

Legislative Testimony
Public Health Committee
HB5541 AAC Services Provided by Dental Professionals and Certification for Advanced Dental Hygiene Practitioner
Wednesday, March 21st, 2012
John A. Raus, DMD

Senator Gerratana, Representative Ritter and members of the Public Health committee, my name is John Raus and I have been practicing dentistry for 36 years in Stamford Connecticut. I am a member of the Board of Governors for the Connecticut State Dental Association and a participating dentist in the Connecticut Dental Health Partnership.

Questions:

1. To what extent is the dental access issue in Connecticut and if so..,
2. Will creation of a midlevel provider solve dental access in Connecticut and if so..,
3. Of all the available midlevel models which is the best suited midlevel model for Connecticut.
4. Effectiveness of the Department of Public Health scope of practice process.

1. Within the Department of Public Health (DPH) Committee meeting discussion, there was to be no presentation of opinion. We were requested to present documentation. At the DPH meeting it was made abundantly clear, by data supplied by the Department of Social Services, that there did not exist a Medicaid access problem but rather a utilization issue. The necessary infrastructure exists, the shortfall was getting patients to utilize the available service. On Dental Day at the LOB, March 14th, it was reiterated that 99.4% of children on Medicaid have access to at least two dentists within ten miles of their home and any child in an emergent state is seen within 24 hours for care and that the same child could have an appointment for routine care within two weeks. This was lauded as impressive by the attending healthcare community and state officials, some of whom are in attendance today. It was also noted that Connecticut placed amongst the nation's leaders in this category. This feat is a realization of what the state and the private sector can accomplish with mutual cooperation. It is a show of force for the 1300 plus providers in this state who participate in the Connecticut Dental Health Partnership, formerly known as Husky. In other words, there is no shortage of providers. ADHP would expand the number of providers.

2. ***"Although it seems conceivable that the creation and utilization of a mid-level oral health provider such as an ADHP has the potential to enhance access to quality and affordable healthcare in Connecticut primarily through increased utilization, there was no documented current practice data provided to support this theory."*** (page 14, Scope of Practice Review Committee Report on Advanced Dental Hygiene Practitioners)

This statement makes the assumption that utilization will increase by increasing the number of providers. In order to be eligible for federal assistance dollars, the mid level model will have to exist in both the public and private sector. In the extreme sense, will an ADHP or dentist on every street corner make people more amenable to seek treatment? The current utilization level for those individuals with private dental insurance is about 60%. The current utilization level within the Connecticut Dental Health Partnership according to DSS is 57%.

3. At the DPH meetings, the Dental Health Aide Therapist midlevel model (DHAT) was introduced. The midlevel model currently is in use in Alaska and its efficacy has been studied and documented by the Kellogg Foundation. I have attached a comparison for your review of ADHP, DHAT and two other models. Because of time limitations and its directive, the DPH report chose to focus its efforts on ADHP and not the DHAT therapist model (page 3). If we are truly good stewards of the state's resources and advocates for the poor then we must consider all the alternatives and their treatment, safety and cost effectiveness. Adoption of ADHP will very well preclude the ability to seek out and proof, if needed, a more appropriate mid level model.

4. "The committee was not presented with draft statutory revisions for review. Should the Public Health Committee decide to raise a bill related to the CDHA's scope of practice request, The Department of Public Health along with the pertinent organizations that were represented on the scope of practice review committee to review this request (CDHA and CSDA) respectfully request the opportunity to work with the Public Health Committee on such a proposal." (page 4 , Scope of Practice Review Committee Report on Advanced Dental Hygiene Practitioners)

Unfortunately there was no opportunity for all committee participants to review/rebut/comment on the report or to have input on the language included in this Bill.

I participated in the DPH process, as a representative from the Connecticut State Dental Association, attending the two scheduled meetings. At that time there were three proposed dental scope changes, EFDA, ITR and ADHP. Each was discussed and it was noted that each of these scope requests are distinctively different, enjoying a commonality in that they all pertained to dentistry and purported to perhaps impact access. It is particularly frustrating and I am dismayed that this Bill collectively joins all three together and does not foster discussion allowing each to rise or fall on merit or lack thereof. I think this completely defeats the envisioned PRI process, a process which we at the Connecticut State Dental Association supported.

In closing, to those who support the proposed ADHP model, please demonstrate first the need with verifiable documentation then personally guarantee that implementation of ADHP will meet all objectives and solve the "access" issue to the extent the proponents claim. If that be the case, I will endorse its passage and I will encourage my colleagues to do the same. I would also like to thank the members of the Public Health committee for allowing me to submit this testimony.

Respectfully,

John A. Raus, D.M.D.
john_raus@hotmail.com
108 Slice Drive
Stamford, Ct 06907
203 918 0162

	Advanced Dental Hygiene Practitioner (ADHP)	Alaskan Dental Health Aide Therapist (DHAT)
Developed by	American Dental Hygienists' Association www.adha.org/adhp	Alaska Native Tribal Health Consortium (ANTHC) – Community Health Aide Program www.anthc.org
Stage of Development	ADHP educational competencies were finalized in 2008. The first educational program based on ADHP competencies began in Fall 2009.	DHAT practice began in Alaska in 2004. The first graduates from the U.S.-based DENTEX program began practice in 2008.
Education/ Training	Master's level education at accredited institution; open to individuals currently licensed as dental hygienists who have a Bachelor's degree	24-month program administered by ANTHC in partnership with the University of Washington DENTEX program
Regulation/ Licensure	Providers are already state licensed dental hygienists. ADHP is envisioned to be state licensed and regulated.	Providers are certified and regulated by Indian Health Service's Community Health Aide Program.
Proposed Settings	Community and public health settings, possibly private practice	Remote Alaskan villages
Proposed Supervision	Collaborative arrangement envisioned with strong communication and referral networks; presence of a dentist not required; use of teledentistry.	Remote/general supervision of a dentist; presence of a dentist not required; use of teledentistry
Other Relevant Information	ADHA convened an ADHP Task Force, an ADHP Advisory Committee, and sought input from approximately 200 stakeholder groups in developing ADHP competencies. Several national stakeholders, including the National Rural Health Association and National Rural Education Association, support the ADHP model. Language in the report accompanying the FY 2006 Labor/HHS Appropriations encourages federal agency support of the ADHP. Metropolitan State University is the first education program to begin guided by ADHP competencies. Eastern Washington University and the University of Bridgeport Forbes School of Dental Hygiene have formal commitments to begin ADHP programs.	Formal evaluations of DHAT practice have demonstrated that irreversible dental procedures can be safely and effectively delivered by non-dentists. Dental therapist models are prevalent in more than 50 countries internationally. DHAT providers are often Alaskan Natives who reside or grew up in the remote villages they serve. The Kellogg Foundation began a comprehensive two-year study to evaluate effectiveness in 2008.
Preventive Scope	<ul style="list-style-type: none"> • Oral health and nutrition education • Full range of dental hygiene preventive services, including complete prophylaxis, sealant placement, fluoride treatments, caries risk assessment, oral cancer screenings • Expose radiographs • Advanced disease prevention and management therapies (e.g. chemotherapeutics) 	<ul style="list-style-type: none"> • Oral health and nutrition education • Sealant placement • Fluoride treatments • Coronal polishing • Prophylaxis • Expose radiographs
Periodontal Scope	Provide nonsurgical periodontal therapy.	Provide nonsurgical periodontal therapy.
Restorative Scope	<ul style="list-style-type: none"> • Preparation and restoration of primary and permanent teeth • Placement of temporary restorations • Placement of pre-formed crowns • Temporary recementation of restorations • Pulp capping in primary and permanent teeth • Pulpotomies on primary teeth • Uncomplicated extractions of primary and permanent teeth • Place and remove sutures • Provide simple repairs and adjustments on removable prosthetic appliances 	<ul style="list-style-type: none"> • Restorations of primary and permanent teeth • Placement of pre-formed crowns • Pulpotomies • Nonsurgical extractions of primary and permanent teeth
Additional Competencies	<ul style="list-style-type: none"> • Local anesthesia and nitrous oxide administration • Diagnosis within scope of practice • Limited prescriptive authority (for prevention, infection control and pain management) • Triage • Case management • Health care policy and advocacy • Health promotion for individuals, families, communities • Patient referral 	<ul style="list-style-type: none"> • Local anesthesia administration • Patient referral

Minnesota Dental Therapist /Advanced Dental Therapist (DT/ADT)	Community Dental Health Coordinator (CDHC)
<p>Minnesota State Statute and Rules www.dentalboard.state.mn.us</p>	<p>American Dental Association www.ada.org</p>
<p>Educational programs for the DT (at the University of Minnesota School of Dentistry) and ADT (at Metropolitan State University) began in Fall 2009.</p>	<p>Curriculum complete and initial educational pilot program began in Winter 2009.</p>
<p>Educational programs for the DT (at the University of Minnesota School of Dentistry) and ADT (at Metropolitan State University) began in Fall 2009.</p>	<p>Completion of 18 months of training.</p>
<p>Providers required to hold state license; can be dually licensed as a dental hygienist and administer dental hygiene scope.</p>	<p>Providers envisioned to be certificated; no formal state licensure</p>
<p>Settings that serve low-income and underserved patients, or are located in designated dental health professional shortage areas.</p>	<p>Community and public health settings</p>
<p>DT – General or indirect supervision depending on service ADT – Collaborative management agreement with dentist, presence of a dentist not required for most services</p>	<p>Onsite or general supervision, depending on service</p>
<p>Minnesota is the first state to legislate new, mid-level oral health providers, the DT and ADT. A thirteen-member workgroup, comprised of various stakeholders, made recommendations on scope, supervision and education.</p>	<p>The ADA convened an internal workgroup to develop CDHC curriculum. The ADA and ADA Foundation have committed nearly \$7 million to fully fund CDHC pilot programs over five years.</p>
<p>The ADT education program at Metropolitan State University is guided by the ADHP competencies, competencies for the New General Dentist, and requires students to be licensed and actively practicing as a dental hygienist.</p>	<p>The University of Oklahoma, UCLA (in conjunction with Salish Kootenai College in Montana) and Temple University in Philadelphia are CDHC pilot sites.</p>
<p>The DT program at the University of Minnesota does not require an oral health-based baccalaureate degree or licensure as a dental hygienist for admission to the program.</p>	<p>CDHC trainees are recruited from the communities the provider is intended to serve.</p>
<p>Initial graduates of DT/ADT programs are anticipated to enter the workforce in mid-2011.</p>	
<ul style="list-style-type: none"> • Oral health and nutrition education • Sealant placement • Fluoride varnishes • Coronal polishing • Oral cancer screenings • Caries risk assessment • Expose radiographs 	<ul style="list-style-type: none"> • Oral health and nutrition education • Sealant placement • Fluoride treatments • Coronal polishing • Scaling for Type I Periodontal patients • Collection of diagnostic data
<p>N/A</p>	<p>N/A</p>
<ul style="list-style-type: none"> • Restorations of primary and permanent teeth • Placement of pre-formed crowns • Placement of temporary crowns • Extractions of primary teeth • Nonsurgical extractions of permanent teeth (ADT only) • Direct /indirect Pulp Capping • Pulpotomies on primary teeth • Atraumatic restorative therapy 	<ul style="list-style-type: none"> • Palliative temporization (with hand instrumentation only) • Placement of temporary restorations
<ul style="list-style-type: none"> • Local anesthesia nitrous oxide administration • Dispense analgesics, anti-inflammatories, and antibiotics • Provide, dispense, administer analgesics, anti-inflammatories, and antibiotics (ADT only) • Assessment and treatment planning as authorized by collaborating dentist (ADT only) • Repair of defective prosthetic devices • Placement and removal of space maintainers • Stabilization of reimplanted teeth 	<ul style="list-style-type: none"> • Development and implementation of community-based oral health programs • Case coordination • Administrative/office management procedures • Triage