

Testimony H.B. No. 6275  
AN ACT CONCERNING CERTIFICATION OF  
ADVANCED DENTAL HYGIENE PRACTITIONERS

Senator Gerratana, Representative Ritter, Senator Markley, Representative Srinivasan and distinguished members of the Public Health Committee, my name is Marie Paulis and I have been a registered dental hygienist for 23 years and my experience includes private practice in both general and periodontal practices, public health clinic experience, and as an educator. I earned my Master's degree in DH Education in 2010.

### **The Need**

I work in Bridgeport where the need for dental care is real and cannot be ignored. I encourage anyone who does not believe there is a lack of dental care in our state to follow me around for a day and you will hear otherwise from those to whom I am providing dental hygiene care. In 2012, a Connecticut Department of Public Health survey revealed that 42% of seniors, most of whom did not have insurance, at long-term care facilities and 29% attending meal programs had untreated tooth decay.<sup>1</sup> According to the Health Resources and Services Administration (HRSA), in 2015, 5 of the 8 counties in Connecticut have identified dental shortage areas.<sup>3</sup>

The U.S. Department of Health and Human Services released a workforce analysis report just last month, February 2015, about the projected growth in the numbers of dentists and dental hygienists based on current trends. The report states that all 50 states continue and will continue to see a shortage of dentists beyond the year 2025, whereas most states see an overabundance of dental hygienists. HRSA recommends alleviating the dentist shortage by maximizing the productivity of dental hygienists; states it will provide support to states that develop programs to address the dentally underserved; and, "...supports the training of advanced dental hygienists who will expand dental hygienist roles to the maximum allowable under state scope practice laws."<sup>4</sup>

### **Why Dental Hygienists?**

A mid level dental hygiene provider just makes sense. Dental Hygienists, at their current level of education, as licensed health professionals in the State of Connecticut, can already administer local anesthesia or "give a shot of Novocain" as better known to the general public. We are doing it safely every day in order to provide thorough, pain-free dental hygiene treatment for our patients.

Here is a description of a typical dental hygiene visit, based on our *current* level of education. A typical appointment includes:

- A thorough medical history review
- Taking vitals, including blood pressure, pulse, respiration
- Charting of existing dental restorations
- Periodontal charting, including classification of disease
- Creation of a dental hygiene treatment plan
- Dental hygiene diagnosis
- Implementation of dental hygiene treatment, including the administration of local anesthesia, placement of dental sealants, and other therapies as needed.

If, during this process, the patient presents with medications, medical conditions, or tooth conditions that prevent safe treatment, we do not proceed and make the proper referral, based on our assessment. In public health settings or when we are working without a dentist present, we complete this in collaboration with a dentist. The dentist/dental hygienist relationship in my

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experience has always been a positive one and I am perplexed as to why this potential position would be looked upon as anything but a professional and positive experience for all involved, most importantly the client receiving optimal care. I want to stress that this position is a step on the ladder and not a big leap, in comparison to what we are already doing in daily practice.

### **Evidence of Safety and Success**

Perhaps the concern is because it is a change and change makes people uncomfortable. Where is the evidence that this will be successful? Just recently, in 2014, Minnesota, the first state to develop a mid-level dental hygiene provider called the Dental Therapist or Advanced Dental Therapist, started producing results. Interestingly, Minnesota, like Connecticut, ranked high nationally for meeting oral health care needs of the general public, but, like Connecticut, great disparities exist in meeting the needs of people of color, the elderly, and those considered “low-income.” After tracking the Dental Therapists from August 2012 to December 2013, the Minnesota Department of Health and Minnesota Board of Dentistry published a report expressing overwhelmingly positive results.<sup>2</sup>

They surveyed 1,382 patients, interviewed staff, and reviewed administrative data from the clinics and other sites in which the 32 Dental Therapists were employed. One-third of the patients said they experienced a reduction in wait and travel times. They served 6,338 new patients. Clinics reported personnel cost savings, increased dental team productivity, improved patient satisfaction, and an increased ability to serve more underserved people. The report also concluded that emergency room visits might have been reduced in the area because those with dental emergencies were being seen in a timelier manner. In addition, the Dental Therapist, being able to address more simple and urgent patient needs, freed up the dentist to be able to address more involved cases, thereby increasing overall production and efficiency of the facility. In conclusion, the mid level dental hygiene provider position is proven to be achieving exactly what it was meant to do, or in the words of the Minnesota Department of Public Health, “...fulfilling statutory intent, serving predominantly low-income, uninsured, and underserved patients.”<sup>2</sup>

### References:

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