Kansas Dental Project
Joint Venture

Purpose

In 2009, the W.K. Kellogg Foundation launched a national initiative to expand access to oral health care through innovative and community-driven solutions to dental care workforce shortages that exist in much of the United States. In 2010, Kansas was selected as one of six states selected to receive a three-year, $150,000 grant from the W.K. Kellogg Foundation to participate in The Dental Therapy Project: Expanding Care to Every Community. Following are key components of the Kellogg Foundation's nationwide efforts:

- Raising awareness of the dental care crisis nationally.
- Bringing stakeholders together to build national momentum for new ways to expand the dental care workforce.
- Funding an innovative, community-based program that has brought sorely needed dental care to Alaska Natives in remote areas by training and deploying dental therapists.
- Supporting the American Association of Public Health Dentistry to convene an expert panel to examine and recommend a standardized educational curriculum for dental therapists and promote consistency in the growing field of dental therapy in the U.S.
- Working with interested organizations to promote community-based workforce efforts aimed at expanding access to dental care.
- Supporting studies to understand the oral health needs across the country, evaluate the quality of care provided by dental therapists in Alaska, and better understand other provider models.

The Kellogg Foundation hired Community Catalyst, a national advocacy organization that builds consumer and community participation to shape health systems, to provide the six participating states with technical assistance and other support. In Kansas, the implementation leadership team consists of a collaborative of three agenciesto spearhead the Kansas Dental Project. Kansas Action for Children is the lead organization and fiscal agent. Kansas Association for the Medically Underserved and Kansas Health Consumer Coalition are the other two partners, and all are prior or current REACH grantees.

Rather than endorse the dental therapy model as the only solution to the access problem in Kansas, REACH and other health funders in Kansas were interested in creating a statewide dialogue around oral health access issues and engaging consumers and other stakeholders in the conversation. In 2010, the United Methodist Health Ministries Fund and the Kansas Health Foundation provided an additional $50,000 each in funding for statewide efforts to explore alternative provider models and to raise awareness about oral healthcare access issues in the state. In 2010, REACH approved a $20,000 grant to fund grassroots organizing activities associated with this project. In 2011, Health Care Foundation of Greater Kansas City joined the effort with a $50,000 grant.

Background/Need

National statistics: Forty-nine million Americans live in Health Resources and Services Administration (HRSA)-designated dental shortage areas where there are not enough dentists to provide routine oral health care. Millions more cannot afford to pay for dental care. Implications of these access issues include:

- More than a third of all children ages 2 to 9 from poor families had untreated cavities.
- Only 1 in 3 children enrolled in Medicaid received dental services in 2006.
- Thirty-seven percent (37%) of non-Hispanic black children and 41% of Hispanic children have untreated tooth decay, compared with 25% of white children.
- More than a third of adults surveyed by the American Dental Association in 2003 reported they that had not seen a dentist in the previous year, citing cost as the primary reason.
- The U.S. would need nearly 9,700 new dental practitioners to overcome our nation's dental care shortages.
- It is estimated that the number of active dentists in the U.S. will decline over the next decade.

Kansas statistics: In a statewide oral health workforce assessment conducted by Kansas Department of Health and Environment's Bureau of Oral Health (Fall 2008 through Spring 2009), the following survey findings document the disparities.

- Ninety-three of the 105 counties in Kansas (89%) contain Dental Health Professional Shortage Areas. Thirteen counties have no dentist at all. Both Wyandotte and Allen Counties are considered a Dental Health Professional Shortage Area.
- Only 25% of Kansas dentists accept patients insured through Medicaid. Comparatively, 80% of medical doctors see Medicaid patients as part of their practice.
- For the second straight year, Kansas received a "C" grade in the Pew Center on the States Report titled "Cost of Delay" released in February 2010. http://www.pewcenteronthestates.org/uploadedFiles/Cost_of_Delay_web.pdf. Kansas only meets four of the eight policy benchmarks that landed other states an "A" grade, which included adoption of state policy that authorizes new primary care dental providers.
- Kansas' annual Report Card published by Oral Health America in 2009 graded Kansas a "D-" in Access to Care as a result of low availability of dentists, pediatric dentists, %age of counties without a dentist, few medical dental providers and %age of counties without a Medicaid dentist.

Dental Therapy—One Alternative Provider Model

Dental therapy began in the 1920s in New Zealand and is now well-established around the world in 52 countries with advanced dental care systems. In the Alaska model, dental health aide therapists, under the general supervision of a dentist, provide preventive services, fillings, extractions and other basic dental repair services for children. These services are provided as part of the well-established Community Health Aide Program, thus the name dental health aide therapist. Working with the University of Washington, the Alaska Native Tribal Health Consortium established a two-year training program that to date has certified 16 dental health aide therapists with another 14 in training. The recruitment efforts represent emphasize cultural competency and workforce development in that therapists are recruited from their native community with the intent that they return to that community to provide care.

The Alaska model is based on two years of intensive training that stresses competency in oral disease management, behavioral management and community oral health promotion skills. Following the training, which includes substantial clinical practicum experience, dental health aide therapists continue to practice their skills under the direct supervision of a dentist through a 400-hour externship. Once their training is complete, the therapist practices under general supervision of the dentist, making use of telemedicine and other technologies. It is important to note that the therapist practices only under the license and at the discretion of the dentist, much as a nurse practitioner practices under the general supervision of a physician.

In 2009, Minnesota created a new midlevel position, the dental therapist, to provide care for underserved patient populations in the state under the license of Minnesota-licensed dentists. The scope of practice includes preventive services, restoration of primary and permanent teeth, extractions and select other basic dental repair services that are focused on children. Dental therapists in that state will be required to earn a bachelor's degree in dental therapy. A second level of dental therapist, the advanced dental therapist was also created.

To become an advanced dental therapist in Minnesota, one must have a bachelor's degree in dental therapy, practice for at least 2,000 hours as a dental therapist, graduate from a master's level advanced dental therapy program and pass a board-approved exam to demonstrate competency. Advanced dental therapists will be able to practice off-site without a dentist present but are still required to obtain the approval of a supervising dentist prior to performing restorative and surgical procedures. They also will be able to perform nonsurgical extraction of advanced periodontally involved permanent teeth but only with the approval of the supervising dentist.

Other Dental Workforce Models

A proposal by the American Dental Association is being piloted to create the position of Community Dental Health Coordinator. Suggested scope of practice is limited preventive and palliative care and extensive care coordination services. Pilot training programs require

high school graduates to learn both community health worker skills and preventive and palliative dental procedures in an 18month program.

The American Dental Hygienists' Association has proposed a provider model called the Advanced Dental Hygiene Practitioner. Scope of practice would include traditional hygiene services, basic dental repair and tooth extractions, administration, policy, and research. Suggested training is a one- or two-year post-bachelor's master's degree program.

In the United States, the American Association of Public Health Dentists is convening a panel to recommend a standardized curriculum to ensure consistency in the field, and to establish an accrediting body.

Please see the following link for a policy brief discussing various alternative dental provider models and associated policy issues relative to scope of practice, training and supervision. http://www.wkkf.org/knowledge-center/resources/2010/Training-New-Dental-Health-Providers-in-the-U-S-Policy-Brief.aspx.

Proposed Kansas Workforce Model

In Kansas, the deployment of extended care practice (ECP) hygienists has improved access to screenings and fluoride varnish applications in schools and nursing facilities but access to emergency and/or restorative dental treatment is still problematic for low income Kansas residents especially in rural and poor areas of the state.

Without policy intervention, these service gaps and the resulting oral health problems will grow as the supply of dental providers declines. More underserved people will likely delay care and lose teeth as a result.

Other states - and 52 other countries - are addressing their dental workforce shortage problems by implementing alternative dental provider models such as the Dental Therapist. In Kansas, the model currently envisioned is a Registered Dental Practitioner (RDP). Registered Dental Practitioners are not designed to replace dentists. Rather, Registered Dental Practitioners would be a critical part of the dental team, receiving 500 hours of direct supervision before working under the general supervision of a dentist to provide preventive care and routine procedures. By focusing on routine procedures and Kansans who don't have access to a dentist, registered dental practitioners have the potential to provide dentists more time to focus on the more complex procedures they are trained to do.

Registered Dental Practitioners operate as part of a team with dentists and dental hygienists - much like the partnership nurse practitioners, physician's assistants and other providers have with medical doctors. Registered dental practitioners are trained to provide evaluation and preventive services, such as inspection, dental radiography, cleaning above the gum line, and basic restorative services. They cannot provide the more advanced services that dentists provide, such as root canals; and they can only operate under the supervision of a dentist.

The RDP Model proposed in Kansas is reflected in legislation proposed during the 2011 legislative session in House Bill 2280 and Senate Bill 192. The following link reflects the key

components of the proposed RDP legislation
http://www.kansasdental.com/uploads/2011_dental_myths.pdf.

To view the actual proposed legislation, please go to
http://www.kslegislature.org/li/b2011_12/year1/measures/hb2280/ and
http://www.kslegislature.org/li/b2011_12/year1/measures/sb192/.

Since the launch of the project in 2010, twenty-three organizations in Kansas have joined the Kansas Dental Project Coalition in support of the legislation:

Association of Community Mental Health Centers
Children's Alliance of Kansas
Disability Rights Center of Kansas
Kansas Action for Children
Kansas Advocates for Better Care
Kansas Area Agencies on Aging Association
Kansas Association for the Medically Underserved
Kansas Association of Community Action Programs
Kansas Association of Homes and Services for the Aging
Kansas Association of Local Health Departments
Kansas Children's Service League
Kansas Dental Hygienists' Association
Kansas Farmers Union
Kansas Health Care Association
Kansas Health Consumer Coalition
Kansas Public Health Association
Kansas Statewide Homeless Coalition
Keys for Networking
Medical Service Bureau
National Alliance on Mental Illness, Kansas Chapter
Oral Health Kansas
Success by 6 Coalition of Douglas County
Youthville

Opposition to the RDP model has been primarily from dentists and the Kansas Dental Association. Testimony against the legislation centered on four primary issues and concerns: 1) whether or not a dentist shortage actually exists in Kansas and whether or not access to care is as significant as portrayed by proponents, 2) patient safety in the absence of direct supervision by a dentist, 3) quality and extent of education and training of RDP's, and 4) scope of practice issues, i.e. the specific allowable procedures to be provided by RDP's.

Project Summary

In its first year, the Kansas Dental Project focused on activities in three areas including communications, policy development, and grassroots organizing. The activities were all designed to elevate the dialogue about dental workforce and access issues, and to explore alternative workforce models that might improve access to dental care in rural communities and for the medically underserved. The project's many accomplishments include:

Communications: The project established a dedicated website, www.kansasdental.com, which provides timely information about the project and highlights the project's communication activities. The key communication strategies included producing and disseminating a series of three YouTube videos that tell the story of dental access issues from the perspective of communities across the state, producing and disseminating a policy brief and a myth versus fact sheet, and a six-city editorial board tour to garner media coverage about dental workforce and access issues.

Policy Development: After convening key stakeholders at the state level and hosting a series of community meetings to seek input, the project spearheaded the development of a Kansas-specific model to begin to address our dental workforce and access issues. The proposed solution, known as a Registered Dental Practitioner (RDP), is reflected in House Bill 192 and Senate Bill 2280, both of which received hearings in their respective committees. Key components of the proposed RDP legislation can be accessed at the following link http://www.kansasdental.com/uploads/2011_dental_myths.pdf.

While neither bill emerged from committee this year, both bills remain alive for further consideration during the 2012 Session of the Kansas Legislature. In addition to developing and advancing a potential policy solution, the project garnered the support of three dentists, all of whom were willing to testify in support of the proposed solution, and also secured 23 organizational members for the statewide coalition.

Grassroots Organizing: The project visited six Kansas communities to discuss dental workforce and access issues with residents and to seek their input on alternative workforce models. The project also gathered more than 100 stories from local residents in target communities facing challenges in accessing dental care. Select stories are featured on the project website, and district-specific stories were disseminated to members of the relevant House and Senate committees prior to the bill hearings.

Lead Agency/Additional Partners

Kansas Action for Children is the lead agency, in collaboration with the Kansas Association for the Medically Underserved and Kansas Health Consumer Coalition.

REACH Request/Leverage

The funding request to REACH is for $40,000 for two additional years of activity, which will provide support for staff responsible for implementing the project goals. Efforts will focus primarily on

1) Development of a Kansas specific curriculum and obtaining institutional support for curriculum adoption, and
2) Development of a countervailing body of evidence and consumer voice in support of the RDP model.

REACH dollars leverage an additional $300,000 - $150,000 from W.K. Kellogg Foundation, $50,000 from United Methodist Health Ministry Fund and $50,000 from Kansas Health Foundation. Health Care Foundation of Greater Kansas City joined the effort in 2011 with $50,000 in funding.

Budget

Attached.

Kansas Action for Children
Dental Therapist Project
2011-2012: Two Year Budget

Revenue	Total Project	Requested from REACH
REACH Healthcare Foundation	40,000.00	40,000.00
W.K. Kellogg Foundation	300,000.00	
Kansas Health Foundation	100,000.00	
United Methodist Health Ministry Fund	103,531.00	
Health Care Foundation of Greater Kansas City	50,000.00	
Total Revenue	**593,531.00**	**40,000.00**

Expenses		
Lobbying – Contract Labor	5,000.00	0.00
Lobbying Salaries	619.00	0.00
Lobbying Benefits	93.00	0.00
Lobbying Payroll Taxes	62.00	0.00
Lobbying – Direct	4,114.00	0.00
Lobbying – Grassroots	53,500.00	0.00
Salaries	161,062.00	32,000.00
Benefits	24,160.00	4,800.00
Payroll Taxes	16,105.00	3,200.00
Occupancy	17,426.00	0.00
Indirect	14,635.00	0.00
Equipment	3,000.00	0.00
Office Supplies	4,066.00	0.00
Phone/Internet	7,186.00	0.00
Communications	28,882.00	0.00
Travel	2,180.00	0.00
Professional Fees	16,758.00	0.00
Conferences and Meetings	3,500.00	0.00
Subgrants: KAMU, KHCC	231,183.00	0.00
Total Expenses	**593,531.00**	**40,000.00**
Total Project Expenses	**593,531.00**	**593,531.00**