Date: March 7, 2018

To: The House Committee on Health and Human Services

From: Dr. Nick Rogers, President, Kansas Dental Association and Practicing Dentist in Arkansas City for 39 years.

RE: **Support SB 312 – Dental Therapist Compromise Bill**

Good afternoon Chairman Hawkins and members of the Committee,

I am Dr. Nick Rogers, President of the Kansas Dental Association and for 39 years have been a general dentist in Arkansas City. In addition to my private practice, I served as Region VII Head Start Oral Health Consultant as a part of the American Academy of Pediatric Dentistry's Head Start Oral Health Initiative's grant for three years. My practice also includes two other dentists which are my son and my daughter-in-law. Our practice has worked hard to provide access to quality dental care for those we serve. In addition, we accept **ALL** children, 19 and under with medical cards (both Title XIX and Title XXI). We also have a disproportionately large number of patients, both adults and children, with special health care needs. We support the local Head Start Program by providing dental care to their children regardless of ability to pay.

Arkansas City has a significant population from a lower socio-economic level as well as a growing minority population. According to Dr. Ron Ballard, superintendent of Arkansas City schools, 71% of the children in Arkansas City are on the free and reduced lunch program (61% free and 10% reduced). In addition, Arkansas City has a large number of citizens with special health care needs since the closing of the state hospital in our county in 1985.

My daughter-in-law, Dr. Nicole Rogers, has created a school program in conjunction with the Kansas Department of Health and Environment's Bureau of Oral Health. In short, the objective is to establish dental homes for children in need, but also includes providing preventive care to

those children that do not currently have access using portable dental equipment within the school setting. The data gained is shared with KDHE.

The reason for the longer introduction is to demonstrate that our practice shares the same desire to increase access to oral health as the other proponents of the SB312. With the experience that I have gained in providing care for those that have limited access to dental care, I feel the lack of direct supervision provided to the proposed dental therapist in the past bills would not allow them to provide safe dental treatment. Those that do not access dental treatment, for whatever reason, usually represent a medically, emotionally and socially fragile population. With this fragile population, unexpected circumstances arise regularly. I, as well as my staff, have had to seek and continue to seek training to improve our care and address to overcome the continual unexpected obstacles and challenges that we encounter in providing treatment for this fragile population. With the limited amount of training provided coupled with the fact that in previous bills that there may not be a dentist present to manage the possible complications increases the danger to the patient has previously been a concern.

In January of this year, the Kansas Dental Association voted to support SB 312 overwhelmingly. When presented to the Executive Committee, the vote was 5-0-1 in support of the bill. It was then passed on the governing body of the Kansas Dental Association, the Board of Delegates, where it passed 32-2 to support SB312. I personally support SB312 and the decision of the Kansas Dental Association to support SB312.

With the current proposed model, the supervising dentist will be on the premises to assist in an unexpected circumstance or an undesired outcome. The supervising dentist can also supervise only 3 dental therapists assuring adequate coverage if an emergency should arise assuring the patient's safety. One of the procedures allowed is the removal of "primary teeth" with 50% root resorption. Primary teeth, with the roots intact, can be some of the more difficult teeth to remove due to the divergent roots which are much greater than those of permanent teeth. Many times it is necessary to surgically section the tooth for removal and the frequency of fracturing the tip of the root is great. This cannot be predicted even with X-rays. The determination of an "easy extraction" can only be made retrospectively. With the current restriction of 50% root resorption

minimizes the risk of complications and if they should occur, the dentist will be available to assist.

SB 312 as written would allow dentists to practice “at the top of their profession”. The dentist would provide treatment for the harder cases while the dental therapist will provide treatment for the “simple” procedures and cases. If the proposed position is used in such a manner, a dental practice has the ability to increase the number of patients receiving dental care. This would further increase access to dental care.

The current dental statutes allow our dental auxiliaries along with the dental therapist, to preform many procedures. With the current low reimbursement from Medicaid, I must fully use the auxiliary that I work with to maintain the costs of overhead and at the same time provide quality care. With the use of the Extended Care Hygienists and the dental therapist, I will be able to increase the treatment in our school outreach program as described above as well as providing dental treatment to those patients confined in nursing homes. All of the treatment performed by the axillary personnel (assistants) is done within the scope of the dental practice act and under **DIRECT** supervision allowing the dentist the opportunity to intervene if unexpected circumstances should occur.

The Kansas Dental Association continues to work to increase access to dental care within the state. The KDA, in partnership with Delta Dental and Kansas Dental Charitable Foundation, created the KIND (Kansas Initiative to New Dentists) scholarship program, which is privately funded and has successfully located dentists in areas of Kansas that are designated need areas for the past several years. Currently, these dentists are increasing access to dental care in places that previously were underserved. With the utilization of a dental therapist created by SB 312, even more patients would receive care in these offices.

I believe the most important part of this legislation is that this bill calls for the department of health and environment and the Kansas dental board to submit a joint report to the legislature on or before the first day of the 2030 regular session of the legislature that details the effects that enactment of sections 1 through 3, have on access to dental care in rural Kansas, including, but

not limited to: The number and geographical distribution of practicing dental therapists; the number of dentists supervising dental therapists; the number of participating Medicaid providers; the treated and untreated tooth decay rates of Medicaid beneficiaries; urgent need rates; and federally designated dental health professional shortage areas. Allowing this bill to work without changes in the scope of procedures will allow for an impartial study on the effectiveness of this newly created position.

I am dedicated in working to improve access to those who have the least or are most challenged to receive dental treatment, but I believe it should be the best dental care possible that is supervised, accomplished effectively, efficiently, without sacrificing quality. I believe this can be accomplished with SB312 and the newly created dental therapist that will be available to the dental profession. I would urge the Committee to support the proposal.

I would like to thank the committee for your time to hear my concerns. Thank you.

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