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treatment for alcohol or chemical dependency, the physician may desire to treat only one addiction at a time and not potentially complicate the primary addiction treatment with treatment for nicotine withdrawal.

To simply allow "all patients on the 4-West nursing unit" or "all psychiatric patients" to smoke is clearly too broad a distinction to be considered valid medical criteria. The medical criteria should be realistic, based on sound medical judgment, and supported by a valid, defensible rationale.

The "physician's prescription" should be based on the established medical criteria and should be specific for each patient who is allowed to smoke. The patient's physician must write an authorization in the patient's medical record stating that the patient meets one or more of the predefined medical criteria.

Some physicians have expressed concerns about potential future liability, such as in the case of a patient who develops lung cancer years after the physician "authorized" the patient to smoke in the hospital. The Joint Commission suggests either that the physician not write such an authorization (hence his or her patients would not be allowed to smoke) or that the hospital develop and use a standard consent form that essentially holds the physician and hospital free from any future liability. The consent form might simply indicate that the physician counseled the patient about the risks of smoking. Further protection would be provided by documentation of this discussion in the patient's medical record.

Of course, a hospital and its medical staff may choose not to permit medical exceptions to the smoking policy. The standard does not require a medical staff to define medical criteria for exceptions to the smoking prohibition.

Hospital Building(s)

Whether professional office buildings on the hospital campus are subject to the smoking standard depends on whether patient care services are provided in those buildings. If the surveyed hospital directly provides or sponsors patient care services in a professional office building on its campus, the standard does apply. This would be true irrespective of whether the professional office building is physically connected to, or separate from, the surveyed hospital.

When a professional office building—used solely by physicians and other health care practitioners in private practice—is physically connected to the hospital either by an enclosed walkway or doorway, the standard applies because the building is considered part of the hospital. A similar professional office building not physically connected to the hospital would be exempt from the standard.

Professional office buildings that are not located on the surveyed hospital campus are subject to the standard only if the hospital directly provides or sponsors patient care services that are to be surveyed under the "Hospital Sponsored Ambulatory Care Services" chapter of the 1992 *AMH*.

In buildings that are controlled (owned and operated) by the surveyed organization and separate from the main hospital building, but that house an off-site hospital operation, such as a financial department, smoking would *not* be allowed if the following situations apply: patient services are rendered in this building, patients have a reasonable need to enter the building, or the structure is otherwise subject to survey under the *AMH*. If the surveyed organization occupies any patient care space within a building that it does not control (for example, leased space in a larger building), only the space that it occupies is required to be smoke free.

Smoking would not be allowed on the roofs or balconies of the hospital as these areas are part of the hospital building. Smoking would be allowed in breezeways and open courtyards. The standard otherwise neither extends to open areas outside of surveyed hospital buildings nor applies to the general hospital grounds.

Authorized Patient Smoking

Joint Commission standards do not specify any engineering-related requirements such as a dedicated heating, ventilation, and air conditioning system. However, in the interest of avoiding passive smoking for nonsmokers, authorized patient smoking should, to the extent possible, be confined to an area(s) that is remote from nonsmoking patients. Given obvious fire safety risks, smoking in bed and around flammables, such as oxygen, should be prohibited.

Smoking by Others

Because the new standard lacks any provision that permits staff, physicians, visitors, or patients' family members smoking in the hospital buildings, the question arises as to whether smoking is allowed in separate structures on the hospital campus that are designated as smoking areas for individuals other than patients. As long as these structures are not physically connected to the surveyed hospital (other than by an *open* walkway), the standard would not apply to such structures.

Questions about the smoking standard should be directed to Glenn D. Krasker, associate director of standards, at (708) 916-5955.

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Denise Mase

MEMBERS OF THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE:

Good afternoon. Madame Chairman, members of the committee. Thank you for the opportunity to speak about HB ~~3621~~ 3126 I support HB ~~3621~~ 3126. My name is Denise Maseman. I am a dental hygienist and the dental hygiene member of the Kansas Dental Board. I would like to address you today from two perspectives, that of a dental board member and as a dental hygiene educator.

My initial remarks are made as a member of the Kansas Dental Board. You are aware that the Board endorsed and requested introduction of HB ~~3621~~ 3126 I suspect you have heard or will hear that there was a split vote on the Board's request for introduction and endorsement. I was one of the dissenting votes and would like to clarify that my reasons for opposing the Board's action did not relate to the content of this bill.

A major concern of mine is the potential for modification to this bill. It is my expectation that you will receive requests for modifications that would significantly alter this bill. I strongly urge you not to modify this bill. That concludes my remarks as a Dental Board member.

As a faculty member from Wichita State University, I would like to present an educator's viewpoint. I strongly support the changes regarding dental hygiene practice. The major changes to dental hygiene practice in this bill are the introduction of general supervision and administration of local anesthesia and nitrous oxide. General supervision, in particular, the section that deals with allowing hygienists into such sites as nursing homes would expand access to care for the citizens of Kansas.

Allowing hygienists to administer local anesthesia would improve the efficiency of dental care delivery by the dentist and hygienist. The hygienist would not have to disrupt the dentist to request local anesthesia administration for a hygiene patient. A major role of hygienists today is the treatment and prevention of periodontal disease. Root planing, a very common treatment for periodontal disease, is more comfortable for the anesthetized patient.

Current dental hygiene education in Kansas prepares hygienists to practice in the manner described in this bill. Both dental hygiene programs in Kansas teach local anesthesia and nitrous oxide administration. A primary reason is that three border states of Kansas (Colorado, Missouri, and Oklahoma) allow hygienists to administer local anesthesia and some graduates locate there. Preparation for local anesthesia is extensive. In addition to basic sciences and the local anesthesia instruction, students receive education in head and neck anatomy and pharmacology.

In Kansas, dental hygiene students receive an Associate of Science degree. The total credits for the curriculum run from the low 80

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to the high 70 credit hour range. This is well beyond the typical 60 hour associate degree. The curriculum includes basic skills (such as English and Speech), natural sciences (Chemistry, A&P), social sciences (such as sociology and psychology) and dental hygiene sciences. Dental hygiene students receive 3-4 semesters of hands-on clinical instruction approximating 550 hours. During those clinics, they learn to evaluate a patient's medical history; assess the need for dental hygiene care, perform all dental hygiene procedures, and evaluate the care they have delivered.

General supervision and anesthesia administration for hygienists is a natural evolution in dental care. The delivery of medical care by formally educated and licensed members of the medical team does not always require the presence of the physician. Hygienists are capable of delivering quality prescribed care without the presence of the dentist. Thank you for your time.

Respectfully,

Denise Maseman

Denise Maseman

3-18-92

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3-18-92
attm #4
89-282

STATE OF KANSAS

DIVISION OF THE BUDGET
Room 152-E
State Capitol Building
Topeka, Kansas 66612-1578

JOAN FINNEY, GOVERNOR
GLORIA M. TIMMER, Director

(913) 296-2436
FAX (913) 296-0231

March 9, 1992

The Honorable Carol Sader, Chairperson
Committee on Public Health and Welfare
House of Representatives
Third Floor, Statehouse

Dear Representative Sader:

SUBJECT: Fiscal Note for HB 3126 by Committee on Public Health and Welfare

In accordance with KSA 75-3715a, the following fiscal note concerning HB 3126 is respectfully submitted to your committee.

This bill would allow licensed dentists to delegate certain tasks to properly qualified dental assistants and dental hygienists. Under HB 3126, the Board may establish guidelines and regulations regarding delegation of dental procedures and may also determine if competency testing is required for certain procedures that are performed by dental assistants.

The Kansas Dental Board notes that while dental hygienists are currently tested and licensed, dental assistants are not. HB 3126 does not mandate testing or licensing of dental assistants; however, any competency testing which the Board might require for dental assistants would increase agency expenditures by an indeterminable amount. Actual costs cannot be predicted because the number of dental assistants currently employed in the state is unknown.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

cc: Carol Macdonald, Dental Board

701

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3-18-92
Attm # 5

Philip Elwood

DELEGABLE FUNCTIONS
HOUSE BILL NO. 3126
The Kansas Experience

By: H. Philip Elwood
of Goodell, Stratton, Edmonds & Palmer
515 Kansas Avenue
Topeka, KS 66603

A. Overview

1. The Statute K.S.A. 65-1423(g)

2. The Notice of October 1988

3. The Reaction from the Profession

B. The Real Issue -- What is the Practice of Dentistry?

- What control of the delegation of functions does the practice of the Public Health, Safety and Welfare require?

- What control can be enforced?

- What is the rural dentist to do?

C. The Proposed Bill -- H.B. No. 3126 -- Evolvement

- Kansas Dental Board developed the basic concepts.

- Efforts at compromise with the Kansas Dental Association were made -- without success.

- Other concerned dentists finalized the language based on recommendations from the Board.

- The Board has endorsed this draft and asks it be passed in this form.

D. The substantive changes are significant, but simple.

1. The problem clauses:
K.S.A. 1423(g)
(3) Any and all correction of malformation of teeth or of the jaws.
(4) Any and all administration of general or local anaesthesia of any nature in connection with a dental operation.
(5) A prophylaxis.

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Attm #6

2. Key changes

(a) Dental hygienists

(i) General supervision

(ii) Administration of local (block and infiltration) anaesthesia and nitrous oxide.

- With prior training

- Under supervision as required by the Board

(iii) Work in patient homes and care homes - i.e., alternative settings approved by the Board

(b) The dental assistants.
Delegation of functions to assistants is permitted-IF:

-under direct supervision,

-the assistant is qualified and properly trained,

-the act is performed in the customary manner,

-the act does not violate the limitations of the statute,

-the person is not represented to be qualified to practice dentistry.

--Not everything can be delegated. New Section 3(a)(3) and (4) set out certain "carve outs", i.e., procedures which can only be performed by a dentist or dental hygienist.

--i.e., only dentists can:

-diagnose and plan treatment

-perform surgical or cutting procedures on the hard or soft tissue

-write a prescription

-place a final restoration

-administer a general anaesthetic

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Conclusion: The Board has by majority vote determined rules which reflect the state of the art and science of dentistry today.

The Board has determined these rules will protect the public health, safety and welfare.

These rules can be enforced and will allow the Board to do its job.

The changes are not legal issues; they are matters which involve a delicate mix of professional judgment and public policy.

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3/18/92
HB 3126

REMARKS BY DR. ESTEL LANDRETH

Representative Sader and Members of the Public Health and Welfare Committee,

I would like to thank you for the opportunity to appear before you today in support of House Bill #3126.
I am Estel Landreth and I have practiced dentistry continuously for 25 years in Kansas, and for 7 of those years I had a satelite practice in a small community of 1900 people.
I am here today as President of the Kansas Dental Board to ask your support of House Bill #3126.

In 1988, a very narrow, restrictive legal interpretation of the Kansas Dental Practice Act was issued, and was in conflict with the previous 1980 Dental Board interpretation which was very liberal. This most recent interpretation left many dentists practicing in violation of the Dental Practice Act. This has led to four years of confusion, which has compromised the Dental Boards' ability to fulfill its' mission, which is to protect the health and welfare of the people of Kansas.
Representatives, the LAW must be changed. The dentists of Kansas need a clear understanding of exactly what the law is.

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attm. # 7

The following questions are the guidelines the Dental Board used to assess the current Dental Practice Act.

1. How is dentistry being taught in dental schools, hygiene schools, and dental assisting programs.
2. How is dentistry being practiced in Kansas and the rest of the country.
3. What are the laws of other states, and what is being done to modernize their laws.
4. What are the public needs in the area of quality of care, accessibility, and containment of health care costs.

After many long hours and phone calls to other Dental Boards as well as practicing dentists, a new Dental Practice Act was written. The basic premise of the proposal is as follows: The Board is requesting general supervision for hygienists. What this means is that a dental hygienist could clean teeth in a dental office, without the dentist being present, if the dentist has examined the patient within seven months. We also ask that hygienists be allowed to see home-bound patients or patients in care homes if they have been examined by a dentist during the previous seven months and the dentist has prescribed preventive care. This is a very important issue. The older age group is the most rapidly growing group in our population, and the most

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neglected group as far as receiving dental care. This bill will allow regular examination by a dentist, and regular preventive care by a hygienist. the quality of care will be vastly improved for this age segment, as very little care is given to home bound patients at the present time.

This bill will also allow for administration of local anesthetic by hygienists. For a hygienist to do this he or she must have proper training and the supervising dentist must be in the office. Proper education will be mandated by the Dental Board in order to ensure the quality of care.
The local anesthetic course taught at the University of Missouri in Kansas City, for a dentist, includes sixteen hours of lecture time, four hours of lab, and two years of clinical experience. The equilivent course for hygienists includes the same number of lecture hours, with thirty two hours of lab - versus four hours for a dentist - and one year of clinical experience.

The Board recognizes that general supervision and administration of local anesthetic by hygienists is in conflict with the current policy of the American Dental Association. However, twenty eight states currently allow general supervision of hygienists, and fifteen states allow administration of local

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anesthetic by hygienists. In a recent random survey of eleven of these state dental boards, no complaints have resulted from general supervision or the administration of local anesthetic by hygienists.

I have distributed a letter from the Oklahoma Dental Board stating that since 1980 Oklahoma hygienists have been administering local anesthetic and to date not one complaint has been issued. With that in mind, bolstered by the telephone survey, the Kansas Dental Board feels it is appropriate to adopt similar regulations.

House Bill #3126 holds the dentist responsible for all acts delegated by the dentist. The Board has been careful to protect the critical non-reversible acts which should be performed only by the dentist. Lists of delegable duties have proven to be unenforceable and focus attention on individual procedures rather than the outcome of treatment.
In an effort to control rising costs, dental auxilliaries must be allowed to perform non-critical and reversable duties under the direct supervision of the dentist.
Because of the ever changing practice of dentistry, the Dental Board will continue to establish rules and regulations that will set standards regarding the types of dental procedures

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Pg 4 of 6

to be safely delegated or require competency testing.
The time has come for Kansas to upgrade the Dental Practice Act in an effort to attract and retain highly capable and qualified professionals.

The Kansas Dental Association is promoting an alternate program for the training of dental hygienists. This is basically an "in-office" training program for dental auxilliaries to learn hygiene techniques. The Board feels that this is a quality of care issue, and strongly opposes this concept. There is only one state that has this type of program and it is not recognized by any other state or testing service. This preceptor, or apprentice program has been in Alabama for over fifteen years without being adopted by any other state. There are significant budget implications if the Kansas Dental Board has to design and administer such a program.
The curriculum for dental hygiene programs must be approved by the American Dental Association's Council on Accreditation. The Dental Board feels that it is inconsistant to limit the duties of a graduate of an accredited dental hygiene program while allowing an in-office trained person to provide dental hygiene services.

The purpose of the Kansas Dental Board is to protect the

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health and welfare of the citizens of Kansas, and for this State to adopt a compromized dental hygiene training program is inconsistent with the philosophy of the Kansas Dental Board.

The changes as proposed in House Bill 3126 are not anything radical and have been adopted in many states, and will modernize the practice of dentistry.

The Kansas Dental Board urges your support of this legislation as submitted.

Thank you for your time and consideration.

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pg 696

Margaret Brett

Testimony in Support of Kansas House Bill 3126

The following testimony has been compiled in support of House Bill Number 3126 by the Dental Hygiene instructors at Johnson County Community College. The Dental Hygiene Program at JCCC provides students with the opportunity to provide care and education to patients of all ages and backgrounds at the clinic located on campus. Students also become involved in the community by providing care at the program's extended campus sites including Veterans Administration Hospitals, Lakemary Center for Exceptional Children, Kansas School for the Deaf and KU Medical Center Pediatric Dental Clinic.

Our science based curriculum (e.g. Head & Neck Anatomy, Dental Therapeutics, etc.) not only prepares the students for current dental hygiene practice within various healthcare delivery systems but also provides a foundation for continued formal education and professional growth.

The General Education courses (e.g. Interpersonal Communication, Nutrition, etc.) within the curriculum assist the students in developing the assessment skills necessary to provide individual oral health instruction to their patients as well as participate in community group health programs.

Basic Science and Dental Science courses (e.g. Microbiology, Dental Radiology, Periodontics, etc.) provide the necessary background information for assessing patient health needs, and developing and providing patient care.

The Dental Hygiene Science aspect of the curriculum includes such courses as:

.....Clinical Dental Hygiene

.....Developmental Dentistry

.....Dental Radiology

.....Pathology/Periodontology

.....Community Dental Health

.....Dental Therapeutics (Pharmacology & Local Anesthesia) and

.....Dental Materials

These courses enable each student to perform clinical and health education functions as an integral member of the dental care team. Learning experiences and practice time for all clinical procedures assures each student the opportunity to develop their competence in performing primary preventive and therapeutic functions.

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The performance by JCCC dental hygienists on both national written board examinations and clinical dental hygiene board examinations has maintained high levels of achievement. Upon completion of our two year dental hygiene program, the students are awarded an associate degree and are eligible for licensure. Our graduates are very marketable and are well known and recognized in the dental community for their professionalism and preventive expertise.

Therefore, if House Bill 3126 is passed, the graduates of Johnson County Community College's Dental Hygiene Program will have the opportunity to provide preventive dental care to more Kansans (under general supervision) who otherwise may not have access to care. In addition, better quality and more comprehensive preventive and therapeutic dental health services (e.g., local anesthesia and nitrous oxide) can be provided to more Kansans.

Renee Arnett, R.D.H., M.S. Renee Arnett, RDH, MS

Margaret Biethman, R.D.H., M.S. Margaret Biethman, RDH, MS

Polly Pfister, R.D.H., B.S. Polly Pfister R.D.H. MS

Kim Stabbe, R.D.H., M.S. [illegible] R.D.H., M.S.

Joseph Jirovec, D.D.S. Joseph Jirovec DDS

Robert Johns, D.D.S. Robert A. Johns, DDS

Richard Patrick, D.D.S. Richard Patrick DDS

Robert Rosevear, D.D.S., M.S. Robert A. Rosevear, DDS.

Denise Franklin, R.D.H., B.S. Denise Franklin RDH., B.S.

Kelly Jones, R.D.H., B.S. Kelly A Jones, RDH

Carla Newell, R.D.H., A.S. Carla J Newell RDH.

Judy Runser, R.D.H., B.S. Judith A Runser, RDH, BS

Mary Zender, R.D.H., A.S. Mary P. Zender RDH

Attach 8
3-23-92

Renee Ar
(written my

Testimony, 1992

House Public Health & Welfare Committee

My name is Renee Arnett. I have been a licensed dental hygienist since 1980. I have been a member of the Kansas Dental Hygienists' Association and a dental hygiene educator at Johnson County Community College, Overland Park, Kansas since 1982. During the summer of 1982, I participated in an advanced program of study in the dental management of persons with disabilities at the University of Washington, School of Dentistry, entitled "DECOD" (Dental Education in Care of the Disabled). This unique program provides an avenue for dentists, dental hygienists, and dental assistants to receive individualized didactic and clinical instruction on the delivery of dental care and rehabilitation services for persons with a disability. The clinical component of the program included rotations to institutions and clinics for the developmentally disabled, to rehabilitation centers and to a geriatric long-term care facility where we worked in close collaboration with other health professionals in the planning and delivery of dental care. I have also been serving as the American Dental Hygienists' Association (ADHA) Liaison to the Board of Directors of the Academy of Dentistry for the Handicapped (ADHA), since 1988.

My following letter of testimony is in support of House Bill #3126.

Dental hygienists are licensed dental professionals. Based on society's present and projections of future needs and demands and advancing technology in the health care fields dental hygienists can presently function in a variety of roles. They are:

- Administrator/Manager
- Change Agent
- Clinician
- Consumer Advocate
- Educator/Health Promoter
- Researcher

To quote from the American Dental Hygienists' Association (ADHA) Dental Health Initiative Hearings on Needs: "Dental Hygienists, collaborating with other allied health personnel can make a significant difference in the national effort to increase access to affordable health care. The services dental hygienists provide are relevant to both oral health and such other concerns as disease prevention, mental and social health, promotion, alcoholism, drug abuse, and problems relating to aging, They are also relevant to new settings such as rural clinics, health maintenance organizations and hospices...The dental hygienist's clinical role can be effectively utilized in non-traditional practice settings, and achievement of optimal oral health can be greatly enhanced for patients. The abilities to provide preventive dental care services, and the commitment to meet the needs of the public exist in the dental hygiene profession."

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In the November 1988 issue of Access, Kathy Shroder, ADHA Governmental Affairs Specialist, was quoted to say, "A dental hygienist has at least two full years of clinical and didactic education focused on the preventive aspects of oral health---which exceeds the amount of class time directed to prevention in the dental school curriculum. A hygienist has passed written and clinical competency tests in those preventive procedures in order to be licensed. Requiring a dentist's presence during dental hygiene treatment does not affect the quality of patient care. However, requiring the dentist to be present places an unnecessary barrier between patients and dental hygiene care. Moreover, it excludes a large number of people who cannot visit the private dental office from receiving dental hygiene care."

According to the most recent National Health Surveys, it is estimated that 10% of the total U.S. population has never visited a dental office, and that 55% have not done so in the last year.(1) Reducing the obstacles to allow dental hygienists to deliver quality oral health care under a combination of general and direct supervision can greatly impact the access to care for some of the following special population groups in the state of Kansas:

low income families
institutionalized elderly
HIV patients
handicapped or disabled (group home and community based)

The U.S. Bureau of the Census has estimated that by the year 2000 there will be nearly 35 million persons age 65 or older.(2) Currently, more than 1.3 million Americans reside in long-term care facilities,(3) and it is estimated that 25% to 40% of all elderly individuals will require institutionalization at some point before death.(4) In these facilities, diseases of the teeth and mouth are among the most prevalent health care problems. This lack of attention to oral hygiene should not be correlated with apathy, but with the result of a staggering work load of the nursing staff and their lack of the perceived need for oral hygiene. The staff must be sensitized to the pain, infection, and esthetic embarrassment elderly patients experience as a result of poor oral hygiene. They need to be aware of the relationships between oral health and conditions such as xerostomia, diabetes, and rheumatic heart disease. The effects of medications and treatments such as radiation therapy for cancer also must be understood, as well as the signs and symptoms of oral cancer.(5) The dental hygienist working under general supervision can become an active staff member. In-service training programs can educate the staff or long-term care facilities on the proper care for dental prostheses, effective oral hygiene procedures, and recognition of oral emergencies. The dental hygienist could also perform initial patient oral exams, treat periodontal disease with an oral prophylaxis, performs oral cancer screenings, provide routine recall evaluations and coordinate a dental referral system for restorative, prosthetic and additional dental needs individualized to each patient.

In October 1990, new federal regulations (OBRA 1987) to improve access to dental care for residents in as many as 15,600 federally funded nursing homes became effective. These new regulations mandate that nursing homes must provide or obtain emergency dental care for

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all residents on a 24 hour basis as well as routine dental services that are covered by the relevant state Medicaid plan. In the past, nursing homes were only required to assist residents in obtaining dental care. Another beneficial regulation now in effect requires nursing homes to make comprehensive assessments of residents' dental condition. Application of these requirements, however may be interpreted in different ways by different institutions. For example, a dental condition assessment does not necessarily have to be determined by a dentist. A licensed dental hygienist would be an excellent choice for a professional to serve the nursing homes in Kansas given his/her level of training and knowledge of oral care.

Public Law 88-164, enacted in 1963, has lead to extensive deinstitutionalization of persons with mental retardation from a peak institutionalized census of 194,650 in 1967 to 91,440 by 1988.(6) This population now depends on the community-based health care system for medical and dental care. They may reside in foster homes, group homes, or with their own families. A recent Feature Article in the November-December 1990 issue of Special Care In Dentistry discussed the results of a survey that looked at the availability of dental services to the developmentally disabled persons residing in a north central Florida community. It indicated that 40% of caretakers experienced difficulty in locating dentists willing to provide comprehensive dental services for residents. According to the caretakers, although 75% of the residents were cooperative dental patients, dentists were reluctant to provide service is for a variety of reasons, including financial disincentives, inadequate knowledge and preparation, and a lack of proper equipment.

It is apparent that the deinstitutionalization and normalization processes will continue in our society, leading to a greater number of developmentally disabled individuals who depend on existing community-based health services. Accredited dental hygiene programs provide students with exposure to the delivery of dental hygiene services to a variety of special needs patients. Dental hygienists are well qualified to meet the needs of all patients both in the traditional setting as well as be adaptive to non-traditional settings.

The Mission Statement of the American Dental Hygienists' Association is "To improve the public's total health by increasing the awareness of and access to quality and health care." I believe that House Bill #3126 will allow Kansas dental hygienists to better meet the dental needs of the present and future special population groups within Kansas communities.

Sincerely,

Renee Arnett, RDH, MS

Renee Arnett, R.D.H. M.S.

P&W
3-18-92
Attm #9
29384

1. Reidy, Mary C., "Jumping the Hurdles: A Look at Access to Care," Access, November 1988, 7-9.

2. American Association of Retired Persons, and U.S. Department of Health and Human Services, A profile of older Americans: 1988. Washington, DC: Administration on Aging, 1988. PF 3049 (1288) D 996.

3. Call R, Berkey D. Compliance with long-term care regulations: advocacy or passive neglect, Gerodontics 1987; 3: 165-8.

4. Vicente L, Wiley JA, Carrington, RA. The risk of institutionalization before death, Gerontologist 1979, 19: 361-6.

5. Power, Pamela A. Shared responsibility for oral health in long-term care facilities.

6. Braddock D, Hemp R, Fujivra G, Bachelder L, Mitchell D. Third national study of public spending for mental retardation and developmental disabilities. University of Illinois of Chicago; Institute for the Study of Developmental Disabilities, 1989, 12-5.

KINH Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842-3088

TESTIMONY PRESENTED TO
THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE
CONCERNING HB 3126

March 18, 1992

Madam Chairperson and Members of the House Public Health and Welfare Committee:

Kansans for Improvement of Nursing Homes has observed over many years that there is all too often a serious lack of emphasis on oral and dental hygiene in nursing home care, to the detriment of the comfort, cleanliness, and nutrition of nursing home residents. We have observed, also, the reluctance of many dentists to take their practice to the nursing home, instead expecting that patients will be brought to them.

We can understand the dentist's preference for performing complicated procedures in his or her own well-equipped office. However, we believe that much routine care generally performed by dental hygienists could equally well be carried out on the adult care home premises under the general supervision of the dentist who would be expected to examine the patient at reasonable intervals and to be familiar with the care needs of the patient. Further, the more frequently the dental needs of nursing home residents can be observed by a trained person better versed in oral hygiene care than are nurse aides or, in many instances, even licensed nurses, the greater the likelihood that those needs can be properly addressed. Timely routine dental care can prevent a multitude of physical ills, from extensive dental repair to nutritional deficiencies.

KINH's purpose today is to point out to you that there is, indeed, a problem of assuring adequate dental care in nursing homes and to ask your careful consideration of HB 3126 as a cost-effective step toward its solution.

Marilyn Bradt
Legislative Coordinator

PHHW
3-18-92
attm #10

Charles A. Ritter, Jr., D.D.S.
723 S. Ohio
Salina, Kansas 67401
(913) 823-2472

Statement by Dr. C. A. Ritter
House Committee on Public Health and Welfare
H.B. 3126
March 18, 1992

Madam Chairman and members of the Committee, my name is C. A. Ritter. I am a dentist in general practice in Salina, Kansas. I am also a member of the KDA Executive Council, which is the governing body of the Kansas Dental Association. I appreciate the opportunity to appear before you today to share the reasons I oppose House Bill 3126.

First, I oppose the bill because it will lower the quality of dental care for the people of Kansas. The Kansas Dental Association carefully reviewed -- and rejected -- the major changes in this bill. Second, I oppose the bill because it is self-serving. The splinter group of dentists who are lobbying the bill want you, the Kansas Legislature, to approve changes in dental practices that their fellow dentists have thoroughly reviewed and consistently rejected.

There are generally three categories of personnel on the dental care team: the dentist, who typically has eight years of education -- four years of dental school plus a four-year college degree; the hygienist, who performs the prophylaxis procedure, also known as cleaning teeth, and who must have a minimum of two years of training after high school; and the dental assistant, who works directly with the dentist who treat the patients and whose training is provided by the dentist or in a vocational-technical school program.

House Bill 3126 will lower the quality of dental care available to the people of Kansas in several ways. The bill would permit dental assistants to perform procedures that only the dentist has the skill and judgment to perform. These procedures include taking impressions for dentures and crowns, bonding orthodontic brackets to the teeth, and performing pulpotomies, a potentially painful procedure that involves removing the tissue from the inside of the tooth. My colleagues will discuss the dangers of delegating these procedures.

In addition, the bill would permit dental hygienists to clean teeth, without the on-site supervision of a dentist. Current law requires the dentist to be in the office while hygienists are working on patients. Current hygiene training is based on the team concept that a dentist will be providing on-site supervision.

PHW
3-18-92
Attm # 11

As the KDA testified last year during consideration of very similar hygiene legislation in the Senate committee, general supervision is a dangerous idea. Dentists need to be on-site and available for consultation with the hygienist. Otherwise, oral cancer, periodontal disease, and dental caries may go undetected. Early detection is critical for successful outcomes.

Eliminating the requirement for on-site dental supervision is hazardous for another reason. Prophylaxis involves much more than the scraping of teeth with a dental instrument. Prophylaxis requires an evaluation of the total health of the patient -- an evaluation that only the dentist has the judgment to make.

A common complication of prophylaxis is transient bacteremia. That is, bacteria getting in the bloodstream and causing anything from a mild fever to a life threatening infection of the heart. Please keep in mind that next to a tooth extraction, prophylaxis is one of the bloodiest, most invasive procedures in a dental office.

Permitting hygienists to work in nursing homes without the on-site supervision of a dentist would be unconscionable. Many elderly people have severe and multiple health conditions that make teeth cleaning especially hazardous. These conditions include artificial joints, heart disease, neurological conditions, diabetes, hypertension, kidney and liver disease which are treated with complex medications. In these cases, it is essential that the dentist evaluate the patient prior to the cleaning and remain available for consultation. The consequences of permitting hygienists to perform prophylaxis without the on-site supervision of a dentist could be tragic. We should not create a two-tiered system of dental care. All hygiene services should be performed with the same supervision regardless of location.

Is the Kansas Dental Association concerned about access to dental care for nursing home residents? Very much so. The KDA continues to work in this direction. In addition to ongoing charitable care by dentists the KDA operates a program that refers low-income seniors to dentists who have agreed to accept a reduced fee. We are working to increase public awareness that certain Medicaid patients in nursing homes can pay for dental care from their monthly income. We have also worked to reestablish an adult dental program under Medicaid, which will go a long way toward addressing the problem of access to care. Prospects for the necessary appropriation look good.

The simple fact is that hygienists working as volunteers will not begin to meet the needs of nursing home residents. It is unfortunate that nursing home residents are being used to advance the cause of the hygiene group.

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3-18-92
Attm #11
pg 2 & 10

The second reason I oppose this bill is that it serves only the narrow interests of a small group of dentists who refuse to accept the judgment of their peers.

By way of background, the Kansas Dental Association is an open, democratic professional association that represents nearly 1200 dentists or about 80 percent of the dentists in Kansas. KDA policy is set by the Executive Council, which is made up of dentists elected by the members of their local dental society.

The Executive Council this winter reviewed a number of proposed policy changes relative to our current practice act. In democratic fashion, the Executive Council carefully considered and ultimately rejected, the major policy changes contained in this legislation.

I deeply regret that there is a group of dentists whose self-interest outweighs the protection of the public and prevents them from accepting the professional judgment of the majority of their peers.

The attached letter from Dr. Ken Riley helps explain the Dental Board's narrow endorsement of this bill. Also, attached are the minimum changes that need to be made in the bill to protect the public health.

Madam Chairman and members of the Committee, action on this legislation would send the wrong message. Action would signal that anytime a member of a professional group disagrees with the majority of their peers, the legislature will step in to mediate.

The legislature must chose whether dentistry will remain a profession concerned first and foremost with providing the best possible care to our patients or dentistry become solely a business venture with economic gain as its primary focus.

I ask that this legislation not be passed and that the dental community in Kansas be permitted to review and resolve questions of dental practice. The Kansas Dental Association will continue to review its policies and include all members of the dental care team -- dentists, hygienists and assistants -- in the discussion.

Thank you for this opportunity to express my opposition to this legislation.

PHHCC
3-18-92
Attm # 11
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FEB - 3 1992

K. R. RILEY, D.D.S., P.A.
107 SOUTH 6TH
HIAWATHA, KANSAS 66434

January 16, 1992

Dr. Howard Schneider
113 East Lincoln Street
Box 703
Wellington, Kansas 67152

Dear Howard:

I am writing in order to inform you as to what has happened in regards to the Dental Practice Act. On December 13, 1991, I met with you and Jim for an honest purpose and that was to negotiate with you in good faith in order to develop a Dental Practice Act that would protect the safety and welfare of the citizens of the State of Kansas, and also an act that would be fair and enforceable for the dentists of Kansas. I enjoyed working with you and Jim and I thought it was a very productive meeting.

It was my opinion that the meeting of December 14, 1991, went quite well as the Kansas Dental Association was able to give the Kansas Dental Board the needed input. It was refreshing to find that after four long years of poor communication that both entities were so close to an agreement.

It was my understanding that the Kansas Dental Board would vote on January 11, 1992, to accept the proposed Dental Practice Act that I had worked out with you and Jim. To my complete surprise, another Practice Act was presented. I was completely unaware of this other draft and had not had the opportunity to review it in any manner. It is my understanding that only two of the Board members knew about this proposal.

It is my opinion that the new proposal was drawn up by a special interest group for the purposes of simply lining their own pockets without any desire to provide good dental care or protection for the safety and welfare of the citizens of Kansas.

I am ashamed at the actions taken by the Dental Board and I apologize to you, Jim, and the Kansas Dental Association.

Sincerely,

Dr. K.R. Riley

KRR:dmc

P&W
3-18-92
attm #11
pg 4 & 10

Session of 1992

HOUSE BILL No. 3126

By Committee on Public Health and Welfare

2-25

AN ACT concerning dentistry; relating to the delegation of certain acts; concerning the practice of dental hygiene; authorizing delegation of certain dental acts to dental assistants; amending K.S.A. 65-1423 and 65-1456 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 65-1423 is hereby amended to read as follows: 65-1423. Nothing in this act shall apply to the following practices, acts, and operations:

(a) To the practice of his profession by a physician or surgeon licensed as such *a person licensed to practice medicine and surgery* under the laws of this state, unless he *such person* practices dentistry as a specialty; or

(b) to the giving by a qualified anaesthetist or registered nurse of an anaesthetic for a dental operation under the direct supervision of a licensed dentist or physician *person licensed to practice medicine and surgery*;

(c) the practice of dentistry in the discharge of their official duties by graduate dentists or dental surgeons in the United States army, navy, public health service, coast guard, or veterans' bureau; or

(d) the practice of dentistry by a licensed dentist of other states or countries at meetings of the Kansas state dental association or components thereof, or other like dental organizations approved by the board, while appearing as clinicians;

(e) to the filling of prescriptions of a licensed and registered dentist as hereinafter provided by any person or persons, association, corporation, or other entity, for the construction, reproduction, or repair of prosthetic dentures, bridges, plates, or appliances to be used or worn as substitutes for natural teeth, provided that such person or persons, associations *association*, corporation, or other entity, shall not solicit or advertise, directly or indirectly by mail, card, newspaper, pamphlet, radio, or otherwise, to the general public to construct, reproduce, or repair prosthetic dentures, bridges, plates, or other appliances to be used or worn as substitutes for natural teeth;

(f) to the use of roentgen or x-ray machines or other rays for

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making radiograms or similar records, of dental or oral tissues under the supervision of a licensed dentist or ~~physician: Provided, however,~~ *person licensed to practice medicine and surgery except* that such service shall not be advertised by any name whatever as an aid or inducement to secure dental patronage, and no person shall advertise that ~~he~~ *such person* has, leases, owns or operates a roentgen or x-ray machine for the purpose of making dental radiograms of the human teeth or tissues or the oral cavity, or administering treatment thereto for any disease thereof;

~~(g) except as hereinafter limited to the performance of any dental service of any kind by any person who is not licensed under this act, if such service is performed under the supervision of a dentist licensed under this act at the office of such licensed dentist. Provided, however, That such nonlicensed person shall not be allowed to perform or attempt to perform the following dental operations or services:~~

~~(1) Any and all removal of or addition to the hard or soft tissue of the oral cavity.~~

~~(2) Any and all diagnosis of or prescription for treatment for disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws, or adjacent structure.~~

~~(3) Any and all correction of malformation of teeth or of the jaws.~~

~~(4) Any and all administration of general or local anaesthesia of any nature in connection with a dental operation.~~

~~(5) A prophylaxis.~~

Sec. 2. K.S.A. 65-1456 is hereby amended to read as follows: 65-1456. *(a)* The board may suspend or revoke the license, license certificate and renewal certificate of any registered and licensed dentist who shall permit any dental hygienist operating under such dentist's supervision to perform any operation other than that permitted under the provisions of article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory *of the provisions* thereof *or supplemental thereto*, and may suspend or revoke the license of any *dental* hygienist found guilty of performing any operation other than those permitted under article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory *of the provisions* thereof *or supplemental thereto*. No license or certificate of any dentist or dental hygienist shall be suspended or revoked in any administrative proceedings without first complying with the notice and hearing requirements of the Kansas administrative procedure act.

(b) (1) The practice of dental hygiene shall include those ~~educational,~~ preventive, and therapeutic procedures which result in the

Insert new section:

Amend K.S.A. 65-1455 as follows:

(a) No person shall practice as a dental hygienist in this state until such person has passed an examination by the board under such rules and regulations as the board may adopt. The fee for such examination and the certificate fee shall be fixed by the board pursuant to K.S.A. 65-1447 and amendments thereto. An annual registration fee shall be paid to the board in the amount fixed by the board pursuant to K.S.A. 65-1447 and amendments thereto.

(b) The board shall issue licenses and license certificates as dental hygienists to those who have passed the examination in a manner satisfactory to the board. Each license certificate shall be posted and displayed in the office in which the hygienist is employed, but no person shall be entitled to such license and license certificate unless such person shall be more than 18 years of age, of good moral character and a graduate of a school approved by the board for dental hygienists or has completed such other training program for dental hygiene as the board may approve. The board shall approve only those dental hygiene schools which require the study of dental hygiene and which the board determines have standards of education not less than that required for accreditation by the commission on dental accreditation of the American Dental Association or its equivalent.

(c) The board shall adopt rules and regulations establishing the criteria which a school for dental hygienists shall satisfy in meeting the standards of education established under subsection (b). The board may send a questionnaire developed by the board to any school for dental hygienists for which the board does not have sufficient information to determine whether the school meets the requirements of subsection (b) and rules and regulations adopted under this section. The questionnaire providing the necessary information shall be completed and returned to the board in order for the school to be considered for approval. The board may contract with investigative agencies, commissions or consultants to assist the board in obtaining information about schools. In entering such contracts the authority to approve schools shall remain solely with the board.

(d) Any person practicing dental hygiene in violation of the provisions of this act shall be guilty of a misdemeanor, and the board may revoke or suspend such person's license therefor.

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Attmt #11

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.

(2) Included among ~~those educational,~~ *the* preventive and therapeutic procedures are the ~~instruction of the patient as to daily personal care,~~*:*

(A) Protecting the teeth *and supporting structure* from dental caries~~,~~ *and disease;*

(B) the scaling and polishing of the crown *tooth* surfaces ~~and~~*;*

(C) administration of local (block and infiltration) anaesthesia and nitrous oxide;

(D) removal of overhanging restoration margins and periodental surgery materials; ----- strike *"removal of overhanging restoration margins and"*

(E) the planing of the root surfaces, in addition to the curettage of those soft tissues lining the free gingiva to the depth of the gingival sulcus; and

(F) such additional ~~educational,~~ preventive and therapeutic procedures as the board may establish by rules and regulations. -------- insert:
(G) application of flouride treatments as a prophylactic measure, used in conjunction with a prophylaxis;
(H) application of dental sealants.

(c) Subject to such prohibitions, limitations and conditions as the board may prescribe by rules and regulations, any licensed dental hygienist may practice dental hygiene and may also perform such dental service as may be performed by a dental assistant under ~~the provisions of K.S.A. 65-1423~~ *section 3* and amendments thereto.

(d) The practice of dental hygiene shall be performed under the ~~direct or indirect~~ *general* supervision of a licensed dentist at the office of such licensed dentist *except that the administration of local anesthesia shall be under the direct supervision of a licensed dentist at the office of the licensed dentist.* ~~The board may designate by rules and regulations the procedures which may be performed by a dental hygienist under direct supervision and the procedures which may be performed under the indirect supervision of a licensed dentist.~~ *The administration of local anesthesia shall be performed by a dental hygienist who has completed a course of instruction as the board may designate by rules and regulations. The degree of supervision of any additional procedures not listed under subsection (b)(2) shall be determined by the board.* ------ strike *"general"* in line 25; reinsert "direct or indirect".

------ reinsert lines 28 through 32

----- strike lines 35 and 36

(e) As used in this section~~, "indirect supervision" means that the dentist is in the dental office, authorizes the procedures and remains in the dental office while the procedures are being performed and~~*:*

(1) "Direct supervision" means that the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and before dismissal of the patient evaluates

----- reinsert lines 37 through 40

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the performance.

(2) "General supervision" means a licensed dentist may delegate verbally or by written authorization the performance of a service, task or procedure to a licensed dental hygienist under the supervision and responsibility of the dentist, if the dental hygienist is licensed to perform the function, and the supervising dentist examines the patient at the time the dental hygiene procedure is performed, or during the seven calendar months preceding the performance of the procedure, except that the licensed hygienist shall not be permitted to diagnose a dental disease or ailment, prescribe any treatment or a regimen thereof, prescribe, order or dispense medication or perform any procedure which is irreversible or which involves the intentional cutting of the soft or hard tissue by any means. A dentist is not required to be on the premises at the time a hygienist performs a function delegated under this paragraph (2).

----- strike lines 2 through 15

(f) Nothing in this act shall be construed to prevent a dentist from authorizing a dental hygienist employed by the dentist to instruct and educate a patient in good oral hygiene technique or to provide a medication as ordered by the dentist to a patient. This act does not prohibit removal of cementum by a dental hygienist during root planing and curettage.

(g) All work performed by a dental hygienist in the practice of dental hygiene, as defined in this act, shall be performed in the dental office of the supervising dentist or dentists legally engaged in the practice of dentistry in this state, by whom the dental hygienist is employed, or under the supervision of a supervising dentist in an alternative approved setting, including, but not limited to, an adult care home or the patient's home, provided that the hygienist is licensed to perform the delegated procedure and the supervising dentist examines the patient during the seven months preceding the performance of the procedure by the dental hygienist or at the time the procedure is performed, except where employed by schools, hospitals, state institutions, public health clinics or other institutions that have applied to and been approved by the Kansas dental board as a proper location for the performance of a dental procedure.

----- strike lines 22 through 35

(h) The board may issue a permit to a licensed dental hygienist to provide dental screening as an employee of the state of Kansas, or any subdivision thereof, at any public institution or facility under the supervision of the governing body of such public institution or facility under such terms and conditions as the board may reasonably establish in such permit. Such permit shall be for a period of one year and shall be subject to renewal annually at the time the license for dental hygiene is renewed.

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New Sec. 3. (a) A person licensed to practice dentistry may delegate to any qualified and properly trained dental assistant acting under the dentist's direct supervision any dental act that a reasonable and prudent dentist would find is within the scope of sound dental judgment to delegate if, in the opinion of the delegating dentist, the act can be properly and safely performed by the person to whom the dental act is delegated and the act is performed in its customary manner, not in violation of this act or any other statute, and the dental assistant to whom the dental act is delegated is not represented to the public as being authorized to practice dentistry. A dentist may not:

(1) Delegate an act to an individual who, by order of the board, is prohibited from performing the act;

(2) delegate the administration and monitoring of nitrous oxide to a dental assistant unless such person has completed a course of instruction in the administration and monitoring of nitrous oxide approved by the board;

(3) delegate the performance of any of the following acts to a person not licensed as a dentist or dental hygienist:

(A) The removal of calculus from the natural and restored surfaces of exposed human teeth and restorations in the human mouth, provided that nothing herein shall be deemed to limit the delegation by a dentist of the polishing of exposed human teeth to a qualified dental assistant;

(B) root planing or the smoothing of roughened root surfaces;

(C) administration of local (block and infiltration) anesthesia; or

(D) any other act the delegation of which is prohibited by the rules and regulations of the board.

(4) delegate the performance of any of the following acts to a person not licensed as a dentist:

(A) Comprehensive examination or diagnosis and treatment planning;

(B) a surgical or cutting procedure on hard or soft tissue;

(C) the prescription of a drug, medication or work authorization;

(D) the placement of any final restoration; or

(E) the administration of a general anesthetic agent.

(b) As used in this section, a "dental assistant" is a person who is employed by and works in the office of a licensed, practicing dentist and who performs one or more delegated dental acts under the direct supervision, direction and responsibility of such dentist; "direct supervision" means the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and, before dismissal of the patient, evaluates the

---- line 2, delete "dental assistant"; insert "no licensed person"

---- line 9, delete "dental assistant"; insert "non-licensed person"

insert:

(F) the taking of an impression for a final restoration, appliance or prosthesis;

(G) the making of an intraoral occlusal adjustment;

(H) the performance of direct pulp capping and pulpotomy;

(I) the final placement and intraoral adjustment of a fixed or removable appliance;

(J) any other act the delegation of which is prohibited by the rules of the Board.

--- delete "comprehensive"

---------- delete "or"

---- line 37, delete the word "a" through the semicolon on line 40.

Offered 3-18-92 Adopted

performance.

(c) The delegating dentist remains responsible for a dental act by a person performing a delegated dental act.

(d) The board may by rule and regulation establish guidelines not inconsistent with this section regarding the types of dental acts that may be properly or safely delegated by a dentist to a qualified dental assistant including a determination as to which delegated dental acts, if any, require competency testing before a person may perform the act.

(e) A dental act that may be delegated by a dentist to a dental assistant may also be delegated by a dentist to a dental hygienist.

(f) The board may adopt and enforce rules and regulations not inconsistent with the laws of this state to determine the number of dental hygienists which may be employed by a dentist as necessary to protect the public health and safety.

Sec. 4. K.S.A. 65-1423 and 65-1456 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

---- delete lines 4 through 9

---- delete lines 12 through 15

insert:
(e) The board may adopt and enforce rules not inconsistent with the laws of this state.

Attach #11
3-18-92

Orthodontic
Pediatric dentistry

Tom L. Barth, D.D.S.

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PEDIATRIC DENTISTRY

House Committee on Public Health and Welfare
House Bill 3126
March 18, 1992
Statement by Dr. Tom Barth

My name is Tom Barth. I am a specialist in Pediatric Dentistry practicing in Manhattan, Kansas. I'm also currently the Secretary of the Kansas Dental Association.

Accompanying my statement is a letter from Dr. John Carter, a practicing orthodontist and a clinical professor of orthodontics at the University of Missouri at Kansas City, and Dr. Don Thompson, an Overland Park orthodontist, on the importance of the dentist personally placing orthodontic bands and brackets on the teeth.

I feel that both direct pulp caps and pulpotomies should not be performed by dental assistants as House Bill 3126 would allow. Both procedures involve the direct exposure of the nerve inside the tooth. To properly perform each procedure, the dentist must evaluate the amount of exposure, the area of the exposure, the type of bleeding occurring at the site, and the probability that the procedure will be successful.

The direct pulp cap is used on permanent teeth when a small, usually mechanical or traumatic exposure of the nerve occurs. A small amount of medication is placed over the exposure. Crucial to the success of this procedure is the correct placement of this medication.

The pulpotomy is usually used on primary teeth, but also can be used occasionally on permanent teeth. When a nerve exposure occurs, a major portion of the nerve is completely removed. Cotton pellets soaked in medication are placed in the tooth. They are then removed and the remaining tissue in the tooth is evaluated for bleeding. If bleeding is controlled, a medicated paste is placed in the tooth which is then restored.

It is very important for the dentist to perform these procedures, so that the pulp can be evaluated to ensure that the procedure is a success.

Abscesses, cellulitis and tooth loss can result from incorrectly performing these procedures. Clearly they should not be performed by anyone other than a dentist.

Thank you for your consideration of these comments. I would be glad to respond to any questions the Committee might have.

PH&W
3-18-92
Attm #12

UNIVERSITY OF MISSOURI-KANSAS CITY

School of Dentistry

Department of Orthodontics
650 East 25th St.
Kansas City, Missouri 64108-2795
TELEPHONE (816) 235-2141
FAX: (816) 235-2157

March 17, 1992

To Whom It May Concern:

The placement of bands and bonds on teeth for orthodontic treatment is a critical step towards the proper treatment finish.

The exact location that these attachments have on each tooth dictates the final position of the tooth as it relates to the teeth on either side of it as well as to the teeth in the opposite arch.

If all teeth had the same crown anatomy with identical shape, proportions and relationship to their roots then a safe, standardized placement could be established so that anyone with proficient hand to eye coordination would be able to select, place and cement orthodontic appliances.

Unfortunately the crowns of our natural teeth widely vary in shape, proportion, and size from patient to patient and even within the same patient.

It is not uncommon to have dissimilar shapes of the same teeth on the right and left sides in the mouth as well.

Additionally, the proper placement of a band and/or bond on a tooth is also necessary to gain the proper orientation of the root of each tooth. It is not only necessary to have the proper placement on the tooth of the band or bond for special alignment but also so that the root of the tooth is properly aligned with the crowns. Again, as nature will be, the crown does not always align itself with its root making it a more difficult judgement call for the doctor to properly align the bracket to "straighten" the crown of the tooth and to also upright the root at the same time.

I have been training graduate orthodontic residents for the

RH/rlw
3-18-92
atlm #12
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UNIVERSITY OF MISSOURI-KANSAS CITY

School of Dentistry

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past ten years in biomechanics at the UMKC School of Dentistry to be able to see these subtle differences in order to properly place a fixed orthodontic edgewise appliance.

I hope you can appreciate the degree of training and expertise that an operator needs to instantaneously and accurately make judgements in the bracket position.

There is not "cookbook" for placement. We do have general guidelines as to where brackets and the bonds must go but the final judgement depends on the individual attention of the operator to the individual characterizations of each tooth.

The only person qualified to make these determinations is the trained dentist. Once these bands and bonds are placed we all have a reluctation to change their position.

Hopefully poor judgement calls to proper band and bond orientation are corrected during future patient visits.

I have always personally banded and bonded all of my cases. There isn't a case that I haven't needed to correct several bonds or bands.

With this in mind you can see that the error in placement with auxiliaries banding and bonding should be and would be greater.

Next to the importance of having the knowledge of knowing how to move the teeth is the knowledge and skill to accurately place the orthodontic appliance on the teeth. Please keep this judgement and skill in the laps and the trained eye of the doctor and not his auxiliary.

John W. M. Carter, D.D.S., M.Sc.D.
Clinical Associate Professor of Orthodontics

JWC: lam

PdrW
3-18-92
Atlm #12
pg 3 of 4

A Specialist in Orthodontics

D.J. THOMPSON, D.D.S., M.S.D.

7000 West 121st Street Overland Park, Kansas 66209
(913) 491 3545

March 16, 1992

To Whom It May Concern:

This is to express my concerns about having dental assistants placing bonds and bands as part of an orthodontic procedure.

The placement of these appliances affects the position of the teeth and is very critical to the overall treatment. The position of the bonds and bands is many times varied to effect better tooth position in the finished result. This change can best be determined by the dentist.

Wrong placement of these orthodontic appliances can cause directional movement which must be corrected. This excessive movement sometimes causes root damage to the teeth.

It would be my recommendation to not allow assistants to final place the bands and bonds.

Sincerely,

D.J. Thompson, D.D.S., M.S.D.

DJT:dk

PH+W
3-18-92
Atlm #12
RJ424

Clifford W. VanBlarcom, D.D.S., M.S.D.

5350 W. 94th Terrace, Suite 205
Shawnee Mission, Kansas 66207-2572
(913) 649-4946

Statement by Dr. Clifford VanBlarcom
House Committee on Public Health and Welfare
House Bill 3126
March 18, 1992

Thank you, Madam Chairman, for this honor of briefly addressing all of you about some of my concerns regarding this bill.

I have been licensed as a dentist and specialist in prosthodontics in Kansas for almost 21 years. Thus, it is perplexing and upsetting to me to now find before you a broad bill to extensively liberalize our Dental Practice Act. I am opposed to the bill in its current form.

How well will the properly trained dental assistant accomplish a complex dental procedure such as making impressions? I never cease to be astounded at how difficult it is to accomplish what should otherwise be a simple task, such as make an impression of someone's mouth, when other problems crop up. The patient gags or bites down in the midst of the impression – what happened to the impression material – was it swallowed? What if the patient should aspirate some material in the midst of its setting? Occlusion of the airway by impression materials would quickly and effectively create an incident of major proportions in an otherwise quiet environment. Where's the doctor when the patient is obstructed? Does the "qualified dental assistant" know what to do when there is not time to get a more qualified other (that is the dentist) in the operatory? Who will take on this responsibility?

P&HCW
3-18-92
attm #13

Suppose no such adverse incident should occur. Is the impression too large or too small? Is the impression adequate? Is it correct? How well will the delegating dentist remember the arch form of the patient whose impression is in front of he or she now? If an error should exist, and believe me, they occur frequently, what are its consequences? A prothesis such as a denture or crown created from a distorted impression can damage tissues, both hard and soft; it can displace tissue, move teeth, split teeth, expand or contract palates. It can alter the jaw joints. It can result in a poorly adapted prothesis into whose voids oral tissue will flow, creating tissue enlargement. Who is responsible then?

I have seen many examples of seemingly "qualified dental assistants" final results from adjacent states in my office which would not pass the test our Board asks me to render on their behalf to candidates seeking certification of the Board. I often wonder if the dentist reviewed these results.

Finally, why are we playing with our citizens rights to excellence in dental care? This bill will do nothing to enhance dental care in Kansas, and I believe it will open up a whole new avenue of citizens complaints to our already overworked Board.

Send a message and reject this bill! Kansans seek quality dental care by practitioners devoted to and working directly with their patients. The greatest reward in dental care is to be able to look your patient in the eyes and say, "I am your personal practitioner; what has been done, I did for you myself".

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