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THE PRIMARY CARE ASSOCIATION OF KANSAS

Kansas Action For Children

Senate Bill 312 Neutral Testimony
Senate Public Health and Welfare
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Denise Cyzman, Executive Director, Kansas Association for the Medically Underserved
Annie McKay, President & CEO, Kansas Action for Children

Chair Schmidt and Members of the Committee:

Thank you for your willingness to consider strategies to ensure every Kansan receives regular, high-quality dental care. The Kansas Association for the Medically Underserved (KAMU) and Kansas Action for Children provide leadership for the Kansas Dental Project, a collaborative effort by Kansas citizens, community leaders, and health care professionals to address the dental workforce shortage and improve access to dental care in rural and underserved areas. This project's goal has always been to ensure more Kansans can get needed dental care. As we asses any new proposal, we evaluate whether it will expand access to care beyond current law.

All of the clinics that KAMU serves provide primary, dental, or behavioral health care – or some combination – to all Kansans regardless of who they are, where they live, how much money they make, or if they have health or dental insurance. Of the 44 member clinics served by KAMU, 30 provide dental services, including three clinics that are solely dedicated to providing dental care. KAMU member clinics are an essential component of the dental delivery system in Kansas. Collectively, they are the largest dental care system that serves uninsured and Medicaid beneficiaries in Kansas. In 2016, these clinics provided dental care to more than 93,000 Kansans. They also treated thousands of children in schools across the state. That sounds impressive, and it is. Sadly, it does not begin to touch the unmet need for oral health care services.

KAMU member clinics need dental therapists to meet the demand for dental care. Between 2012 and 2016, KAMU clinics experienced an increase in more than 18,000 dental patients. During that time, the number of dentists employed by the clinics decreased by three FTE positions (although numerous clinics are seeking to fill open positions). Safety net clinic dentists see an average of 2,300 patients annually. Compare that to 1,500 – the optimal number of patients seen by a private practice dentist according to AFTCO Transition Consultants. **Our member clinics see the need for increased access to dental care every day and feel the burden of not being able to fully meet that need.** Let us not forgot, we are not just talking about numbers here. We are talking about newborns, children, young adults, adults, and senior Kansans. We are talking about the ability of Kansas children to learn and thrive; giving our adults the best chances to be employed; assuring our babies are born healthy; and allowing our seniors to grow old gracefully and with dignity.

Does Senate Bill 312 expand access to care? It does, but not to the extent it could. **KAMU member clinic CEOs and their dental providers believe that the supervision restrictions in**

Senate Bill 312, as written, will prevent meaningfully expansion of access to care. In Senate Bill 312, **"direct supervision"** is defined to mean the dentist **in the dental office** personally **diagnoses** the condition to be treated, personally **authorizes** the procedure and, before dismissal of the patient, **evaluates** the dental therapist's performance. That is, the dentist must be on site and involved in the care of each individual patient before and after the dental therapist delivers care. By contrast, **"general supervision"** means that a dentist can be off-site while dental therapists provide the care within their authorized scope of practice. General supervision allows dental therapists to bring care to settings where dentists are not available. Without doubt, general supervision provides the greatest chance of meeting the unmet need.

In Senate Bill 312, certain procedures – including drilling and filling cavities – may **only** be performed with direct supervision, for the duration of the dental therapist's career. One alternate is to consider requiring direct supervision for a set number of hours (500 hours or more), allowing the dentist to carefully monitor the safety and quality of the dental therapist's work before they can perform the procedures under direct supervision. Of course, if the dentist is not comfortable with the dental therapist's work after the 500 hours, an extension can be required. This is what has been proposed in previous legislation to establish dental therapists, and what is in place in other states.

If dental therapists cannot practice without directly involving a dentist while they are delivering needed care, we will not see significant improvement in access to dental care. For that reason, the Kansas Dental Project is currently working to seek agreement with the Kansas Dental Association, the Kansas Dental Board, and policymakers to clearly define "direct supervision" as having a dentist in the office or on the premises and involved in a way that maximizes access to care while assuring the provision of high-quality care. **With that change, and alignment with the current extended care permit hygiene scope of practice, Senate Bill 312 will represent one step forward in Kansas' journey to improve access to dental care.**

We are concerned that this legislation does not expand access to care to the same extent other proposals have and, as such, will not meet all the needs of all the Kansas Dental Project coalition members. In particular, we are mindful that any supervision restriction that requires a dentist to be on-site means that dental therapists will not reach underserved areas that do not have dentists available, limiting care in rural areas, schools, nursing homes, and other long-term care facilities and service centers.

However, our organizations believe this legislation is a good starting point for establishing a dental therapy provider in Kansas and improving access to oral health care services. We appreciate your willingness to consider this issue and urge you to consider our recommendations regarding supervision for dental therapists.