CONNECTICUT DENTAL HYGIENISTS' ASSOCIATION, INC.
ADVOCATES FOR ORAL HEALTH MANAGEMENT

American Dental Hygienists' Association
Connecticut

August 15, 2013

Jennifer L. Filippone, Chief
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12MQA
P.O. Box 340308
Hartford, CT 06134

RE: Scope of Practice Request in accordance with Public Act 11-209

Dear Jennifer,

Attached is a written copy of the Connecticut Dental Hygienists' Association Scope of Practice Request in accordance with Public Act 11-209. If you have any questions concerning this request or if you require any additional information, please contact me. My contact information is listed below.

Thank you.

Sincerely,

Celeste Maida Baranowski, RDH
CDHA Legislative Chair
Cell: (203) 253-9468
E-Mail: cmbrdh@aol.com

EFFECTIVE DATE: July 1, 2014
SCOPE OF PRACTICE REQUEST
Written Request to DPH

Respectfully Submitted By;
The Connecticut Dental Hygienists' Association, Inc.
CDHA - August 13, 2013

The act allows any person or entity acting on behalf of a health care profession seeking legislative action in the following year's legislative session that would (1) establish a new scope of practice or (2) change a profession's scope of practice, to provide DPH with a written scope of practice request. This must be done by August 15 of the year preceding the start of the next regular legislative session.

Criteria
The request submitted to DPH must include:

1. ***a plain language description of the request;***

The request is to provide for licensed, registered dental hygienists, who complete additional specified mid-level education and testing requirements, to provide an enhanced scope of services in public health settings.

Building on the education and skills of the licensed registered dental hygienist, this mid-level provider will complete a Master's degree program, will have additional clinical skills, will be competent in skills necessary to navigate the complex health care systems, advocate for patients, and effectively manage a clinic or practice. This mid-level provider will provide diagnostic assessment, educational, preventive, palliative, therapeutic, and restorative services through a collaborative agreement, thus increasing the capacity of public health programs to provide early intervention and comprehensive care to patients. The mid-level provider will be a licensed registered dental hygienist who continues his/her education to obtain a Master's degree in order to become competent in additional clinical services, evidence-based practice, research, health policy and advocacy, practice management and more. This mid-level provider will be able to administer the full range of preventive services currently offered by licensed registered dental hygienists, in addition to minimally invasive restorative services, removal of exfoliating (loose) or mobile teeth and limited prescriptive authority such as analgesics, anti-inflammatory medication (prescription strength ibuprofen) and antibiotics, as stated in the midlevel curriculum. The mid-level provider 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. This mid-level provider will not replace any member of the dental team; instead the mid-level provider will supplement the ability of the existing dental workforce to reach patients currently disenfranchised from the oral health care delivery system. Graduates of the mid-level provider Master's program will have demonstrated competency, through successful completion of the mid-level provider education program and passage of examinations.

It is envisioned that applicants will be issued an endorsement to their current dental hygiene license. The mid-level provider endorsement will be subject for renewal each licensure period. Applicants for renewal of the mid-level provider endorsement will be required to complete additional continuing education coursework prior to renewal.

2. **public health and safety benefits that the requestor believes will occur if the request is implemented and, if *applicable, a description of any harm to public health and safety if it is not implemented;***

Studies by highly respected academic and research institutions, such as the PEW Charitable Trust, support that non-dentist; mid-level practitioners provide safe, high-quality dental care. No study has ever found the care to be unsafe or to put patients at risk. Mid-level dental providers in over 40 countries work successfully to improve access and reduce costs. If patients are able to more easily access needed care early, the tendency to seek emergent care in the Emergency Room (ER) of a hospital will be lessened. The ER treats the symptoms and refers for follow-up treatment. They do not solve the underlying more serious dental problem. If there is not access to follow-up, comprehensive care, the patient ends up back in the ER and the cycle continues. This is a safe step toward breaking this cycle. The public will benefit with access to early restorative intervention and comprehensive care. Mid-level providers are common in medicine. This mid-level provider is akin to a nurse practitioner or an APRN (Advanced Practice Registered Nurse). Mid-level providers in oral health exist in over 40 countries as well as in Alaska and Minnesota. Research demonstrates that the care provided by mid-levels is safe and will help increase access to care. The mid-level provider would work collaboratively with the current dental team and other healthcare providers. The mid-level provider, built on the current dental hygiene license, will be educated and regulated.

3. ***the impact of the request on public access to health care;***

Connecticut has experienced difficulty in providing access to restorative care, especially in the adult population. Many public access programs are in the communities where health care is needed. There are currently two licensed dental providers: Dental hygienists and dentists. There is a difficulty recruiting and retaining dentists to provide restorative services in public health settings. The dental hygienist provides preventive oral health care directly to patients in public health settings. The mid-level provider will increase the care to underserved populations, by increasing the capacity of programs to provide preventive and restorative services in a cost effective manner. The mid-level provider will work as part of an interdisciplinary health team, in collaboration with dentists, dental hygienists, dental assistants and other healthcare professionals to deliver services. The mid-level provider is not proposed to replace any member of the dental team. The mid-level provider will supplement the ability of the existing dental workforce to provide expanded oral healthcare, in public health settings. A public health program's ability to increase treatment time efficiently reduces the barriers to care that patient's experience such as lack of transportation, time away from work or school and cost. Increased capacity reduces wait times for patient appointments and allows for early intervention of 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 social impact of the public's health; producing positive and rewarding outcomes.

4. ***a brief summary of state or federal laws governing the profession;***

The Registered Dental Hygienist (RDH) is an oral health professional licensed in each state. Like other licensed health professions, Connecticut state law dictates the licensing requirements and scope of practice for the licensed registered dental hygienist in Connecticut. The Connecticut Department of Public Health, DPH, regulates the dental hygiene profession, creating continuing education requirements for the licensed dental hygiene professional. Chapter 379a of the Connecticut General Statutes, CGS, stipulates that 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, many licensed registered dental hygienists work in public health settings and have National Provider Identification (NPI) numbers. Licensed registered dental hygienists presently treat Medicaid patients; Medicaid is a federal / state sponsored program.

The law allows licensed registered 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 planing 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 and collaboration in the implementation of the oral health care regimen.

Although dental hygienists provide services under the general supervision of a dentist in private offices (the dental hygiene procedures are performed, but the dentist need not be present), the law permits dental hygienists with two years experience to work without the supervision of a dentist in public health facilities, such as but not limited to a community health center, a group home, a school, a health department, a preschool operated by a local or regional board of education or a Head Start program.

The Connecticut Dental Hygienists' Association (CDHA) envisions this proposed mid-level provider scope to include the current dental hygiene scope and license as a pre-requisite and amend state statute to add the educational requirements and additional skill set to provide diagnostic assessment, educational, preventive, palliative, therapeutic, and restorative services to underserved populations, in public health settings.

5. ***the state's current regulatory oversight of the profession;***

The Registered Dental Hygienist (RDH) is a licensed professional and practices under the regulations set forth in the Connecticut State Statutes pertaining to Dentistry; Chapter 379a. Section 20-111-1 addresses the regulations for mandatory continuing education for annual licensure renewal. Currently, 16 face to face continuing education credits are required every two years. The Connecticut Department of Public Health (DPH) oversees the dental hygiene profession. Registered Dental Hygienists in Connecticut are licensed and required to prove continuing education and carry liability insurance. The mid-level provider is envisioned to be a licensed registered dental hygienist, with expanded education, training and additional skills. The Connecticut Dental Hygienists' Association (CDHA) envisions the mid-level provider scope to include the current dental hygiene scope and license, as a pre-requisite. State statute would be amended to add the expanded educational requirements and diagnostic assessment, preventive, palliative, therapeutic, and restorative services beyond the current dental hygiene scope.

6. ***all current education, training, and examination requirements and any relevant certification requirements applicable to the profession;***

Currently dental hygienists can have an Associate's, Baccalaureate or Master's degree and also additional certifications such as local anesthesia. 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 written and clinical examinations.
The clinical exam: The North East Regional Board (NERB) of Dental Examiners, Inc. administers the ADHLEX (American Dental Hygiene Licensing Examination) which is the dental hygiene examination that is approved by ADEX (American Board of Dental Examiners), a nation-wide consortium, which develops reviews and approves examinations in dentistry and dental hygiene which are administered by state and regional testing agencies. NERB is one of the participating regional testing agencies, now administrating this examination.
The Examination in Dental Hygiene consists of two Examinations: The Computer Simulated Clinical Examination (CSCE) is a computer based examination, approximately 2 hours in length, and usually takes place by appointment at a Prometric Testing Center. The Patient Treatment Clinical Examination (PTCE) is approximately 4 hours in length and is scheduled at a clinical examination site. Both Examinations must be passed to receive NERB Status. NERB Status is recognized by the participating NERB licensing jurisdictions. The NERB Local Anesthesia Examination may be taken as part of the certification process for dental hygienists to administer local anesthesia. The Local Anesthesia Examination for Dental Hygienists consists of a 50 question multiple-choice computer based examination administered at a Prometric Testing Center. The Local Anesthesia computer-based exam will be required in 2014 along with the CSCE and Patient Treatment exam for ADEX status.

The written exam: The Joint Commission on National Dental Examinations (JCNDE) is the agency responsible for the development and administration of the National Board Dental Hygiene Examination (NBDHE). This 15-member Commission includes representatives of dental schools, dental practice, state dental examining boards, dental hygiene, dental students, and the public. A standing committee of the JCNDE includes other dental hygienists who act as consultants regarding this examination. The NBDHE is intended to fulfill or partially fulfill the written examination requirement, but acceptance of National Board scores is completely at the discretion of the individual state. A state may place any limit on acceptance of National Board scores that it deems appropriate. For example, some states accept National Board scores only if earned within the last five to 15 years. Currently, all United States licensing jurisdictions recognize National Board results. These jurisdictions include all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.

The local anesthesia certificate: The Connecticut Department of Public Health (DPH) accepts a local anesthesia certificate of completion. Connecticut licensed registered dental hygienists who have completed the approved course receive a certificate stating that they are certified to administer local anesthesia, limited to infiltration and mandibular blocks, under the indirect supervision of a licensed dentist in the state of Connecticut. The local anesthesia certified, registered dental hygienist has demonstrated successful completion of a course of instruction containing the basic and current concepts of local anesthesia and pain control in a program accredited by the Commission on Dental

Accreditation (CODA), or its successor organization, that includes: Twenty hours of didactic training, including but not necessarily limited to, 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 shall include the direct observation of the performance of procedures. Local Anesthesia for the Dental Hygienist in the State of Connecticut is listed in CGS, Chapter 379a, and Sec. 20-126 l.

The law allows licensed registered dental hygienists to provide educational, preventive and therapeutic services. The mid-level provider curriculum is designed to build upon and extend the body of knowledge and competencies of the Baccalaureate dental hygiene education. The education and training requirements would include a Master's level education specific to the mid-level provider. The mid-level provider will be a licensed registered dental hygienist who continues his/her education to obtain a Master's degree in order to become competent in additional clinical services, evidence-based practice, research, health policy and advocacy, and practice management. The mid-level provider requires a Master's degree specific to the mid-level provider education; any other Master's degree would not qualify. The mid-level provider will be able to administer the full range of preventive services offered by dental hygienists, in addition to minimally invasive restorative services, removal of exfoliating (loose) or mobile teeth and limited prescriptive authority such as analgesics, anti-inflammatory medication (prescription strength ibuprofen) and antibiotics, as stated in the mid-level provider curriculum.

The Master's education program will be offered in an institution accredited by the State of Connecticut Department of Higher Education Advisory Committee on Accreditation. When a new practitioner is developed, such as this one, accreditation agencies wait until the first education programs have been established and the first graduates enter practice before they establish accreditation standards. The Commission on Dental Accreditation (CODA) convened the *Task Force on New Dental Team Members* to investigate whether the Commission should establish a process of accreditation for educational programs *in new areas of allied dentistr*y. CODA is recognized by the U.S. Department of Education (USDE) to accredit dental and dental-related education programs conducted at the postsecondary level. State dental boards can set the specific scopes of practice for dental personnel where the boards have jurisdiction, and state dental boards can certify educational and training programs without accreditation by CODA. CODA's proposed standards for dental therapy education programs will be released for public comment. Stakeholder groups will have several opportunities to comment on the proposed standards for dental therapy education.

7. ***a summary of known scope of practice changes requested or enacted concerning the profession in the five years preceding the request;***

Preceding this request, a change in the dental hygiene scope of practice in Connecticut was passed in a Public Act in 2005. Public Act 05-213, *An Act Concerning Access To Oral Health Care*, which allows in sections 7, 10, licensed registered dental hygienists to administer local anesthesia in accordance with the provisions of Chapter 379a of the Connecticut General Statutes, Sec. 20-126l, subsection (d). —infiltration and mandibular blocks—under a dentist's indirect supervision.

An ADHOC committee was established by DPH Commissioner Galvin in 2004. CDHA also supported the changes to the Dental Practice Act as defined in legislation and developed during the meetings with the Oral Health Access Ad Hoc Committee as defined in House Bill 5636 passed during the 2004 Legislative Session, Special Act No. 04-7.

The Committee was given seven specific areas to review; among them were workforce models and access to care. Numerous meetings were held with representatives from DPH, state legislators, dental hygiene, dentistry and dental assisting prior to and as a subsequence of the Special Act 04-7, *An Act Concerning Oral Health Care*. At that time, there was an understanding among the parties involved that workforce models to address access to oral health care would be enacted in subsequent years. The Connecticut Dental Hygienists' Association (CDHA) has participated at these meetings and all discussion.

In 2009, 2010, 2011, 2012 and 2013, legislation was introduced in Connecticut requesting a scope of practice change to establish a mid-level provider, the Advanced Dental Hygiene Practitioner (ADHP). This legislation garnered bipartisan support from legislators and passed overwhelmingly out of the Joint Committee on Human Services during Legislative Sessions in both 2010 and 2011. In the 2012 session, the Public Health Committee was evenly split on the ADHP proposal. The proposal died in committee on the tie vote.

2009 HB 5630 – AAC The establishment of Licensure of an Advanced Practice Dental Hygienist – had public hearing but no committee vote

2010 HB 5355 – AAC An Advanced Dental Hygiene Practice Pilot Program- passed out of committee – no house vote

2011 HB 5616 - AAC An Advanced Dental Hygiene Practice Pilot Program – voted out of committee no house vote

2011 Public Act 11 – 209 – Program Review and Investigation (PRI) August 11, 2011 ADHA CT (CDHA) --- Answered 12 Questions posed by Department of Public Health as part of a scope of practice request for mid level provider (ADHP). ADHA CT (CDHA) participated in all discussions and meetings with the Program Review and Investigation process.

2012 HB 5541 - AAC Services Provided by Dental Professionals and Certification for Advanced Dental Hygiene Practitioners - died in a tie 14 - 14 vote in the committee.

2013 HB 6589 - AA Establishing a Task Force to Study the Scope of Practice for Dental Hygiene – had public hearing but no committee vote.

In addition, a change was requested for the regulations pertaining to licensure to increase the hours of continuing education needed to renew the dental hygiene license.

8. the extent to which the request directly affects existing relationships within the health care delivery system;

The majority of licensed registered dental hygienists are employed in private practice dental offices working under the general supervision of a dentist; general supervision does not require a dentist to be on the premises. Licensed Registered Dental Hygienists exercise the dental hygiene roles, make decisions regarding patient care and then carry out the best decision for the patient. This scope of practice request will not affect private dental practices.

Currently, in public health settings throughout Connecticut licensed registered dental hygienists, with 2 or more years of experience, work without the supervision of a dentist. They exercise the dental hygiene roles, make decisions regarding patient care and then implement treatment that supports the best decision for the patient. Licensed, Registered Dental Hygienists' (RDH) working in public health settings work collaboratively with dental and other health professionals in an integrated care model. Licensed, Registered Dental Hygienists refer patients in need of additional care to dentists and other healthcare providers.

Similarly, the proposed mid-level provider will continue existing relationships of referral and consultation as well as establish a formal collaborative agreement; so that patients in need of services outside of the mid-level provider's scope will be able to access comprehensive care. The mid-level provider will not replace any member of the dental team. The mid-level provider will supplement and increase the ability of the existing dental workforce to reach patients currently disenfranchised from the oral healthcare delivery system.

9. the anticipated economic impact of the request on the health care delivery system;

A 2011 report from the PEW Center on the States indicates that mid-level providers make it financially viable for most dental practices to see Medicaid patients. While these numbers speak to the private dental practice, they demonstrate the increased efficiency and productivity of a mid-level provider. The PEW report noted the absence of mid-level providers in their report on Connecticut. The mid-level provider would increase access to healthcare and increase the affordability in public health settings. Public health programs operate with limited resources and need the most cost

effective professional providing services in order to meet budgets. The midlevel provider is expected to have a salary that is between that of a dental hygienist and a dentist. By adding this new provider to the current public health system of care, patients who are currently unable to access restorative care will have a new pipeline to the oral health care delivery system.

A study from the Journal of the American Dental Association (JADA) indicates that uninsured and underserved patients visit hospital emergency departments for tooth pain and dental care; however, emergency departments are not equipped to provide definitive oral health care. When definitive care is not provided, patients may repeatedly return for treatment of the unresolved condition. The result is expensive emergent care billed to Medicaid or the uninsured patient. The mid-level provider would provide comprehensive care to underserved patients thus decreasing the likelihood of the patients need to visit emergency departments for oral health care.

According to a Pediatric Dentistry article: *"A comparison of Medicaid reimbursement for non-definitive pediatric dental treatment in the emergency room versus periodic preventive care":* a three-year aggregate comparison showed Medicaid reimbursement for in-patient emergency department treatment ($6,498) versus preventive treatment ($660). This revealed that on average, the cost to manage symptoms related to dental caries (cavities / decay) on an in-patient basis is approximately 10 times more costly than to provide dental care for the same patients in a private or public setting dental practice. There has been an increase in the number of current licensed, registered dental hygienists who show interest in higher education and many have enrolled in Baccalaureate and Masters Programs. The establishment of a mid-level practitioner provides a professional career ladder which is attractive to potential candidates, creates new job opportunities in the healthcare sector and helps expand the diversity of the healthcare workforce.

10. regional and national trends in licensing of the health profession making the request and a summary of relevant scope of practice provisions enacted in other states;

Dental hygienists work in a host of settings to deliver clinical care. Each state enacts its own laws determining the services dental hygienists can perform, the settings in which they can practice, and the supervision under which they practice. Currently,
35 states allow dental hygienists to initiate preventive oral health care in settings outside of the private dental office without specific authorization from a dentist;
37 states allow dental hygienists to perform temporary restorations;
45 states (including DC) permit dental hygienists to administer local anesthesia; and
32 states (including DC) permit dental hygienists to administer nitrous oxide.

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 provision of more preventive care, there 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.

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. In 2003, the first class of Native Alaskans enrolled in a two year dental therapy program at the University of Otago (New Zealand), with support from the Alaska Native Tribal Health Coalition. Upon completion of their two year education, the Dental Health Aide Therapists (DHAT) took their training back to Alaska to provide basic oral health care in the remote tribal areas of the state. By 2007, a DHAT education program was created at the University of Washington's School of Medicine to provide a two-year training program (one year in the classroom and one year in a clinical environment) before graduates are given the opportunity to provide limited oral healthcare in underserved tribal areas in Alaska.

In 2004, the American Dental Hygienists' Association (ADHA) became the first national oral health organization to propose a new oral health provider, the Advanced Dental Hygiene Practitioner (ADHP) and the ADHP competencies were created. In 2009, Minnesota became the first state to pass legislation creating mid-level oral health practitioners, a dental therapist and an advanced dental therapist, making new providers a reality in the lower 48 states. Minnesota became the first state to legislate the creation of midlevel oral health providers – the Dental Therapist (DT) and

Advanced Dental Therapist (ADT). The DT concept is modeled after the physician's assistant model in medicine which requires on-site supervision for most services provided. The University of Minnesota's School of Dentistry currently offers a Bachelors level DT program. The ADT is modeled after the nurse practitioner model in medicine and is designed to facilitate collaboration between the ADT and dentist, but does not require on-site supervision.

Metropolitan State University offers a Master's level program in which students are educated using the Advanced Dental Hygiene Practitioner (ADHP) competencies. A prerequisite of this program is dental hygiene licensure and a Baccalaureate degree. The first class of ADT students graduated from Metropolitan State University in June 2011 and will practice with dual ADT and dental hygiene licensure.

In addition to Alaska and Minnesota, the W.K. Kellogg Foundation announced it was spearheading a $16 million campaign to establish a mid-level practitioner model in Kansas, New Mexico, Ohio, Vermont, and Washington State. The trend is towards combining the dental therapist model with a dental hygiene based model.

11. ***identification of any health care professions that can reasonably be anticipated to be directly affected by the request, the nature of the impact, and efforts made by the requestor to discuss it with such health care professions;***

Proposed to work in public health settings, this mid-level provider would positively impact the oral healthcare delivery system by providing an additional point of entry for patients currently disenfranchised from the system. This scope of practice request will not affect the private dental practice. The mid-level provider would not replace any member of the dental team. The mid-level provider is proposed to work collaboratively with dentists, dental hygienists, dental assistants and other health professionals to ensure that underserved patients are able to access preventive, therapeutic and restorative services. In addition, the mid-level provider will make necessary referrals to dentists and other health professionals, serving to strengthen the crucial link between the oral, medical and community health networks. The mid-level provider will supplement the ability of the existing dental workforce to reach underserved patients in public health settings. Beginning with the ADHOC committee established by the Commissioner of the Connecticut Department of Public Health (DPH) in 2004, numerous meetings have been held among representatives from dental hygiene, dentistry and dental assisting. Discussions addressed workforce models and access to care both prior to and subsequent to the Special Act 04-7, *An Act Concerning Oral Health Care*, as mentioned previously. The Connecticut Dental Hygienists' Association (CDHA) has participated in the discussions and will continue to be available in the future.

12. ***and a description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.***

With the implementation of the Patient Protection and Affordable Care Act in Connecticut and with the launching of Access Health, it makes sense to expedite the endorsement of this mid-level dental provider to accommodate the increase in access to healthcare in Connecticut.

A licensed registered dental hygienist plays an important role on the oral healthcare team; preventing oral disease and treating it while it is still manageable and can save critical healthcare dollars in the long-run. Licensed registered dental hygienists must graduate from an accredited dental hygiene education program (typically three or more academic years in length) and pass national written and regional clinical examinations prior to obtaining a license. Additionally, once licensed; registered dental hygienists are required to take continuing education courses in order to renew their license.

Licensed registered dental hygienists are educated and trained to provide preventive oral healthcare including prophylaxis, fluoride application and sealants. Connecticut statute allows the licensed registered dental hygienist with two years experience to provide preventive care to patients in public health settings without supervision. While this allows the public increased access to preventive oral healthcare, low income and uninsured patients in need of additional restorative care often experience barriers in accessing care from a dentist. Among these barriers are lack of transportation, inability to get time off from work or school and inability to find a dentist who will accept Medicaid patients. By utilizing the existing workforce of over 3,500 registered dental hygienists licensed in the state of Connecticut along with the proposed Master's degree program, this mid-level practitioner provides a timely solution to

the access to care crisis. Licensed registered dental hygienists have completed coursework in anatomy, biology, microbiology, physiology, chemistry, general pathology, oral pathology, histology, pharmacology, dental morphology, psychology, sociology, nutrition, dental materials, individualized oral hygiene instruction, public health and infection control, among other courses.

The mid-level provider 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 mid-level education will prepare this provider 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 mid-level provider 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 mid-level provider 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 ensures patient safety and provides a professional career ladder thereby expanding employment opportunities in public health care for Connecticut.

References:

American Dental Hygienists Association ADHP Resource Center: http://adha.org/adhp/index.html

State of Connecticut, Department of Public Health. Dental Hygienists. Chapter 379a. http://www.ct.gov/dph/lib/dph/practitioner_licensing_and_investigations/plis/dentalhygiene/dh_stats.pdf.

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H.B. 6819, Public Act 05-213, An Act Concerning Access To Oral Health Care http://www.cga.ct.gov/2005/ACT/PA/2005PA-00213-R00HB-06819-PA.htm

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Exemptions

Instead of submitting a scope of practice request to DPH, a person or entity can request an exemption. (But since the act allows, rather than requires, the scope of practice request, it is unclear when a person or entity would submit an exemption request.)

An exemption request must include a plain language description and the reasons for the request, including (1) exigent circumstances that require an immediate response to the scope of practice request, (2) a lack of dispute about the request, or (3) any outstanding issues among the health care professions that can easily be resolved. The exemption request must be submitted to DPH by August 15 of the year preceding the next regular legislative session.

Notification to the Public Health Committee

By September 15 of the year preceding the next session, DPH, within available appropriations, must (1) give written notice to the Public Health Committee of any health care profession that has submitted a scope of practice or exemption request to the department and (2) post the request and the requestor's name and address on its website.

Impact Statement

Any person or entity acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written statement to DPH by October 1 of the year preceding the next legislative session. The person or entity must indicate the nature of the impact, taking into consideration the criteria listed above, and provide the requestor with a copy of the impact statement. By October 15 of the same year, the requestor must submit a written response to DPH and any person or entity that submitted an impact statement describing at a minimum, areas of agreement and disagreement between the respective health professions.

SCOPE OF PRACTICE COMMITTEES

Membership

By November 1 of the year preceding the next legislative session, the DPH commissioner must, within available appropriations, establish and appoint members to a scope of practice review committee for each timely scope of practice request the department receives. The committees consist of:

1. two members recommended by the requestor to represent the health care profession making the request;
2. two members recommended by each person or entity that submitted a written impact statement to represent the health care professions directly impacted by the request; and
3. the DPH commissioner or her designee who serves in an exofficio, non-voting capacity.

The DPH commissioner or her designee serves as the committee chairperson and may appoint additional committee members representing health care professions with a proximate relationship to the underlying scope of practice request if the commissioner or her designee determines it would help to resolve the issues.

Committee members serve without compensation.

Duties

The committee must review and evaluate the scope of practice request, subsequent written responses to the request, and any other information the committee deems relevant. This must include (1) an assessment of any public health and safety risks associated with the request, (2) whether the request may enhance access to quality and affordable health care, and (3) whether the request improves the ability of the profession to practice to the full extent of its education and training. The committee may seek input from DPH and other entities it determines necessary to provide its written findings.

After finishing its review and evaluation of the scope of practice request, the committee must give its findings to the Public Health Committee by the following February 1. It must include with its findings all the material it considered during its review process. It terminates on the date it submits its findings to the Public Health Committee.

Evaluation

By January 1, 2013, the act requires the DPH commissioner to evaluate the scope of practice request process and report to the Public Health Committee on its effectiveness in addressing these requests. The report may also include recommendations from the scope of practice review committees on measures to improve the process.

OLR Tracking: JK:KM:VR:ts