Statement for the record against Kansas Senate Bill (SB) 312

Licensure of Dental Therapists

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By

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Thank you for the opportunity to enter a statement for the record on this important public health issue. Please note my resolute opposition to SB 312 on the licensure of dental therapists in Kansas. There is no evidence that suggests that dental therapists would improve the oral health disparities and access to care for underserved populations in Kansas. If this unsubstantiated model of dental care is established and resources are allocated to these endeavors, our underserved communities will wait even longer for a real solution that has lasting impact and significance.

Access to Care

- Dental therapists are not the solution to access to dental care for underserved Kansans

Proponents of the dental therapist bill 312 suggest that it will expand dental services to underserved communities. Yet, there is no language in the Kansas senate bill that identifies a term of practice for a dental therapist in a designated health professional shortage area. There is no language in the bill that specifies that population data will be used to ensure Kansans have access.

Let's look to a state that has implemented dental therapists and see if access has changed. Minnesota adopted a dental therapist model in 2009 and the first graduates began working in 2011. The dentists in the state along with the American Dental Association opposed the legislation for reasons such as concerns for patient safety and they argued that Minnesota had sufficient dentists in the state to provide care. This is similar to how the dentists in Kansas have opposed mid-level provider legislation for 9 years.

A five year retrospective study on dental therapists was conducted as required by Minnesota law titled "Early Impacts of Dental Therapists in Minnesota". In the three year span of the study (2011 to 2013), 6,338 new patients were seen by 32 dental therapists. Since the 32 therapists worked different time periods each week, their full time equivalent was 7. The average patients seen per week by dental therapists averages out to 4 patients per week. An average pediatric dentist sees 115 patients per week. Evidence is lacking to say the least that dental therapists are making an impact.

Included in this statement is a map of the counties in Minnesota served by dental therapists from the Academy of General Dentistry 2016. The map includes "designated" and "not designated" health professional shortage areas. Twelve of the 42 dental therapists (29%) are practicing in Hennepin County. Hennepin County, is home to Minneapolis, the largest city in the state, and is known for the best suburbs to raise a family. Dental therapists that practice in the Twin Cities account for 73%. The maldistribution of providers doesn't bode well for access. Dental therapy is still in it's early stages, so workforce migration is not yet in full force.

Impact on oral health

- Unintended consequences

What are the implementation costs of sustaining a mid-level provider system? The economics on this issue are not in the literature. The costs associated with dental therapist accreditation will necessitate further allocation of resources from Kansas Dental Board services, licensing, and examinations. Finding faculty for *existing* dental schools to educate dental professionals is difficult at best. Additional faculty members will be required for dental therapist education. This will inevitably create shortages in faculty positions for dental education. If dental therapists are going to do the simpler procedures so that dentists can focus on the more complex procedures, we need to understand the ramifications of shifting educators away from dental education. Will there be adequate training for the complex procedures?

The W. K. Kellogg Foundation along with other third party organizations and news agencies have issued reports touting the success of the dental therapist. Their reports are largely commentaries and opinions and make broad-based conclusions. The focus is often on the perceived technical competence of the dental therapist while avoiding the actual impact on oral health. Improvements in oral health in populations treated by dental therapists should be compared with improvements in populations treated by dentists.

Existing dental care system has untapped capacity

- Kansas is not lacking in qualified dentists.
- Hygienists with Extended Care Permits are part of the solution.

Statistics from the Kansas Dental Board indicate a steady rise in active licensees with Kansas practice locations and this includes general dentists and specialists. The number of pediatric dentists in the state has increased from 33 in 2011 to 46 in 2016. That's a 28% increase in 5 years. The American Academy of Pediatric Dentists report 70% of their members accept Medicaid in their practices. In Wichita, 9 out of 10 pediatric dentists are treating Medicaid-eligible patients. Focus on expanding the dental team to include hygienists with extended care permits is needed to improve access to dental care and to fully utilize the training programs already available in our state.

The American Dental Association has advocated for the science of dentistry and public health since 1859. In a news release from February 2017 titled "ADA Responds to News Coverage of Dental Therapists", access to care is addressed. The ADA states, "There is no available data that demonstrate new models that replicate what dentists already do well have increased access to care at a lower cost. Data from the ADA's Health Policy Institute (HPI) indicate the current number of dentists will continue to grow through 2035 and outpace population growth. In addition, more than 27% of dentists indicate they have the capacity to add more patients."

Dental therapists may have difficulty finding employment in Kansas. In Minnesota, dental therapist graduates are having trouble gaining and sustaining employment. This excerpt from "A Review of the Minnesota Dental Therapist Model" is telling: a "25-year-old dental therapist from the University of Minnesota, with more than $80,000 of student loan debt, commented: 'I graduated in 2012 and was unable to find a job until fall 2013. The clinic cut my job after only four months. They had originally hired me because of a grant incentive.'" When the grant money runs out, the return on investment is in question, or the rural servitude is complete, the position is no longer utilized.

Increasing Medicaid reimbursements

- This is a part of the solution for increasing utilization of preventive dental services and decreasing unmet oral health needs.

In Minnesota, dentists and dental therapists are reimbursed at the same rates. The state is not saving money on dental procedures. They are not saving in emergency room dental related visits either.

Senator Schmidt says the state of Kansas cannot encourage increased reimbursements until there is more solid financial footing. If we lack the funding for Medicaid reform that actually presents a real solution, why would we reallocate existing funds and assign new funds for a non-solution?

We don't need a dental therapist in Kansas. Alaska, with its state wide distances between providers, has very different challenges that appear to be met with the dental therapist. In Kansas, where our distance between providers is much less, need to look to states such as Texas, Maryland, Michigan, and Connecticut and gain knowledge from their evidence-based solutions to reform state Medicaid programs that increase dentist participation and access to care. When compared to control groups of children in other states that had the same Medicaid policy through 2007 to 2012 to groups of children that lived in states that increased dental fees paid to Medicaid providers, the children in states with Medicaid reform had increased utilization of oral health services and decreased unmet dental needs. In Texas, the utilization of preventive services increased by 17% in Medicaid-eligible children, by 6.2% in Connecticut, and by 5.3% in Maryland.

Kansas has enough dentists to provide care to the underserved, but they cannot afford to. With Medicaid reimbursement at $0.40 on the dollar, this does not pay their practice overhead. Private insurance reimbursements are above $0.70 and higher.

Summary

The last dental therapy school in Canada was closed in 2011. The reasons are complex yet noteworthy. The federal government in Canada discontinued funding for several reasons including inability to effectively recruit dental therapists to public service due to higher salaried positions in the private sector, resistance from organized dentistry, and the lack of return on investment related to dental therapist education programs.

The dental therapists in Canada were choosing to practice in the private sector. What makes SB 312 different? Dental therapists are not the solution for the underserved populations in Kansas. Even with dental therapists, the issues of low reimbursement are ever present. Corporate Medicaid clinics will create a market that draws therapists out of the rural areas and back to the private sector.

I ask that you oppose SB 312 in favor of continuing to work toward the very best oral health solution for our underserved children and adults. I appreciate your time and thank you for your commitment to the residents of Kansas.

References

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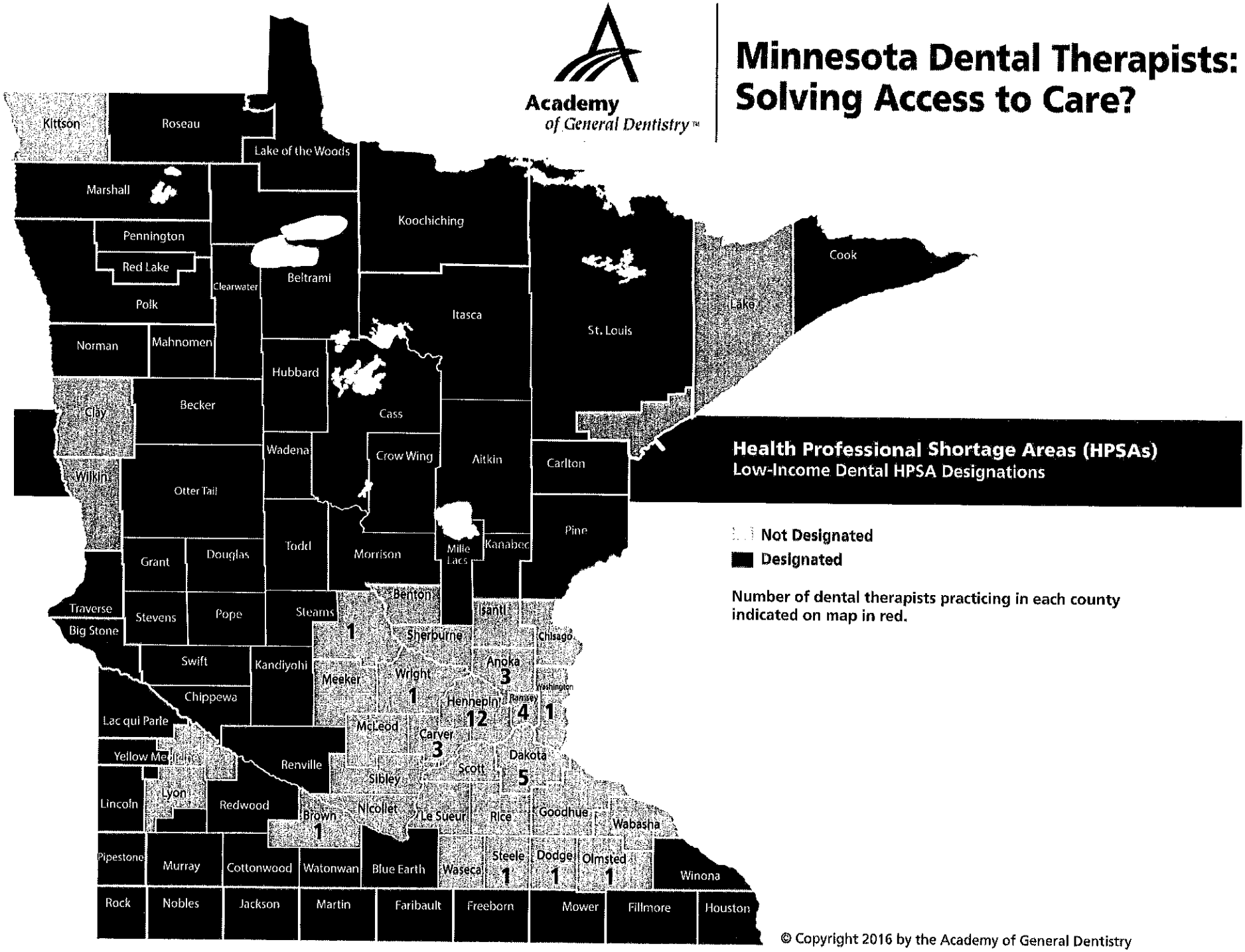
Minnesota Dental Therapists: Solving Access to Care?



Health Professional Shortage Areas (HPSAs)

Low-Income Dental HPSA Designations

Not Designated

Designated

Number of dental therapists practicing in each county indicated on map in red.