REACH
healthcare foundation

February 1, 2018

To: Senator Vicki Schmidt, Chair
Senate Public Health and Welfare Committee

From: Brenda R. Sharpe, President and CEO
REACH Healthcare Foundation

Subject: Senate Bill 312 – Licensure of Dental Therapists

Thank you for the opportunity to submit written testimony on SB 312—Licensure of Dental Therapists. We are grateful for the Committee's willingness to hold a hearing on dental therapy, and particularly want to thank Senator Vicki Schmidt for bringing all concerned parties to the negotiating table. Progress has been made.

The REACH Healthcare Foundation has a laser focus on increasing access to health care for individuals who are uninsured and underserved. Our foundation has championed dental therapy as a proven model to address the critical oral health workforce shortage in Kansas for nearly eight years. We have hosted numerous conversations, summits, forums and educational opportunities for and with dentists, dental hygienists and stakeholders across the state. REACH has supported the Kansas Dental Project and its coalition of more than 50 supporting organizations since its inception, which has submitted an alternative dental therapy bill, SB 308.

Our Board of Directors, which has included a number of practicing dentists, dental hygienists, dental faculty and oral health researchers, has followed carefully the national movement of adding dental therapists to the dental team in states across the country. Several of us have personally visited existing programs in Minnesota, Alaska and Washington State, as well as reviewed the most current research on the safety and effectiveness of dental therapy.

Regrettably, after a thorough review of the provisions of SB 312, REACH is unable to support the bill as currently written. Instead, we encourage the committee to amend the bill so that it more closely resembles SB 308.

SB 312 creates two primary areas of concern for our foundation. While they may appear to be compromises that would allow the model to move forward in Kansas, two aspects will in fact continue to unnecessarily limit access for individuals in rural and high poverty areas where there are few practicing dentists and even fewer who accept Medicaid.

1) **SB 312 creates an unacceptable exception to Kansas' long-standing commitment to reciprocity for health care providers.** The Commission on Dental Accreditation, or CODA, adopted dental therapy accreditation standards in 2015, following three years of review, study and comment. Programs accredited by CODA in other states to date include those that educate and clinically train dental therapists to a scope of practice that differs significantly from what is proposed in SB 312 regarding supervision by a licensed dentist. For instance, dental therapists in other states are able to extract mobile adult teeth, such as those that might appear in an individual with periodontal disease.

To establish a scope of practice in Kansas that does not mirror those developing in other states poses significant problems for a licensee's reciprocity. Kansas has worked hard on reciprocity issues in **every other area of health** so that we can recruit an adequate workforce and compete on a national scale. Dental therapy should not be an exception.

2) **SB 312 reinforces the current, ineffective model of requiring the dentist to be physically present in order for a patient to receive care.** In Kansas, we desperately need dental therapists who live in areas of high need or who are willing to be deployed to geographically isolated communities and settings such skilled nursing facilities, community health clinics, schools and child care centers. Dentists have been reluctant to establish practices serving these patient populations due to financial and other reasons, thereby limiting access to those in need. A dentist committed to expanding their practice to underserved areas, or to working in a community health center, or in their own private practice should be able to hire a dental therapist from an accredited dental therapy education program, oversee their training and clinical skills, and then deploy them as necessary.

   In other states effectively using this team model of care, the dentist is not required to be physically present, but rather readily accessible to the dental therapist, who has been fully trained to practice within their authorized scope of procedures and to refer all other matters to their supervising dentist. Technologies such as telemedicine and teledentistry are employed to allow frequent and immediate interactions between health providers living and serving in remote areas and their supervising provider.

REACH stands ready to help support the development of CODA-accredited curriculum and training programs should the Legislature pass legislation to add dental therapists to the team. We also will help to support robust evaluations of the model's impact on access to care and financial viability of health centers and practices that employ dental therapists.

We thank you for your time and thoughtful examination of SB 312.

Best regards,

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