

**Legislative Testimony**  
**Human Services Committee**  
**HB 5355 AAC An Advanced Dental Hygiene Practice Pilot Program**  
**Tuesday, March 2, 2010**  
**Jack Mooney, DMD**

Senator Doyle, Representative Walker and honorable members of the Human Services Committee, my name is Dr. Jack Mooney and I have been practicing dentistry in the Town of Putnam for the past twenty years. I currently own a private practice and participate in a Private Practice Partnership with Generations, a Federally Qualified Health Clinic based in Willimantic. I am also a Home By One provider. My private practice sees over 400 Medicaid children and adults. I currently Chair the CSDA's Access to Care Committee and I am dedicated to finding workable solutions to increase utilization for the underserved. I am respectfully writing in opposition of HB5355. My Committee's examination of this proposed model has demonstrated that it is not a cost effective solution and where it currently exists internationally, it has had little affect on addressing Access. Personally having exhaustively studied the issue of Access, I feel that it is our responsibility to design and encourage models that have been demonstrated to positively affect Access utilization. The underserved of Connecticut deserve no less.

Last year my Committee took on the task to examine ten models of care (four included work force additions) to see if they were applicable to Connecticut. Based on the exhaustive work of our Committee we came to the following conclusions for Connecticut:

1. Private Practice model was the most efficient model delivering care in Connecticut. This legislative body had the courage two years ago to raise the Medicaid fees. Prior Utilization numbers were in the high teens; today it is around 41%. Typical utilization numbers in states with even much higher reimbursement rates lag in the 30-35% range.

2. According to DSS and Benecare, emergencies for children are addressed within 24 hours and the waiting time for a routine appointment is typically two weeks. Most of this care is provided by the private sector.
3. To address those kids who cannot access the system for various reasons, our Committee has advocated for increased collaboration between FQHC's and the private practitioner utilizing the School Based Clinic model.
4. Investigation of innovative work forces found that where they exist, they do not affect Access. In fact of the four work force additions evaluated (Advanced Dental Hygiene Practitioner (ADHP), Community Dental Health Coordinator (CDHC), Expanded Function Dental Assistant (EFDA) and Dental Health Aide Therapist (DHAT) only DHAT was found to positively affect Access and did so only when specific conditions were met. The most important condition that was required was adequate government funding

HB 5355 has several flaws that have probably already been pointed out to you. It is not a scientifically designed "pilot" because it does not predict that the model could fail and what the consequences of that failure might be. I can tell you that internationally where this model exists (Australia to name one) ADHP has failed to address Access. Nationally there are at least two well known examples of hygienists being granted increased independence under the guise of increasing Access to the underserved. In Colorado during the mid 1990's hygienists were allowed to independently practice hygiene as a solution to that states Access issues. Today there are less than twenty doing so and their practices are located not in underserved areas but in the suburbs. In Connecticut Hygienists were given the ability to be independently reimbursed in nursing homes to address the Access issue there. Today less than five do so. This record of failure and the failure of this model to serve the underserved should not be ignored. In fact outside Foundations (PEW and Kellogg) who are major stakeholders in the Access discussion, do not endorse this model. The Academy of Pediatric Dentistry and the Association of Public Health Dentists major providers in the Access issue do not endorse this model. Their analysis of the ADHP model is that it is too costly to

train with not enough education for the broad application of scope increase that ADHP demands.

This bill uses Access as a guise to the real debate of increased scopes. As you are now probably aware, increased scopes requests generates passionate responses from individuals on both sides of the issue. The Public Health Chairs in their wisdom asked PRI to study the issue and come forth with protocols and guidelines to assist legislators with these requests. This bill circumvents the proposed PRI guidelines with a proposed pilot of a failed model. It also does not address accreditation, competency testing and regulation requirements of the Department of Health. All of this will cost money in a state facing massive deficits for the foreseeable future. My Committee's suggestion for the few highly motivated individuals who would want to follow this career path would be to fast track them into the University Of Connecticut School Of Dental Medicine where they and the public would benefit from a full dental education.

I thank you for your time and effort and I am available to answer any question you have at any time.

Respectfully Submitted,

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