

Legislative Testimony
HB 5616 AAC Licensure Of Advanced Dental Hygiene
Practitioners
Human Services Committee
Tuesday, March 2, 2010
Bruce Tandy, D.M.D.

Senator Musto, Representative Tercyak and members of the Human Services Committee, my name is Dr. Bruce Tandy. I am a private practice general dentist in Vernon and Coventry who treats Medicaid children and adults, participates in the Home by One program, and am one of the leads on the Mission of Mercy project. I am also the Past President of the Connecticut State Dental Association (CSDA) representing over 2400 dentists and members of the dental team who communicate, educate, advocate, and collaborate on oral health issues and provide care to the citizens of Connecticut. I thank you for the opportunity to present this written testimony to you in opposition to HB 5616.

Access to oral health care for those individuals who do not have insurance or the financial means to seek treatment has been problematic since I entered practice 30 years ago. The difficulty is that access to care is a multi-factorial issue that has been debated with limited success. The definition of access, financial constraints, education of the target populations, and the ability of these populations to value, seek, utilize, and follow-up on their care, all have to be dealt with to achieve the plethora of access goals. The capacity in the system, from a manpower and dollars and cents standpoint, has also been inadequate and prevented success. In the past 3 years, however, there has been great progress in answering these challenges.

Access to care in Connecticut has taken a leap forward following the settlement of a 7 year lawsuit to increase Medicaid reimbursements for children under the age of 21. The suit allocated dollars and cents at 55% of the UCR rate for most dental procedures, instituted administrative changes at DSS, developed educational programs for the target population, and increased case workers to manage patient flow. Dentist participation increased to over 1200 providers bringing the capacity in the system to its highest level in a decade. Children can now be seen within 1 week of requesting an appointment and dentists continue to request the referral of more patients from Benecare and DSS. Pilot programs such as Home by One, which establishes a dental home for children and education for their parents, is changing the future needs of children. Utilization, which has now been identified as the true issue in the access equation, has increased to one of the highest levels in the nation with the increase in case workers, administrative improvements, and recognition of the value of school based programs. The CT State Dental Association (CSDA) /CT Foundation For Dental Outreach (CFDO) Mission of Mercy, public service broadcasting in collaboration with CPTV, and the development of an oral health curriculum with

educators statewide, have all contributed significantly to the success seen across the state. The PEW Foundation, recognizing this, awarded the state of CT an 'A' in handling access to care for children, one of only 6 states in the nation. The Commonwealth Fund, a foundation looking to develop high performance health care, also ranks Connecticut in its top group when evaluating oral healthcare care for children. All of this has been accomplished in a collaborative effort by the CSDA, oral health collaborative groups, and the state government agencies of DPH, DSS, and the legislature.

As noted, the capacity in the system due to the huge increase in the number of providers has not kept the CSDA from continuing to look at this issue from all sides. The CSDA has researched and reviewed over 10 different models of new providers for the dental team from around the world. We have found that access to care and scope of practice is really mutually exclusive. Increasing scopes of practice has **not been shown to increase access** to dental care for the target populations in applications internationally and domestically except in highly specific instances where major government funding and community based demand was factored in. New models may have value in CT, but they must be studied rigorously first to show improvements in access to care of the target population before any decision of implementation is made. An evidence based approach versus an emotional decision is necessary to achieve the desired outcome. A year ago, we referenced the impending independent studies to determine the economic feasibility of alternate models, a natural place to start in this time of fiscal constraint. The preliminary results on a study done in 4 states, including Connecticut, to be published in the next few months, showed the addition of a dental therapist into FQHCs provided little economic benefit to the delivery model. This was due to the fact that most procedures, 90% to be exact, were accomplished by members of the dental team other than the dentist. This was also with a lower cost provider than an ADHP. It is interesting to also note that most studies being done by the Pew and Kellogg Foundations on access to care with new provider models are evaluating dental therapists, not ADHP.

What else have we learned this past year as the workforce debate has expanded across the country?

1. In CT, with the proposed decrease in the budget dollars and the elimination of the second cleaning and checkup for well patients, the capacity in the system for the most utilized services actually increases.
2. Across the country, dental therapy is the model being evaluated in the private and public sectors as one of the answers to increasing oral healthcare capacity. The American Dental Association (ADA) is also completing pilot studies on the Community Dental Health Coordinator (CDHC). There are no evaluations on ADHP at this time by the health foundations or any other agency due to the cost to educate and employ the model and a lack of evidence that it will increase access to care.

3. No other states in the country have passed legislation to allow a new dental provider other than Minnesota's unique models, which are having difficulty attracting students, and Alaska. This is in spite of heavy lobbying and financial backing by the Pew and Kellogg Foundations. Pew has also not prioritized Connecticut due to the successes seen in access to care for children in the state.
4. Utilization is the primary focus as even with increased capacity and funding, only 42% of those children eligible for care are seeking it. Education, oral health curriculums, and continued emphasis on prevention are key to improved oral health and increasing the target populations valuing of these services
5. At the New England Rural Health Conference a year ago, representatives of the American Dental Association (ADA), American Dental Hygiene Association (ADHA), and foundations in support of dental therapy, were unable to provide support or projected support data relative to increases in access to support their workforce extender models. Much still needs to be learned to make informed decisions on any new models no matter who the proponent is.
6. The demographics of the dental workforce have not changed with an adequate number of providers remaining in the workforce due to delayed retirements and the planned opening of 20 new dental schools, one right here in New England, may continue to keep the workforce at an adequate level.
7. Studies have failed to show significant improvement in economic feasibility of dental therapists in FQHC's, have shown limited improvements in the bottom line of private practices who employ therapists, and have not proved increased access to care in Alaska.

More studies are in the offing and will continue to allow all of the stakeholders to make educated decisions on workforce changes relative to access to care. With the limited data available today, a decision on any model may be premature.

Let us not confuse the issues in this case. If we want to discuss access, let's do it. If we want to discuss scope of practice, let's do that too. The Program Review & Investigations (PRI) Committee has reintroduced a bill to make data driven access to care decisions on scope of practice issues. Dental Therapy, Interim Therapeutic Restorations, Expanded Function Dental Assisting, and ADHP should be evaluated by this process. Yet the dental team as presently composed is truly making a difference. Please allow these changes to take effect, expand, and following data driven outcome assessment, determine what is truly best for the public. Making decisions on provider models to increase access to care

without data to support an expected outcome is doomed to fail. Do not believe, based on others experience that passing this bill will increase access to care in Connecticut. Please reject HB5616 and give the positive changes in our oral health care delivery system a chance to improve the health of the citizens of Connecticut and allow data driven studies to help all of us who care about oral health make informed decisions on a decidedly emotional issue Thank you.

I would be glad to answer any questions today or in the future.

Respectfully Submitted,

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