

Legislative Testimony
Human Services Committee
HB 5616 AAC An Advanced Dental Hygiene Practice Pilot Program
Tuesday, March 2, 2011
Jack Mooney, DMD

Senator Musto, Representative Tercyak 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 one 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 700 Medicaid children and adults. I currently Chair the CSDA's Access to Care Committee and we are dedicated to finding workable solutions to increase utilization for the underserved. I am respectfully writing in opposition of HB5616. 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.

Two years ago 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. Because of this courage 60% of Medicaid patients are now seen in the private practice setting.
2. According to the Department of Social Services (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 advocated for increased collaboration between FQHC's and the private practitioner utilizing the School Based Clinic model. The CSDA's School Based Committee has been working actively with stakeholders in designing a system that allows volunteer dentists to work collaboratively together with FQHC's.
4. Investigation of innovative work forces found that where they exist, they do not affect Access much less the overall oral health of a given population. 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

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 well to do 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 (ADHP) to serve the underserved should not be ignored. 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. Also the National Dental Association, the most prominent minority

dental association has spoken out against any model that does not allow the poor the full benefit of surgical treatment by a dentist.

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 the Program Review & Investigations committee (PRI) to study the issue last year and come forth with protocols and guidelines to assist legislators with these requests. This bill circumvents the proposed PRI guidelines with a proposed failed model. It also does not address accreditation, competency testing and regulation requirements of the Department of Public Health. All of this will cost money in a state facing massive deficits for the foreseeable future.

Having studied and trying to be part of the solution to the issue of Access I find myself advocating for those indigent patients, making sure that any delivery system we develop focuses on getting care to this group. This model has already failed internationally and doesn't have any support outside the hygiene leadership community. Why our state still thinks it is relevant, while other stakeholders have dismissed this model, is perplexing and disappointing. We need models that positively affect Access because the poor in our state deserve no less.

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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