

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 Jonah Barasz. I am a second year dental student at the University of Connecticut School of Dental Medicine, in Farmington. I am also a board member of the UConn chapter of the American Student Dental Association (ASDA), where I hold the position of legislative liaison. Please accept this as my written testimony opposing HB 5630.

Through this testimony I wish to share with you my perspective as a current dental student regarding the fundamental purpose and scope of this proposed legislation. Additionally, I describe the rigorous didactic and clinical requirements and training we receive in dental school, preparing us for the challenges we will face upon graduating.

I. Access to Dental Care is a Problem; the Solution Requires a Team Approach Supported by Evidence-Based Research

As students in the UConn School of Dental Medicine (SDM), we are very conscious about the issue of access to care. We are committed to our charge as future dentists to deliver the highest quality of care to our patients and our duty as healthcare professionals to speak up for and actively protect the interests of our fellow residents of Connecticut and beyond. It is clear that with the proposal before the legislature, the members of the Connecticut Dental Hygienists' Association (CDHA) and the Connecticut Dental Assistants Association (CDAA) equally share our grave concern for those persons who have not had access to timely, high quality comprehensive dental care. We can all agree that it is imperative that we work together as a dental team to resolve our shortcomings in this matter. We must evaluate in earnest every proposal and suggestion put forth. And, we must never lose sight that our priority is to protect the oral health of the people of this State and to make certain that when we promise to deliver increased access to care it will not be at the expense of quality of care. To that end, any changes to our current delivery structure must not be made in haste, but rather employ evidence-based research analyses so that we can execute such improvements in a targeted and prudent manner.

II. The Access to Care Problem Has Several Root Causes, All of Which Must be Addressed if a Solution is to be Successful

While access to care is a nation-wide problem, the magnitude and contributing causes to this problem varies from state to state. The lack of access to care in Connecticut is the result of several contributing factors that must be addressed by the dental healthcare

team. These factors include reimbursement rates (for which recent changes have been made), dental health education especially to underserved populations, transportation issues, patient follow-up, cultural differences, and language barriers among others. In several other states, a contributing factor to the access to care problem is due to a significant shortage of practicing dentists (i.e. Maine). We are very fortunate that Connecticut does *not* have this problem. However, while we have a sufficient number of dentists, there is a disconnection between the providers of care and the delivery of that care to the underserved. These are all real barriers to care for many in our State. Thus, the solution to the access to care problem *MUST* address each one of these in order to have the potential to be successful.

III. The Proposed ADHP Model Fails to Address Connecticut's Access to Care Problem, and Has No Evidence-Based Data to Support Such a Change to Our Dental Care Delivery System

While I greatly appreciate the CDHA and CDAA efforts to be proactive in putting forth legislation, the proposed ADHP model is not supported by evidence-based research. It would be irresponsible to radically change our dental care delivery system to one that has not been thoroughly vetted in terms of its ability to increase access to care and to provide the appropriate level of care for their target patient population. The proposed bill fails to address the major obstacles to access to care. Nowhere in HB 5630 does it address issues of language, culture, transportation, or education of the underserved. If we do not make these issues a focus in the solution to access, we will continue to fail the underserved in our State.

Through my association with UConn ASDA, I have had the privilege of attending the monthly Connecticut State Dental Association (CSDA) meetings. These meetings are comprised of dentists from all corners of the State and from all backgrounds. They bring with them a tremendous diversity of experiences including: service as dentists in US military; careers in private practice serving in urban, suburban, and rural communities; and careers devoted to public health research, development of school-based dental programs, access to care initiatives, and academia. Our monthly meetings are high energy and passionate discussions concerning the current delivery structure, proposals to improve that structure (for increased access to quality dental care), the evaluation of models put forth in other states and other countries, and presentations of the relevant evidence-based studies. The CSDA is very cognizant of the multifaceted problem at hand. They are actively pursuing solutions that can be supported by scientific data to fully address the problem.

IV. The Underserved Population are Often the Most Medically Compromised and Require Complex Dental Care, Which is the Impetus to Increase their Access to Dentists with the Appropriate Didactic and Clinical Training and to Reject a Two Tiered Dental Care System

Prospective patients of the UConn SDM clinics are required to undergo a dental and medical history screening interview. By and large, these prospective patients represent

the underserved of our State and are the target population of the proposed legislation. Many of these patients have not had regular dental care, and frequently come to the clinics with multiple dental issues. Additionally, these patients very often have extensive and complex medical conditions, some of which are controlled under the care of a physician, but many of which are uncontrolled. Treatment planning for these patients is never straight forward.

As much as our training at UConn SDM is centered on learning how to treat patients (i.e. surgical procedures including using instruments to remove infected hard and soft tissue), we also learn how to anticipate potential problems and adjust our procedures accordingly. Additionally, we are trained in how to proceed when a situation arises that could not be or was not anticipated. Such situations are not uncommon in the medically compromised patient.

The dental school education is very rigorous. Students at UConn SDM take their first two years of basic medical science classes with the medical students. That is, we sit in class together, have the same lecturers, and take the exact same exams. The philosophy at UConn is that the students are educated as doctors who specialize in dentistry. This intensity and focus for us to fully know the human body, in health and in disease, enables us to understand the medical conditions of our patients, which often dictates how we approach treating their dental issues. Without our extensive medical background, we would not be able to confidently provide safe and appropriate care to our patients no matter how healthy or medically compromised they may be. The following outlines the curriculum at UConn SDM:

Year 1

Basic Medical Sciences: **660 hours**

Curriculum: Human Systems – Human Biology; Organ Systems 1, Organ Systems 2; Organ Systems 3

Correlated Dental Science Curriculum: **300 hours**

CTiD (critical thinking in dentistry); Infection Control; Oral Diagnosis; Dental Morphology; Oral Histology/Physiology; Cariology; Operative Dentistry; Mentor Program; Clinic Activities

Year 2

Basic Medical Sciences: **600 hours**

Curriculum: Human Development & Health; Mechanisms of Disease

Correlated Dental Science Curriculum: **450 hours**

CTiD; Growth/Development; Oral Medicine; Oral Radiology; Anesthesia; Periodontics; Endodontics; Operative Dentistry; Dental Occlusion; Oral Surgery; Mentor Program; Clinic Activities

Year 3

Team Clinics and Rotations: **1,000 hours**

Patient Treatment; Dental Therapy; Rotations

Dental Science Curriculum: **700 hours**

Lectures and pre-clinical labs

Year 4

Team Clinics and Rotations: **1,500 hours**

Patient Treatment; Dental Therapy (Rehabilitation); Rotations; Student Group Practice; Competency Tests; Community-Based Care Activities

Dental Science Curriculum: **154 hours**

Advanced Topics

The curriculum proposed for the training of the ADHP is not defined in the proposed legislation. However, a proposed curriculum crafted by the American Dental Hygienists' Association (ADHA) was adopted on March 10, 2008, by the ADHA Board of Trustees. The proposed two year post-graduate curriculum is as follow:

Didactic Courses (21 credits) – roughly equivalent to **158 classroom hours** per year

Theoretical Foundations of Advanced Dental Hygiene Practice (3 credit hours)

Translational Research (3 credit hours)

Healthcare Policy, Systems & Financing for Advanced Practice Roles (3 credit hours)

Management of Oral Healthcare Delivery (3 credit hours)

Cultural Issues in Health and Illness (3 credit hours)

Advanced Health Assessment and Diagnostic Reasoning (3 credit hours)

Pharmacological Principles of Clinical Therapeutics (3 credit hours)

Advanced Practice Clinical Courses (16 credits) – roughly **360 hours** per year

Community-based Primary Oral Healthcare I-IV (12 credit hours)

Management of Dental Emergencies and Urgent Care (1 credit hours)

Capstone Community Practice (3 credit hours)

A UConn dental student will graduate with a total of 5,364 clinical and didactic hours, whereas the ADHP graduate would only have 1,036 such hours.

It is important to state that the ADHA has never attempted to imply that the ADHP training is comparable to that of a dental education. However, the ADHA does imply that the ADHP training is sufficient to safely diagnose, treatment plan, and perform surgical procedures (i.e. removal of infected hard tissue) for some of the most medically compromised members of our society. Moreover, if we were to adopt the position of ADHP as proposed, we would be sending the message that a two tiered dental care system is acceptable; a licensed dentist for those with financial means, and a lesser trained dental auxiliary for the underprivileged. I wholly reject the notion that this is the best solution that we can come up with.

I urge you to reject HB 5630; allow the recently made changes to the Medicaid reimbursement to demonstrate effectiveness; and enable the CSDA, CDHA, and the CDAA dental team to continue a dialogue and the due diligence required to solve our

access to care problem. We all understand the urgency of this situation and are committed to finding its solution.

Respectfully Submitted,

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