

**Legislative Testimony**  
**Public Health Committee**  
**HB6275 An Act Concerning Certification for Advanced Dental Hygiene Practitioners**  
**Wednesday, March 11, 2015**  
**Bruce Tandy, DMD**

Senator Gerratana, Representative Ritter and members of the Public Health committee, my name is Bruce Tandy and I have been practicing dentistry for 36 years in the towns of Vernon and Coventry. I am a Past President of the Connecticut State Dental Association (CSDA), the Co Chair of the Connecticut Mission of Mercy, and am one of the more than 1,900 dentists who provide services to the patients of the CT Dental Health Partnership. I have also actively participated in the lobbying for the scope review process and provided testimony during the hearings for the CSDA. I thank you for the opportunity to present this testimony to you in opposition to HB 6275.

Writing this testimony, I had a great sense of de ja vu as we are back to talking about a model of access to care capacity expansion that is unnecessary, unproven, and previously debated and deemed unacceptable by previous meetings of the state legislature over the past 10 years. With the increase in Medicaid providers to over 1,900, the Department of Social Services has testified that there is no access to care issue for children in the state of Connecticut. Utilization of available services, based on DSS and independent research data, continues to be the issue, not capacity, even though we have some of the highest utilization rates in the country due to the success of the CT Dental Health Partnership Program. To add more capacity, at a time when it has been proven that this is not the issue, is problematic. Failing to utilize strategies that have been implemented successfully worldwide, are acceptable to all oral health stakeholders, and can truly improve utilization of oral health care services by the neediest of our state residents, is irresponsible.

Seven years ago, the CSDA took it upon itself, to take an evidence based approach to the access to care issue in the state. Data from around the world, was reviewed, digested and used to develop positions not just on ADHP, but dental therapists, EFDAs, ITR(Interim therapeutic restorations), and CDHC (Community Dental Health Coordinator). Emotion was not going to be the driver on this issue. We believed that if we were going to take a position, it would not be out of fear for our profession, but out of the hope for the improvement of oral health in Connecticut. The stance we ultimately took was not necessarily in lock step with our parent organization, the ADA, but allowed us to arrive today with a huge success story in helping the children of CT.

Five years ago, noting the extreme use of volunteer, professional, and legislative resources needed to deal with the annual emotional debate on access to care and workforce models, we worked diligently to help DPH establish a process to allow an evidence based approach to the legislative process for establishing scope of practice decisions. Many of us provided information to help the process accomplish its goal. The reports to this Committee were reasonably accurate and informative. Yet based on the bill we are debating, the process did not successfully accomplish the original intent of the committee, in my opinion. The strongest case was made for ITR and EFDA, with EFDA being placed before you again this year as ITR has not been accepted by the CDHA without expansion of scope to the ADHP level, a self serving position, not one of public health. For the Committee's information, I have attached a copy of the report from the Scope of Practice Review Committee on Interim Therapeutic Restorations (ITR) for Dental Hygienists.

As an individual involved on multiple levels in bringing better oral health care to our state through Mission Of Mercy and the Access Committee of the CSDA, I would like to bring a different perspective to this discussion.

I have participated as a panelist with the PEW and Kellogg Foundations, major proponents of an alternative dental provider, none of which is an ADHP. I have heard of all the potential workforce models and their possible effect on access to care. I have also seen that the data does not support another provider model here in CT. The education, regulatory, legislative, and political hurdles are indeed daunting, and has driven this decision making process into a long term strategic discussion. We have seen this in CT based on the 7 year lawsuit that raised the fees to 50 cents on the dollar for dental services and another 9 years of debating the ADHP concept. In the meantime, how many children have missed school, not fallen asleep, and not participated in just being a kid, due to dental pain that could have been avoided by allowing a simple, easily taught, worldwide accepted procedure provided by the present hygiene workforce in school based programs. The latest Institute Of Medicine report stressed that we should maximize the use of the present dental team to make improvements in oral health. ITR, as an example of a widely accepted modality, should not be provided by only ADHP trained hygienists as presented in previous debates and legislation, but all appropriately trained hygienists, a much larger workforce.

Another example of how we have changed the oral health landscape is a recent research paper by our UCONN faculty reviewing the changes in the oral health landscape and outcome assessment of the utilized modalities to accomplish these changes. It was shown that by increasing Medicaid fees to 50% of usual fees, increasing the network of dentists to adequate capacity, and the use of case workers to get children to the care, has had a profound effect. When these pieces fell into place, a huge increase in utilization occurred with restorative and surgical services increasing significantly. Five years later, the children of CT are having preventive services done at an increasing rate as their disease has overwhelmingly been reduced. A national success story and model that should now be applied to adults.

The professional, advocacy, and legislative partners have all made an amazing difference in this state in access to care as noted previously. But utilization, the true issue, can only be improved by education, oral health literacy, use of case workers, and the focus on eliminating barriers to care. Money and effort spent in this arena will yield tangible results, devoid of politics and emotion, and effect change quickly and inexpensively. Let's focus on proven ways to get needed care to our citizens. We all have the best interests at heart otherwise we would not be involved in this discussion.

In closing, I would like to again respectfully thank the members of the Public Health committee for allowing me to submit this testimony and would urge you to oppose this bill and focus on what we can do NOW, not 5 years from now, for those in need of oral healthcare in CT. If you should have any questions I will do my best to make myself available at your convenience.

Sincerely,

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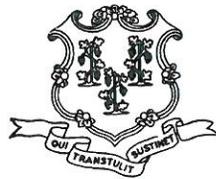


# Report to the General Assembly

An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations:

Scope of Practice Review Committee Report on Interim Therapeutic Restorations (ITR) for Dental Hygienists

**Jewel Mullen, MD, MPH, MPA, Commissioner**  
**02/01/2012**



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State of Connecticut  
Department of Public Health  
Report to the General Assembly

An Act Concerning the Department of Public Health’s Oversight  
Responsibilities relating to Scope of Practice Determinations for Health Care  
Professions: Interim Therapeutic Restorations (ITR) for Dental Hygienists

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## ***Executive Summary***

In accordance with Public Act 11-209, the Connecticut State Dental Association (CSDA) submitted a scope of practice request to the Department of Public Health to change the scope of practice for dental hygienists. CSDA submitted a scope of practice request to increase the scope of dental hygiene practice to include interim therapeutic restorations (ITR) with hand instruments in public health and institutional settings. The Department also received two additional scope of practice requests related to dental care and services: a request from the Connecticut Dental Hygienists Association (CDHA) related to advanced dental hygiene practitioners and a request from the Connecticut Dental Assistants Association (CDAA) related to expanded function dental auxiliaries. The Department made a decision to combine the scope of practice review committees due to the complexity of the issues and because the impacted parties are the same for all of the requests. The decision to combine the committees was supported by scope of practice review committee members. A separate report, however, is being submitted for each of the scope of practice requests as the issues are very distinct.

The scope of practice review committee reviewed and evaluated the CSDA's request to expand the dental hygiene scope of practice as well as subsequent written responses to the request and additional information that was gathered through the review process. Literature and other information reviewed and evaluated by the scope of practice review committee demonstrated that Interim Therapeutic Restoration (ITR) with hand instruments is a safe and effective procedure that should be included within the dental hygiene scope of practice, and would be particularly useful in the public health settings where dental hygienists are already treating patients who may benefit from this procedure. Evidence supports that the procedure is successful in slowing the disease process and buys additional time for the patient to get an appointment to see a dentist for more definitive care. It should be noted that practitioners must be careful in educating patients that ITR is not complete treatment and stress the importance of the need for follow-up care with a dentist. In addition, evidence supports the view that in most cases, providing an interim measure such as ITR is far better than simply allowing the decay to continue. ITR would also allow a hygienist to restore and prevent further decalcification and carries in young patients, uncooperative patients or patients with special needs when the placement of traditional dental restorative materials are not feasible. Studies are available that demonstrate that while ITR is not a definitive treatment, it may stabilize the diseased dentition for up to 4 years.

If ITR is added to the scope of dental hygiene practice, the practice act must also be clarified to include references to dental hygiene triage and diagnosis. It would be within the dental hygienist's discretion to triage the patient and determine whether ITR is appropriate at that time or whether an immediate referral to a dentist is required. Education and training related to the performance of ITR can certainly be incorporated into existing accredited dental hygiene education programs moving forward and an interim program could be developed by Connecticut's accredited dental hygiene programs or the dental school to allow currently licensed dental hygienists to gain competency in this procedure.

The scope of practice review committee did not identify any public health and safety risks associated with the request, provided the changes would be implemented in conjunction with the above recommended statutory revisions related to the dental hygiene practice act and educational programs are able to offer the necessary training. Evidence provided by the CSDA demonstrated that enactment of these changes has the potential to enhance quality and affordable health care in Connecticut and enhances the ability of the dental hygiene profession to practice to the full extent of its education and training.

The committee was not presented with draft statutory revisions for review. Should the Public Health Committee decide to raise a bill related to CSDA'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 (CSDA and CDHA) respectfully request the opportunity to work with the Public Health Committee on revised statutory language.

## ***Background***

Public Act 11-209, An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations for Health Care Professions, established a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of this act, persons or entities acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written impact statement to the Department of Public Health. The Commissioner of Public Health shall, within available appropriations, establish and appoint members to a scope of practice review committee for each timely scope of practice request received by the Department. Committees shall consist of the following members:

1. Two members recommended by the requestor to represent the health care profession making the scope of practice request;
2. Two members recommended by each person or entity that has submitted a written impact statement, to represent the health care profession(s) directly impacted by the scope of practice request; and
3. The Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, non-voting member of the committee.

The Commissioner of Public Health was also authorized to expand the membership of the committee to include other representatives from other related fields if it was deemed beneficial to a resolution of the issues presented.

Scope of practice review committees shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an

assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. Upon concluding its review and evaluation of the scope of practice request, the committee shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of Public Health (DPH) is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

### ***Scope of Practice Request***

The Connecticut State Dental Association (CSDA) submitted a scope of practice request to increase the scope of practice of dental hygienists to include interim therapeutic restorations (ITR) with hand instruments in public health and institutional settings.

### ***Impact Statements and Responses to Impact Statements***

Written impact statements in response to the scope of practice request submitted by the CSDA were received from the Connecticut Dental Hygienists Association (CDHA) and the Connecticut Association of Endodontics (CAE). CDHA provided very specific comments and requested that a scope or practice review committee be established to review the request as it directly impacts the scope of practice of its members. While CDHA acknowledged the merits of ITR, they do not see implementation of this proposal as a solution to improving access but as another "band aid application" when comparing it to a more comprehensive approach such as the advanced dental hygiene practitioner. CDHA also expressed concern that patients may perceive ITR as complete treatment and that follow-up care is not indicated. CAE supports the proposal. CSDA submitted written responses to both the CDHA and CAE, which were reviewed by the scope of practice review committee.

### ***Scope of Practice Review Committee Membership***

In accordance with the provisions of Public Act 11-209, a scope of practice review committee was established to review and evaluate the scope of practice request submitted by the CSDA. The Department received three scope of practice requests related to dental care and services: the request submitted by the CSDA, which is the subject of this report; a request from the Connecticut Dental Hygienists Association (CDHA) related to advanced dental hygiene practitioners; and a request from the Connecticut Dental Assistants Association (CDA) related to expanded function dental auxiliaries. Because the issues are complex and the impacted parties are the same for all of the requests, the scope of practice review committees were combined. Committee members specific to this request included:

1. Two members recommended by the CSDA;
2. Two members recommended by the CDHA; and
3. The commissioner's designee (chairperson and ex-officio, non-voting member).

Although the Connecticut Association of Endodontics submitted a written impact statement, they opted not to have specific representation on the scope of practice review committee.

### ***Scope of Practice Review Committee Evaluation of Request***

CSDA's scope of practice request included all of the required items identified in PA 11-209 as outlined below. Additional clarifying information was obtained during the review and evaluation of this request.

#### Health & Safety Benefits

CSDA identified the following health and safety benefits associated with implementing the scope of practice request:

Interim Therapeutic Restorations (ITR) may be used to restore and prevent further decalcification and caries in young patients, uncooperative patients, or patients with special health care needs, and when traditional cavity preparation and/or placement of traditional dental restorations are not feasible and need to be postponed. Additionally, ITR may be used for step-wise excavation in children with multiple open carious lesions prior to definitive restoration of the teeth. The use of ITR has been shown to reduce the levels of carcinogenic oral bacteria in the oral cavity. The procedure involves removal of caries using hand instruments by hygienists with caution not to expose the pulp. Leakage of the restoration can be minimized with maximum caries removal from the periphery of the lesion. Following preparation, the tooth is restored with an adhesive restorative material such as self-setting or resin-modified glass ionomer. ITR has the greatest success when applied to single surface or small 2 surface restorations. Follow-up care with topical fluorides and oral hygiene instruction may improve the treatment outcome in high caries-risk dental populations.

Similar information was also provided by the CAE in support of this request.

#### Access to Healthcare

CSDA identified that implementation of the scope of practice request would have the following impact on access to health care:

Increasing the capacity of the dental delivery system with 1,300 dentists treating the Medicaid population does not increase utilization of dental services to the level of the population with the financial means to seek care. This is due to socioeconomic issues such as the ability of the parents of children to take time from work, arrange transportation, or valuing such services. In school based programs, these children do have access to care, mostly by hygienists, who see lesions that could be treated by this therapy. Due to the short and cost effective training period to teach this competency, it can have an immediate effect on the target population. Failure to implement such a change will continue the present status of care in schools and institutions across Connecticut.

#### Laws Governing the Profession

Chapter 379 of the Connecticut General Statutes governs the profession of dentistry. Chapter 379a of the General Statutes governs Dental Hygienists.

#### Current Requirements for Education and Training and Applicable Certification Requirements

Chapter 379 of the Connecticut General Statutes governs the profession of dentistry. Chapter 379a of the General Statutes governs Dental Hygienists.

#### Summary of Known Scope of Practice Changes

Multiple bills have been put forward to increase the scope of practice for dental hygienists to include new competencies, but none have passed within the last five years.

#### Impact on Existing Relationships within the Health Care Delivery System

CSDA identified that the implementation of this scope of practice request would have the following impact on existing relationships within the health care delivery system:

The request increases the scope of practice for dental hygiene to address the determined needs of the target population. This collaborative effort by organized dentistry and dental hygiene may improve the relationship between the organizations. The dental hygiene profession will be responsible for implementing the increased scope of practice in treating patients in public health and institutional settings.

#### Economic Impact

CSDA presumes that due to increased utilization of this dental service, disbursements for such services will increase the expenses to the state for Medicaid dental services. DSS has confirmed that ITR is a covered service regardless of whether it is performed by a dentist or a dental hygienist. CSDA also suggests that the state may ultimately save money due to a potential decrease in emergency room visits that may be avoided if hygienists are allowed to perform ITR which will stabilize patients until they are able to receive more definitive care.

#### Regional and National Trends

CSDA identified the following regional and national trends in related to dental hygienists and the performance of ITR:

Concepts to increase access to care are being debated around the country. New provider models have been proposed in many states with enactment occurring in multiple locales. However, increased access to care and utilization has not been proven by any of these models as of yet. ITR has proven its efficacy in the US and around the world and has been included in many of the diverse models of care being proposed around the country. Currently 30 states allow hygienists to perform ITR to some degree. ME and OR allow it without supervision whereas the following states have

various limitations to specific ad advanced categories or certification of hygienists and all require the dentist to authorize and be on-site: AL; AZ; AR; CA; FL; IL; KS; KY; MD; MN; MS; MT; NE; NV; NH; NJ; NY; NC; OH; RI; TN; TX; VT; VA; WA; WV; WI and WY.

#### Other Health Care Professions that may be Impacted by the Scope of Practice Request as Identified by the Requestor

CSDA indicates that the dental hygiene profession will be responsible for implementing the increased scope of practice in treating patients in public health and institutional settings. They also indicate that multiple meetings with key stakeholders, including CSDA, CDHA, CDAA and the Connecticut Health Foundation, regarding increased scope of practice for dental hygienists have been positive but final resolution had not been reached.

#### Description of How the Request Relates to the Profession's Ability to Practice to the Full Extent of the Profession's Education and Training

CSDA indicated that once dental hygienists are educated and trained to perform the increased scope, implementation of this scope of practice change should allow an increase in care delivered to the target population. They also indicated that discussions they have had with the University of Connecticut, School of Dental Medicine relative to this educational process have been positive and could be instituted in a short period of time.

### ***Findings and Conclusions***

The scope of practice review committee reviewed and evaluated the CSDA's request to expand the dental hygiene scope of practice as well as subsequent written responses to the request and additional information that was gathered through the review process. Literature and other information reviewed and evaluated by the scope of practice review committee demonstrated that Interim Therapeutic Restoration (ITR) with hand instruments is a safe and effective procedure that should be included within the dental hygiene scope of practice, and would be particularly useful in the public health settings where dental hygienists are already treating patients who may benefit from this procedure. Evidence supports that the procedure is successful in slowing the disease process and buys additional time for the patient to get an appointment to see a dentist for more definitive care. It should be noted that practitioners must be careful in educating patients that ITR is not complete treatment and stress the importance of the need for follow-up care with a dentist. In addition, evidence supports the view that in most cases, providing an interim measure such as ITR is far better than simply allowing the decay to continue. ITR would also allow a hygienist to restore and prevent further decalcification and carries in young patients, uncooperative patients or patients with special needs when the placement of traditional dental restorative materials are not feasible. Studies are available that demonstrate that while ITR is not a definitive treatment, it may stabilize the diseased dentition for up to 4 years.

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