800 SW Jackson, Ste. 1312
Topeka, KS 66612

785.235.6039 (phone)
785.233.5564

www.oralhealthkansas.org

Testimony Before the House Health & Human Services Committee

Overview of Efforts to Improve Access to Dental Care in Kansas

January 30, 2006

Chairman Morrison and Members of the Committee:

Thank you for the opportunity to appear before you today to talk about Oral Health Kansas, the statewide oral health coalition, and to provide an overview of our efforts to improve access to dental care in Kansas. My name is Teresa Schwab, and I am the Executive Director of Oral Health Kansas, Inc.

History of the Coalition

In 2002 and into 2003, stakeholders from across the state, frustrated with the state of oral health in Kansas, began meeting with the idea of creating a statewide oral health coalition that would provide a coordinated effort and voice for improving oral health and access to dental care in Kansas. After months of effort, the organization began operations in October 2003. The original steering committee identified five strategic areas that would provide direction to the work of the new organization, which included Prevention, Access to Care, Oral Health Status, Leadership and Workforce.

In the last two years, the coalition has grown to approximately 130 individual and organizational members, representing widely diverse backgrounds, like Head Start, community clinics, educational institutions, associations, advocacy organizations and private dentists and hygienists. The original funding was provided by United Methodist Health Ministry Fund, Sunflower Foundation, Kansas Health Foundation, Blue Cross and Blue Shield of Kansas, Delta Dental Plan of Kansas and the Kansas Dental Association. Our funder base has grown to include Delta Dental Plan of Kansas Foundation, Doral

Dental, Kansas Dental Charitable Foundation and the Healthcare Foundation of Greater Kansas City.

Access to Dental Care

In January 2005, Kansas Health Institute (KHI) released a report entitled *The Declining Supply of Dental Services in Kansas: Implications for Access and Options for Reform*. This report provided groundbreaking information and data to the coalition and has been the driving force of our efforts to improve access to dental care in the state. The report clearly showed that many poor and rural Kansans lag significantly behind an accepted standard for dental care and oral health—the gaps in services caused in part by a limited supply of dentists, especially in rural areas. The study showed that without policy intervention, the ratio of dentists to total population is projected to fall steadily and significantly through at least 2045.

Last January, in partnership with KHI, Oral Health Kansas held a two-day Workforce Summit upon the release of the report. Stakeholders from across the state were invited to participate in a process of designing a set of priorities for the coalition, specific to dental workforce.

From the Summit, three clear priority goals emerged:

- To increase the supply of dentists, especially in low-income and rural areas
- To increase the supply of oral health care services, especially in low-income and rural areas
- To improve data, monitoring and reporting

Each of the priorities includes a list of strategies, a "menu" of options, which allows the coalition flexibility when designing programs to address the needs. Overarching all priorities and strategies is the recognition that there is no "magic bullet" that will solve all workforce issues facing our state—this means the coalition must remain focused on a multi-year, multi-strategy approach that demonstrates efforts in the immediate, mid *and* long term.

I would like to spend the remainder of our time discussing two workforce strategies in particular.

Extended Care Permits

In 2003, many of you were involved in the passage of legislation that allows dental hygienists to work in certain extended care settings under the general supervision of a dentist. Sponsoring dentists must have a valid license and may sponsor up to five hygienists—the dentist does not have to be on-site to provide the supervision.

The law provides the opportunity for dental hygienists registered in Kansas to provide specific community-based hygiene services in the following settings: Head Start, public

and nonpublic accredited schools, local health departments, indigent health care clinics, state correctional institutions, and with additional training, in adult care homes, hospital long-term care units, state institutions or at the home of a homebound person who qualifies for the federal Home and Community Based Services (HCBS) waiver.

Oral Health Kansas has felt this is a particularly promising way to promote and increase access to preventive dental services throughout the state. With funding from United Methodist Health Ministry Fund, our organization has spent the last year developing a tool kit that includes practice models, sample agreements, frequently asked questions and other helpful tips, and delivering training to increase utilization of the extended care permits among dental hygienists and their community partners.

Currently in Kansas, there are 40 dental hygienists holding extended care permits, issued through the Kansas Dental Board. Although we feel we have made great strides in this area, you may feel this number remains relatively small. Through our work, we have discovered this is a somewhat foreign model of service delivery for most hygienists, who are used to traditional hygiene practice within a dental clinic or private dental practice. Use of the extended care permits is fairly entrepreneurial, and as such, requires some patience in developing both the interest and motivation on behalf of hygienists, dentists and/or extended care sites and the technical expertise to build a sustainable practice model.

Oral Health Kansas remains committed to the use of extended care permits, and as such, will continue to provide training and explore opportunities for partnerships and expansion of current dental hygiene programs.

Advanced Education General Dentistry (AEGD) Residency Program

As you all are well aware, Kansas does not have a dental school. In a reciprocal in-state tuition agreement with the University of Missouri-Kansas City (UMKC) School of Dentistry, Kansas students get approximately 22 seats at in-state tuition. In exchange, approximately 490 students from Missouri are eligible to receive in-state tuition in architectural programs at the University of Kansas or Kansas State University. Next year, the number of seats will increase to 25 for Kansas students at UMKC School of Dentistry.

Nearly 18 months ago, talks began with a group of stakeholders that specifically focused on the lack of educational opportunities in Kansas for future or existing dentists. As discussions progressed over time, the committee came to the conclusion that creating a clinical residency program likely made the most sense, striking a balance between current resources and potential benefits to the state. In the summer of 2005, Sedgwick County, on behalf of Oral Health Kansas, commissioned Triangle Associates of St. Louis, Missouri, to conduct a study regarding the feasibility of creating an AEGD residency program, which is a one-year, post-doctoral training program for dentists. The committee received the report at the end of December 2005, and it was publicly

released just last Wednesday at the Sedgwick County Commission meeting. (The full report and Executive Summary can be found on our website at www.oralhealthkansas.org.)

The results of the study clearly showed that an AEGD residency program is not only feasible in Kansas, but also has many factors leaning already in its favor, including high demand nationwide for similar residency programs, broad community support, availability of federal support through Graduate Medical Education (GME) monies and possible Health Resources Service Administration (HRSA) funds for new programs. A residency program like this will not only serve the immediate needs in the community, but it also increases the likelihood of dentists considering Kansas as a permanent location for practice.

The overarching goal in building a premiere clinical training program for dentists is the potential impact on access to care for Kansans. In the short-run, AEGD residents will provide dental care primarily in a community clinic located in Wichita. However, in the long-run, it is our hope to create opportunities for residents that will allow them to develop relationships with local practitioners and to experience community-based dentistry in rural and underserved areas. Coupling these experiences with programs that offer technical assistance directly to communities, we believe we can increase the likelihood that residents will remain in our state to provide care in rural and underserved areas.

Upon presentation of the study results, there is a clear commitment by the steering committee to move AEGD forward in Kansas. The timeline suggested by the study indicates that it is possible to have the first class of residents begin in August 2008.

There are essentially four sources of revenue for an AEGD program, including income from clinical activities (billable services through Medicaid, HealthWave and private insurance), GME funds, on-going appropriations from public sources and grants by private funders. For an August 2008 opening, it is imperative that we begin the process of recruiting a full-time program director in the next few months. To accomplish this, the steering committee has agreed to have a significant portion of start-up costs in the bank by July 1, 2006. There is an early strong indication from a consortium of funders that private support in the range of $750,000-850,000 will be available by that date. As is typical of most private funding sources, we are expecting one-time start up funds but not on-going, continued support. This sets up an opportunity for the creation of an extremely effective public/private partnership.

Despite having billable services, GME funds and private support, there is still an indication that public support will be necessary. To meet accreditation standards, residents must see a variety of patient populations, including the indigent and patients with private insurance, offering each resident an array of practice opportunities. States that do not have reimbursement for adult Medicaid (like Kansas) often must strike a balance in their patient mix that favors providing more care to the privately insured. With on-going state

support, the financial burden on this AEGD program would be lessened, allowing our scale to tip in favor of increased services to the underserved/uninsured.

Because the release of the report was so recent, committee members are working diligently together to work out many of the details; however, Oral Health Kansas and our community partners will be working within the appropriations process to discuss state support.

<u>Conclusion</u>

Again, I want to sincerely thank you for the opportunity you have given me here to talk about access to dental care. I know it is an issue that concerns many of you, and I hope you have found this discussion useful.

Rest assured, there is a commitment and a passion on behalf of our members that all Kansans receive adequate dental care, and we will continue to do what we can to have a positive impact on the current situation in Kansas.

I am happy to answer any questions you may have.

Respectfully submitted,
Teresa R. Schwab, LMSW
Executive Director