

**Legislative Testimony**  
**Public Health Committee**  
**HB 6275 AAC Certification of Advanced Dental Hygiene Practitioners**  
**Wednesday, March 11, 2015**  
**Carolyn J. Malon, D.D.S.**

Senator Gerratana, Representative Ritter and Members of the Public Health Committee, my name is Dr. Carolyn J. Malon. I have been practicing dentistry in Connecticut for 29 years. In addition to the private practice of dentistry, I have worked at the Community Dental Center at St. Francis Hospital, served as the dental consultant in a nursing home in New Britain for ten years, and volunteered my time at CT Mission of Mercy and at Give Kids a Smile events. I am a Husky provider.

I am submitting this testimony in opposition to HB 6275, An Act Concerning Certification of Advanced Dental Hygiene Practitioners. I have testified against this concept numerous times over the last six or seven years because I believe that the ADHP model is flawed, and will do nothing to improve access to dental care as designed. Past versions of the same bill have either died in committee, or passed through the Human Services Committee and gone no further. This particular bill, as written, is so ambiguous that I do not understand what services its proponents wish to provide.

In 2012, I participated in the scope review process under the Department of Public Health, where the merits of the ADHP model were debated. The result was inconclusive as regards addressing access to care by the creation of ADHP. With such a lukewarm result of a study undertaken by an arm of our own government, I am bewildered that the Public Health Committee continues to debate the ADHP model year after year. I have attached a copy of the 2012 report from the Department of Public Health to the General Assembly for the Committee's information.

As in the past, the supporters of an ADHP claim that this model of provider will help to improve access to dental care in Connecticut. Since the model was first proposed many years ago, the landscape in our state has changed dramatically. We currently have over 1,900 dental providers participating in HUSKY. Children enrolled in Medicaid in Connecticut are accessing dental care in higher percentages than children with private dental insurance. The reimbursement rates for adults enrolled in Medicaid are still so low as to be an obstacle, but adults are accessing dental services as well, both in private offices and in public health settings.

At this time, there is no state regulatory agency with oversight responsibilities for quality of care standards associated with an ADHP, such as the State Dental Commission which regulates dentists. In order to obtain a license to practice, dentists must demonstrate clinical competency by passing a series of examinations, including a practical clinical exam by an independent

testing agency. There is no such agency and no such examination process for ADHPs, as this model does not exist anywhere else in the U.S.

How will the Department of Public Health ensure competency of ADHP's and patient safety? Will a new agency be required to create an examination process, and to oversee quality of care? How much will this cost the state?

The educational model which has been proposed for Advanced Dental Hygiene Practitioners in past iterations of this bill is a lengthy process, resulting in a Master's degree. Since most dental hygienists in practice currently have only an Associate's Degree, this could require hygienists to stop working for four years in order to attain their degrees. And at what cost? Would they be able to recoup the cost of this additional education by treating low income patients? The uninsured? I still do not understand how this would work out financially.

There continue to be unanswered questions regarding the Advanced Dental Hygiene Practitioner, which lead me to once again oppose this model and the bill which would establish ADHP. Therefore, I respectfully request that the members of the Public Health Committee vote against HB 6275, and the Advanced Dental Hygiene Practitioner model which it would create. I am available to speak to any member by phone or answer your questions by email, should you wish further information.

Thank you for your time.

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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  
Advanced Dental Hygiene Practitioners

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**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: Advanced Dental Hygiene Practitioner

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## *Executive Summary*

In accordance with Public Act 11-209, the Connecticut Dental Hygienists' Association (CDHA) submitted a scope of practice request to the Department of Public Health to establish an Advanced Dental Hygiene Practitioner (ADHP), a mid-level oral health provider who will provide an expanded scope of oral health services to underserved individuals in public health settings. The Department also received two additional scope of practice requests related to dental care and services: a request from the Connecticut State Dental Association (CSDA) related to the addition of Interim Therapeutic Restorations (ITR) to the dental hygiene scope of practice 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.

Untreated dental disease affects an individual's ability to learn, work and function in daily life and results in substantially higher costs to the health care system. A lack of preventive services and patient education, as well as delays in receiving care, can also result in more costly treatment. In Alaska and in other countries, mid-level providers have been shown to improve access for underserved populations and provide safe, high quality care. Many states have also attempted to address these issues by allowing dental hygienists to engage in expanded functions while several states are still considering the creation of a mid-level provider, including the advanced dental hygiene practitioner and the dental therapist. The major differences between the two models include education and training requirements, level of dental supervision and requirements for a collaborative management agreement, and setting where services are provided. The ADHP model proposed by the CDHA as endorsed by the American Dental Hygienists' Association (ADHA) builds upon the education, training and experience of licensed dental hygienists who have been practicing for a minimum of two years and would require additional graduate level education and training and practice under a collaborative agreement with a licensed dentist. The dental therapist model creates a mid-level provider who does not necessarily have a dental background, has no clinical experience and would practice under the supervision of a dentist pursuant to a collaborative management agreement. Although the scope of practice committee reviewed each of these models, the committee focused its evaluation on the CDHA's request to establish an ADHP.

In reviewing all of the information provided, the scope of practice review committee did not identify any specific public health and safety risks associated with allowing appropriately educated and trained dental hygienists to engage in expanded functions. Committee members support the CSDA's proposal to increase the scope of dental hygiene practice to include interim therapeutic restorations (ITR) with hand instruments in public health and institutional settings and establishing a pathway for licensed dental hygienists to become Expanded Functions Dental Auxiliaries (EFDAs) as outlined in the Connecticut Dental Assistants Association's (CDAA's) separate scope of practice requests. The ITR and

EFDA proposals would expand the current scope of practice for dental hygienists but neither of these proposals would establish a new mid-level provider. Although the CDHA has been clear that they are not looking for independent practice, the proposed scope of practice and collaborative practice agreements that would allow ADHPs to perform irreversible procedures with minimal to no supervision by a licensed dentist raises significant concerns for opponents of the ADHP model. The ADHP model has also been compared to the Advanced Practice Registered Nurse (APRN), however there is still no national certification program for ADHP including competency examinations akin to those established for the APRN. The absence of a nationally accredited education and training program raises additional concerns for opponents. There is no national dental therapy examination but the Central Regional Dental Testing Service (CRDTS) has developed a dental therapy examination for Minnesota. There is currently only one advanced level education program in the nation to prepare mid-level oral health providers that is comparable to the proposed education included within the CDHA's ADHP proposal. The Minnesota program graduated its first class of seven students less than a year ago and it is too soon to draw any conclusions about impact on access, utilization or cost as no actual practice data is available yet. Other than Minnesota and Alaska, mid-level oral health practitioners are not authorized to practice in any other states. Connecticut's colleges and universities are reluctant to establish a costly master's degree program without the ADHP being a recognized, licensed profession.

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 health care in Connecticut primarily through increased utilization, there was no documented current practice data provided to support this theory. Data provided by the Department of Social Services (DSS) suggests that access is no longer an issue for the Connecticut Medicaid population; utilization is the problem. More specifically, utilization for restorative care is particularly problematic. DSS also indicated that reimbursement for services provided by a new provider type such as the ADHP would be available however Federal reimbursement laws direct that a State cannot create a new provider type to provide services solely for the Medicaid population; the new provider type would have to be authorized to provide services to individuals who have commercial insurance as well as the uninsured, in addition to the Medicaid population. Creation of a mid-level ADHP would expand the dental hygiene profession's ability to practice to the full extent of the profession's current 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 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.

## ***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 and chairperson 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 dental Hygienists Association (CDHA) submitted a scope of practice request to establish an Advanced Dental Hygiene Practitioner (ADHP), a mid-level oral health provider who will provide an expanded scope of oral health services to underserved individuals in public health settings.

Building on the education and skills of the licensed registered dental hygienist, this mid-level provider will have completed a Master's degree program in advanced dental hygiene, will have additional clinical skills, be competent in skills necessary to navigate the complex health care system, advocate for patients, and effectively manage a clinic or practice. The ADHP will work as part of an interdisciplinary health team, in collaboration with dentists, dental hygienists, dental assistants and other health care professionals to deliver care. The ADHP will not replace any member of the dental team; instead the ADHP will supplement the ability of the existing dental workforce to reach patients currently disenfranchised from the oral health care delivery system.

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

Written impact statements in response to the scope of practice request submitted by CDHA were received from the Connecticut State Dental Association (CSDA), the Connecticut Association of Endodontics (CAE), the American Association of Oral and Maxillofacial Surgeons (AAOMS), the American Academy of Pediatric Dentistry (AAPD) and the Connecticut Society of Pediatrics (CSP). Although these organizations are interested in developing a mid-level oral health provider, they do not support the ADHP model. CDHA submitted written responses to the impact statements, 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 CDHA. The Department received three scope of practice requests related to dental care and services: the request submitted by the CDHA, which is the subject of this report; a request from the Connecticut State Dental Association (CSDA) related to the addition of interim therapeutic restorations (ITR) to the dental hygiene scope of practice; and a request from the Connecticut Dental Assistants Association (CDAA) 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 representation from:

1. the Connecticut Dental Hygienists' Association;
2. the Connecticut State Dental Association;

3. the Connecticut Association of Endodontics;
4. the American Association of Oral and Maxillofacial Surgeons;
5. the American Academy of Pediatric Dentistry/Connecticut Society of Pediatrics; and
6. the commissioner's designee (chairperson and ex-officio, non-voting member).

Representatives from the Department of Social Services, the Department of Public Health's Office of Oral Health and the Dental Assisting National Board (DANB) also participated in meetings and provided valuable information to the committee.

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

CDHA's scope of practice request included all of the required elements identified in PA 11-209. Relevant information is outlined below.

#### Health & Safety Benefits

The Connecticut Dental Hygienists Association (CDHA) provided documentation of studies showing that mid-level practitioners provide safe, high-quality dental care. These studies demonstrate that if patients are able to access needed care earlier, the tendency to seek emergent care will be lessened. Emergent care does not solve the underlying, more serious dental problems. If the patient does not have access to follow-up appointments, he or she does not receive comprehensive care and the patient ultimately ends up back in the Emergency Room and the cycle will continue. CDHA believes that the use of mid-level practitioners is a step toward breaking this cycle and would provide access to early restorative intervention and comprehensive oral care.

#### Access to Healthcare

Historically, access to restorative care in Connecticut has been a challenge and it has been difficult to recruit and retain dentists to provide restorative services in public health facilities. Public health facilities include licensed health care facilities such as nursing homes and school-based health clinics, community health centers, group homes, schools, pre-schools and head start programs and programs offered or sponsored by the Federal Special Supplemental Program for Women, Infants and Children (WIC). Licensed dental hygienists currently provide preventive oral health care directly to patients in public health settings. The proposed ADHP would work as part of an interdisciplinary health team, in collaboration with dentists, dental hygienists, dental assistants and other healthcare professionals to deliver services, and would not replace any member of the dental team, but rather supplement the ability of the existing dental workforce to provide expanded oral healthcare in public health settings.

The ADHP proposal anticipates that a public health program's ability to increase treatment time efficiently reduces the barriers to care that patients experience, such as lack of transportation, time

away from work or school and cost, and that increasing capacity will reduce wait times for patient appointments and allow for early intervention with problems that can lead to more costly treatment. Coordination with other dental, medical, and social service providers allows for maintenance of individual quality care and enhances the general health of the population, producing positive and rewarding outcomes.

Data provided by the Department of Social Services (DSS) suggests that access is no longer an issue for the Connecticut Medicaid population; utilization is the problem. More specifically, utilization for restorative care is particularly problematic. Many patients only seek preventive care and don't know about or understand the importance of oral health. For example, some school based health centers only offer preventive care and although community dentists are available to provide restorative services, parents are not bringing their children for the necessary follow-up care. Dental providers including dental hygienists and dentists recognize that the dental home is the key, and through the ADHP mode, hygienists want to be an extension of the dental home not to be independent of that. DSS also indicated that reimbursement for services provided by a new provider type such as the ADHP would be available however Federal reimbursement laws direct that a State cannot create a new provider type to provide services solely for the Medicaid population; the new provider type would have to be authorized to provide services to individuals who have commercial insurance as well as the uninsured, in addition to the Medicaid population.

#### Laws Governing the Profession

The Registered Dental Hygienist (RDH) is an oral health professional licensed in each state. Like other licensed health professions, Connecticut law dictates the licensing requirements and scope of practice for the licensed dental hygienist in Connecticut. The Connecticut Department of Public Health (DPH) regulates the dental hygiene profession pursuant to Chapter 379a of the Connecticut General Statutes (CGS).

Connecticut law allows licensed dental hygienists to provide educational, preventive and therapeutic services including: complete prophylaxis; the removal of calcareous deposits, accretions and stains from the supragingival and subgingival surfaces of the teeth by scaling, root planning and polishing; the application of pit and fissure sealants and topical solutions to exposed portions of the teeth; dental hygiene examinations and the charting of oral conditions; dental hygiene assessment, treatment planning and evaluation; the administration of local anesthesia under certain conditions and collaboration in the implementation of the oral health care regimen.

Dental hygiene services may be performed under the general supervision of a dentist, which means the dental hygiene procedures are authorized by the supervising dentist, but does not required the onsite presence of the dentist. The law permits dental hygienists with two years of experience to work without the supervision of a dentist in public health facilities. The CDHA proposes that the statutes be amended to recognize a mid-level provider, the Advanced Dental Hygiene Practitioner, who would be a licensed dental hygienist who has completed additional education and training to provide educational,

preventive, palliative, and selected therapeutic and restorative services and would be authorized to provide such services to underserved populations, in public health settings.

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

In order to qualify for dental hygiene licensure in Connecticut, an applicant must be a graduate of a dental hygiene program accredited by the Commission on Dental Accreditation (CODA) and successfully pass a written and clinical examination. Currently, dental hygienists can have an Associate's, Baccalaureate or Master's degree and also additional certifications such as for administration of local anesthesia. Licensed dental hygienists are also required to complete mandatory continuing education activities as a condition of license renewal.

Connecticut licensed registered dental hygienists who have completed an approved course in basic and current concepts of local anesthesia and pain control may administer local anesthesia, limited to infiltration and mandibular blocks under the indirect supervision of a licensed dentist. The local anesthesia program must include twenty hours of didactic training, including the psychology of pain management, a review of anatomy, physiology, pharmacology of anesthetic agents, emergency precautions and management, and client management; instruction on the safe and effective administration of anesthetic agents, and eight hours of clinical training which includes the direct observation of the performance of procedures. "Indirect supervision" means a licensed dentist authorizes and prescribes the use of local anesthesia for a patient and remains in the dental office or other location where the services are being performed by the dental hygienist.

#### Summary of Known Scope of Practice Changes

Within the last five years, enactment of Public Act 05-213 allowed licensed registered dental hygienists to administer local anesthesia in accordance with the provisions of Chapter 379a.

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

CDHA reported that the majority of licensed dental hygienists are employed in private practice dental offices working under the general supervision of a dentist. "General supervision" means that dental hygiene procedures are performed with the knowledge of the dentist, but the dentist is not required to be on the premises when such procedures are being performed. The proposed scope of practice request will not affect private dental practices.

Currently, in public health settings throughout Connecticut licensed dental hygienists with two or more years of experience work without the supervision of a dentist. They provide the full scope of dental hygiene practice allowed in this setting and work collaboratively with dental and other health professionals in an integrated care model and refer patients with needs outside of the dental hygienist's scope of practice, including the coordination of such referrals for treatment to a licensed dentist or

other healthcare providers as appropriate. The proposed ADHP would continue existing relationships of referral and consultation as well as establish a formal collaborative agreement with a licensed dentist so that patients in need of services outside of the ADHP scope will be able to access comprehensive care. The ADHP is not intended to replace any member of the dental team, and would supplement and increase the ability of the existing dental workforce to reach patients currently disenfranchised from the oral healthcare delivery system.

Opponents of the ADHP proposal are concerned that implementing this scope of practice as requested by CDHA would negatively impact the working relationship of the dental team. They believe that independent hygienists would be competing for patients without being able to provide the full range of dental services that are typically delivered in the dental office, and that individuals who utilize these ADHPs might find themselves with compromised access to the dentist due to the lack of coordination of services inherent when dental hygienists are allowed to practice and bill for services without the benefit of a supervising dentist. There was no evidence provided to support these remarks. CDHA has been clear that they are not looking for independent practice, and that the proposed scope of practice would be incorporated into collaborative practice agreements between hygienists and licensed dentists.

#### Economic Impact

In December 2010, the PEW Center on the States issued a report titled "It Takes A Team: How New Dental Providers Can Benefit Patients and Practices." The report assesses the implications on patient capacity and revenue associated with the use of dental hygienists and new types of allied dental providers such as dental therapists and dental-hygienist therapists in private dental practices. Key findings in the report include: Allied providers can strengthen the productivity and financial stability of dental practices; allied providers can help practices treat more Medicaid-insured patients in a financially stable way; Medicaid reimbursement rates play a critical role; and fully utilizing allied providers is key to realizing productivity and profit gains. Although the PEW report focused on private dental practices and the introduction of "allied providers" (not necessarily the ADHP model), CDHA infers that the findings demonstrate the increased efficiency and productivity of a mid-level provider, such as the ADHP. There were no studies or data provided to the scope of practice review committee to show the projected economic impact of the use of allied providers, including but not limited to the ADHP, in public health settings.

The CDHA asserts that the ADHP model would increase access to healthcare and affordability in public health settings. Dental programs in public health settings operate with limited resources and need the most cost effective professional providing services in order to meet budgets. Opponents of this proposal are concerned that the ADHP model, which would require the completion of a master's degree program, would have a negative economic impact on the health care delivery system related to the expectation that the ADHP will demand a higher salary. It is expected that the ADHP mid-level provider would earn a salary that is between that of a dental hygienist and a dentist. While the PEW report identified above does caution that practitioners who are required to undergo lengthier periods of training or education generally demand higher salaries, the report does not necessarily suggest a

negative impact on the health care delivery system; it does however reflect that revenue benefits that dentists would otherwise accrue by hiring new providers into their private practices would be reduced.

Other than Minnesota and Alaska, mid-level oral health practitioners are not authorized to practice in any other states. It is premature to draw any conclusions or make any forecasts about the impact a new mid-level provider type will have on access, utilization or cost as no actual practice data is available yet from the Minnesota program. No current data from the program in Alaska was provided. In addition, the potentially significant costs for educational institutions to develop a new program must be considered.

### Regional and National Trends

While the national trend is to allow dental hygienists to work to the full extent of their education with limited or no supervision, which currently benefits the public in the provision of preventive care, literature suggests that there still remains a gap in access to restorative care. In recent years, stakeholders throughout the United States have identified a need for the creation of a mid-level oral health provider who can perform restorative services. However, the difficulty in Connecticut and in many other states continued to be overcoming disputes over who this mid-level oral health provider should be (i.e., ADHP, dental therapist, both), the appropriate level of education and training, and the level of dental supervision that should be included within collaborative practice agreements.

#### *--Alaska Model*

In 2002, a group of Native Alaskans were sent to New Zealand to receive dental therapy training in an effort to enhance dental services available in their isolated tribal villages. By 2007, a Dental Health Aide Therapist (DHAT) education program was created at the University of Washington's School of Medicine. Graduates of this two-year training program are authorized to provide limited oral health care services in underserved tribal areas in Alaska. The W.K. Kellogg Foundation reports that there have been no recent studies focusing on the quality of care associated with the DHAT model because the model is now an established standard of practice in the countries where they exist.

#### *--Minnesota Model*

In 2009, Minnesota became the first state in the U.S. to enact legislation creating a mid-level dental provider, the dental therapist, who will provide basic oral health and dental services to underserved patients and communities. The legislation was enacted to address Minnesota's access issues primarily in rural communities, nursing homes and group homes, community clinics and health centers, head start programs, hospital emergency rooms and Indian reservations. Minnesota's goals included improving access by filling gaps where there are not enough dentists, to extend the capacity of existing dentists and provide basic treatments where no dentists are available. The program is part of a broader strategy to improve access. The Minnesota model is not based on the dental hygienist model.

There are two levels of mid-level dental providers that will be licensed by the Minnesota Board of Dentistry: basic dental therapist and advanced dental therapist. Practice is limited to underserved patients and populations and practice is supervised by a dentist through a written collaborative management agreement. The advanced dental therapist is authorized to perform the full scope of practice of the dental therapist without a dentist on-site and may also perform oral evaluation, assessment (not diagnosis) and formulation of a treatment plan; simple extractions of diseased teeth; provide (not prescribe), dispense and administer analgesics, anti-inflammatories and antibiotics.

The University of Minnesota, Dental School offers both a Bachelor's degree program and a Master's degree program for dental therapists. There is no prior clinical experience required for entry into the University of Minnesota, Dental School programs. The Metropolitan State University Master of Science in Oral Health Care Practitioner Program is the educational program for advanced dental therapists. A bachelor's degree, an active dental hygiene license and prior clinical practice are prerequisites for acceptance into the program. The University of Minnesota expects to graduate the first Dental Therapist class in 2013. Metropolitan State University's inaugural program of seven students graduated in 2011. After graduation, dental therapist students must also pass a comprehensive examination prior to becoming licensed.

The Minnesota program is too new to draw any conclusions about the impact advanced dental therapists have on access, utilization or cost as no actual practice data is available yet. Other than Minnesota and Alaska, mid-level oral health practitioners are not authorized to practice in any other states.

*--Outside of the U.S.*

Dental therapists are currently utilized in over 50 countries, including New Zealand, Australia, Canada, Malaysia, Tanzania and Great Britain. Education and training requirements and scope of practice varies. It is also important to recognize that the standard of care provided in many other countries is not necessarily consistent with the level of care provided in the U.S. Factors such as the differences in their health care delivery systems, educational costs and geography must all be considered when comparing the use of mid-level providers in other countries with models being considered in the U.S.

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

CDHA's proposal would limit the ADHP's practice to public health settings. As such, CDHA identified that the scope of practice request does not affect private dental practices. The ADHP is not intended to replace any member of the dental team and would work collaboratively with dentists, dental hygienists, dental assistants and other health care professionals to ensure that underserved populations are able to access preventive, therapeutic and restorative services. In addition, the ADHP will make necessary referrals to dentists and other health professionals, serving to strengthen the crucial link between oral, medical and community health networks. It is expected that the ADHP will supplement the ability of the existing dental workforce to reach underserved patients in public settings.

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

The ADHP Master's degree curriculum builds upon the fundamental knowledge and skills achieved at the Baccalaureate level along with the registered dental hygiene license. It fosters independent thinking and learning needed for evidence-based clinical decision-making, advanced responsibility and scope of practice. The advanced education will prepare the ADHP to use sound clinical judgment and evidence-based decision making to determine within their scope of practice when patients can be treated, when they require further diagnosis and when referral is needed to a dentist or to other healthcare providers. The ADHP will work as part of an interdisciplinary health team, in collaboration with dentists, dental hygienists, dental assistants and other healthcare professionals to deliver care. The ADHP will enhance and supplement the existing dental team's ability to reach patients looking for oral healthcare services within the public healthcare system. The additional education required for ADHP ensures patient safety and provides a professional career ladder thereby expanding employment opportunities in public health care for Connecticut.

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

Untreated dental disease affects an individual's ability to learn, work and function in daily life and results in substantially higher costs to the health care system. A lack of preventive services and patient education, as well as delays in receiving care, can also result in more costly treatment. In Alaska and in other countries, mid-level providers have been shown to improve access for underserved populations and provide safe, high quality care. Many states have also attempted to address these issues by allowing dental hygienists to engage in expanded functions while several states are still considering the creation of a mid-level provider, including the advanced dental hygiene practitioner and the dental therapist. The major differences between the two models include education and training requirements, level of dental supervision and requirements for a collaborative management agreement, and setting where services are provided. The ADHP model proposed by the CDHA as endorsed by the American Dental Hygienists' Association (ADHA) builds upon the education, training and experience of licensed dental hygienists who have been practicing for a minimum of two years and would require additional graduate level education and training and practice under a collaborative agreement with a licensed dentist. The dental therapist model creates a mid-level provider who does not necessarily have a dental background, has no clinical experience and would practice under the supervision of a dentist pursuant to a collaborative management agreement. Although the scope of practice committee reviewed each of these models, the committee focused its evaluation on the CDHA's request to establish an ADHP.

In reviewing all of the information provided, the scope of practice review committee did not identify any specific public health and safety risks associated with allowing appropriately educated and trained dental hygienists to engage in expanded functions. Committee members support the CSDA's proposal to increase the scope of dental hygiene practice to include interim therapeutic restorations (ITR) with hand instruments in public health and institutional settings and establishing a pathway for licensed dental hygienists to become Expanded Functions Dental Auxiliaries (EFDAs) as outlined in the

Connecticut Dental Assistants Association's (CDAAs) separate scope of practice requests. The ITR and EFDA proposals would expand the current scope of practice for dental hygienists but neither of these proposals would establish a new mid-level provider. Although the CDHA has been clear that they are not looking for independent practice, the proposed scope of practice and collaborative practice agreements that would allow ADHPs to perform irreversible procedures with minimal to no supervision by a licensed raise significant concerns for opponents of the ADHP model. The ADHP model has also been compared to the Advanced Practice Registered Nurse (APRN); however there is still no national certification program for ADHP including competency examinations akin to those established for the APRN. The absence of a nationally accredited education and training program raises additional concerns for opponents. There is no national dental therapy examination but the Central Regional Dental Testing Service (CRDTS) has developed a dental therapy examination for Minnesota. There is currently only one advanced level education program in the nation to prepare mid-level oral health providers that is comparable to the proposed education included within the CDHA's ADHP proposal. The Minnesota program graduated its first class of seven students less than a year ago and it is too soon to draw any conclusions about impact on access, utilization or cost as no actual practice data is available yet. Other than Minnesota and Alaska, mid-level oral health practitioners are not authorized to practice in any other states. Connecticut's colleges and universities are reluctant to establish a costly master's degree program without the ADHP being a recognized, licensed profession.

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 health care in Connecticut primarily through increased utilization, there was no documented current practice data provided to support this theory. Data provided by the Department of Social Services (DSS) suggests that access is no longer an issue for the Connecticut Medicaid population; utilization is the problem. More specifically, utilization for restorative care is particularly problematic. DSS also indicated that reimbursement for services provided by a new provider type such as the ADHP would be available however Federal reimbursement laws direct that a State cannot create a new provider type to provide services solely for the Medicaid population; the new provider type would have to be authorized to provide services to individuals who have commercial insurance as well as the uninsured, in addition to the Medicaid population. Creation of a mid-level ADHP would expand the dental hygiene profession's ability to practice to the full extent of the profession's current 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 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.