

Legislative Testimony
Human Services Committee
HB5616 AAC Licensure Of Advanced Dental Hygiene Practitioners
March 1, 2011
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Senator Musto, Representative Tercyak and members of the Human Services committee, my name is Jonathan Knapp and I have been practicing dentistry for 18 years in the town of Bethel. I am an active provider in the Connecticut Medicaid program who has many, and is still accepting, patients in that plan. My office participates in the Home By One project for infants, and I provide pro bono care to many other residents of our state including free oral health screenings to seniors throughout western Connecticut. I am a board member of the Connecticut Foundation For Dental Outreach and a core participant in the Connecticut Mission of Mercy Project (CT-MOM). I thank you for the opportunity to present this testimony to you in opposition to HB 5616.

This bill and this concept are not new. Since 2004 we have been holding meetings among stakeholders to address the issue of access to dental care for Connecticut's neediest citizens. During that time, the CSDA has presented, developed, and promoted many initiatives aimed at improving access and availability of care for those on Medicaid, as well as those who are under or uninsured. With the enactment of the carve-out, along with the significant improvement in the Medicaid program for children, we have recruited over 1200 providers and continue to enlist more. But it doesn't end there; we have also worked to promote the school-based delivery model and developed a curriculum for oral health education in schools. We have collaborated with CPTV to create TV programming on the connection between oral health and overall health. Our MOM project, along with smaller mini-MOM's have provided several million dollars worth of free care to our citizens. Contrary to what we heard last year, we did not turn any kids away from the MOM Project. In fact, the success of the HUSKY Program has made it possible for all kids who were previously underserved to easily find a dental home. We had so few kids coming to the MOM event last year (because they are being seen in their own communities) that the pediatric dentists switched to seeing adults.

Lastly, we have asked the legislature to support the Donated Dental Services Program, which has assured a minimum of \$300,000 in additional free care if the state would fund \$85,000 for a local administrative position – a 3 to 1 guaranteed initial ROI, which is likely to go higher. Although that particular request has not been granted yet, we will continue to advocate for it because of its tremendous value proposition for our state. All of these efforts have resulted in Connecticut being ranked in the top states in terms of providing oral health care to the previously underserved. The Pew Foundation, and the Commonwealth Fund, who each rate the states on access to oral healthcare, have both recognized our state for the success we have had in providing services for our kids.

While many other projects have germinated and grown since 2004, the only answer that we have heard from the Connecticut Dental Hygiene Association, to address access, is to enact the American Dental Hygienist Association's ADHP model. This same model, put forward in 2009 as HB5630, and last year as HB5355, is again before you in HB5616. It appears not to have evolved or to have been enhanced in any way from where it was 7 years ago, and most importantly it has not been enacted anywhere since it was first put forward. During that same time period, other proposals have garnered the attention of foundations, policymakers and other stakeholders, and are being scrutinized and moved forward in research projects to determine their effectiveness at improving access. In all that time, I am not aware of any funding, from any agencies, in support of the ADHP

model, despite a keen awareness of its presence by those who most actively seek to improve delivery of oral healthcare.

Last year it became apparent that this is not truly about access, when that ADHP bill was morphed into a way to create a career ladder for hygienists. The reality is that alternative masters programs already exist in dental hygiene for various roles in education, administration, and public health. The most appropriate next step on a career ladder would be for the legislature to provide appropriate pathways for motivated hygienists, who meet the rigorous academic qualifications demanded for admission, to enter dental school.

There are additional misconceptions that exist with regard to this entirely new provider. It is easy to fall into the trap of thinking that this practitioner will cost less. Fiscal viability must be keenly scrutinized, and consideration given to where this new provider will fit in the salary scheme of existing healthcare practitioners. Hygienists in the Hartford and Bridgeport areas, many of whom have only a two year associates degrees, are commanding yearly compensation in the range of \$70,000 to \$80,000 or more¹. Conservative estimates on how much this Master's-level education will cost the student, based on financial information from Fones School of Dental Hygiene in Bridgeport, range from \$135,000-\$150,000 total. A student with loans in excess of \$100,000 will be looking for, and expect jobs that pay over \$100,000 per year; a figure that would not be sustainable in public health settings, for the limited scope of procedures that are reimbursed by government dollars. The reality is that private practitioners who participate in HUSKY are still "cost-shifting" some of the burden to private paying patients, in order to provide the care to HUSKY clients at the reduced rates that are paid. Proponents of this bill have said that salaries for this new position will not be more than the current salaries for hygienists. If that is the case, we will never see enough hygienists opting to pursue this Masters degree to make any significant impact on increasing utilization of dental services.

We have consistently attended meetings since 2004 in an effort to reach common ground on these discussions however, proponents of the ADHP model have yet to provide the needed facts in order to make evidence-based decisions on behalf of the most vulnerable of our citizens. What it all boils down to is that this is a scope of practice issue. In an effort to move the process along, last year the CSDA supported the legislation put forward as a result of the PRI Committee process, HB5258-2010, which set out parameters by which a request for increased scope would be allowed or denied. We need a systematic, rigorous methodology to determine the merits of scope of practice requests like this one. For the reasons outlined above, and because of the possibility of an evidence-based process from PRI, I urge you to defeat this latest ADHP bill, HB5616.

In closing, I would like to again respectfully thank the members of the Human Services committee for allowing me to provide this testimony. If you have any questions, I would be happy to address them at your convenience.

Sincerely,
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