

Date: Wednesday, March 20, 2013

Legislative Testimony to the Public Health Committee

Regarding: H.B. No. 6589, An Act Establishing a Task Force to Study the Scope of Practice for Dental Hygienists

Submitted by: Marie Paulis, RDH, MSDH

Senator Gerratana, Representative Johnson, Senator Slossberg, Representative Miller, and Members of the Public Health Committee,

My name is Marie Paulis and I am a registered dental hygienist with 20 years of clinical experience and an educator in the State of Connecticut. I live in Milford and work in Bridgeport, educating dental hygiene students at both the University of Bridgeport and Southwest Community Health Center. I am also President of the Bridgeport Dental Hygienists' Association.

I oppose RB No. 6589, An Act Establishing a Task Force to Study the Scope of Practice for Dental Hygienists, because this study has already been done, both in the State of Connecticut and beyond. I do, however, support the creation of a mid-level dental hygiene provider, who is able to work in a public health setting, in collaboration with a dentist. I think it is time the act on the existing research instead of spending more time and resources proving what has already been established...that the mid-level dental hygiene provider is a safe, effective, proven dental practitioner that is able to meet the needs of the public health community. As has been established, the mid-level dental hygiene practitioner would work in collaboration with a dentist, by virtue of a formal, written collaborative agreement.

The mid-level dental hygiene provider has been established under various titles.

Titles for this position include the Advanced Dental Therapist in Minnesota. The name of this position is irrelevant and is not controlled by dental hygienists. No matter what initials are chosen to represent this mid-level provider, the key attributes of the ADHP or mid-level provider, or Advanced Dental Therapist, are as follows:

- The hours of education for the scope of practice are comparable to or more than the those same skills taught in dental schools;
- This mid-level dental hygiene provider will work in public health settings;
- A formal, written collaborative agreement will guarantee that the mid-level provider will have the support of a dentist
- Evaluative measures will be in place and to guarantee clinical and didactic competence of the mid-level practitioner, just as current dental hygienists are educated to the highest standards;
- This is not a two-tiered system, where the "have-nots" are getting lesser quality care. In contrast, this position will enable more dental providers to reach populations are not currently able to afford basic dental treatment and will introduce formerly underserved dental patients into a system that will be able to meet their needs in a caring, cost-effective manner;
- The scope of practice has been studied already and the safety of this model has been proven, both in the State of Connecticut and around the world. I would be happy to discuss all the established research.
- Please consider that in 2014, thousands more people will qualify for dental treatment because of the Affordable Care Act. How is Connecticut preparing for this?

Collaborative Agreement

The Advanced Dental Hygiene Practitioner would serve as part of a team of healthcare providers. Dental hygienists are already educated to provide referrals for medical and dental conditions outside of our scope of practice. As an ADHP, practitioners would work in collaboration with a dentist by virtue of a formal collaborative agreement. A *collaborative agreement* is "a formal written document that outlines the professional practice between a licensed dental hygienist and a dentist" (Normandale, 2010). The committed parties agree to provide the optimal treatment for the patient while working together within each other's scopes of practice. The services outlined in a collaborative agreement may be performed without the physical presence of a dentist.

Collaborative agreements are widely used in medical practice, between nurse practitioners and physicians, for example (Mertz, 2011). Additionally, they are used in dentistry between dentists and public health hygienists and in Minnesota between Advanced Dental Therapists and dentists. The collaborating dentist, ADHP, and place(s) of employment should retain copies of the collaborative agreement. Items addressed in a 2-3 paged collaborative agreement may include:

- Dentist and ADHP contact information, license numbers, and signatures
- Declaration of achievement of pre-requisite licensure/hours for ADHP
- ADHP agreement to practice within scope of practice (CT Statute# ___)
- Statement of both parties to maintain professional liability insurance
- Specification of location where ADHP services will occur and administrator contact information
- ADHP statement of agreement to refer to collaborating dentist
- Dentist statement to accept referrals from referring ADHP or to contact ADHP in the event of need for a referral to a different provider

- Declaration that all patients received a “Consent to Treatment” prior to receiving treatment from the collaborating ADHP or dentist
- List of medical conditions requiring pre-treatment consultation between the ADHP and dentist and/or physician
- Agreement to review this collaborative agreement and resign at least once per year or upon change

Safety Record of Mid-Level Dental Hygiene Providers

The W.K. Kellogg Report, A Review of the Global Literature on Dental Therapists (2012), investigated the safety and effectiveness of mid-level dental practitioners in 2012. This report is a 460-paged document compiled by 4 lead authors, and 14 contributing authors, who are distinguished dentists and dental school professors; therefore, to dismiss its significance would be negligent. According to the Kellogg Foundation’s report, the mid-level dental provider has been utilized in 54 countries around the world, with the first models in place over 50 years ago. In 2009, the Dental Therapist model was put into place in Minnesota. There have been quite a few studies, in Alaska, Canada, and New Zealand, to name just a few, where the work within the limited scope of practice of a graduating mid-level dental provider was compared to that of a graduating dental student and evaluated by dental professors who did not know which provider completed the work. The skills completed by mid-level providers were found to be at least comparable to skills of dental students, and in some cases, better. In addition, studies in the United States in the 1970’s in Iowa and Massachusetts showed that dental hygienists could perform clinical skills outlined in the mid-level provider scope of practice to the same competency as a dentist, given the proper education. There have been no identifiable safety issues with a mid-level dental provider and the benefits to public health systems are well documented. It is unfounded to question the safety of a provider model that has been well established as safe and effective (Nash, et al., 2012).

ADHP Fiscally Responsible

The ADHP mid-level dental provider has been proven to meet the public health need for dental care, while reducing the economic burden on government. This model is fiscally responsible because a large part of health care cost is the cost of labor. “Therefore, the use of the lowest-cost labor that is adequately trained to provide particular services should bring savings to the delivery system” (Mertz, 2011). Dental clinics write off a significant portion of services a year and it will make the clinics more sustainable, without state, federal, or grant dollars (Cauthon, 2013). Fifteen states, including Connecticut, already recognize registered dental hygienists as Medicaid providers (ADHA).

The ADHP would be part of a public health system already in existence and would be an employee of the public health system, thereby, avoiding the additional overhead that is so prevalent in private dental offices. Since most dental offices are private businesses, there are high overhead costs involved in establishing and maintaining a dental practice. Therefore, it is more difficult to make a profit with reimbursement from Medicaid being lower than private insurance reimbursement. According to David Nash, DDS, in an article titled *Nothing to Smile About* (2012), “Dentists establish practices where people can pay for dental care, and they do not practice where people cannot afford to pay for care.” An ADHP working within the already established public health system would provide cost effective, high-quality care within a system that already has the resources to accept and submit Medicaid claims.

In addition to holding many other high-ranking medical positions, the Honorable Dr. Louis Sullivan, a physician who was the secretary of Health and Human Services from 1989-1993, published an article in the NY Times in April of 2012 that concluded: “Public officials should foster the creation of these midlevel providers- and dentists should embrace the opportunity to broaden the profession so they can expand services to those in need.”

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