Senator Gerratana, Senator Somers, Representative Steinberg and distinguished members of the Public Health Committee, my name is Marie Paulis and I am the Legislative Chair for the Connecticut Dental Hygienists’ Association and Director of the Dental Hygiene Program at the University of New Haven.

I’d like to start by asking you a question: Should Connecticut limit the type of providers able to address access to care issues? Let’s talk about this issue with the people it really involves…the populations who would get treated, the population who would seek the degree, and the population of providers and employers who would work with them. To be honest, those who oppose this position don’t have to have anything to do with it. The research shows this to be safe and effective. If a dental provider or facility does not like the dental therapist, he or she does not have to hire one.

Based on CODA Accreditation Standards for the Dental Therapist, approved in 2015, the scope of the dental therapist includes approximately 18 procedures beyond that of a dental hygienist. The scope of a dentist includes approximately 600 procedures. This is a very limited scope of practice. Dental hygienists in Connecticut are already certified to administer local anesthesia and have been doing that for over 10 years.

I have been told by some that the reason this has not passed before is because of the fear that we dental hygienists are going to want own our own practices. If that is what we wanted, then we would be asking for that. We do not want to own our own practices. We want to be dental hygienists; prevention specialists; public health specialists; who are able to treat simple problems to help our patients who are having difficulty getting treatment without our help.

Our public health populations in need of care, and both Connecticut and Minnesota have between 10%-11% of the population below the poverty level, deserve to be treated with respect and get the dental treatment they need. Federal figures show that 4 in 10 adults nationally had had no dental visits in the past year and 1 in 5 seniors have untreated cavities.

Although this is a new concept in the United States, it is not new in other countries. As of 2012, 54 countries utilized dental therapists. Dental therapists have been shown to bring in revenue far exceeding the cost of their employment. For example, in Minnesota “In 2012, two dental therapists provided care to 1,352 patients, many of whom received regular access to dental care for the first time,” states a 2014 study by The Pew Charitable Trusts. “When compared to the reimbursement value of the care they delivered, the therapists exceeded their costs of employment by a combined $216,000.” This early treatment by one of these therapists helped save $95,000 in Medicaid expenses in 2012. (PEW, 2012)

Objective research reports from Minnesota involving over a thousand patients, multiple employment settings, and multiple employers have demonstrated the clinical, financial, and social benefits of the dental therapist. Again, if a provider does not want to employ a
Dental Therapist or utilize him to his full capacity, the dentist is certainly not required to do so.

Resources:
