

Legislative Testimony
H.B. 5630 AAC The Establishment Of Licensure For An Advanced Dental
Hygiene Practitioner
Public Health Committee
Monday, March 16, 2009
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My name is Dr. John A. Raus. I am a participating Husky dentist in Stamford and I have been in practice for almost 34 years. I am opposed to the Advanced Dental Hygiene Practitioner (ADHP) as proposed in House Bill 5630.

In light of the current budget deficit, future projected deficits and the many issues that this bill raises, a few observations/questions come to mind:

1. According to the new CHIP legislation, the GAO is to undertake studies of dental care for children in general, and specifically to look into the feasibility and appropriateness of using qualified midlevel dental health providers in coordination with dentists to improve access for children to oral health services and public health overall. These studies will be conducted to ascertain the level of impact ADHP may or may not achieve in dealing with Access. ADHP currently does not exist anywhere in the United States. Thus ADHP is considered to be experimental in nature and yet unproven. Have any studies been done to document the impact of ADHP in Connecticut with respect to Access? I believe the answer is no.

2. Tooth decay and periodontal disease have been documented since the 1970's as being totally preventable. Have efforts been made to fully promote state wide in-school education and prevention programs? Would this not be more cost effective then instituting an untested operative model?

An idea in the way of caries prevention would be to publish the cariogenicity of food stuffs on the packaging label much like what is done with respect to fats, carbohydrates, proteins and sugar.

3. Were DPH, the CT State Dental Association or the CT Dental Commission consulted in the creation of this proposed legislation?

4. The ADHP prototype is the New Zealand Dental Nurse. It is a model developed in a country where there are no practicing dentists for thousands of square miles. This does not apply in Connecticut. Connecticut has the 6th highest dentist to patient ratio of any state in the nation.

5. Access is not just a provider issue. It has many components: availability of practitioners, funding, patient education and cultural mores. In my opinion, the greatest obstacles to Access in Connecticut have been past administrative

aggravations, trepidations about patient compliance and a lack of adequate funding. The recently settled Medicaid lawsuit created reasonable fees, and mandated administrative changes and educational programs for the target population. It also established case workers to manage patient flow. Husky participation by dentists has grown to 818 since August of 2008. Unless there is adequate funding, any provider system will wither and return to an almost dormant state. Witness the recent suggestions brought forth in the proposed budget cuts. Old system obstacles are reintroduced as well as cuts in funding. These, as past experience has shown, are both proven methods to hinder Access. It is a digression to the same 1990's rhetoric but expecting a different result. We in Connecticut have experienced an absence of adequate and consistent year to year funding. No expansion in the number of providers can overcome Access if there is no money to pay for it.

The ADA News reported in an article entitled "A Medicaid Solution" from its February 2, 2009 issue:

...several years ago, with support of the Michigan Dental Association, Michigan's Department of Community Health formed a public-private partnership with Delta Dental of Michigan to administer dental Medicaid benefits in 21 counties and to reimburse participating dentists at competitive market rates. The program, referred to as the Healthy Kids Dental, is now available in 59 of 83 Michigan counties and serves over 200,000 Medicaid enrollees with 91 percent dentist participation. Since its inception eight years ago, the HKD program has seen an increase in the number of dentists participating in caring for the Medicaid insured, an increase in the number of children receiving care, a reduction in restorative procedures and a reduction in missed appointments. (p. 4)

The suit-related changes to the Husky program are moving Connecticut in the same direction, the difference being we are not yet a year old and Michigan has the experience of eight years. Has any study been completed regarding the effectiveness of the participating Husky dentists in answering the Access issue in Connecticut?

6. How many years will it require to bring ADHP into being and how does that time frame impact Access in 2009, 2010, 2011 and 2012?
7. What are the costs to the state today and in future expenditures, in dollars and time, to create, implement and oversee a currently non-existent ADHP position?
8. The Commission on Dental Accreditation (CODA) is recognized by the U.S. Department of Education as the accrediting body for pre-doctoral dental education, advanced general dentistry and specialty education, as well as dental hygiene, dental assisting and dental laboratory education programs. Only four of the Commission's 30 members are appointed by the ADA. The rest of the

Commission is composed of representatives from the American Dental Hygienists' Association, the American Dental Assistants Association, the National Association of Dental Laboratories, Post Doctoral General Dentistry, Recognized Dental Specialties, the general public and students.

Bill 5630 assigns ADHP program accreditation to the Connecticut Board of Governors of Higher Education and the American Dental Hygienists' Association (lines 367-374). There is no mention or requirement that the program be CODA approved. With all due respect to the Board of Governors and the Hygienists' Association, neither is an authority with respect to restorative dentistry or dental medicine. Furthermore 5630 relies on DPH for examination, regulation and oversight. DPH currently relies on dentist volunteers to oversee dentistry through the state Dental Commission. Who within the DPH will test for clinical competency and who will ensure the public safety? What measures will be used to assess clinical competency? Please note, the demands of dentistry have become so sophisticated that New York State now requires one year of post graduate residency training prior to eligibility of obtaining a license to practice dentistry.

9. The estimated education cost for an ADHP theoretically is \$180,000 (six years at \$30,000 per year). Will ADHP be private practitioners or state employees? If so, what would be the salary demands of ADHP and how would this impact available state funding? Would they also be eligible for benefits as a state employee? If other states initiate ADHP, what financial incentives will be required to keep ADHP in Connecticut?

Lines 439 to 444 define the location in which ADHP will be allowed to practice as a public health facility (which constitutes a community health center, group home, public preschool, school or head start program) or a dental health professional workforce shortage area. Who will determine (and by what means) which community health center will have an ADHP present? Who will be responsible for the cost of the equipment and overhead associated with running the clinics? Will there be costs to the state to equip and operate dental facilities that utilize ADHP? Will ADHP treat only Husky participants, the uninsured or patients who are privately insured as well? Connecticut dentists currently have the facility, equipment, knowhow and staff to overcome the Access issue without any additional costs to the state.

10. Dental school is minimally an eight year undertaking. HB 5630 calls for a six year program to fulfill the ADHP requirements. The UConn dental student will graduate with a total of 5,364 clinical and didactic hours of training whereas the proposed ADHP graduate would only have 1,036 such hours. No ADHP training programs currently are in existence.

Pediatric and geriatric patients, because of age and physiology, require specialized care. There are health and management issues in these age groups.

Pedodontics is a subspecialty of dentistry requiring a master's degree beyond that of dental school. In medicine, eldercare is evolving into a specialty field. Are the educational requirements called for in HB 5630 adequate to treat these patients? What will be the liability issues for a "collaborative dentist"?

11. As a first year dental student at the University of Connecticut, I was enrolled in the medical school. For the first two years, I attended class with the medical students, taking the same exams, doing the same labs/cadaver dissections and was expected to perform at the same level as my medical counterparts. The subject matter consisted of pharmacology, physiology, pathology, biochemistry, microbiology, anatomy, histology, and social/behavioral sciences. Competency testing on a national level was provided by:

- A. The National Medical Board Part One and the National Dental Board Part One at the end of my second year; and
- B. In the fourth year, the National Dental Board Part Two and the Northeast Regional Board Exam. The NERB consisted of two days of clinical testing and one day of didactic testing.

I once asked Dean Lewis Fox why an extensive medical education was necessary *just* to be a dentist. He explained that statistically speaking, more people visit a dentist than a physician. As a member of the healthcare team it is imperative that a dentist be capable of assessing health, recognizing pathology and making referrals to the physician counterpart. The dentist should be capable of analyzing medical ramifications of dental treatment to the same degree as the physician.

Dean Fox also stated that within my lifetime of practice, I would be treating a patient population that did not exist in 1972. These future patients would be beneficiaries of medical advancements. They would be modern day survivors of potentially life threatening illnesses, and we as dentists, need the knowledge to assure their safe dental treatment.

In my experience of 34 years of practice, Dean Fox has proven to be correct.

Thank you for your time.

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