



Testimony of Dr. Daniel N. Minnis, Proponent SB-192

Good afternoon Madame Chair and Committee Members. My name is Dr. Daniel Minnis and I thank you for the opportunity to testify today in support of the Registered Dental Practitioner Bill SB-192.

I am a private practice dentist of 22 years in Pittsburg Kansas. In that time, I have dedicated 30% of my practice to care for Medicaid recipients, Head Start children, the mentally challenged, frail elders, individuals living with HIV and Hepatitis C and high risk pregnant mothers.

Currently, I serve on the Board of Directors for the Community Health Center of SEK, a non-profit safety-net clinic. I founded the first CHC/SEK Dental Clinic in 2005. During my tenure at CHC/SEK we have opened four Dental and Medical Clinics and will open our fifth clinic in Baxter Springs next month. I serve on the Board of Directors for Southeast Kansas Community Action Program (SEKCAP) Head Start and am a past board member of Oral Health Kansas and past chairman and adviser to the Kansas Mission of Mercy. I am also a volunteer faculty member of the University of Missouri Kansas City School Of Dentistry. I am a member of both the Kansas and American Dental Associations but must admit I am extremely disappointed and ashamed of their opposition to dental mid-level providers.

My work with vulnerable populations has been recognized on local, State, and national levels and SEK leads the State in solving the access to care issues.

I am here today to represent the thousands of children and other vulnerable populations in Kansas who are affected by my professions unwillingness to work on real and long term solutions to access to dental care. I also represent a growing minority of dentists who feel it is vital to develop a Registered Dental Practitioner Program to increase access to care.

What Is The Problem?

Access to dental care has been a dilemma for Kansas as long as I have practiced. We as a profession have applied a multitude of possible solutions to this issue and we have failed. Dentistry is a monopoly as is evident by our self regulation, stringent anti-corporation laws, mal-distribution of dentists, lack of Medicaid providers, and lack of mid level practitioners.

Our profession has a social responsibility to expand access to care and we have broken this covenant by maintaining and protecting our monopoly while denying vulnerable populations tooth and life saving care.

KDA testimony in front of the House declared an access to care victory by extracting 4,300 teeth at the Hutchison Kansas Mission of Mercy, filling a record number of 5 gallon buckets full of teeth. At each KMOM thousands of teeth are extracted leaving patients partially or completely toothless. How would you legislators respond if the Kansas Medical Association bragged about how many fingers and toes they amputated during a Mission of Mercy. As a past Chairman and adviser to the Kansas Mission of Mercy I can testify, first hand, that we leave patients handicapped when we leave their communities. This fact alone that we remove thousands of teeth each year at KMOM is evidence enough that we are in a crisis and we as a profession and you as legislators can begin today to bring resolution to this crisis.

Safety First

My fine and honorable colleagues, of the KDA, will testify before you tomorrow that Mid Level Providers are undereducated, undertrained, and unsafe. They will not provide you with any research or studies to substantiate this false claim but instead are trying to scare you into believing you are putting your constituents at risk by passing this Bill. Having spent the last 22 years trying to eliminate the "access to care" issues in Southeast Kansas I am confident and can assure you the Registered Dental Practitioner

will be a safe and vital component to solving the dilemma we face. Each and every report concurs that Mid Level Dental Providers perform equal standards of care as a dentist for the small scope of procedures they are intensely trained to do. We can guarantee safety to the public by developing a Registered Dental Practitioner Program unique to Kansas and superior to all other dental therapist models in 53 countries and now 2 States. As part of my testimony, you have in front of you multiple research reports substantiating the safety and standards of care of Mid Level Dental Providers. This research was conducted by dentists and in every instance the standard of care and safety is upheld. The Kansas Dental Board will license the Registered Dental Practitioner to further insure safety to the public. The RDP will work under the supervision of a dentist and will not be an independent practitioner but instead an employee and new member of the dental team.

History of Opposition to Mid Level Providers in Kansas

In 1906 the profession of dental hygiene was founded despite strong resistance from dentists. It took another 40 years for all states to license dental hygienists, which were our first mid level dental providers. Despite this initial resistance, dentists now realize the vital role dental hygienists play in the dental health of our public. My colleagues will tell you they were instrumental in developing the Extended Care Permit Hygienist in Kansas but I contend they were in strong opposition to the ECP hygienist during its inception. In this session of legislation they now have a new Senate Bill expanding the duties of the ECP they once vehemently opposed. Just as dentists were wrong to oppose dental hygienists in 1906 and ECP hygienists in 2001, they are wrong to oppose the Registered Dental Practitioner in 2011. **Dentistry is 50 years behind the medical profession concerning mid level providers.** Our medical colleagues have physician assistants, nurse practitioners, nurse anesthetists, EMS, and midwives to name a few.

My colleagues testified for the KDA comparing Dental Hygiene School and the Registered Dental Practitioner Program as an equivalent to sending a high school student to a vocational/technical school for 2 years. This is far from the truth due to the fact that all Kansas Dental Hygiene Programs require college pre-requisites prior to entering the program. Each Dental Hygiene Student completes 15-44 college credit hours prior to acceptance into the programs. Upon completion of Dental Hygiene School and the 18 month Registered Dental Practitioner Program the RDP will have between 3 1/2 years and 5 1/2 years of intense dental training as compared to the 4 years of dental training we dentists receive. Twenty eight dental schools across the US offer accelerated or direct entry dental programs accepting dental students after 2 years of college credits. I happen to be a dentist who does not have a college degree because of early acceptance into UMKC School of Dentistry in 1984.

Risk, Benefit, and Charitable Care

In 2007, two Medicaid children died from lack of access to care. Deamonte Driver, age 12 and Alexander Callendar, age 6. You have in my testimony a picture of Deamonte after his surgery. Unfortunately Deamonte did not survive. A simple \$80 extraction should have saved his life. Ultimately the State of Maryland paid out in excess of \$250,000 in hospital and surgical charges. A Child from Coffeyville Kansas was dangerously close to sepsis and shock when we treated him for life threatening dental disease because of lack of access to care. Dental decay is the most prevalent childhood disease and legislators and dentists alike must be bold and creative if we are to bring resolution to this crisis. The benefits of dental mid level providers are well documented in 53 countries and Kansas has the opportunity to develop a Registered Dental Practitioner Model which will become a "gold standard" for other States to envy and adopt.

While it is unfair to lay the burden of these children's deaths at anyone's feet, my profession's general unwillingness to treat Medicaid patients is at least partially to blame.

In Kansas, only 136 Private Practitioners, out of 1400 total dentists, see more than 100 Medicaid children in a year. Dentists blame the bureaucracy of Medicaid as the reason they do not participate. I beg to differ, in this opinion, and am proud to say Medicaid claims submissions are a breeze and reimbursement is weekly. In my private practice we performed in excess of \$1.1M worth of dentistry on 2800 Medicaid

children visits and were reimbursed \$500,000 in 2010. This translates to treating 11 Medicaid children per day. My private practice is at capacity and children must wait up to three months for restorative care. The addition of a Registered Dental Practitioner in private dental offices and Community Health Centers would dramatically increase access to care for Medicaid children. Medicaid children are our most vulnerable population and highest risk for serious illness and death due to untreated decay. The real reason most dentists do not treat Medicaid children is simple supply and demand. Dentists have a plentiful supply of commercial and self pay patients due to the shortage of dental providers especially in rural areas. There is no demand to treat Medicaid children because the dentist's chairs and schedules are already full. The dentists who treat a large number of Medicaid recipients do so because we feel we have a social responsibility to care for those who cannot care for themselves.

The KDA testified that every dentist in Kansas provides \$33,000 in charitable or reduced fee care each year for a total of \$47 Million dollars annually. This is absolutely false. They extrapolated this number from a Pew Foundation Report which ironically advocates the development of mid level practitioners. The report actually comes from the "ADA Key Dental Facts 2008" and says only 70% of the dentists in the US provide an estimated average of \$33,000 in reduced fee or charitable care annually. Since Medicaid pays out \$27,000,000 annually and the majority of this reimbursement goes to the 136 Private Practice Dentists and 30 Community Health Dentists the reality is that non Medicaid Dentists may only perform about \$8,800 in reduced fee or charitable care versus \$33,000. The Kansas Dental Association, and I am a concerned member, is not being truthful in testimony to legislators. I am confident these are inadvertent mistakes brought on by their passion but mistake or not they are providing you with invalid data. It is imperative that legislators have valid data to decide the merit of this Bill.

Here are the real facts and substantiated data you should consider as you contemplate this Bill.

1. There are 1425 active dentists in Kansas. (Kansas Dental Board/Facts and Stats 2010)
2. The number of Medicaid billing dentists who saw 100 or more beneficiaries under the age of 21 is 166, only 12% of the total number of dentists. (KHPA/State Synopsis)
3. The number of counties in Kansas without an enrolled Medicaid dentist is 19. (KHPA/State Synopsis)
4. The number of counties in Kansas without an enrolled SCHIP dentist is 27. (KHPA/State Synopsis)
5. The current number of counties in Kansas with no dentist at all, is 13. (KHPA/State Synopsis)
6. State dental policies fail 1 in 5 children. (The Pew Center on the States, Cost of Delay)
7. Dental Decay is the number 1 childhood disease and the US Surgeon General called dental disease the "silent epidemic". (The Pew Center on the States, Cost of Delay)
8. Only 34-40% of Kansas Medicaid children receive dental treatment, not the 70% claimed by the KDA. (CMS Medicaid/CHIP Oral Health Services)
9. Children between 2-5 years old, with decay, has increased 15% in the past decade. (The Pew Center on the States, Cost of Delay)
10. More than 51 Million hours of school is missed each year in the US due to dental illness. (The Pew Center on the States, Cost of Delay)
11. The US Surgeon General reports that untreated dental disease in children impairs classroom learning and behavior and both social and cognitive development. (The Pew Center on the States, Cost of Delay)

12. Children die from untreated dental disease which causes systemic infections.
13. Children with severe dental disease grow up to be adults with severe dental disease which impairs their ability to work.
14. Restorative treatments delivered by dental mid levels are equivalent in standard of care to that of dentists. (Dental Therapists: A Global Perspective, Nash)

The KDA claims their comprehensive oral health initiative, currently in the Senate, is the answer to our crisis but it does not go far enough to impact access to care. They will tell you raising Medicaid reimbursement rates and including adult Medicaid dental coverage will bring in new providers. Increasing Medicaid rates has historically never increased providers. It is not feasible for the State to raise reimbursement rates in this economic climate. It is however prudent to pass SB-192 to create a new dental practitioner who will receive intense education and training, be board certified, work under the supervision of dentists, and benefit the vulnerable populations of Kansas.

Last month, the Kansas Dental Association notified members saying, quote "We had an all-star lineup of dentists who opposed that bill on behalf of the Kansas Dental Association." They were referencing HB 2280. Their comment about an all-star lineup might give one the impression we are playing some kind of a game. I am here to convince you this is not a game but instead a crisis in access to care. Children and adults continue to suffer and even die from untreated dental disease.

Dr. Edwin Mehlman, past American Dental Association Vice President and Trustee wrote a letter to the ADA stating the ADA and State Associations are acting "like an ostrich with its head in the sand" by not working with organizations to help develop mid level provider programs. I am asking this committee to help the KDA pull its head out of the sand and instruct us to work together to develop a Registered Dental Practitioner Program unique to Kansas and designed to deliver vital dental care to vulnerable populations.

I would hire a Registered Dental Practitioner in my private practice tomorrow and allow them to perform procedures within their scope on myself, my family members, and my patients. The Registered Dental Practitioner could provide vital care to an additional 1500 Medicaid children/year in the typical office or clinic. We have an opportunity to develop a new dental practitioner model for Kansas which will benefit both patients and the dentists who employ these practitioners. I encourage you to seize this opportunity and as legislators help bring an end to the suffering of our vulnerable populations in Kansas.

Respectfully yours,

Daniel N. Minnis DDS