Approved: February 21, 1995

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans at 1:30 p.m. on February 14, 1995 in Room 423-S of the State Capitol.

All members were present except: Representative Greta Goodwin - excused
Representative Dee Yoh - excused

Committee staff present: Norman Furse, Revisor of Statutes
Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Lois Hedrick, Committee Secretary

Conferees appearing before the committee:
Representative Henry Helgerson
Sandy Strand, Kansans for Improvement of Nursing Homes
Kim Stabbe, Kansas Dental Hygienists Association
Thomas Bell, Kansas Hospital Association
Annette Siebert, Kansas Homes and Services for the Aging
Dr. Scott Kennedy, Dentist, Topeka
Nancy Little, Dental Health Educator, Wichita-Sedgwick County Health Department
Dr. James Mixson, Associate Professor and Coordinator of Geriatric Dentistry, University of Missouri-Kansas City
Ms. Gerry J. Barker, Assistant Professor, Department of Diagnostic Sciences Coordinator of Oncology Education, UMKC
Pamela Overman, Director, Division of Dental Hygiene, UMKC
Dr. Estel Landreth, President, Kansas Dental Board
Dr. Brick Scheer, Dentist, Wichita
Nancy Crump, Dental Hygienist, Mission
David Hanzlick, Kansas Dental Association
Dr. Cynthia Sherwood, Dentist, Independence
Dr. Robert Wood, Oral and Facial Surgeon, Topeka

Others attending: See Guest List, Attachment 1.

Chairperson Mayans opened the hearing on **HB 2304.**

HB 2304 - Practice of dental hygienists authorized in adult care home, hospital, state institution or school

Representative Henry Helgerson, a proponent of the bill, stated that over the past several years, in developing the state's appropriations, the state has not had sufficient money to provide preventive dental care for patients in its institutions. There are many in nursing homes who do not receive even primary dental care. That brought forth this proposal; the decision being to come up with additional money to either take these patients to the dental office or treat them where they are. The idea of schools providing such care is a part of the proposal, but he said he is not "wed" to that.

Sandy Strand, Legislative and Community Liaison for Kansans for Improvement of Nursing Homes, Inc., testified in support of **HB 2304**. She provided the committee with the reasoning for their support and provided a copy of nursing facility regulations on quality of care and dental services, and an excerpt from *KIHN News* about "Dental Care for the Medicaid Resident" (see Attachment 2).

Kim Stabbe, President of The Kansas Dental Hygienists' Association, testified in support of the bill, stating that the bill will benefit many who are in need of basic preventive dental care. She outlined the educational background of hygienists and their professionality, and suggested the bill should state specifically the intent of the bill--which is general supervision (see Attachment 3).

Thomas L. Bell, Senior Vice President/Legal Counsel, of the Kansas Hospital Association, supported the bill by allowing hygienists to perform services in hospitals and other institutions under authority granted by the bill (see Attachment 4).

Annette Siebert, Director, Government/Legal Affairs for the Kansas Association of Homes and Services for the Aging, stated the association's support of **HB 2304**, setting out the reasons it believes it will improve dental care to nursing facility residents in a cost effective manner (see Attachment 5).

Dr. Scott Kennedy, a Topeka dentist, offered testimony in support of the concept of **HB 2304**. He described his experience as a consulting dentist for two nursing homes, and from that he expressed reservations with the bill's implementation as is being proposed, noting the OSHA or Dental Board standards probably could not be met in a nursing home setting. He made suggestions that the bill be altered to designate a mandatory, separate area in such settings and to find a funding mechanism for payment of services (see Attachment 6).

Nancy Little, Dental Hygienist and Dental Health Educator at the Wichita-Sedgwick County Health Department, testified in support of **HB 2304**, stating the bill will provide preventive dental care to the increasing number of school children who do not have access to such care (see Attachment 7).

Dr. James M. Mixson, Associate Professor and Coordinator of Geriatric Dentistry, University of Missouri-Kansas City, offered testimony about the aging and the increasing possibility of oral disease. He pointed out the important role the dental hygienist could play in oral care of the patients of long-term care facilities (see Attachment 8).

Ms. Gerry J. Barker, Assistant Professor, Department of Diagnostic Sciences, and Coordinator of Oncology Education, UMKC School of Dentistry, offered support for **HB 2304** by stating a change to general supervision for dental hygienists will provide oral care for compromised individuals (see Attachment 9).

Pamela Overman, Director of the Division of Dental Hygiene, UMKC School of Dentistry, presented testimony in support of **HB 2304**. She recounted the findings of a 1984 Wichita State University Dental Hygiene needs assessment survey; and outlined the education program of dental hygienists, saying they are competent health care providers, capable of providing cost-effective services to clients in nursing homes and other institutions (see Attachment 10).

Dr. Estel Landreth, President of the Kansas Dental Board, testified that the board favors **HB 2304**. He suggested that the bill be amended by adding "either the supervising dentist is personally present, or the services, tasks and procedures are limited to the cleaning of teeth, education and preventive care." Dr. Landreth described the 1992 bill, with broader authority and passed by the Legislature, was vetoed by Governor Finney. The Dental Board sees no problem with compliance to the rules and regulations as hygienists are highly educated and licensed. He displayed equipment now available for use outside the dental office that is portable and even usable for bedside care. (See testimony, Attachment 11).

Dr. Brick Scheer, a practicing dentist, in testifying for **HB 2304**, stated for the past five years he has scheduled 1-1/2 days per month to examine and treat residents of nursing homes. He said he did not know of any other dentist in Kansas who does this. In his testimony, Dr. Scheer described the need for dental care in nursing facilities; suggested a plan for dentists to examine nursing home patients and determine their care plans, and hire a dental hygienist to perform the cleaning services; and stated that despite a large problem of dental neglect, it is not economically feasible for dentists to treat these patients (see Attachment 12).

Nancy Crump, Dental Hygienist, of Mission, expressed support for **HB 2304**, stating the elderly has been sadly neglected (see Attachment 13).

The hearing was opened to questions of the proponents. Representative Henry asked Dr. Landreth about the portable equipment he had displayed. Dr. Landreth indicated it is easy to purchase the equipment and it would be effective for use in nursing homes. He said portable X-ray equipment is also available but not as effective as the larger mobile units. He suggested several organizations could cooperate to purchase the larger mobile units and have economical services.

Representative Merritt asked Dr. Landreth if he had any idea how many states currently allow this type of

procedure. Dr. Landreth replied 41 states allow some degree of work done by hygienists under general supervision. Representative Merritt asked if we are dealing with dual criteria, asking if it is possible to establish one criteria outside of the dental office and another criteria with the dentist seeing a patient every so often and the hygienist carrying out the care plan. Dr. Landreth replied 21 states allow that now to some degree. Representative Merritt asked if he favored giving authority to permit hygienists to work independently? Dr. Landreth replied "no." Colorado has had independent hygienist practitioners for ten years (and some west coast states, too), but few, if any, actually operate in that fashion.

Representative Haley asked Dr. Kennedy and Dr. Scheer about getting adequate facilities in the nursing homes. Dr. Kennedy replied he is aware of three nursing homes in Topeka who have set aside such areas. Dr. Scheer reiterated his concerns of such areas being sterile because of blood contamination, etc. He said there's contamination if a patient even drools.

Representative Freeborn asked who pays for the services. Dr. Mixson stated some have dental insurance, some have Social Security or Medicaid (although Kansas does not pay for dental care for those over the age of 21). Representative Freeborn stated a high percentage in nursing homes are on state assistance. Dr. Mixson answered that is the problem separate from this bill.

Chairperson Mayans opened the hearing to the opponents.

David Hanzlick, representing the Kansas Dental Association, spoke in opposition to **HB 2304**, stating his belief that the bill is a simple and wrong solution to the difficult problem of providing oral health care in nursing homes. He stated the core issue is that you have dental staff members who want to exercise the professional privilege of a dentist without the education. Mr. Hanzlick raised questions about present dental care for nursing home patients, the problems of neglect being paramount, as well as the financing of such care (see Attachment 14). Mr. Hanzlick stated that he had also distributed written testimony of Dr. Ronald G. Wright, a member of the Kansas Dental Board (Attachment 15), in which he pointed out that most people in adult care facilities are dependent on Medicare or Medicaid and neither will pay for oral hygiene for those over 21.

Dr. Cynthia Sherwood, Dentist from Independence, spoke in opposition to **HB 2304**, stating (1) dental hygients are an important part of the dental care team but are not trained to provide care on their own; (2) on-site supervision by dentists is essential for quality care; (3) in states where hygienists are unsupervised and hygienists' services are permitted, hygienists do not work in nursing homes (see Attachment 16).

Dr. Robert Wood, Oral and Facial Surgeon, Topeka, related the Kansas Dental Association Geriatric Committee's opposition to **HB 2304**. (Dr. Fred Clark, Oral and Facial Surgeon of Topeka, prepared the written testimony being presented by Dr. Wood, but could not attend the meeting today.) Dr. Wood indicated the solutions to the oral health problems of nursing home residents include (1) insuring that nursing home residents get daily teeth cleaning; (2) insuring there is financial access to care; and (3) providing dedicated, properly equipped facilities in nursing homes (see Attachment 17).

Chairperson Mayans opened the meeting to questions for the opponents. Representative O'Connor asked why schools are included in this bill. Nancy Little stated the schools make patient referrals and stated that there is a need for preventive care for school age children who do not have access to such care.

Representative Gilmore stated this proposal is really about additional costs to the state. Mr. Hanzlick stated that was the point the Kansas Dental Association made--if there is not a funding commitment, the patients will not receive care.

The meeting was adjourned at 3:10 p.m.

The next meeting is scheduled for February 15, 1995.

HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST
FEBRUARY 14, 1995

NAME	REPRESENTING
Rich Guthrie	Health Midwest
Nancy Little	Health Dept. Wichita
BRICK SCHEER	DENTIST
Nancy L. Crump	Dental Hygienist - K.C., Ks.
[illegible] DDS	Dentist
Gerry Barker Dental	Dental Hygienist Educator
Pamela Overman Dental	Dental Hygiene Educator
Kim Stabbe, RDH	Pres. Ks. Dental Hygienists' Assn.
PATTI Shuttz - KDHA Leg.	chair & Dental Educator
Annette Sibert	KAHSA
ESTEL LAWRETH	KANS. DENTAL BOARD
Michelle Peterson	Ks Governmental Consulting
John Peterson	Ks Hospital Assn
David Hanzlick	KS Dental Assn
Robert Wood	KDA
Scott Kennedy	Dentist
Terri BOBBA	KSNA
Joe Furjanic	KCA
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KS

HOUSE H&HS COMMITTEE
2 - 14 - 1995
Attachment 1-1

HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST
FEBRUARY 14, 1995

NAME	REPRESENTING
JIK Shively	KS. Legal Services
Jeffrey Santelli	KNA
C. Ream	KAOM

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 HEALTH AND HUMAN SERVICES
CONCERNING HB 2304

February 14, 1995

Mr. Chairman and Members of the Committee:

KINH 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. Lack of adequate staff for daily routine care, lack of dental equipment and space in nursing facilities, and inadequate Medicaid reimbursement are some of the factors identified by dentists, hygienists, nursing homes, and consumers as contributing to the problem.

We have also observed the reluctance of many dentists to take their practice to the nursing home; the majority prefer instead that patients are brought to their offices. Many nursing home residents are so severely debilitated that transporting and treating them pose significant difficulties for the patient, the nursing home, and ultimately for the dental office staff.

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 delegated by the dentist and carried out on the adult care home premises. The dentist would be expected to examine the patient at least yearly 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 care can prevent a multitude of physical ills, from extensive dental repair to nutritional deficiencies. A publication on care of nursing home patients distributed by the Kansas Dental Association asserts:

> ORAL HEALTH, SPECIFICALLY PREVENTIVE ORAL HEALTH, LEADS TO AN IMPROVED QUALITY OF LIFE, IMPROVED PSYCHOLOGICAL AND EMOTIONAL CONDITION, IMPROVED MEDICAL CONDITION, AND ULTIMATELY, A HEALTHIER AND HAPPIER INDIVIDUAL.

For the majority of nursing home residents, the costs of a dental hygienist's services could be covered in a variety of ways: by payment from private funds, by dental insurance, or reimbursed by

Medicaid through the P.E.T.I. program. For those residents who have only SSI income, no source of payment is available for care by either dentists or hygienists.

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 for your support of HB 2304 as a modest, but positive and potentially cost-effective step toward its solution.

Respectfully submitted,

Sandy Strand

Sandra Strand
Legislative and Community Liaison

QUALITY OF CARE

28-39-152. Quality of care. Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and the plan of care.

(a) Activities of daily living. Based on the comprehensive assessment of the resident, the facility shall ensure that:

(1) each resident's abilities in activities of daily living improve or are maintained except as an unavoidable result of the resident's clinical condition. This includes the resident's ability to:

(A) Bathe;
(B) dress and groom;
(C) transfer and ambulate;
(D) toilet;
(E) eat; and
(F) use speech, language or other functional communication systems.

(2) each resident is given the appropriate treatment and services to maintain and/or improve the level of functioning as described above in subsection (1).

(3) a resident who is unable to perform activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility shall ensure:

(A) Residents are bathed to ensure skin integrity, cleanliness and control of body odor;
(B) oral care is provided so that the oral cavity and dentures are clean and odor is controlled;
(C) residents are dressed and groomed in a manner which preserves personal dignity;
(D) residents who are unable to eat without assistance are offered fluids and food in a manner which maintains adequate hydration and nutrition; and
(E) preservation and/or enhancement of the resident's abilities to obtain fluid and nutrition in a normal manner.

(b) Urinary Incontinence. The facility shall ensure that:

(1) Residents who are incontinent at the time of admission or become incontinent after admission are assessed, and based on that assessment a plan is developed and implemented to assist the resident to become continent unless the resident's clinical condition demonstrates that incontinency is unavoidable;

(2) residents who are incontinent are kept clean and dry to ensure skin integrity and prevent body odor;

(3) residents who are admitted to the facility without an indwelling catheter are not catheterized unless the resident's clinical condition demonstrates that catheterization is necessary; and

(4) residents with indwelling catheters receive appropriate treatment and services to prevent urinary tract infections and to restore normal bladder function if possible.

(c) Pressure ulcers. Based on the comprehensive assessment, the facility shall ensure that:

DENTAL SERVICES

28-39-159. Dental services. Each facility shall assist residents in obtaining routine and 24-hour emergency dental care.

(a) The facility shall:
(1) Maintain a list of available dentists for residents who do not have a dentist;
(2) assist residents, if requested or necessary, in arranging for appropriate dental services; and
(3) assist residents in arranging transportation to and from the dentist's office. (Authorized by and implementing K.S.A. 39-932; effective November 1, 1993.)

KINH Kansans for Improvement of Nursing Homes, Inc.
913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842 3088

Excerpt from:

KINH NEWS July-August 1992
Margaret Farley, BSN, JD
Editor and Executive Director, KINH

Dental Care for the Medicaid Resident

A Medicaid resident who has some income, such as Social Security or a small pension, is generally expected to apply all of that income to the cost of his or her nursing home care except for $30 monthly reserved for personal needs. However, a resident can direct that all or a portion of that income go to pay for dental care or other medical services not included in the state Medicaid plan. The resident who receives the service - in this case dental care - presents the bill to SRS, which reduces the resident's share of the nursing home bill for the following month by that amount. The resident then pays the dentist's bill and Medicaid pays the remainder of the nursing home costs.

For example, nursing home resident, Mrs. F., has a total monthly income of $780, coming from Social Security and a small pension. She would ordinarily apply all but $30 of that income, or $750, to the nursing home bill of $1,250 and the state Medicaid program would pick up the remaining $500. However, if one month Mrs. F. needs to have a bridge replaced at a cost of $200, she may do so. She will present the dentist's bill to the local SRS office. They will deduct the $200 from the $750 she owes the nursing home so that she can pay the dentist. She will then pay the nursing home $550 and Medicaid will pay the nursing home $700.

SRS has not typically made it known to Medicaid residents that this option for securing "non-covered services" such as dental care is available. Consumers need to use the program when dental care or other medical services are needed. Timely routine dental care can prevent a multitude of physical ills from extensive dental repair to nutritional deficiencies.

ss
2/14/95

THE KANSAS DENTAL HYGIENISTS' ASSOCIATION
CONSTITUENT OF THE AMERICAN DENTAL HYGIENISTS' ASSOCIATION

February 14, 1995

House Health & Human Services Committee
Statehouse
Topeka, KS 66612

Dear Committee Members;

My name is Kim Stabbe, I am the President of the Kansas Dental Hygienists' Association's (KDHA). I have been a practicing, registered dental hygienist since 1982. KDHA supports the premise and intent of House Bill #2304 (HB #2304) which advocates general supervision. We believe that the Dental Practice Act changes addressed in it will benefit Kansas populations who are in need of dental hygiene care by increasing their access to preventive dental care. Most oral diseases are fully preventable.

There are presently 40 states in the U.S. that allow dental hygienists to provide dental hygiene care under some form of general supervision. I practiced dental hygiene full-time for three years in Iowa. Iowa at that time and presently has general supervision for the practice of dental hygiene. This supervision enabled me to provide dental hygiene care prescribed by the dentist for patients in need of my services when the dentist was not in the office. The dentist and the patients felt comfortable with me providing dental hygiene care without the dentist being present. The Kansas Dental Hygienists' Association's (KDHA) 1990 survey of Kansas dental hygienists found that 82% of those surveyed believed that they should be able to practice under general supervision. There are special populations (e.g. elderly, mentally and physically disable, AIDS, etc.) in Kansas who are in need of dental hygiene care and could receive care if general supervision were implemented in the Dental Practice Act.

Dental hygienists are licensed professionals. Since 1981 the American Association of Dental Schools (AADS) has recommended that CPR certification be implemented into dental and dental hygiene schools' curriculum. The KDHA 1992 delegable duties survey of dental assistants and dental hygienists found that 71.7% of the responding dental hygienists were certified in CPR. Any dental office emergency is first handled by performing basic life support.

Dental hygiene programs are accredited by the American Dental Association's Commission on Dental Accreditation. Explicit guidelines and standards must be followed in order to maintain accreditation and to assure that each program is providing current, up-to-date content in all curricular areas. This includes recognition of signs and symptoms of disease and referral to the

appropriate health care provider. Courses such as Oral Pathology and Periodontology support the foundation on which a hygienist builds to identify concerns and report them to the dentist. Thorough head, neck and oral cavity examinations are done on each patient as a form of oral cancer screening. Pharmacology and Clinical courses teach the hygienist to be proficient in reviewing the patient's health records, comprehension of the drugs patients are taking and management of emergency situations.

KDHA believes that HB #2304 should state specifically the intent of the bill which is general supervision. Stating general supervision in this bill will clarify for all dental professionals the type of supervision a hygienist is to practice under in this section. The approval of HB #2304 would increase the availability of dental hygiene care to many Kansans who currently are not receiving basic preventive dental care.

Sincerely,

R.D.H., M.S.

Kim Stabbe, R.D.H., M.S.
KDHA President
8010 Country Club Drive #1
Overland Park, Kansas 66212

KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

Memorandum

February 14, 1995

TO: House Health & Human Services Committee

FROM: Thomas L. Bell,
Senior V.P./Legal Counsel

RE: **HOUSE BILL 2304**

The Kansas Hospital Association appreciates the opportunity to comment in support of HB 2304. This bill would allow dental hygienists to perform services in hospitals and other institutions under certain circumstances.

Our latest figures show that sixty-one hospitals (approximately 47 percent of the community hospitals in Kansas) provided long-term care, in addition to providing acute hospital care. We think HB 2304 would give hospitals, especially those providing long-term care, the ability to better serve their patients.

We think the bill includes provisions that protect the patient from procedures performed inappropriately. The dental hygienist must be supervised by a licensed dentist. In addition, a licensed dentist must have delegated the performance of the task. With regard to services within an institution such as a hospital, that institution must also be concerned about those persons who enter the facility to perform services. The potential for liability exposure dictates that a hospital be cautious about those individuals it allows to perform services.

Thank you for your consideration of our comments.

TLB / pc

HOUSE H&HS COMMITTEE
2 - 14 - 1995
Attachment 4

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

KAHSA
KANSAS ASSOCIATION OF
HOMES AND SERVICES FOR THE AGING

To: House Health and Human Services Committee

From: Annette Siebert
Director, Government/Legal Affairs

Date: February 14, 1995

Re: House Bill 2304 - Dental Hygienists

Thank you for the opportunity to testify in support of House Bill 2304.

The Kansas Association of Homes and Services for the Aging is a trade association representing over 150 not-for-profit retirement, nursing and community service providers throughout Kansas. KAHSA members provide diverse services to individuals in a variety of settings including over 9,600 nursing facility beds, over 3,900 senior duplexes and apartments and a wide range of community services such as assisted living/personal care, home health care, congregate meals, and adult and intergenerational day care.

KAHSA supports this bill because it seeks improve dental care to nursing facility residents in a cost effective manner.

Currently, in the vast majority of circumstances, nursing facilities must transport residents to the dentist's office for all treatments, including routine dental hygiene procedures. Allowing hygienists to practice dental hygiene in the limited circumstances described in the bill will assist nursing facilities to maintain good dental health for their residents:

* It will enhance more frequent resident contact with dental hygienists.

* It will provide additional opportunities to assist in training nursing facility staff in daily oral care.

* It will make it easier for dentists to follow their patients after they enter a nursing facility.

* It will reduce the cost and trauma of transporting residents to the dentist's office.

The limitations included in the bill also provide significant protections:

* The requirement that the dentist delegate the performance to the dental hygienist under his or her supervision and responsibility makes it clear that the dentist

700 SW HARRISON, SUITE 1106
TOPEKA, KANSAS 66603-3759
913-233-7443
FAX: 913-233-9471

has the ultimate responsibility for the hygienists' performance.

* The requirement that the supervising dentist examines the patient at the time of the dental hygiene procedure or has examined the patient within the previous year provides additional protections to the resident.

In the interest of improving the quality of dental care for nursing facility residents, KAHSA supports HB 2304.

Thank you for the opportunity to testify.

Scott C. Kennedy, D.D.S.

1107 S.W Gage Blvd., Suite 100
Topeka, Kansas 66604

Tel: (913) 271-7477

House Committee on Health and Human Services
Comments on H.B. 2304 by Scott C. Kennedy, D.D.S.
Feb. 14, 1995

Mr. Chairman, members of the House Committee on Health and Human Services, I am Dr. Scott Kennedy and I am a dentist in private practice in Topeka and Burlingame. I am here today to speak in favor of the concept embodied in H.B. 2304.

I am a consulting dentist for two nursing homes. One has a current residency of 55 people, with 50 of those residents qualified for Medicaid. The other nursing home has 41 residents, with 26 qualified for Medicaid coverage. Neither home has any facilities for providing any type of dental treatment. In my visits to these two facilities, I find the residents sorely lacking in the basic oral health care provided by daily brushing and flossing. In considering the provisions in H.B. 2304, as a private practitioner, I have reservations with its implementation as proposed. I am very uncomfortable with allowing an employee of mine to provide services in a nursing home under my supervision and responsibility. I do not feel that a bloody, invasive dental treatment, such as cleaning the teeth, can be safely provided in a nursing home and still comply with current OSHA Standards for Bloodborne Pathogens, CDC Guidelines, or to the Kansas Board of Dental Examiner's rules and regulations for sterilization and disinfection unless there is a dentist on site and a designated, properly equipped, appropriately staffed, separate treatment area where these services can be performed. Untrained nursing home staff or nursing home residents cannot be allowed to wander into the treatment area to potentially spread disease by contaminating instruments and equipment , or to potentially become infected by contaminants after dental treatment has been performed, any more than they should be allowed into an operating room in a hospital before or after surgery. The previously mentioned regulations are meant to provide such safeguards. Nor would I attempt to suggest , for all involved, that nursing homes be exempted from such regulations. I would offer the following options to alter this legislation in an effort to truly provide treatment to this population, rather than rhetoric:

1. Provide a mandatory, separate area in all nursing homes of 50 or more capacity, specifically designated , equipped and staffed for dental and/or minor invasive medical procedures. Cost to set up such an area could conceivably be accomplished for under $50,000.00 per facility. In lieu of this, perhaps several nursing homes could purchase a mobile dental unit which could rotate between facilities. Initial cost would be significantly higher, however, several nursing homes combining to pay for and use such a vehicle could approximate the cost of the of a treatment room within the nursing home. This could be the preferred option in rural areas.

2. Provide a means to properly and adequately fund both equipping and staffing nursing home facilities. The salary range of a dental hygienist is between $30,000.00 and $40,000.00 per year, and there is a severe shortage of practicing hygienists in most areas of the state. I cannot afford to pay a hygienist to provide treatment without some mechanism of payment for services.There currently is no adult dental program for Medicaid recipients in Kansas, and very limited coverage , mainly for extensive procedures, such as oral cancer surgery, under Medicare.

By addressing these two issues, dental services could be more widely provided to a population which requires such care. I would encourage this Committee to find solutions to the proposals I have presented today in an effort to help bed-ridden residents in Kansas nursing homes to obtain a greater access to appropriate dental care. I feel that these issues must be addressed in the initial phases for H.B.2304 to be an effective vehicle for providing this access.

My name is Nancy Little, I am a registered dental hygienist and Dental Health Educator at the Wichita-Sedgwick County Health Department, with a Master's Degree in Health Science. I have supervised the Children's Dental Clinic at the Health Department for **eleven years.** I worked in private practice for **three years** prior to working in public health. I am here today to ask for **your support for House Bill 2304.**

The Children's Dental Health Program at the Wichita-Sedgwick County Health Department is a dental program for children age **5 through 15** who have no dental insurance, no medical card and who meet low-income guidelines for free or reduced school lunches. These families **simply cannot afford to pay for the extensive dental care** their children need. Last year **650 children** had their **first dental visit** at the health department clinic, however; if legislation is passed to allow dental hygienists to provide services in public health settings, **many more children could get much needed preventive dental care including dental cleanings, fluoride treatments and pit and fissure sealants to prevent decay in permanent teeth.** Currently, there is a four month waiting list for the Children's Program, with over three-hundred children waiting for a first visit.

Over ninety percent of the children referred to the program by school nurses have **never** seen a dentist, and the nurse usually becomes aware the child needs help because he or she has left class with a toothache. Typically, children seen in the clinic have **rampant or gross dental caries affecting several teeth,** with draining abscesses and infection. This past school year twenty-seven volunteer dentists gave 600 hours to provide fillings, crowns, extractions and other treatment. Volunteer dentists filled **395** baby teeth and **517** permanent teeth, and removed **194** baby teeth and **21** permanent teeth. You would be shocked at the extensive and severe decay the children have.

Many times parents are not aware of the child's dental problems, or think the toothache, like a stomach ache, will just go away, or they use home remedies to ease a toothache when they just do not have the money to take the child to the dentist. Because the children have **so many** cavities, parents face a dental bill they can't pay so they defer treatment, taking the child only when the pain becomes intense, and the child receives only emergency treatment. Clearly, this does not teach or promote a positive attitude towards going to the dentist. Unfortunately, postponing necessary dental care can have long term consequences: the loss of teeth, pain, difficulty in chewing, and crooked permanent teeth. Prevention in the early years saves money, prevents missed school days, and preserves the permanent teeth for better nutrition, higher self esteem and straight, healthy teeth.

Wichita-Sedgwick County Department of Community Health
1900 East Ninth Street-Wichita, Kansas 67214-3198 (316)268-8401

There are nearly 20,000 children in the Wichita area who meet low-income guidelines for dental services and we know from school dental screenings that many of these children do not receive any dental care because dentists doing dental exams report seeing some of the **same** children with decayed teeth year after year.

At this time our clinical services are limited, because dental hygienists can provide care to children only when a dentist is present. We have two dental chairs and could provide preventive care to many **more children**. This bill would allow dentists to prescribe dental cleanings, fluoride treatments and pit and fissure sealants and then these procedures could be done by dental hygienists, in the same way thousands are done in other states.

With this legislation, preventive dental care can be provided to the increasing number of children who do not have access to care. Please support House Bill 2304, to increase access to dental care for all Kansans.

Nancy Little, RDH, MHS
Dental Health Educator

General Supervision for Dental Hygienists in Kansas

Providing the Oral Health Needs for an Underserved Population

James M. Mixson, DMD, MS
Associate Professor and
Coordinator of Geriatric Dentistry
University of Missouri-Kansas City

For the first time in history, most older adults have their own teeth. Sixty-five percent of adults 65 and older have natural teeth. On average, an older adult has 17 teeth (NIH Oral Health Survey of U.S. Adults, 1985-86). As a result, older adults, and in particular, the frail elderly, are at risk for more serious oral disease involving the teeth and gums than ever before. The dental hygienist could play an important role in oral care for residents of long term care facilities, including routine cleaning of teeth, screening for oral cancer and other dental diseases, labelling dentures, educating the staff and establishing oral care plans.

There are 29,000 new cases of oral cancer per year and 5,000 oral cancer deaths. Nine - five percent of persons diagnosed with oral cancer are over 40 years old with the average age at diagnosis of 60. (Silverman, 1985). Hygienists can be an important link in the oral care team by identifying suspicious lesions for their dentist to diagnose or refer.

Numerous long term studies have shown the effectiveness of conservative, anti-infective scaling and root planing as a treatment for periodontal disease (Caffesse and Quinones, 1993). Thorough cleanings by a hygienist at 1 to 3 month intervals can be highly effective (Stiefel et al, 1984). Studies have shown that nursing home residents have poorer oral hygiene and periodontal health than the general population. Kiyak (1993) found 72% of residents had poor oral hygiene and 50% had signs of oral disease. Berkey (1991) found 76% of residents had two-thirds of the tooth crown covered with plaque debris and calculus. This unmet need can be addressed by allowing hygienists with general supervision to treat this group that has limited access to routine dental care.

Dental caries, especially root caries, is a significant problem for older adults. Sixty to eighty percent of nursing home residents have evidence of root caries (Banting, 1986). One study showed routine cleanings and topical fluoride treatments slowed the increase in root caries by one-third and reversed the number of initial caries by 40% (Wallace et al, 1993). Again, hygienists can be a critical team member in preventing root caries in this at risk population.

Finally, hygienists can provide much needed and routine training to the nursing staff. Regular training of staff is critical as turnover of nursing aids can be 50% or greater (Zahrt, 1992). The hygienist can teach aids how to properly clean residents' mouth and dentures. They can develop specific oral care plans for individuals, setting appropriate goals which the nursing staff can include in the overall care plan for the residents.

The preventive oral care needs of many nursing home residents are going unmet because of poor health, limited funds, transportation problems, and poorly trained staff. The dental hygienist under general supervision could provide regular training and preventive care to this underserved and increasingly at risk population.

References

Banting DW: Epidemiology of root caries. Gerodontology, 5:5-11, 1986.

Berkey DB, Berg RG, Ettinger RL and Meskin LH: Research review of oral health status and service use among institutionalized older adults in the United States and Canada. Special Care in Dentistry, 4:131-136, 1991.

Caffesse RG and Quinones: Outcome studies of periodontal modalities. Current Opinion in Periodontology, 6:170-177, 1993.

Kiyak HA: Oral health problems and needs of nursing home residents. Community Dent Oral Epidemiology, 21:49-52, 1993.

National Institutes of Health: The national survey of oral health in U.S. employed adults and seniors: 1985-86. DHHS Publication No. 87-2868. Rockville, MD: 1987.

Silverman S: Oral cancer. New York, The American Cancer Society, 1985.

Stiefel DJ, Rolla RR and Truelove EL: Effectiveness of various preventive methodologies for use with disabled persons. Clinical Preventive Dentistry, 6:17-22, 1984.

Wallace MC, Retief DH and Bradley EL: The 48-month increment of root caries in an urban population of older adults participating in a preventive dental program. Journal of Public Health Dentistry, 53:133-37, 1993.

Zahrt LM: The cost of turnover in a home care agency. Caring Magazine, 11:60-66, 1992.

B05-0195

General Supervision for Dental Hygienists in Kansas

Gerry J. Barker, R.D.H., M.A.

Assistant Professor
Department of Diagnostic Sciences
Coordinator of Oncology Education
University of Missouri-Kansas City
School of Dentistry

February 14, 1995

I am a registered dental hygienist and an Assistant Professor in the Department of Diagnostic Sciences at the University of Missouri-Kansas City School of Dentistry. I have coordinated the Oncology Education Program at the dental school since 1981. As program coordinator, I have the opportunity to participate on interdisciplinary teams with physicians and allied health care professionals to provide care for medically-compromised patients at Truman Medical Center and Children's Mercy Hospital. Patients from other regional hospitals or long-term care facilities may be referred for care to the Special Patient Care Center at the dental school, but frequently they cannot be transported because of a serious medical or disabling condition. I receive numerous calls requesting an in-hospital patient consultation to address the oral hygiene needs of a patient, but due to the present dental practice acts, I am not allowed to provide care for these patients in the State of Kansas without the supervision of a dentist.

Because the nurses and nurses aids are designated to provide for the patients' oral care needs, I have offered to do numerous nurse in-service programs. To adequately address the nurses' needs, I always question the participants before the presentation to assess their knowledge of the mouth and oral hygiene aids. Responses repeatedly indicate that these nurses and aids have had little training in oral care issues and frequently they comment that they ignore these duties because of their lack of knowledge. These in-services may enlighten a few nurses and aids, but in a one-hour presentation I cannot adequately educate them on how to do a thorough oral assessment and design individualized oral care plans. Many of these patients need dental hygiene services but do not have access to them.

A book written by Dr. Austin Kutscher entitled, The Mouth in Critical and Terminal Illness, documents that oral discomfort and infections can accelerate decline and death. He writes, "This is not the time to abandon patients...late in life and in chronic stages of disease, the mouth assumes proportionately greater importance. Maintenance of the highest level of oral hygiene is an essential objective...the mouth is the source of eating, drinking, and talking...oral discomfort from dried secretions, ulcerations, and loss of oral function can be totally overwhelming to the psychic state of the patient." Oral disease also can be the source of a fatal infection.

A change to general supervision for dental hygienists would allow dental hygienists to provide dental hygiene services to patients confined to a hospital or institution after the dentist has diagnosed the condition to be treated. Providing optimum oral care for compromised individuals will increase the frequency of thorough oral assessments, will reduce the risk of oral and systemic infections, will improve their nutritional status, and provide physical and psychological comfort. All Kansas residents deserve this level of oral and dental hygiene care.

School of Dentistry
Division of Dental Hygiene

University of Missouri-Kansas City
650 E. 25th Street
Kansas City, Missouri 64108-2784

816 235-205(
Fax 816 235-2

UMKC

TESTIMONY RELATED TO ORAL HEALTH CARE FOR NURSING HOME RESIDENTS

In the April 1994 Journal of Dental Education, information was compiled from a variety of Federal Public Health documents revealing that 60% of the American population receives dental care while 40%, over 100 million people, receive no dental care. The majority of individuals who do not have access to oral health care are underserved population groups, institutionalized individuals, chronically ill persons and a growing geriatric population. Because preventive dentistry has been so successful, older adults are keeping their teeth and are increasingly at risk for oral health problems. Untreated oral infections can aggravate other health problems for the institutionalized older adult.

In May of 1994, the Wichita State University, Department of Dental Hygiene, conducted a needs assessment related to dental hygiene services in institutionalized settings. Forty-four surveys were sent to primary nursing home facilities, geriatric institutions and public health agencies in Wichita, Hutchinson, Newton and Salina. Twenty-nine surveys were returned -a response rate of 66%. Eighty-nine percent (89%) of the respondents indicated that providing oral hygiene care to their clients was important and seventy-three percent (73%) indicated they could use a dental hygienist to provide those services. Currently oral hygiene services are being provided in 62% of the responding institutions by Nurse Aids or Certified Nurse Assistants-individuals who are not formally trained in oral health care. Only two institutions reported employing a dental hygienists, while five facilities reported having access to a consulting dentist.

Current legislation in the State of Kansas prohibits the practice of Dental hygiene in any setting without the direct supervision of a dentist. (This is not the case in other states.) This law poses a major barrier to oral health care for all institutionalized and community based clients since few agencies employ dentists. Dental hygienists in the State of Kansas are graduates of either college or university based programs accredited by the American Dental Association's Commission on Dental Accreditation; have successfully completed stringent national and regional Board examinations and are licensed to practice by the Kansas Dental Board.

Dental Hygienists are extremely well educated in overall patient assessment, including the evaluation of a patient's health history, and in the delivery of clinical and preventive services. Dental hygienists receive 48 hours of oral pathology education in comparison to 70 hours in the dental curriculum; dental hygienists have 12 hours in medical emergency education compared to 16 hours for dental students. Both dental and dental hygiene students receive 16 hours

of training in CPR training. Dental students receive approximately 2,500 hours of clinical training while dental hygiene students receive 900 hours. Dental hygiene students clinical hours are concentrated solely on patient assessment and the delivery of preventive and periodontal services while the dental student's focus in on all aspects of dentistry including fillings root canals, crowns and bridges, dentures and surgical procedures. In fact, the number of hours spent on preventive and dental hygiene services by dental students (approximately 10-15% of their clinical time) is very minimal in comparison to the 900 hours required of dental hygiene students.

Dental hygienists are competent dental health care providers, capable of providing cost effective services to the clients of institutions currently not receiving dental hygiene care or being cared for by technical staff such as nurse aids. The dental hygienist can also recognize when referral to a dentist is necessary. Registered dental hygienists emphasize promotion of health and prevention of disease, thus enhancing the overall quality of life for the institutionalized individual.

Respectfully submitted by:

Salme Lavigne, RDH, MS
Chair, Department of
Dental Hygiene
Wichita State University

Pamela Overman, Director
Division of Dental Hygiene
UMKC School of Dentistry

ESTEL L. LANDRETH, DDS, P.A.
4620 EAST DOUGLAS • SUITE B • WICHITA, KANSAS 67208
(316) 685-9276 • FAX (316) 685-2973

February 14, 1995

STATEMENT IN SUPPORT OF HB 2304

presented by: Estel Landreth, D.D.S.

Chairman Mayans and Committee Members:

My name is Estel Landreth. I have been a general dentist in Wichita for 26 years. I am a member of the Kansas Dental Board, and have been president of that board for the past 3 1/2 years. I am also a delegate to the Kansas Dental Association from the Wichita District Dental Society.

The Kansas Dental Board favors House Bill 2304, with an amendment. We suggest that "either the supervising dentist is personally present, or the services, tasks and procedures are limited to the cleaning of teeth, education and preventive care."

This bill does not change the scope of practice of dental hygiene, it only provides for preventive care to be provided in different locations (as in care homes for the elderly). This bill mandates that a DENTIST examine and prescribe treatment, and that the DENTIST be responsible.

In 1992 a much broader bill passed both the House and Senate, but was vetoed by the Governor. That year 26 states allowed some form of this type of care. This year 41 states allow similar kinds of alternate locations for care. Although not specific, this figure does indicate a national trend for increasing access to dental care in settings other than the dental office. This bill will allow access to care for groups of people in Kansas who now get very little, or no care.

The Dental Board sees no problem with compliance to the rules and regulations mandating sterilization standards. Care homes and care facilities such as hospitals are well informed and equipped to handle laundry and bio-hazard waste disposal. Our rules and regulations are based on CDC standards, which have to be complied with in these settings already.

Equipment is now available for use outside the dental office. It is portable and mobile, usable for bedside care.

ESTEL L. LANDRETH, DDS, P.A.
4620 EAST DOUGLAS • SUITE B • WICHITA, KANSAS 67208
(316) 685-9276 • FAX (316) 685-2973

The question has to be asked: Are hygienists trained to recognize and deal with the needs of the aged? The Board feels that they are. They are well educated; they are tested; and they are LICENSED by the state. Most hygienists are required by regulation to be certified current in CPR. DENTISTS ARE NOT required to be current in CPR! Hygienists are educated to recognize abnormalities in the mouth. Most care home residents do not have regular oral examinations by anyone, but as an added safeguard, this bill requires a dentist to examine each patient before a hygienist can deliver care.

This bill was introduced by neutral parties outside of dentistry who felt a need for this care to be available. I ask you to judge this bill on its' own merits, not on politics.

Thank you for your time.

11 - 2

Chairman Mayans and Representatives,

I am Dr. Brick Scheer and have been a practicing dentist for the past twelve years. For the past five years I have scheduled one and one-half days per month to examine and treat the residents of nursing homes.

When examining residents of a new nursing home I find that approximately 80% of these residents will not visit a dentist in a dental environment for the rest of their lives. Of those residents who have some of their teeth, 75% will have at least one abscess. Many of these abscesses can infect the blood stream causing health problems in any part of the body. Because they will not be seeing a dentist again the resident must suffer silently, or not so silently, until their death.

The underlying cause of the abscesses is neglect of one's dental hygiene. These residents literally cannot clean their own teeth and usually must rely on the nurses on staff, who have no professional training in dental hygiene, for their daily cleaning. Of the two groups who are trained in dental hygiene, dentists and hygienists, it is economic suicide for a dentist to spend much time in a nursing home and it is against the law for a hygienist to clean a resident's mouth unless a dentist is there with him or her.

I propose we allow a dentist to examine a nursing home resident and make a determination as to how often the person will need someone else to clean their teeth. For many this will be daily. The dentist can then hire a full time hygienist who's sole job is to clean the residents' teeth as often as the dentist has prescribed. In order for this to work the hygienist must be allowed to work from the dentist's orders while he or she is not present. This is commonly referred to as general supervision. Once this is possible it will be more realistic for a nursing home facility to dedicate a room for dental hygiene and procure the necessary equipment. By using a trained professional to do the cleaning the abscesses can not only be identified for treatment but many can also be prevented.

As a dentist who is active in the treatment of nursing home residents, I hope you can see the dilemma we currently face. Despite the presence of a large problem, it is economically unfeasible for us to treat the dental problems that exist in nursing homes. And when we are called in to help we usually end up treating the symptoms, toothaches and abscesses, instead of the problem which is inadequate daily hygiene. Thank you for your time.

Credentials:

Graduated Dental Hygiene in 1965.
Earned M.S. in Social Gerontology and M.S. in Psychology.
For ten of the past 30 years, I have worked in the field of aging.
I am currently licensed and practicing dental hygiene full-time in the Argentine district of K.C., Ks. and reside in Mission, Ks.

In every program for the elderly that I have been involved with since 1979, we have had as our goal, enabling older adults to live longer, healthier and more independent lives. It has been my professional exxperience that the area of oral health care for the elderly has been sadly neglected.

The oral cavity is a vital and necessary part of the human anatomy. Poor oral health can be the cause of a whole range of potentially debilitating and isolating conditions among the elderly. These conditions may include poor nutrition, inability to take medications, unecessary pain and discomfort, inability to communicate properly, a loss of self-esteem and embarrassment, isolation, depression, and even death.

According to the Surgeon General's Report on Nutrition and Health in July, 1988, "In 1979, one-sixth of all accidental deaths in people over the age of 75 appeared to have been caused by poor or ill-fitting replacement teeth." The inability to masticate properly, complicated by the reduction of salivary flow in the elderly, predisposes the elderly to airway blockage.

The medical professionals now responsible for the oral health of older Americans in nursing homes have had limited exposure to the oral cavity, whereas the dental professionals spend their lives doing nothing else. As we sit in deliberation this afternoon, there are many older adults in nursing homes whose over-all health could be enhanced through the education, preventive and palliative therapies that the dental professionals are trained to offer.

I'd like to leave you with this one thought. Like many of you in this room, I have spent a lifetime caring for my teeth. I would like to know that should I ever be in a situation where I could no longer care for myself, and be placed in a nursing home, that the quality of my oral health care would continue.

KANSAS DENTAL ASSOCIATION

Statement by David Hanzlick
Before the House Committee on Health & Human Services
H.B. 2304
February 14, 1995

Mr. Chairman and members of the Committee, my name is David Hanzlick. I am the Assistant Director of the Kansas Dental Association. I appreciate having the opportunity to appear before you today to outline the reasons the Kansas Dental Association opposes this legislation. I would like to raise several issues for you to consider as you listen to the two dentists I will introduce shortly.

First, H.B. 2304 quite frankly is a difficult bill to oppose. The bill as it appears is seductively simple. We've been told, in fact, that it has a strong appeal to the common man. I know you are willing to dig a little deeper into the issue.

I believe members of the Committee started digging into the issue at the bill introduction. One member asked why this bill also speaks of hospitals, state institutions, and schools, if its purpose is to address nursing homes. The answer may be that this bill was really introduced at the request of the dental hygiene association, which had assured their own members and the Kansas Dental Association that they would not introduce a bill again this year.

Second, I know that you will listen to the reasons why letting hygienists work without the supervision of a dentist -- in a nursing home or anywhere else -- is a simple and wrong solution to the difficult problem of providing oral health care in nursing homes.

If you do a little more digging, you will find that, in fact, the core issue here has nothing to do with nursing home residents. Instead, this bill is another in a long line of turf battles you've heard over the past month.

The core issue here is that you have a group of dental staff members who want to exercise the professional privileges of a dentist without paying the price of going to dental school. They are here this year and every year asking for you to grant them through legislation a level of privilege that they have not achieved through education.

If an individual wants to perform the services that a dentist provides -- including treating dental patients without the supervision of another profession -- then going to dental school is a very reasonable approach.

As a conferee stated last week, one segment of a profession, like medicine or dentistry, cannot be pulled out and isolated from the integrated knowledge of the total profession.

5200 Huntoon
Topeka, Kansas 66604
913-272-7360

A service like the cleaning of teeth -- which is much more involved and invasive that "just" cleaning teeth -- cannot be completely and neatly separated from the total responsibility for the management of the patient. That is why dentists complete dental school. That's why the dentist is on-site when patients are receiving care.

That basic fact in no way demeans the important skills and contributions of dental staff members. Rather, it reinforces that the dentist is the person who is appropriately in charge and bears the responsibility -- and liability -- for the care that is rendered.

The third point I want to raise is that this hearing today provides a tremendous opportunity for us to talk about the real issues of dental care in nursing homes.

--Are nursing home residents receiving adequate care, including having their teeth brushed every day? Or are patients being neglected when it comes to daily brushing which is essential for good oral health? And good oral health is essential for good overall health.

--If patients are being neglected and are not having their teeth brushed every day, their oral health will deteriorate to the point that no amount of teeth cleanings by dentists or hygienists will make any difference.

--If patients are receiving daily care, and I very much hope that they are, there is then little need for this bill.

And, of course, there is the important question of how do we finance dental care, especially for the 13,000 nursing home residents in Kansas who are dependent on Medicaid. Nothing is free in life. It is extremely difficult to provide care where money is short or non-existent. I believe this House and this Committee are very well aware of that economic reality.

That is why I was so disappointed last week when I testified before the Senate Ways & Means Committee on the vital importance of providing Medicaid funding for dental care at least for needy Medicaid patients in nursing homes. Money is truly the place where the rubber meets the road when it comes to getting care for nursing home residents. And yet, the two groups who introduced this legislation had "higher priorities". They did not even mention dental care. Yet here they are promoting a non-solution to a very real problem.

I am pleased to have with me today two dentists who will help you as you dig into this issue. To discuss the dental care in nursing homes, I am pleased to have with me today Dr. Cynthia Sherwood, who is a dentist in general practice in Independence, Kansas, and Dr. Fred Clark, who is an oral and maxillofacial surgeon in Topeka, and Chairman of the KDA Geriatric Committee, which has been extremely active in nursing home problem.

STATE OF KANSAS

BILL GRAVES
GOVERNOR

KANSAS DENTAL BOARD
BUSINESS OFFICE
3601 SW 29TH STREET, S-134
TOPEKA, KANSAS 66614-2062
TELEPHONE NO. (913) 273-0780

BOARD OF DENTAL EXAMINERS

February 10, 1995

Chairman Mayans & Committee
Statehouse
Topeka, Ks.

Dear Chm. Mayans and Members of the Committee:

I am sorry that I am unable to be present for the public hearing on House Bill #2304. I do feel very strongly about the content of this bill and its future ramifications to the practice of dentistry and dental health for Kansans.

This bill is, in essence, only a move or a step toward independent practice for dental hygienists. A similar bill was tried in 1992 and was defeated by the Governor's veto.

Specifically, this bill intends to provide dental care for the needy and shut-ins. In truth and application, there will be very little of that. The reasons are several, here are just two: Most people in adult care facilities are dependent on Medicare or Medicaid for all health needs. Neither will pay for any prophylaxis or that type of hygiene if a person is over 21 years of age. Are the hygienists and the doctors going to do only free work?

Secondly, it is very difficult to do any type of dental care in a setting other than the dental office. Positioning the patient, lighting and adequate asepsis are next to impossible. I go to the adult care facilities in our area and cannot do even an adequate cleaning at the facility. Dental work of all types is still best done in the dental office.

The only people who will benefit from this bill are people who wish to set up independent practice for the hygienists. This bill puts them much closer to that.

I feel that dentistry is a very honorable profession and if you look at the cost for the care we provide, you will see that we have kept our costs in dentistry well below inflation and far below other forms of medicine. The reason is very simple. We have maintained that most of the patient care still be done or directly supervised by the dentist. Every time you allow more people to care for a patient independent of the doctor, your costs go up, not down. If you don't believe me, look at health care costs in medicine. How many different people do the job that the doctor did fifteen years ago, or even five? You

STATE OF KANSAS

BILL GRAVES
GOVERNOR

BOARD OF DENTAL EXAMINERS

KANSAS DENTAL BOARD
BUSINESS OFFICE
3601 SW 29TH STREET, S-134
TOPEKA, KANSAS 66614-2062
TELEPHONE NO (913) 273-0780

can see how their costs have risen.

I respectfully request that you defeat this bill. As a member of the State Dental Board, I can see nothing but problems with it.

In closing, I want the committee to know these are only my personal feelings, not the feelings of the Board itself. The Board has never discussed this issue and does not have a consensus on it. All opinions from board members are only his or her own.

Yours truly,

Ronald G. Wright, DDS
Member, Kansas Dental Board

RGW:kh

Statement by Cynthia Sherwood, R.D.H., D.D.S.
House Committee on Health & Human Services
H.B. 2304
February 14, 1995

Mr. Chairman and members of the Committee, my name is Cynthia Sherwood. I am a dentist from Independence, Kansas. I appreciate having the opportunity to share with you the reasons I oppose the legislation you have before you.

I would like to mention that I have a particular interest in this topic since I am a graduate of the Wichita State dental hygiene program and worked as a dental hygienist for seven years before I became a dentist.

In my comments today, I would like to outline three important points that I hope will help this Committee understand why I oppose this legislation:

1. Dental hygienists are an important part of the dental care team; they are not trained to provide care on their own.

2. On-site supervision of dental hygienists by dentists is essential for quality care.

3. In states where unsupervised hygiene services are permitted, hygienists do not work in nursing homes.

The Dental Care Team

The modern practice of dentistry is based on a group of professionals known as the dental care team. The dental care team includes the dentist and the dental staff that is made up of dental assistants and dental hygienists.

The dentist, of course, is the person in charge of all aspects of patient care and the supervision of the team. The dentist generally has eight years of education, including four years of college and a four-year doctoral education in dental school. I have attached a comparison of the education and training of the members of the dental team.

Dental assistants assist the dentist in performing dental procedures like filling cavities and preparing teeth for crowns. Dental assistants may have formal training through a vocational-technical program or may be taught their skills on the job.

Dental hygienists' main role is removing hard deposits from the teeth to prevent or control gum disease. This procedure is known as a prophylaxis or teeth cleaning. Dental hygienists are trained through a two year program at junior colleges or

universities. While some hygienists have a four-year degree, like I do, they all have the same two years of actual hygiene training.

Dental hygiene training focuses on preventing gum disease and tooth decay. The dental hygienists are trained to work under the supervision of the dentist as part of the dental treatment team.

The teeth cleaning the hygienist performs is designed to supplement the patient's own thorough brushing and flossing. Brushing and flossing remove food particles that cause decay. Just as important, brushing and flossing stimulate the gums and help them to remain healthy.

Without good, thorough brushing and flossing at least daily, a patient receives little, if any, benefit from having his or her teeth cleaned by a dentist or hygienist.

The Importance of On-Site Supervision of Dental Hygienists by Dentists

As we've seen, each member of the dental care team has an important and valuable role to play in delivering quality care to the dental patient. Because the dentist is the doctor in charge of patient care, an important responsibility of the dentist is providing appropriate supervision of her staff.

In terms of the legislation before you, permitting hygienists to work in any setting without the dentist's on-site supervision is inappropriate and potentially dangerous. That fact is especially evident in the nursing home setting.

I would like to mention at this point that I treat nursing home residents and I know that the only way to provide quality care is to use an adequately equipped dental operatory. Most nursing homes do not have these facilities. As a result, patients do generally need to be transported to my office, if at all possible. If the patient is bed-ridden, I will attempt to treat the person at the facility.

The dentist needs to provide on-site supervision for a number of reasons. Only the dentist has the medical training required to evaluate the patient's health history and provide medical management, to diagnose conditions in the mouth, and to recommend further treatment.

On-site supervision of the hygienist by the dentist is particularly critical in geriatric facilities. Contrary perhaps to public perception, the cleaning of teeth is a relatively invasive dental procedure that often causes bleeding, especially in the gum tissue of many elderly patients. In fact, teeth cleanings and pulling teeth are the two bloodiest and most invasive procedures performed in a general dental office.

Residents in those facilities often have many different health problems and take many different medications. Dentists understand the implications of the patient's health conditions and medications. I have attached a partial list of health conditions

and medications that have important implications for dental cleanings. These conditions include joint replacements, blood thinners. Without a thorough understanding of these conditions and their implications, patient's health and safety can be compromised.

As I stated, patients who can be moved to dental treatment facilities should be moved. Patients who are so medically compromised that they cannot be moved absolutely require the services of the dentist. In those cases, I go to the nursing facility and provide the best treatment I can under conditions that are far less than ideal. Again, patients treatment should always be performed in a dental facility if it is at all possible. Otherwise, the quality of care suffers.

Hygienists Have Little Interest in Providing Nursing Home Care

The third reason I oppose this bill is the simple fact that in states where hygienists have this inappropriate authority, they do not use it. An explanation of that point is also attached to my testimony.

This bill is a first step in the hygienists' public agenda of becoming independent, primary providers of dental care.

While I understand the hygienists' desire to advance their profession through legislation rather than education, I believe that we need to understand that this particular bill is simply a part of a much larger agenda and has almost nothing to do with facing the real issues involved in improving the oral health care of nursing home residents.

I have attached the text of a resolution from the American Dental Hygiene Association's 1994 House of Delegates that expresses very clearly their desire to be independent providers of primary care with insurance reimbursement. Let's not kid ourselves about the intentions of this bill.

If dental hygienists really wanted to work in nursing homes providing the care that is really needed, they would be in the homes brushing and flossing teeth today. There is nothing in Kansas law that prevents them from providing that care and perhaps some of them are already doing that.

I care deeply about nursing home residents. I treat the residents in my office. I treat them, when necessary, at the facility. Let's talk about real solutions. Let's not be confused by bills that will solve nothing and simply serve to confuse the issue and delay real solutions.

COMPARISON OF DENTAL EDUCATION AND DENTAL HYGIENE/ASSISTANT INSTRUCTION

	Predoctoral Dental	Dental Assistants	Dental Hygiene
Post-secondary Education	Generally eight years of study, usually consisting of four years of college followed by four years of post-graduate dental education.	Generally a high school education with either a one-year training program at a vocational-technical school or training by the dentist.	Generally two years post-high school study leading to an associate degree or certificate.
Scope & Depth of Coursework	Scope and depth of course content are at graduate level and build on a broad background in the basic and social sciences, including chemistry, biology, anatomy, physiology, physics and psychology at the college and graduate level.	Course content at introductory level in vocational-technical programs.	Course content is at college undergraduate level; basic science courses are generally at introductory level.

Terminal Clinical Competencies	Educated and examined in comprehensive dental patient care as follows:
	• assessment of the patient's general, oral and dental health and diagnosis of oral disease and oral sequelae of diseases
	• interpretation of oral and dental radiographs and other diagnostic tests
	• assessing and managing treatment needs of medically compromised patients
	• treatment planning and case presentation
	• preventive services and patient education (nearly all dental hygiene functions fall in this category)
	• pharmacology and therapeutics: management of related complications (e.g., anesthesia, pain management and antibiotic therapy
	• prevention and management of dental and medical emergencies (e.g., shock, aspiration, allergic reactions, heart attack)
	• prevention, diagnosis and management of:
	  • periodontal disorders
	  • restorative procedures
	  • endodontic disorders
	  • oral surgical procedures
	  • orthodontic procedures
	  • prosthetic procedures.
		Dental assistants perform the following functions, among others:
		• exposing radiographs
		• placing sealants
		• applying topical fluoride
		• emphasizing importance of daily care
		• assisting dentist with dental procedures
		• administration and monitoring of nitrous oxide.
			Trained to perform the following clinical dental hygiene procedures and health education functions:
			• performing prophylaxis
			• exposing radiographs
			• applying topical fluorides
			• basic life support (CPR)
			• oral health education
			• applying sealants; root planing
			• administration and monitoring of nitrous oxide.

Summary	Dentists are educated to assume responsibility for comprehensively managing the complete oral health needs of their patients. Dentists render preventive, diagnostic and therapeutic services, including management of the care of medically compromised patients.	Dental assistants' functions are a narrow portion of comprehensive dental care. Dental assisting functions are reversible. All dental assisting functions are taught with the understanding that they will be performed with the on-site supervision of the dentist.	Dental hygiene functions are a defined narrow portion of total dental care. All dental hygiene functions are reversible. All dental hygiene functions are taught with the understanding that they will be performed under the on-site supervision of a dentist.

Common Health Conditions With Important Implications for Dental Treatment*

--mitral valve prolapse
--rheumatic heart condition
--heart valve replacement
--prosthetics

knee replacements
hip replacements
metal plates
screws

--hypertension
--hemophilia
--anemia
--H.I.V. infection
--diabetes
--use of blood thinners such as coumadin, and other medications

*In any teeth cleaning procedure, bacteria enter the patient's blood stream. Healthy patients with normally-functioning immune systems can fight the bacteria without incident. Medically compromised patients, as nursing home residents frequently are, have greater difficulty fighting the bacteria. A local or a generalized infection can result. The dentist needs to be available to assess that risk and act accordingly.

"In Colorado [where dental hygienists can provide services independently], less than 5 percent of the nursing homes have relationships with dental hygienists, and in the state of Washington, only one hygienist provides services to patients in two nursing homes.

In California, where hygienists practice unsupervised under the auspices of a health manpower pilot project, Medicaid was billed only a little more than $3,000 during one year of the project, or less than 2 percent of the total hygiene billings to the Delta plan in that state.

Supervision does not appear to be a significant factor in addressing access problems."

--American Dental Association summary, 1993

American Dental Hygiene Association
1994 House of Delegates

Resolution 11 -- The ADHA advocates that dental hygienists, **as primary care providers**, be recognized by third party payors for direct reimbursement.

Statement by Fred Clark, D.D.S.
House Committee on Health and Human Services
H.B. 2304
February 14, 1995

Mr. Chairman and members of the Committee, my name is Dr. Fred Clark. I am an oral and maxillofacial surgeon here in Topeka. I am also the Chairman of the Kansas Dental Association's Geriatric Care Committee and I regularly care for nursing home residents both in my office and in nursing facilities in the Topeka area.

I appreciate being able to come here today to tell you exactly why I believe the bill before you is a simple and wrong solution to a very difficult problem.

Mr. Chairman and members of the Committee, I hold in my hands the two most important instruments there are in preventive dental care: a toothbrush and dental floss.

If you don't brush and floss each day, or have someone to do it for you, you will have gum disease and your teeth will decay or fall out. It's as simple as that.

As I said, I chair the KDA's work on improving oral health care for nursing home residents. Over the past three years, we've worked through a group we call the State-wide Task Force on Oral Health Care for Nursing Home Residents that brought together on a regular basis representatives of the nursing home industry, senior advocacy groups, government agencies, and others, to discuss how we can improve oral health care in nursing homes.

After considerable discussion, that group reached the conclusion that the single greatest dental care need of nursing home residents is daily brushing and flossing. Again, if the resident's teeth are not brushed and flossed on a daily basis, there is absolutely no hope for that patient to have good oral health.

As a result of that conclusion, the KDA Geriatric Committee increased our already considerable efforts to help the nursing home industry teach their nurse aide staffs about the importance of daily brushing and flossing. We have provided printed information to all the nursing homes in Kansas. I have personally provided continuing education for conventions of the nursing home trade groups, one in Salina and one in Wichita. I even appeared on 'The Vintage Years" on public television to push the dental health message.

I'm pleased to tell you that the KDA's work in this area was recognized with a national 'Award of Excellence' from the American Society of Association Executives. We have worked hard to carry the

message that daily brushing and flossing is essential to good oral health for nursing home residents and for the general public.

Yet here we are today with a bill that will do absolutely nothing to address the real needs of nursing home residents, since it requires nothing in the way of daily brushing and flossing and that's what is needed.

Very simply stated, if you don't get yesterday's breakfast off the patient's teeth, no amount of service by a dental hygienist, or anyone else, will do any good at all.

What are the real solutions to addressing the real oral health problems of nursing home residents?

First and foremost, we need to make sure that residents are getting the daily brushing and flossing that they need.

Are the nursing homes providing this essential care or are the nursing homes neglecting their residents? Kansans for the Improvement of Nursing Homes says that state regulations on oral care are not being enforced and residents are being neglected. The KINH ad is attached for you to look at.

My experience in the nursing homes I serve tells me that the residents are not receiving daily brushing and flossing. Yes, that is neglect. Maybe the regulators need to make sure that daily brushing and flossing is taking place in the nursing homes.

Second, we have to make sure that there is financial access to care. In other words, there simply is no free lunch.

While many dentists and other health care providers provide a lot of charity care, you just can't rely on charity care to meet the needs of the entire Medicaid population in nursing homes.

Today, there is no coverage under Medicaid for adult dental care. Medicaid patients, who are eligible, have to use a process called "patient liability adjustment" to pay for their care. To use the patient liability, the patient or the nursing home must be aware of the provision and how to use it. Using the patient liability adjustment is often not well understood and it is cumbersome. I have attached information about the patient liability adjustment.

Simply put, if you want Medicaid clients in nursing home to have access to care, you either need to make the patient liability adjustment work well, or you need to fund an adult Medicaid program. Again, there is no free lunch. Passing a bill will do nothing to increase care if there is no money available to pay for care. Care

will not appear magically, regardless of who the law says may render the care.

Third, for quality dental care to take place in nursing homes, dentists need dedicated, properly equipped facilities.

Hard as I try, it's extremely difficult to treat nursing home residents without the proper facilities and equipment. Dentists would be much more willing to treat patients in the nursing home if the nursing homes had the proper facilities. The need for a dedicated, equiped treatment facility is especially important in light of the stringent infection control requirements contained in the OSHA blood-borne pathogen standard. Kansans for the Improvement of Nursing Homes recognizes the need for separate treatment facilities. I have attached their policy statement on the matter.

The cost of equipping a dental treatment facility in a nursing home should be no more than $40,000 to $60,000. I believe a dental treatment facility should be a requirement for the home to be licensed. Without adequate treatment facilities, there is very little chance for real improvements in access to dental care in the nursing home.

Mr. Chairman and members of the Committee, the dental needs in nursing homes are great. There is no doubt about it. Solutions, real solutions, are available.

--make sure that patients are not neglected; make sure they get the daily brushing and flossing they absolutely must have to be in good oral health.

--provide the money to make dental care accessible, either through an adult dental program under Medicaid or by improving the way the patient liability adjustment works at SRS.

--encourage nursing homes, perhaps as a licensure requirement, to provide dental treatment facilities.

Mr. Chairman and members of the Committee, the greatest risk of this bill is the risk that, if it passes, people will mistakenly think that something has been done to improve dental care in nursing homes. There will then be less pressure to do what is really needed, to make the changes that are really called for, that will make a real difference in the lives of the 26,000 Kansans who reside in nursing facilities.

Let's find real solutions; let's not settle for window dressing.

Is the Kansas Department of Health & Environment doing its job?

Is it enforcing state regulations designed to protect nursing home patients from neglect?

Kansans for Improvement of Nursing Homes says NO!

Read this sworn statement, typical of recent complaints received by KINH, about the care in a Kansas nursing home.

"They don't do nothing for the mouth. It just makes you sick." (State regulation on mouth care not enforced.)

"There's one lady there that's had a stroke. She has a hard time swallowing but they just force the food into her. As fast as you get it in, she throws it right back up. They just yell at her and tell her to stop it and continue to feed her." (Resident Rights not enforced.)

"You walk through that door, the smell would knock you down. I have found the patients laying there and there is already a brown circle all the way around them. They are soaked. You've got to figure three or even four hours for them to get that way. Their skin is broke down real bad." (State regulation on care of incontinent patients not enforced.)

- Why are regulations not being enforced?
- Is it because nursing home ownership rules the roost in Kansas?
- If you don't want nursing home patients to suffer --

Ask KINH how you can help.

Political advertisement paid for by Kansans for Improvement of Nursing Homes, Inc., Margaret Farley, Executive Director, 913 Tennessee, #2, Lawrence, KS 66044 Phone (913) 842-3088

Jan 12 '95

Page 2 B of Topeka Cap-Jrnl.

17 - 4

DENTAL CARE

The lack of adequate dental care and oral hygiene is a very common problem in nursing home care though regulations require nursing homes to provide or arrange for both routine and emergency dental care and to arrange transportation to the dentist's office if necessary. Routine daily assistance with oral hygiene is too often hurried or neglected entirely by overworked aides. Medicaid payments for dental care are said by the Kansas Dental Association to be indadequate, few nursing homes have on-site provisions for dental care for those patients who are too frail to be transported and too few dentists are interested in or knowledgeable about working with the frail elderly.

Routine dental services should include instruction and supervision of aides to assure that daily oral hygiene is practiced and that residents who cannot adequately manage this function for themselves are assisted as needed. Regular cleaning and treatment should be provided. Dentures should be maintained in good condition, repaired when damaged, replaced when lost.

While overall supervision by an advisory dentist is essential, KINH believes that greater use of dental hygienists for routine cleaning and other simple procedures within their scope of practice should be permitted. Nursing homes should be encouraged to provide working space and equipment for in-house dental care.

EDUCATION AND QUALIFICATIONS

Increase and upgrade training of Activities Directors. KINH believes the role of Activities Directors has the potential for significantly improving the quality of life in nursing homes -- a potential rarely achieved. Training requirements are minimal and the role of the Activities Director too often seen as little more than a glorified aide.

Federal requirements specify the nursing home must provide "an on-going program directed by a qualified professional, of activities designed to meet the interest and the physical, mental and psychosocial well-being of each resident." The term "qualified professional" is not defined. Kansas regulations require that each home have an Activities Director but do not call for any specified number of hours per day or week for that role.

KINH believes that the importance of the Activities Director in the life of the nursing home resident should be recognized and preparation for the role should be significantly upgraded. The Activities Director should be expected to spend a specific portion of working time in that role.

Increase the Social work requirements. Kansas regulations require that the nursing home identify "the medically-related psychosocial needs of each resident" and must meet those needs either with "qualified staff" within the nur-

Post-Eligibility Treatment of Income (patient liability adjustment)

Most Medicaid-dependent residents in Kansas nursing homes can pay for medical services, including dental care, that are not provided by the state Medicaid program.

Under the little-known Post-Eligibility Treatment of Income (P.E.T.I.) provision of the federal Social Security Act, Medicaid patients with supplemental sources of income, such as Social Security and pensions, can use that income to pay for medical services, such as dental care.

The provision is also referred to as an adjustment in patient liability since it reduces the patient's liability to the nursing home. As a result, the state Medicaid program increases its payments to the nursing home by the amount used by the patient for dental or other health care services.

Roughly one-half of the residents of nursing homes in Kansas rely on Medicaid. Most of those individuals have some private income that can be accessed to pay for medical services that are not covered by the state Medicaid program. Those Medicaid patients who do not have private sources of income are limited to a $30 per month personal allowance.

Nursing homes and SRS case managers should be familiar with the patient liability provision of the Social Security Act.

5-10-94

PETI provision offers institutional care funds

Chicago—The ADA wants to tell dentists who treat nursing home patients about a little-known clause in the Social Security Act.

The clause, called the Post-Eligibility Treatment of Income, allows people in nursing homes and group care facilities to set aside supplemental income to pay for dental care and other remedial health care.

This means that in states where Medicaid does not cover adult dental care, there is still a way for adults in institutions to pay for it.

Usually, people on Medicaid who are in residential institutions must turn over all Social Security and other supplemental income each month, except for a $30 personal needs stipend, to the institution, explained Marianne LaVeille, ADA coordinator, access and community affairs.

But PETI allows people in residential institutions to set aside part of their Social Security or other supplemental income each month to pay for remedial health services, including dental care, that Medicaid does not cover. Medicaid, in turn, increases its reimbursement to the institution to compensate for the supplemental income set aside for remedial health care.

"The regulation essentially provides an indirect means for Medicaid to pay for needed dental care in states which provide limited or no dental coverage to adult Medicaid recipients," said Ms. LaVeille.

Until April 1988, Medicaid regulations required states to allow patients in institutions to keep enough of their Social Security and other supplemental income to pay for necessary medical expenses recognized under state law, said Jim Davis, a Medicaid policy analyst with the Health Care Financing Administration in Baltimore.

In April 1988, Medicaid dropped that regulation and gave states the right to restrict supplemental income deductions for remedial health care, noted Mr. Davis.

But in July 1988, Congress passed the PETI provision, which in essence restored the original regulation requiring states to allow patients to set aside portions of supplemental income for health care services not covered by Medicaid.

For example, explained Ms. LaVeille, if a nursing home costs $500 a month and a resident receives $200 a month in supplemental income, that income would be turned over to the nursing home and Medicaid would pay the remaining $300. But if the resident decides to use $100 of his or her Social Security income for dental care, Medicaid would pay the nursing home $400 that month.

Because some patients in residential facilities, such as mentally disabled people, may not understand the intricacies of the PETI provision, it's important for dentists serving these groups to research PETI provisions in their state, said Ms. LaVeille.

"Each state can establish 'reasonable restrictions' to the PETI provision," said Ms. LaVeille, "on the amount of these expenses."

In addition, paperwork and requirements differ from state to state.

For example, some states require dentists providing care under the PETI provision to be Medicaid providers; others do not. In some states, providers are required to follow Medicaid fee schedules; in others, they are not.

"It works differently in Maryland than in Texas than in Washington," said Ms. LaVeille. "So we encourage dentists, state dental directors and dental society staff to learn about this provision and find out whether it provides a viable option in their state for patients who normally would not be treated."

Dentists should check with their state Medicaid office to find out how the PETI provision is set up in their state, she said. Dentists with additional questions can call the ADA using the toll-free number at Ext. 2868. ▪

17 - 7

Official Publication

Kansas Dental Association

Vol. 79 October 1994 No. 4

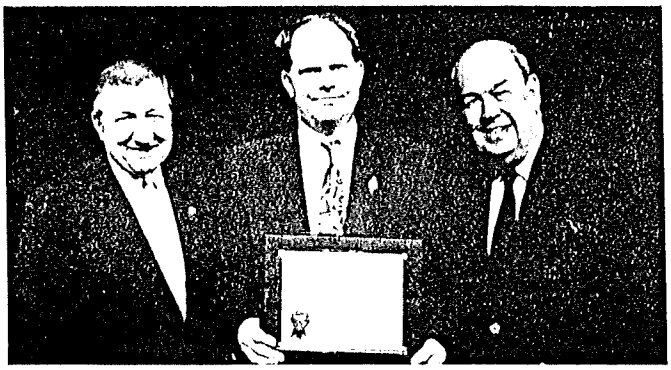
Taking Geriatrics into the '90s

KDA Wins ASAE Geriatric Award

Also in this issue:

17 - 8

Kansas Dental Association's Nursing Home Effort Wins National Award



The Kansas Dental Association's program to improve oral health care for nursing home residents has been selected to receive a 1994 ***Award of Excellence*** from the American Society of Association Executives.

The KDA's nursing home program began two years ago when the KDA Geriatric Committee called together representatives of nursing home trade associations, state regulatory agencies, and advocacy groups representing the concerns of seniors to discuss ways to improve oral health care for nursing home residents.

The group identified daily brushing and flossing as the most important dental need of nursing home residents. In response, the KDA Geriatric Committee developed a continuing education seminar on oral health care that is presented by dentists to nursing home administrators and directors of nursing. The seminar focuses on the daily oral health care techniques and oral health changes caused by the aging process and medications.

The group also agreed on the need to publicize residents' options in financing dental care. Options include the Post-Eligibility Treatment of Income (P.E.T.I.) provisions of the Medicaid program and the KDA's Senior Access program.

The P.E.T.I. provision of Medicaid, also known as the patient liability adjustment, enables most Medicaid-dependent nursing home residents to use their monthly income from Social Security or other sources to pay for dental and other health care services that are not provided by the state Medicaid program.

Under the P.E.T.I. provision, resident's monthly nursing home bill is reduced by the cost of the dental care the patient receives. The state Medicaid program then increases its payment to the nursing home by the same amount to cover the difference.

The KDA Senior Access program also increases access to care. Seniors who meet the age and income guidelines are referred by the KDA to a participating dentist who has agreed to accept a reduced fee for Senior Access participants.

Participants in the KDA nursing home effort include the Kansas Association of Homes for the Aging, the Kansas Health Care Association, Kansans for the Improvement of Nursing Homes, the American Association of Retired Persons, the Kansas Dental Hygienists' Association, the Kansas Department of Social and Rehabilitation Services and the Kansas Department of Health and Environment.

Members of the KDA Geriatric Committee are: Dr. Harold Irick, Kansas City, Chairman; Drs. Fred Clark, Mike Michel, and Robert Jackson, all of Topeka.

The ***Award of Excellence*** is sponsored by the American Society of Association Executives and recognizes associations' contributions to society. Forty-two award winners were selected from among 240 entries submitted this year.

For more information on the P.E.T.I. provision or the KDA Senior Access program, please call the KDA office at 913/272-7360 or 1-800/432-3583.

Post-Eligibility Treatment of Income

(Patient Liability Adjustment)

Most Medicaid-dependent residents in Kansas nursing homes can pay for medical services, including dental care, that are not provided by the state Medicaid program.

Under the little-known Post-Eligibility Treatment of Income (P.E.T.I.) provision of the federal Social Security Act, Medicaid patients with supplemental sources of income, such as Social Security and pensions, can use that income to pay for medical services, such as dental care.

The provision is also referred to as an adjustment in patient liability since it reduces the patient's liability to the nursing home. As a result, the state Medicaid program increases its payments to the nursing home by the amount used by the patient for dental or other health care services.

Roughly one-half of the residents of nursing homes in Kansas rely on Medicaid. Most of those individuals have some private income that can be accessed to pay for medical services that are not covered by the state Medicaid program. Those Medicaid patients who do not have private sources of income are limited to a $30 per month personal allowance.

Nursing homes and SRS case managers should be familiar with the patient liability provision of the Social Security Act.