

Legislative Testimony
HB 5630 AAC The Establishment Of Licensure For An Advanced Dental Hygiene Practitioner

Public Health Committee
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I am Allen Hindin. I graduated from dental school in 1971 and served as a general practice resident and a general dental officer in the US Army Dental Corps, from 1971-74, for which I received the Meritorious Service Award. I have been in various forms of public health dental practice, in CT, including project dentist for the RWJF sponsored UCONN/Hartford Board of Education Model School Health Project, from 1975-81, Director of Dental Services at The Danbury Hospital from 1978-96 and Director of Dentistry with United Cerebral Palsy of The Hudson Valley, Brewster, NY since 1997. I am also staff dentist at The Filosa Convalescent Home and Hancock Hall, making rounds there since the early 1980s. In 1991, I participated in the Pew Trust's Health Professions 2005. Presently, I serve on the Board of Directors of the School Based Health Center in Danbury and the advisory board of the school based dental program. I have been in private practice in Danbury since 1996. I received my MPH in 2003.

I am probably the only practicing dentist with a public health background to testify on HB 5630 today.

I am for and against this proposed legislation, really two distinct pieces, which deserve to be separated so that they might be considered on their individual merits. One is designed to enable licensed dentists to employ certified Expanded Function Dental Assistants (EFDA) in their practices. The other is designed to create an Advanced Dental Hygiene Practitioner (ADHP), a licensed dental hygienist with dental therapist skills, ostensibly for the purpose of increasing access to care.

EFDA has been shown to greatly improve efficiency in practices with large populations of patients requiring restorative dental needs. It is presently supported by the American Dental Association (ADA) and CT State Dental Association (CSDA) policy. Pennsylvania, Ohio and Kentucky have had extensive and only positive experiences since the late 1960s and 70s. Vermont legalized EFDA in the 1980s. Michigan has enabled EFDA as well. California greatly increased the scope of functions of EFDAs in 2008. New York State, just two years ago, adopted legislation legalizing EFDA. There are others. The Indian Health Service (IHS), the US Public Health Service (USPHS) and the US military have used EFDAs to improve clinical efficiency of dentists since the 1970s. Outcome studies have always been positive. Dental public health efforts, in states which allow EFDAs, have also been enhanced by employing them in clinical settings. I employed one at The Danbury Hospital in 1988, under a teaching exemption authorized by the Dental Commission and the A.G.'s office. Her clinical skills were equivalent to that of dentists when it came to placing and adjusting restorations, however we were unable to maintain EFDA due to the physical limitations of our clinical facility.

No state, which has adopted EFDA legislation, has ever repealed any parts of it.

Still, I would not expect miracles in the way of improved access to oral health care services, should you suddenly enable dentists to employ EFDAs. Despite the more than thirty years of positive experience, only 20% of dentists in Ohio employ EFDAs. Eighty percent do not. In Vermont, after almost 25 years, approximately 5% of dentists employ them. Other states demonstrate patterns within the range. In addition, creating programming and recruitment will take time and effort. Facilities will have to be considered as well although some office based training models have been demonstrating effectiveness in training these auxiliaries. What will be in abundance are the many Connecticut dental assistants who are awaiting the career ladder that EFDA will offer. We have heard this repeatedly from their representatives over the years. I have heard it as well. Connecticut should have legalized EFDA during Sunset 1980. It is time to correct that oversight and legalize it now.

The ADHP is only one of at least three other "dental therapist" type mid level providers currently being evaluated in the United States, where approximately 82 million people are identified as dentally underserved. There is presently only one working model, the Dental Health Aid Therapist (DHAT), employed by the Alaska Native Tribal Health Consortium (ANTHC). Native tribe's people were recruited and sent to New Zealand, where "Dental Nurses" have been employed to meet needs of underserved populations since 1921. There they were educated at The University of Otago, during two years, and certified as dental therapists. Upon completion of training, they returned to Alaska, where they became part of a team composed of dentists and others, providing much needed basic dental care for distant Native villagers. DHATs are backed up by dentist team leaders, hub clinics and hospital services, connected by telemetry which provides real time visual images of patients and radiology and records. Last year, the ANTHC began training DHATs at the University of Washington's MEDEX program and provided clinical education at a training site in Anchorage. I visited that site in July.

Worldwide, 53 countries use dental therapists as a means to improve access to oral health care for otherwise underserved populations. I know of none which use the proposed ADHP type model. Saskatchewan employed "School Dental Nurses" for the purpose of providing dental care for school based populations beginning in the late 1960s. This program was highly successful at reducing decayed and missing teeth among the targeted population throughout the province. I visited The Wascanna Institute in Regina, where Sask. Dental Nurses were trained, back in October, 1979. Manitoba has a similar program. The Netherlands became another just this year.

Within the United States, Minnesota is currently deciding upon whether to try a three year DHAT type mid level dental provider or a four year. It may try both. Maine is in the late stages of considering a two year, Alaska style model. The DHAT costs approximately \$60,000 to train. Best guess for the ADHP is approximately four times that figure, including room and board.

While the Alaska DHAT model is entering its fourth year, there are no ADHP demonstration models currently in existence in the United States, only designs. In the meantime, the Kellogg Foundation has awarded a \$1.6 million dollar grant to RTI, a North Carolina research group, for the purpose of studying clinical and behavioral outcomes of the ANTHC's DHAT based program, which has been ongoing since 2005. The outcome of this grant is expected in approximately one year.

Hygienists play a critical role in behavioral health. Diverting them into clinical activities will substantially reduce their effectiveness in this area. This is particularly important as we are now aware of how great the impact of periodontal disease upon management of systemic diseases such as diabetes. According to the CDC, 30% of "Boomers" will be diabetics. Blood sugar levels, over time, have been shown to be substantially reduced by the performance of a thorough dental prophylaxis, four times a year. They may well be the ones who will sit on diabetes management teams, working alongside nurses, physicians and other health professionals. Dental caries is now understood to be a communicable disease, transmitted from mother to child during the first two years. This evidence is solid. What it means is that hygienists will also have a greater role to play in early childhood prevention.

Section 379 provides exemption for schools of dentistry and dental hygiene conducting innovative programs. Even in these hard economic times, there is funding available for "innovative" training programs in dentistry and dental hygiene. If the CT Dental Hygiene Association is committed to the ADHP model, there is actually nothing to stop it from designing and implementing a research project to demonstrate its effectiveness and viability before calling for enabling legislation.

It is for these and other reasons, that adoption of ADHP enabling legislation in HB5630 would be inappropriate at this time.

Respectfully,

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