

Legislative Testimony
Human Services Committee
HB 5616 AAC LICENSURE OF ADVANCED DENTAL HYGIENE PRACTITIONERS
Tuesday, March 1, 2010
John A. Raus, DMD

Senator Musto, Representative Tercyak and members of the Human Services committee, my name is Dr. John A. Raus and I have been practicing dentistry for 34 years in Stamford Connecticut. I am a member of the Connecticut State Dental Association Board of Governors and a member of the organization's Access and Workforce subcommittee. I am also a participating dentist in the Husky Program treating both children and adults. I wish to personally thank you for the opportunity to present this written testimony to you in opposition of HB 5616.

HB 5616, Statement of Purpose:

To increase access to dental care for underserved populations through recognition and use of advanced dental hygiene practitioners in public health settings.

The state is currently making efforts to remedy a \$3.4 billion deficit. Moving forward, any proposal for a midlevel provider must be tested to proof its necessity, efficacy and cost effectiveness relative to any questions regarding Access.

The first issue- Is there a shortage of dental providers in Connecticut? In a February 7, 2011 letter from the Department of Social Services and the Connecticut Dental Health Partnership to Dr. Jon Davis, president of the Connecticut State Dental Association, the answer was demand is being met.(See Attachment).

The second issue- Are there other workforce models besides ADHP? The answer is yes. One model has completed operational testing and is the crux of workforce investigation by the renowned **Pew and Kellogg Foundations**. The model is the Dental Health Aide Therapist (DHAT). The DHAT model was specifically chosen for testing over the ADHP model. Kellogg, in October of 2010, issued an investigative report through RTI International (Project Number 0211727.000.001) that cited some positive findings regarding the model.

The third issue- Cost effectiveness? The Advanced Dental Hygiene Practitioner (ADHP) is a six year program devised under the auspices of the American Dental Hygienists Association. It is not CODA (Council on Dental Accreditation of the American Dental Association which is the accrediting agency for the U.S. government for all things dental) approved. It requires six years of college level training. At an assumed cost of \$30,000 per year of education, the minimally cost for an ADHP graduate would be \$180,000.

In CT State Dental Association (CSDA) studies, we determined the ADHP not to be a viable model because of the length of training, cost to train and the proximity of that length of training to that which is required to become a dentist. The ADHP will require licensure, testing, state regulatory oversight and another level of bureaucracy with associated costs to the state. I believe these are the same conclusions reached by Pew/Kellogg. It is therefore not cost effective for those reasons and may prove cost prohibitive when compensation is determined. If one understands that it requires six years to train an ADHP and eight years to train a dentist, then why not simply become a dentist.

In contrast, the Dental Health Aide Therapist (DHAT) is a two year program. It requires certification and re-certification every two years. There is no licensure. In the U.S., it is in use in Alaska. The DHAT program is taught at the University of Washington in the same program that develops physician's assistants. The DHAT functions under the supervision of a dentist. **The DHAT model is designed to fulfill the same functions as the ADHP but at one third the educational costs and in one third the time for training.** The Connecticut State Dental Association has selected the DHAT as an appropriate model **to pilot test** in Connecticut to determine if such an extender will have impact on Access to dental care.

Another benefit, the DHAT model is designed to draw applicants from the access target community and to return those applicants to that community to serve the community's dental needs. The simplicity of the DHAT program allows the qualified community residents or two year or four year hygienists to become a DHAT thus creating a greater applicant pool. The ADHP program precludes anyone other than hygienists to participate. We believe the operational costs of the DHAT to be less than that of the ADHP and therefore a more financially sustainable program for public health funding.

Fourth issue- Efficacy, does ADHP assure increased Access to dental care? What is the ultimate goal for utilization? Currently the utilization rate for private insurance is 60%. Unfortunately there has yet to be a study that specifically demonstrates that any dental extender model, DHAT or ADHP, will conclusively increase utilization or Access. There are numerous variables that affect both, the number of providers being just one aspect.

In closing, I would like to again thank the Committee for allowing me to testify before you today and would be happy to make myself available, now or at any other time, should you have questions.

Sincerely,

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