February 16, 2021

To the Senate Public Health and Welfare Committee, Room 142-S

Regarding SB 129

I am a dentist licensed in Kansas and Missouri. I have been practicing dentistry for just over five years. I've had experience practicing in a corporate-run dental office, a federally-qualified health center, and private practice.

I submitted testimony about the dental therapist bill three years ago. I am again submitting testimony about the bill SB 129.

I am opposed to bill and do not think that dental therapy practice should be introduced in Kansas because:

1. It would undermine the standard of dental care in Kansas and confuse patients.
2. Ultimately, it would not improve care to underserved areas and populations; in fact, dental therapy might exacerbate the problem if dental therapists aren't obligated to practice in underserved areas.
3. There are better ways to incentivize dentists to practice in underserved areas.
4. The focus should be re-directed from this bill about dental therapists and extended care permits for dental hygienists to improving oral health education efforts to reduce the public's need for fillings and dental care in the first place.

1. The tasks and procedures outlined under direct or general supervision on page 2 and page 3 fall under the training that is specific to dentistry. Dental therapists would have inadequate supervision and accountability even under direct supervision. Dental therapists could introduce more complications and potentially harm the patient if allowed to perform tasks like "preparation and placement of direct restoration", even under direct supervision of the dentist. In layman's terms this means drilling on the tooth, removing decay, and placing a filling.

   During a drilling/filling procedure, to be adequately supervised, the dental therapist would need a dentist leaning over throughout the entire procedure to ensure that the best decisions are made and the patient isn't harmed. Even under direct supervision (page 2, line 32) the dentist would not be watching the dental therapist perform the cavity preparation. Many critical diagnostic decisions and course-corrections can take place in a second during a seemingly "simple drilling and filling" procedure. This procedure is not always straightforward. To prepare and place a direct restoration inside the mouth, one should also be adequately trained in the tooth anatomy and know where the pulp is and how to best avoid a pulp exposure, while ensuring that all decay is removed is possible. They should know if and when an indirect or direct pulp cap should be placed and how to place them. They should know if a tooth should have a root canal. The dental therapist might complete the filling procedure and report to the dentist that an indirect pulp cap was placed; however, how would the dentist know that the dental therapist's clinical judgment and technique was correct throughout the procedure? What if the dental therapist left too much decay and introduced an even bigger problem and potential

infection for the patient down the road? The dentist's knowledge and clinical judgement and skills are needed at a moment's notice to deliver acceptable dental care to the patient, and this isn't possible with dental therapy practice.

In the bill, it states that under general supervision (dentist not present on the premises), dental therapists could diagnose, place temporary fillings, do emergency palliative treatment of dental pain, administer local anesthesia, and recement permanent crowns. Those procedures are outright unacceptable for a dental therapist to do without the dentist. The lack of accountability could result in dental therapists placing unnecessary or harmful temporary fillings, incorrect emergency palliative treatment, or recementing crowns over decayed teeth (when actually decay removal and a new crown was indicated for the patient). Another point: dentists are trained to consider the overall patient's well-being. In order to decide the appropriate emergency palliative treatment of dental pain and whether to give local anesthesia, the dentist must analyze the patient's health history, including how medications and the current state of health may affect dental treatment. The dentist must be prepared throughout the procedure to identify and handle dental emergencies such as a patient fainting from low blood sugar or a patient in anaphylactic shock. What is in the patient's best interest? If the patient has a compromised heart condition, how much and what type of anesthetic can be delivered? I don't think there are any short-cuts in the traditional 4-year accredited dental school for these types of decisions. Dental therapy would mean short-cuts in education that could compromise the health of the patient and deliver inadequate dental care.

Furthermore, the definitions and distinctions between a dental therapist and a dentist would be confusing to most patients. How will the patient be notified and accurately understand the difference in care they are receiving by a dental therapist compared to a dentist? Would patients be given a document similar to this bill being introduced about the scope of dental therapy practice? I think patients could be easily confused and misled into receiving below-standard dental care.

2. Would dental therapists be obligated to practice in dental deserts? If no, then creating dental therapists would not solve the problem of getting dental care to underserved dental deserts. In fact, it would exacerbate the over-served/under-served disparity. This is because the root of the problem would remain: most dental therapists would want to practice in the more-populated city areas, just like the dentists. Drive five minutes around Kanas City and you will notice just how highly-saturated a small area is with dentists. We have more than plenty of dentists! The problem is how to efficiently distribute the existing dentists and incentivize them to go to these dental deserts.
3. How can you get dentists to want to go to these dental deserts? Four ideas:
    a. Offer internships at clinics in dental deserts to dental students after their first year of school to increase exposure to these clinics
    b. Start a one-year mentorship program to dental school graduates at a dental desert clinic. Many recent graduates would appreciate a mentor to show them how to best practice in a small town.
    c. add new technology such as CEREC (reverse 3-D printing) crown machines to clinics in dental deserts. This would incentivize new dentists to want to work at the clinics

because they would have access to modern technology without having to purchase their own updated technologies.

   d. Mobile clinics or arranging rides to and from dental deserts for dentists and/or patients.

4. In my practice of dentistry, I am frustrated by the lack of health/dietary and oral health knowledge by the general public. If the Kansas government would focus on efforts to improve oral health education and preventative efforts, I think Kansans would have improved oral health overall, and less dental disease and reduced need for fillings and extractions. (And overall improved health!). I think from kindergarten on, students in public schools should be exposed to curriculum about oral health and hygiene. Rather than passing this bill SB 129, the government should focus on working with dentists, doctors, and educators to develop this curriculum. For example, we should tell kindergartners about "sugar bugs" and how they should brush their teeth, floss and avoid eating or drinking sugary things like soda pop, candy and chips so the sugar bugs don't make their teeth go bad. And explain to fifth graders how much sugar is in soda pop and how it can affect your blood sugar and also lead to cavities. And give kids disclosing tablets to show where they need to brush better. And explain and practice flossing technique. Could teachers present this curriculum? Could oral health advocates be paid to present this information? Could substitute teachers be trained to present this health information when they sub? Those are a few ideas.

In conclusion, dental therapists would provide below-standard dental care and would exacerbate the over-served-under-served disparity. I suggest focusing on making better incentives for dentists to practice in under-served areas. I also suggest focusing on implementing oral health and hygiene education into schools. Finally, I wonder how Medicaid dental coverage could be improved in Kansas so more dentists would treat Medicaid patients?

Please let me know if you'd like to discuss further.

Sincerely,

Lindy Linscott, DDS