KS Senate Health and Public Welfare Committee
Thursday, February 1, 2018; 9:30 AM
Room N-118, State Capital, Topeka, KS

My name is Nancy Lusk from Overland Park, and I represent the 22nd District of the Kansas House. I am here today to encourage committee members to take a deeper look and you weigh the merits of this proposal.

I wasn't sure whether to testify as a neutral or in opposition today, and finally I have decided to be neutral. The main thing that I hope to accomplish today with my testimony is to encourage all of you to step back and take a deeper look.

Last year after the hearing on the dental therapist bill in the House Health Committee, I gathered up all of the testimonies and really thought about what the Kansas Dental Project proponents had to say. There was so much that I AGREED with.
Is dental health critical to overall health? YES
Would improving availability and access improve overall health outcomes? YES
Does our state have an oral care crisis? YES
Do we need to find a way to significantly improve dental health care for the underserved? YES
Do we want to insure the safety of dental care given? YES
Do we want to make sure that all receive quality dental care, the same level of dental care?
YES, this is important. The poor, those on Medicaid, and those living in rural areas are not inferior people, and do not deserve an inferior, sub-level of care.

I see this as a **multifaceted problem** and personally think it **will take a multifaceted solution**. There are transportation issues. There is a reluctance with many of the poor to go to the dentist. **Medicaid reimbursement rates that only reimburse 35% of the costs are a significant part of the problem.** These are just a sampling of the barriers which need to be analyzed. But all the energy to expand dental care in this state has been focused on only one possible solution for the last eight years.
Create a sub-level Dental Therapist program, even though it addresses none of the things I just listed.
My frustration in reading through last year's testimonies was they left out a lot of information that is necessary to have a full understanding and is necessary to thoroughly vet the dental therapists bill. The great majority (over 30) of the testimonies DEFINED, at length, why dental care is so important to overall

health, and the need to increase the dental care workforce in Kansas but did not explain why the merits of this specific program made it a good solution.

Then there were about half a dozen testimonies which did make further arguments why dental therapists will improve outcomes, which I researched and attempted to vet, and I will list them here.

Claim: The Dental Therapy program has been accredited by CODA, the Commission on Dental Accreditation.
CODA is the accrediting body for all dental programs, including dentists. But CODA did not and has not yet accredited the standards adopted in Minnesota or other states – they only temporarily *APPROVED* them, which is an important distinction. Any new dental education program, which can also be a new college for dentists, is not accredited when it is first established. There is a process of reviews and site visits to judge the work of its graduates, and in general, hoops that must be jumped through.

The Dean of the UMKC serves on one of the CODA review/licensing groups. She told me the that none of dental therapist programs in the states have been *implemented* by CODA yet. Some say that the two programs in Minnesota started in 2009 will probably be accredited by 2020, but CODA has *not* signed off on implementing its accreditation yet.

So how can there be already practicing dental therapists in other states? States may pass laws to make it legal for dental therapists to practice within their state boundaries, and therefore bypass the need for CODA accreditation (though they do so with the assumption that accreditation will eventually come). But when that happens you have a situation where the initial non-reversible judgement to establish dental therapists in a state is being made by politicians, not the expert professionals in the dental field.

If you have any curiosity about the political drama behind the writing of the dental therapist standards passed in Minnesota, I recommend reading **" A History of Minnesota's Dental Therapist Legislation – Or…What the Heck Happened Up There?"** by the MDA (pages 21-22). The reason why Minnesota has two significantly different dental therapist programs is because there was a political battle and throwing in both was the final compromise.

Claim: Dental therapists have been a great success for many years and in many other countries. The U.S. is behind the times. Dental therapists have been proven to provide quality care according to a 2012 expert review of over 1,000 studies and reports.
I went to the link provided in the testimony and researched this claim. Talk about comparing apples to oranges – these programs varied widely, with some only requiring a couple of years of postsecondary education, and generally, they did not have the scope of practice being proposed in this legislation. The publication date was 2012 and the "over 1,000 articles" in the report did not include the first major dental therapist program in the United States, because the Minnesota education program had just started and there were no graduates from it in 2011, when the articles were collected.

An investigation by University of Minnesota School of Dentistry found that the standard of care provided by dental therapist programs in Canada, present day New Zealand, and England "is not consistent with the standard of care provided here in the U.S. Their care delivery systems, educational costs and

geography are very different from ours. These differences must be taken into account when comparing . . . naïve to think that one is simply comparing "apples to apples."

Claim: Most dentists are opposed to this proposed bill because they fear it will impact their turf. They do not want the competition.

It is true that most dentists oppose setting up dental therapists, but is the real reason really to protect their turf? I am not a dentist, but I find the blanket assumption that dentists as a group are only focused on their own self-interests offensive. That is not my experience. Here are the pictures of the four dentists with whom I have talked at length about this issue, and each is anything but self-centered, and all are genuinely concerned about the quality of care that will be delivered.

Dr. Norma Moore, DDS
(She practices in Wichita)

Dr. Susan Cope, DDS
(My dentist & Norma's classmate at UMKC)

Dr. Lindy Cope, DDS
(Dr. Susan Cope's daughter)

Dr. John Fales, DDS
(He favors SB 312)

I have also talked with a least a dozen dentists when they have come once a year to Topeka, and **the dentists have been consistent – their objection has been about five or six specific procedures** in the bills proposed over the past several years. They have wanted to pull back those procedures because they believed they would be beyond the scope of the level of training the dental therapists received, as defined in the legislation. **Because cutting a tooth to prepare it for restoration is irreversible "surgery."**

Here is the list of procedures that Dr. Norma Moore thought went too far in last year's bill, and her explanations of why, which I have paraphrased. (I realize that not all of these procedures are still listed in SB 312 and SB 308, but I have included them all, because this goes to the question of credibility, the question of the legitimacy of the dentists' concern for quality care).

Page 3, Section 2, c:

- Line 25, (14) **Tooth re-implantation and stabilization.**
  These are teeth knocked out from trauma, generally a bloody mess (maybe from a car wreck or sporting accident). The therapists will not have done a full oral surgery rotation to have the knowledge/education to adequately evaluate the surrounding bone for fractures and soft tissue trauma. The "bloody mess" makes it difficult to bond and stabilize the tooth.

- Line 33, (18) **Diagnosis of dental decay and periodontal disease.**
  If the argument for saying this procedure should be included for dental therapists is that the overseeing dentist will be there and will be able to do a backup diagnosis, then why is this procedure needed in the bill? – because if the dentist is going to do backup, this procedure doesn't need to be listed.
  And if dental therapist is at another location, there are obvious problems with allowing this because he or she will not have had the depth of training/education to make such judgements (like how to recognize that a funny lesion on the roof of a mouth is actually a sign of an abscess that cannot be seen via Skype).

- Line 36, (20) **Extractions of primary teeth.**
  Most baby teeth fall out easily. A baby tooth that does not come out easily and requires a visit to a dentist can be caused by the following complication – sometimes the roots of the baby tooth have not been reabsorbed by the permanent tooth pushing up from below. Sometimes a root of the baby tooth will be pushed to the side of the new tooth and will break off under the gum. The residual roots can be very difficult to remove.

[“Preparation” means cutting away the tooth structure].

- Line 1, (24) **Preparation and placement of direct restoration [filling teeth] in primary and permanent teeth.**
  It is extremely important that those who will be performing these procedures learn not only how to take away enough of the decay to get rid of it, but also learn out to not grind away more of the teeth than is absolutely necessary.
  *How many hours of **actual clinical** operative dentistry, (tooth preparation and filling) will they have had? Clarify what they mean by “clinical hours” – consider the quality of the training. Dentists have four years of clinical training starting their freshman year in dental school.*

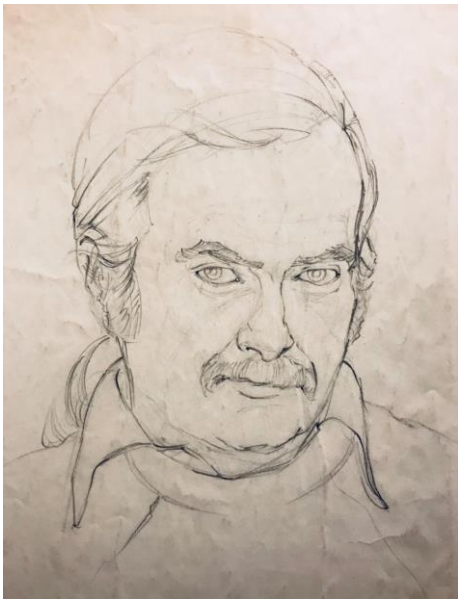
- Line 4, (26) **Preparation and placement of preformed crowns on primary teeth**.
  Primary teeth can be harder to do than permanent teeth because the shape of primary teeth with the widest/thickest point of the tooth being the middle, compared to the widest/thickest point of the secondary tooth being towards the top [giving the crowns something to hold on to without sliding off].

- Line 13, (34) **Prevention of, identification and management of dental and medical emergencies.** *The therapists will not have depth of knowledge/training/education to adequately evaluate and manage their way through the multi-layers of problems that might need to be solved in many crisis situations.*

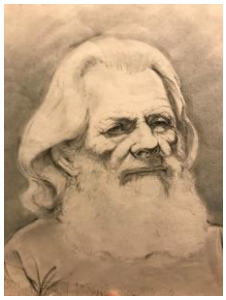
In summary, Dr. Moore said, "We are DDS's, Doctor of Dental Surgery. We diagnose and devise a treatment plan, which usually involves surgery of soft tissue, teeth, and/or bone. No one I have visited with who graduated from dental school ever said, 'I learned way too much and received way too much experience in dental school to perform dentistry.' No one with less than enough experience should be preforming dental surgery on patients i.e. cutting dental preparations.”

Claim: Dental therapists are the equivalent of nurse practitioners, which is a similar workforce model.
Nurse practitioners are advanced practice registered nurses (RNs) who must obtain a four-year bachelor's degree in nursing, pass the RN exam, obtain a nursing license, have one or two years of nursing experience, complete a one-to-three year master's program or equivalent in a nursing specialty, and then they may apply. This is more education than what is required of the dental therapists in SB 312.

Dental therapists are not like nurse practitioners, because dentists are not like doctors in a significant way. Both doctors and dentists need to be in command of a great deal of medical knowledge to know how to diagnose and determine treatment for their patients. But in addition, dentists must master the fine motor skills necessary to execute the procedures. Think of the practice that a violinist or pianist must do. Or the practice and training necessary to master a good golf stoke. There is an important mental connection to motor control that come from training. And this is where I can relate to dentists.



My college degree in fine arts trained me to be an illustrator. Here are examples of drawings I drew in drawing classes – not from photos but of live models. It took many hours of practice before I could totally control in my hand what I saw and wanted to translate to the paper.



But I can only draw with my right hand and not my left. Same brain, but the practiced motor skills are only in one hand.

A nurse practitioner must only have the knowledge of her profession in her head. A dental therapist, like a dentist, must earn muscle memory from operative experience to gain the delicate hand skills needed.

For a good comparison of a dental therapist and a new dentist, see the Testimony of Anthony J. Hilleren to Health Services Committee which I have included in the testimony I am presenting. (More about his testimony later).

Claim: Dental therapists will have more clinic hours in learning how to do specific procedures than the dental students receive, and therefore will be as proficient, if not better.
Separating the training into silos to measure it seems like a distorted way to make the comparison. Will they really have had sufficient operative experience to perform the scope of practice set up in the bill? I haven't had the time to research and pin down the exact hours to hours comparison, and still plan to look into this question.

This I do know. When I toured the UMKC School of Dentistry, I learned that dentist students spend their first two years working on models of teeth before they are ever allowed to work on real patients. All those clinic hours should be included in any comparisons between the number of clinic hours in the education programs of dentists and dental therapists.

Included in my packet is a **testimony given by Dr. Marissa Goplen, DDS**, for a September 2016 dental therapist hearing in the North Dakota legislature. She tells of the difficulties the dental therapist students had in completing the pre-requisite clinic hours for graduation at UM.

Claim: There have been no problems with the work of dental therapists because there have been none reported.
There is an obvious extreme incentive for dentists to not report any failures of their dental therapists and to repair any problems so that the patients do not choose to report them either. Of course, because they do not want to lose their licenses.

I wish to present the **testimony of Dr. Anthony Hilleren, DDS.**
It is directly relatable to SB 312. He presented it to the North Dakota Health Services Committee in September 2016 to share his experience in hiring a dental therapist in his practice in Minnesota. He was not worried about protecting his turf. He embraced the concept of dental therapist and hired a top DT graduate. Unfortunately, it was immediately evident to Dr. Hilleren that his dental therapist's experience was extremely limited.

Please read his testimony. It encapsulates the many apprehensions dentists have had about the expanded scope of practice given to DT's. And it is directly relatable to SB 312 as it exists now. If the DT education program (approved by CODA) was sufficient enough to train dental therapists for their scope of practice, then how do you explain Dr, Hilleren's experience?

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The primary goal of the Kansas Dental Project is to increase dental care to the underserved.
Good goal . . . but will the dental therapists program deliver improved outcomes?
The Minnesota evidence suggests "no."
Looking at the numbers in the two following charts, one can see that **the dental therapist program in Minnesota has not improved overall access to care there.** It shows that utilization has consistently declined in MN since 2012. This isn't a precise linear trend, but overall utilization is trending down year over year.

2012 – 2016 Dental Utilization Analysis in Minnesota

SFY	Payment System	Unique Dental Eligible Enrollees	Enrollee With Any Dental Svc	Pct of Enrollees with Any Dental Svc	With Any Preventive Svc	Pct of Enrollees with Any Prev Svc	With Any Restorative Svc	Pct of Enrollees with Any Restoratv Svc	Legislative action
2012	FFS	233,703	78,991	33.80%	53,227	22.78%	43,268	18.51%	3% rate reduction from 9/1/11-6/30/13, Changed CAD designation- to only the U of m and MnSCU , reduced CAD pmt for Mncare from 50% to 30%.
	MCO	654,390	288,937	44.15%	223,505	34.15%	151,268	23.12%	
2013	FFS	207,850	65,422	31.48%	45,518	21.90%	34,671	16.68%	
	MCO	690,872	300,009	43.42%	231,758	33.55%	155,013	22.44%	Increase CAD from 30% to 35%
2014	FFS	258,503	69,736	26.98%	49,352	19.09%	37,580	14.54%	CAD rate increase from 30% to 35%. Added benefits: house/extended facility call, adult prophy for up 4 times/year, behavior mgmt, add CAD for priv't practice - 55 new providers were added as a result.
	MCO	789,184	320,825	40.65%	246,914	31.29%	167,099	21.17%	
2015	FFS	268,616	73,115	27.22%	51,833	19.30%	38,548	14.35%	
	MCO	943,068	367,069	38.92%	280,297	29.72%	195,249	20.70%	5% base rate increase
2016	FFS	260,831	71,255	27.32%	51,938	19.91%	37,497	14.38%	9.65% rate increase for providers outside of seven county, removes the self-restriction requirement for private pay dentists enrolled in the critical access dental program, and increases CAD reimbursment by 2.5%
	MCO	956,119	367,349	38.42%	284,718	29.78%	195,375	20.43%	

FFS stands for Fee For Service. That is the base rate that is paid directly by MN Dept. of Human Services to a provider rather than through a capitated rate via the Managed Care Organizations for public program enrollees who have dental care though one of the Managed Care Organizations administering the Medicaid dental benefit.
CAD = Critical Access Dental Provider, which is a provider that receives the 37.5% add-on payment if they see over 50% Medicaid per year or 25% outside the seven county metro.

Dental Access By Plan (FFS is Included) (SFY2016)

Description	Total Recipient Count	% with Any Dental Service	% with Any Preventive Service
Medica	351,563	34%	26%
Fee-for-Service	292,762	25%	18%
Blue Plus	276,672	38%	31%
UCare	226,895	32%	23%
HealthPartners	112,501	39%	30%
PrimeWest	44,800	41%	32%
SCHA	43,374	38%	30%
HennHlth	12,790	22%	10%
Itasca MC	9,900	46%	36%
MHP	2,825	39%	19%
	1,374,082		

This document gives an overview of the access numbers by plan for each MCO (Managed Care Organization). You can see that overall, less than half of Managed Care enrollees across all of our health plans received any dental service in 2016. It is less than 40% when you look at any preventive service (prophylaxis).

The numbers for MCOs have gone up because we continue to add more and more Minnesotans on public programs through changes in eligibility requirements (increasing % of federal poverty for eligibility etc.), therefore the enrollee numbers for the MCOs administering the Medicaid dental benefit continues to rise. However, this does not mean that utilization has gone up.

* * * * *

Medicaid only pays for the first dentist/procedure done – not for the second.

The business model for dentists is like no other, because it is much more expensive than it is for any other professional. The average cost for a dentist to set up a practice is around $500k, according to these articles:
http://www.dentistryiq.com/articles/2014/09/starting-a-dental-practice-how-can-you-afford-it.html
Ihttp://www.dentaleconomics.com/articles/print/volume-105/issue-4/science-tech/starting-your-own-dental-practice-keeping-the-debt-load-to-a-minimum.html

This may surprise you, but despite the evidence I have presented, I am NOT taking a NO-NEVER position against having a mid-level dental therapist professional.
I recognize that there has been some success with DTs in some instances in Minnesota.

Commented [NL1]:

I think it will help to understand what worked in Minnesota and why, and what did not work and why. I have a resource of Jeanne Larson, who is the executive director of Northern Dental access. It is a rural, nonprofit community clinic with dentist recruitment challenges in far northeast Minnesota. Jeanne has evidence to demonstrate the potential of a possible dental therapist profession. But she also understands the education, scope of work, and supervision issues that have remained problematic. She has shared her balanced perspective in her memos on the issue and that is the final item in my packet of testimony.

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I still have doubts that SB 312 will increase the access of dental care for the underserved as promised. I still have reservations that the education requirements will fully deliver the skills needed for the scope of practice. But after further discussions about the bill, I recognize that it is a significant improvement over pass proposals.

Looking to the future, I think both the supporters and non-supporters of SB 312 can agree that we still have many dental care issues to resolve. Fully solving dental care access is a multi-layered challenge. Please do not assume the job is done. Extremely low Medicaid reimbursement rates, the trust issue, transportation problems, the dentist shortage, and the list goes on.

I hope that sometime in the near future there might be a Dental Care Task Force similar to the Mental Health Task Force. In June 2017 the legislature passed a budget that included a proviso directing KDADS to establish an 11-member task force the review the mental health system in Kansas. They did an excellent comprehensive assessment of the strengths and weaknesses of the state's current mental health system and make recommendations for improvements.