

Legislative Testimony
Public Health Committee
HB 6275 AAC Certification of Advanced Dental Hygiene Practitioners
Wednesday, March 11, 2015
Jonathan B. Knapp, D.M.D.

Senator Gerratana, Representative Ritter and esteemed members of the Public Health Committee, my name is Jonathan Knapp and I have been practicing dentistry for 20 years in the town of Bethel. I am a Past President of the Connecticut State Dental Association (CSDA), and a past chair The Council on Dental Practice at the American Dental Association. I am a nine year member of the Mission of Mercy Steering Committee and one of the +1,800 dentists who provide services to the patients of the CT Dental Health Partnership. I have also actively participated in scope of practice discussions since 2004, resulting in my voicing of strong support for the scope review process as developed by the Program Review and Investigations Committee and passed by the General Assembly. I thank you for the opportunity to present this testimony to you in opposition to HB 6275 AAC Certification of Advanced Dental Hygiene Practitioners.

Having been involved in these scope discussions with Connecticut hygienists over the past 11 years has provided me with a broad and deep historical perspective on the issues surrounding the desire to enact this completely new and different provider position. I have testified before this committee numerous time in the past on this very issue and these most pertinent issues raised in the discussions have not changed much in the years we have been at this. Since some members of the committee may not have been around for these discussions, or may have only recently become involved, this testimony will be an attempt to capture the most salient, persistent concerns about this bill and provide context from its previous iterations. I will start with more recent versions and work back, as some of the background factors have changed since this quest for increased scope for hygienists began (e.g. the incredible success of the partnership between Connecticut government and Connecticut dentists that is the CT Dental Health Partnership - formerly known as HUSKY).

In 2014, no scope expansion bill for dental hygienists was raised. The sense we were given was that this issue had been discussed *ad nauseum* over the previous years and that it was too contentious to warrant taking up again.

In 2013, **HB 6589, AA ESTABLISHING A TASK FORCE TO STUDY THE SCOPE OF PRACTICE FOR DENTAL HYGIENISTS** was raised in the legislature. It did not pass out of the Public Health Committee because it was duplication of what had already been enacted with the PRI recommended, DPH scope review process outlined in PA11-209, and because there would have been a significant financial cost to perform the study.

In 2012, **HB 5541 AAC SERVICES PROVIDED BY DENTAL PROFESSIONALS AND CERTIFICATION FOR ADVANCED DENTAL HYGIENE PRACTITIONERS** was raised. It also did not pass out of the PH Committee. Excerpts of my written testimony on this iteration of the bill, I hope, will provide more insight into the serious shortcomings of what the hygienists believe will be appropriate for our state (portions are direct quotations from the report issued by DPH after their scope review in response to PA11-209):

As an example from the DPH Executive Summary:

“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.”

Is it possible that this statement reflects the fact that there is no data because the model, as proposed by CDHA and included in HB5541, does not exist and has not been evaluated? And how far will the expanded functions extend? HB5541 makes a quantum leap here. Nothing in the bill precludes ADHPs from performing extractions of permanent teeth on medically compromised or multiply medicated children, adults, or seniors. Additionally, the bill allows for diagnosis by ADHP’s within those same populations who present with the most complicated, complex interactions between their oral health and their overall health.

Again, from the DPH Executive Summary:

“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.”

There are additional, very significant differences between ADHP’s and APRN’s. APRNs do not provide invasive, irreversible procedures – nothing akin to the extractions that would be permitted by HB5541, and the genesis of APRN’s came as a means to address the fact that 80% of physicians are specialists. The reality is that 80% of dentists are primary care family practitioners. Only 20% pursue specialties. Particularly noteworthy is the fact that, given the anticipated effects of the Affordable Care Act, there will be the need for many more hygienists to practice in the traditional role as front line educators about proper oral health and nutrition, and providers of preventive oral health services.

“The ADHP model ... 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... 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...”

Delving into these statements reveals some very key distinctions that actually detract from the ADHP and reflect favorably on the therapist model. At \$50,000-60,000/year in tuition costs, the six years of training for an ADHP create a very expensive \$300,000 model that can only be pursued by those who have those kinds of resources; those who will expect salaries higher than the average of \$80,000-90,000 earned by hygienists in Hartford. These figures are not much lower than the compensation for newly graduated dentists. On the other hand, the shorter and less expensive training involved in becoming a therapist allows for much more culturally, and socio-economically diverse practitioners, with the cultural competence to provide more effective access to care.

And then there is the law of unintended consequences. The CT Dental Hygiene Association will state that more education is required and is pushing for expansion of scope into areas that should demand the education of a dentist. This will ultimately drive the costs of dental care higher as it will push the dental profession to follow the more expensive, specialized model that has occurred on the medical side. If you really want to implement a mid-level provider in our state, is ADHP the right way to do it?

That brings me to what may be the most important piece of this puzzle. Perhaps the greatest disconnect exists between the push to create a mid-level provider and the data from DSS demonstrating that Connecticut no longer has an access problem for our children.

So ultimately, with the disconnect between the lack of evidence in favor of ADHPs, and the blind leap that is the creation of that model in HB5541, the question becomes: Who is this legislation designed to benefit?

In 2011, HB5616 AAC Licensure Of Advanced Dental Hygiene Practitioners was raised. Instead of going through the more relevant PH Committee, this version went through Human Services. Although it passed out of Human Services, it never went any further. Instead, the Connecticut General Assembly wisely chose to pass PA11-209, which enacted the DPH scope review process as recommended by PRI. From my testimony in 2011:

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

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

pathways for motivated hygienists, who meet the rigorous academic qualifications demanded for admission, to enter dental school.

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

We have consistently attended meetings since 2004 in an effort to reach common ground on these discussions however, proponents of the ADHP model have yet to provide the needed facts in order to make evidence-based decisions on behalf of the most vulnerable of our citizens. What it all boils down to is that this is a scope of practice issue.

In 2010, HB 5355, AAC An Advanced Dental Hygiene Practitioner Pilot Program was raised. It passed out of Human Services but did not go any further. Rather than testing the model prior to enacting, it called for the opposite.

From my testimony:

HB5355 is putting the cart before the horse in that it adopts the ADHP model first, and then calls for testing. Adoption of the ADHP model is pre-mature because of the lack of scientific evidence that it will positively impact access. In other parts of the country, there are delivery systems currently undergoing rigorous studies with millions of dollars being spent on outcome assessment. Despite tremendous push over the last eight years or more by some members of the American Dental Hygiene Association and its individual state constituents (starting in Oklahoma in 2002) the ADHP model has not been adopted anywhere. All of the largest foundations have concluded that their support, and their many millions of dollars should be devoted to the pilot-testing of other models.

While this bill goes into great detail on the allowable duties for ADHP's (which introduce many other concerns), it contains no specifics on the construction of the pilot-project, and fails to outline any specific parameters to be used to measure critical aspects of the study, be they positive or negative. In fact, the reporting requirements listed in the bill presume success by calling for mechanisms to expand the model, with no examination of any downside. Proponents of this model will claim that it will save costs, however there is no evidence to support that claim. Simply stating that it costs less to educate someone to the Masters level than it does to

educate a dentist fails to completely examine the costs associated with; developing, educating, credentialing, and sustaining the financial viability of this model in the Connecticut workforce. Any rational pilot-testing project must include scientifically sound evaluations of the economics involved. It is important to note that all of those costs will ultimately need to be borne by state dollars associated with regulatory budgets and state dollars spent on reimbursement rates for the Medicaid program.

This bill does not even mention improving access to care in its Statement of Purpose. The CSDA, which represents over 80 percent of the dentists in Connecticut, is vigorously pursuing various means by which access to oral healthcare can be significantly expanded. The CSDA Access Committee, on which I also serve, along with our Board of Governors and House of Delegates, has been evaluating many models and modalities to improve access. We support comprehensive solutions that include measures that are cost-effective and safe and we will continue to advocate for those. The access Committee has evaluated numerous provider models from around the world in great detail, eventually making a recommendation to the House of Delegates that we support the concept of testing a therapist model. The committee is currently evaluating what such a study might look like and addressing the complexities involved. Among the many questions that must be addressed: What should be measured and what are the appropriate metrics with regard to outcome and the other key factors?

Finally, all the way back in 2009, the first of the many bills on this issue was raised, HB 5630 AAC The Establishment of Licensure for the Advanced Dental Hygiene Practitioner

Even that far back, not long after the General Assembly had wisely chosen to settle the lawsuit, there were signs that we had created something very special - what has today been described as one of the very best delivery systems for dental care under the Medicaid system in all of the United States.

From my testimony:

For many reasons, I believe that the adoption of this new practitioner would be ill advised and pre-mature. If we truly wish to create better access to dental care, we must continue to forge a genuine partnership between practitioners, government, and patient communities. With the settlement of the lawsuit on behalf of children in our state, we regained government as a partner. The reduction and elimination of the administrative hurdles and headaches has rekindled trust between practitioners and the state, and as a result we have seen the numerous ways that the dentists are willing to step up to do our part. Since the beginning of the program we have reached over 800 dentist providers with over 300 dentists signed up in public health facilities – this in only five months! The numerous among us who have had positive experiences are actively spreading the word to our colleagues. Additional dentists are in the credentialing pipeline and more are signing up each week. Factor in all of the pro bono work and educational efforts undertaken by Connecticut’s dentists and the picture becomes even brighter. We haven’t even seen yet how far this partnership will go.

Later on in the testimony I add:

And what about the requirement for an examination for licensure? Other professions have stringent requirements for testing of competency that are administered by nationally recognized certifying agencies with the very specific expertise necessary to do so properly. There is no such entity for the proposed ADHP. Is the DPH equipped to properly examine candidates for a position that involves surgical procedures that would necessitate a clinical exam for practitioners doing the same procedures under a dental license? DPH’s establishment and administration of such an exam must have significant costs attached.

In this extremely harsh economic climate and with the projected state budget shortfalls in the billions of dollars, can Connecticut afford the costs associated with the implementation of this new model?

I apologize for the length of this document and I'm thankful to those who have read it to this point. As you can see, we've been discussing this for a very long time, yet the hygienists who seek to enact this new position have failed to provide evidence based justification that it is a rational, cost-effective model that is needed to address present or future needs for oral health care in our state.

I am available to answer any questions or provide additional information by phone or email, now or at any point in the future.

Respectfully,

Jonathan B. Knapp, D.M.D.
1 Diamond Avenue
Bethel, CT 06801
Tel. 203-748-6935 or 203-240-1911 (cell)
JKnappDMD@sbcglobal.net