The attached resources have been distributed to all members over the course of a 5-week member education campaign during the summer of 2009, regarding various dental workforce models under consideration in our state. This information is being distributed to the House of Delegates for your convenience, and reference during House deliberations.
Dear CSDA members,

Over the course of the summer, your association has been hard at work, as we move closer to the next legislative session. This early fall update is an important one, with significant information that each member of the CSDA should review. I am asking that you take a few minutes to read this message, and review the attached documents so that each of you is familiar with the issues facing dentistry in our state.

This year, we were somewhat successful in moving the access to care debate away from scope of practice towards the access issue itself. With a strong policy agenda that included school based programs as a major tool for eliminating access issues, we were starting to be heard. However, we were still challenged to be an integral part of the solution by the Public Health Committee. We have made great strides in this area as we have increased the number of dentists in the Husky program (Connecticut Dental Health Partnership) to over 1,000. We can now truly say that the capacity of the system, as evidenced by 1 week wait times for Husky patients to be seen versus 6 month waiting periods previously, has been significantly increased to the point that we can focus on the issue of utilization, which is how many of those patients who are eligible for care truly seek it and use it. Data from around the country shows that even when capacity and dollars are increased, utilization only reaches a 35-40% level, well below the 65% of privately insured patients.

Our answer is the support of school based programs to get the patients that need the care to it, in a location they can access. A seminar to better understand these programs was recently convened by the CSDA with the stakeholders who manage them and we learned how we can help to achieve the goal of increased utilization of care. This will continue to be the most important piece of our policy agenda as we now understand how we fit in.

We were also challenged by the Public Health Committee as to what model would truly affect access to care, if we don’t believe that the ADHP (Advanced Dental Healthcare Provider) will. They have seen what has been happening around the country with DHAT (Dental Health Aide Therapist) in Alaska, Minnesota, Washington, and soon in New England. Our former Midlevel Task Force, that developed the Midlevel Model report 2 years ago, was morphed into the Access Task Force to look at the 10 different models developed around the country for an added member to the dental team. The key to this task was to focus on the caveat that whatever model it is, the dentist would be the leader of the team and the model would improve access to care. The process was difficult as there is very little data around the country related to how any model effects access. The Task Force ultimately recommended a 3 pronged model that included a 2 year DHAT, an EFDA (Expanded Function Dental Assistant) as dictated by the CSDA policy passed by the HOD (House of Delegates) and amended in 2007, and a hygienist that could provide Intermediate Restorative Therapy (IRT). All of these providers would work in public health settings, where they could increase capacity and efficiency, except for EFDA, which would work also work in the private sector. This recommendation has been reviewed by the Council on Legislation (COL) and will be sent to the HOD for discussion. No decisions have been made at the present time, just concepts to be discussed.

The CSDA has been communicating to all its members over the past few years about different changes around the country and here at home. However, the alphabet soup (DHAT, OPA, CDHC, EFDA, etc) is
difficult to understand unless you truly take the time to learn it. The Board of Governors and Council On Legislation have determined for the House of Delegates and CSDA members to make an informed, unemotional decision, we must do a better job educating the membership. This program will begin with the EFDA model that is attached to this email. You will also find the Pew Report, which will give you a perspective on what is happening nationally. Every week for the next 5 weeks, a new model will be presented in bullet form. You will also receive a link to the Access page of the website (listed at the end of this letter) for those who want more in depth model information and views from around country and the world.

Why is it important for all of you to become well versed in these models?

1. A membership survey will be distributed over the next few weeks and will ask questions about how you feel about some of the models and changes occurring in the dental profession. We are looking for your feedback through this medium to help shape the future of the health care delivery CT. But we want you to do it with solid information, not only emotion.

2. The CSDA House Of Delegates will discuss these issues in November and we want you to let your delegates know what you think so you can be well represented.

3. The next legislative session is around the corner. You need to be the information source for you legislators not just the lobbyist and leadership who have discussions with these individuals. They value your opinions as constituents more so than us.

4. You need to be the information source for your patients, who have become very involved in the healthcare debate. We need to raise their awareness of the CSDA and what we do for oral healthcare in the state.

Our Strategic Communications Plan has begun to pay off as we are now being viewed more favorably by policymakers as they see our MOM project, increased participation in Husky, CPTV public service broadcasting, charitable dental events around the state, press releases, and lobbying for better oral healthcare in CT. Our goal is to be the leading oral health authority in CT. This can only be accomplished involvement of all CSDA members. Your preferred future is at hand. Help keep us the leader of the dental team and an important convener and collaborative partner in the health care debate. Failure to do so will leave us in a position where decisions are made for us, not with us. We have already seen that across the country. The CSDA leadership looks forward to hearing your opinions, concerns, and ideas. Please do this constructively and professionally. We all have the same goal, to provide the best oral health care to the citizens of CT and for dentists to lead the oral health care team. Happy reading!

Respectfully,

Bruce Tandy
CSDA President
btgolf@aol.com
860-875-2881
860-966-2924(cell)
860-644-8584(home)
Expanded Function Dental Assistants

Background:

Expanded Function Dental Assistants exist in 39 states, are supported by policy of the ADA, and have been in existence for over 30 years. They have been shown to be effective in improving the efficiency of dental providers when used properly and to be capable of placing restorations of equal quality to a dentist when properly trained. This model also allows a career ladder for dental assistants. Their effect on access to care has not been documented as most function in the private sector. You may be able to extrapolate that with increased efficiency of care delivery that access for the underserved may improve. However, there is no data to support this concept. The CSDA passed the following resolutions in 2003 and 2007 which establish support for this position and are now policies of the association. The definitions are included in the following resolutions:

ADOPTED – May 8th, 2003
RES. #13-2003
RESOLVED, that the CSDA endorse the concept of Levels of Dental Assistants as an adjunct to Section 8. Dental Assistants of the Model Dental Practice Act as defined below and underlined:

Section 8. Dental Assistants
A licensed dentist may delegate to dental assistants such reversible dental procedures as he/she may deem advisable, but such procedures shall be performed under supervision and control and the dentist shall assume responsibility for such procedures provided they follow the rules and regulations determined by the Dental Commission. Core Competencies and levels of Dental Assistants will be:

ELDA (Entry Level) – on the job trained, no formal education
DA (Dental Assistant) – 2 years full time or part time equivalency dental assisting experience and or up to 9 months of formal education in a non-accredited/ADA accredited dental assisting education program.
CDA/ RDA (Certified Dental Assistant/Registered Dental Assistant) – any individual who has successfully completed the 3 part Dental Assisting National Board Examination (DANB Exam) (Pathway to sit the examination can be experience or graduation from an ADA accredited dental assisting program.)
EFDA (Expanded Function Dental Assistant) – Qualifications/Education to be determined.
The are 74 core competencies which are specific for each position. Please review the attachment for these procedures.
House resolution HR16-2008 removed composite placement and carving as an approved competency.

Advantages:
1. Increased efficiency of care delivery for the dental care facility when used properly
2. Education is cost effective
3. Provides a career ladder for the dental assistant
4. Proven capable of limited restorative procedures when properly trained
**Disadvantage:**
1. Functions in the private sector
2. Limited effect on access if any
3. Legislative linkage with ADHP

Council of Legislation Action:
Resolved that the CoL provide info packet to the HOD informing them of the current CSDA policy on EFDA, and also informing them that the CSDA intends to pursue this legislatively in Hartford during the 2010 legislative session.
Dental Health Aide Therapist (DHAT)

Background:

DHAT (Dental Health Aide Therapist) is an auxiliary model in Alaska, Minnesota, and possibly other states, that functions under the supervision of a dentist. The model exists entirely in the public health sector. The length of training varies from 2 to 4 years. The 2 year model is being recommended in Connecticut.

Currently the W.K. Kellogg Foundation is supporting Alaska’s Dental Health Aide Therapist (DHAT) training program with a four-year $2.8 million grant. DHATs are trained during one year at the University of Washington MEDEX Program, which has trained Physician Assistants since 1976 and another year at the ANTHC DHAT Training Center in Anchorage. The 1st year program is a five-day-a-week, full-day curriculum of classroom, laboratory and clinical work. The second year consolidates these skills with preclinical and supervised treatment of patients. Students must pass benchmark exams in order to graduate from the program. After graduation students enter a minimum of 400 hours of preceptorship, where they must demonstrate clinical skills under supervision before receiving certification to practice. In addition, DHATs must demonstrate a capacity to function effectively as a team member. Upon certification, DHATs are assigned to provide basic oral health care services in remote tribal clinics and remain supervised by “hub” based dentists who coordinate, supervise and are responsible for overall oral health care. There have been no negative outcomes reported during the almost four years of DHAT provided treatment.

The Dental Health Aide Therapist must meet the same quality of care standards as a licensed dentist providing the same services. Services are restorative, pulpotomy, prophylaxis, and uncomplicated oral surgery. In addition to meeting training requirements and a protracted preceptorship, the DHAT must undergo skill evaluation every two years. Continuing education is also required for recertification.

The Kellogg Foundation and three other funders (Bethel Community Services Foundation, M.J. Murdock Charitable Trust Foundation, Rasmuson Foundation) have funded a two-year comprehensive evaluation of the DHAT program as to how DHAT impacts access and quality of care. This study, by RTI, a North Carolina based research organization, is expected to provide data for creation of evidence-based standards of care for DHAT. Ford, Pew, Allen and RW Johnson Foundations have also been supportive of the DHAT program.

Currently it is estimated that Connecticut has 600,000 to 800,000 residents in need of dental treatment and are without the ability to pay for services at usual and customary fees. With less than 3000 general dentists in Connecticut that would mean a minimum of 200+ additional non-paying or reduced fee patients per general practice dentist. Private practitioners are currently not seeing these patients. DHAT use in public health settings may help alleviate some of the access issues with this population. Data is limited in this regard and may necessitate a pilot project.

Advantages:

1. Currently recognized and utilized in over 52 countries. Enjoy an excellent record in other countries for safety and quality of care. The model was developed 80 years ago in New Zealand. Outside evaluators found their work to meet the standards of care in the U.S.

2. Functions only under the general supervision of a dentist. Functions as an auxiliary, a team member connected to a responsible supervising dentist via teledentistry, including real time video and radiologic oversight as needed. Therapists partner with supervising dentists. Patients who need care beyond the
scope of the therapist are referred to the dentist. Dentists are responsible for diagnosis and treatment planning.

3. Community driven workforce. All applicants are selected from the communities in which they live and in which they will return to practice. Model will work well in Community Health Center and school based settings. It is the only model with a proven track record in improving access.

4. Two year DHATs cost approximately $60,000 to train, the least of any of the proposed therapist models.

5. Certification, rather than license. The DHAT is an auxiliary to the dentist and as such functions under the general supervision of a dentist.

**Disadvantages:**

1. Requires adequate ongoing government funding.

2. Perception of second tier of care

**Council of Legislation action:**

Be it resolved that the Council on Legislation present the 2-year DHAT model for approval to the HOD as a new dental team member, to practice in public health and institutional settings, for the purposes of increasing access to oral health care in CT.
Interim Therapeutic Restorations (ITR)

Background:

Alternative/atraumatic restorative technique (ART) has been endorsed by the World Health Organization as a means of restoring and preventing caries in populations with little access to traditional dental care. Interim therapeutic restoration (ITR) more accurately describes the procedure used in contemporary dental practice in the US. ITR utilizes similar techniques as ART but has different therapeutic goals. ITR may be used to restore and prevent further decalcification and caries in young patients, uncooperative patients, or patients with special health care needs or when traditional cavity preparation and/or placement of traditional dental restorations are not feasible and need to be postponed. Additionally, ITR may be used for step-wise excavation in children with multiple open carious lesions prior to definitive restoration of the teeth. The use of ITR has been shown to reduce the levels of cariogenic oral bacteria in the oral cavity. The ITR procedure involves removal of caries using hand or slow speed rotary instruments with caution not to expose the pulp. The CSDA COL recommends the use of only hand instrumentation by hygienists. Leakage of the restoration can be minimized with maximum caries removal from the periphery of the lesion. Following preparation, the tooth is restored with an adhesive restorative material such as self-setting or resin-modified glass ionomer. ITR has the greatest success when applied to single surface or small 2 surface restorations. Inadequate cavity preparation with subsequent lack of retention and insufficient bulk can lead to failure. Follow-up care with topical fluorides and oral hygiene instruction may improve the treatment outcome in high caries-risk dental populations. There is no literature on this specific model of “Access to Care” other than the DHAT Alaskan Model in the US which allows the providers even more restorative capability

Advantages:

1. Functions only under the general supervision of a dentist. Functions are accomplished by a team member connected to a responsible supervising dentist on premises or via teledentistry, including real time video and radiologic oversight as needed.

2. ITR may be used to restore and prevent further decalcification and caries in young patients, uncooperative patients or patients with special health care needs when the placement of traditional dental restorative materials are not feasible.

3. Training is limited and cost effective

4. Will make improvements in the oral health status of the target population

5. Would have an immediate effect on access to care as team members are already in place and the training of the competency is not difficult.
Disadvantages:

1. Organized hygiene may not accept the concept
2. Does not provide definitive care
3. Increases scope of practice

Council of Legislation action:

Be it resolved that the Council on Legislation supports the practice of ITR for a properly trained hygienist, to include the preparation of a previously carious lesion with a hand instrument and placement of an ITR.
Advanced Dental Hygiene Practitioner

Background:
The Advanced Dental Hygiene Practitioner has been proposed by the ADHA (American Dental Hygienists’ Association) as an answer to the oral health care crisis in America. They cite a number of sources to support their position that there is “a crisis shortage of dentists available to treat millions of Americans, including a concentration of un-served populations in both rural and inner city areas who are unable to obtain care because there are not enough dentists practicing in those areas.” The ADHA claims to have the support of several other organizations: National Rural Health Association, American Public Health Association’s Oral Health Section, National Rural Education Association, and the Special Care Dentistry Association. What role would an ADHP play in delivering oral health care? This new provider would have the following competencies following the training period, which is a Master’s level program for 2 years after a Bachelor’s degree: Provide restorative services that treat infection, relieve pain, promote function and oral health; Preparation of cavities and restoration of primary and permanent teeth using direct placement of appropriate dental material; Placement of temporary restorations; Placement of pre-formed crowns; Temporary recementation of restorations; Pulp capping in primary and permanent teeth; Pulpotomies on primary teeth; Referral: Perform extractions of primary teeth and uncomplicated extractions of permanent teeth; Place and remove sutures; Provide simple repairs and adjustments for patients with removable prosthetic appliances; Recognize and refer patients with pathological conditions for diagnosis and treatment; Prevent potential orthodontic problems by early identification and appropriate referral; Prescribe pharmacologic agents for prevention, control of infection, and pain management utilizing established protocols or in consultation with a dentist or physician; Utilize local anesthesia and nitrous oxide analgesia during the provision of care as appropriate; and prevent, identify, and manage dental and medical emergencies and maintain current basic life support certification.

The CSDA has taken the position that if a new member of the dental team is to be added, they must improve access to care for the underserved. They must increase capacity in the system, be cost effective both educationally and in the delivery of care, and reach the target population. Testimony given by the CSDA during the last session of the Connecticut legislature made the point that this model did not satisfy these requirements. Ultimately, the model did not go to a vote in the Public Health Committee as the question was raised by the legislative leadership that if this isn’t the appropriate model, what is? It is expected that similar legislation will reappear at the upcoming session of the legislature in 2010.

Advantages: (As presented by the ADHA)
1. Increases capacity in the oral health care system
2. Reaches the target population of the underserved
3. Provides a career ladder for the hygienist
4. Proven capable of competencies when properly trained
Disadvantages:
1. This model does not increase capacity of the system as only a limited number of ADHPs will graduate each year.
2. ADHP migrates to the private sector due to higher salaries, missing the target population.
3. There is no effect on access based on world applications and experience.
4. The education is expensive and longer than necessary for the type of position. Add 2 more years and be a dentist.
5. There is not enough training to diagnose oral and systemic disease.
6. Would take students from the limited number hygienists in CT and would be much less likely to draw candidates from (and have them return to) the target populations.
7. There is a limited source of potential candidates as the majority of hygienists have an Associate’s degree.
8. There is no demand for the position when competing with the other more cost-effective options.
9. Financial support from foundations is actively funding studies of other models, not ADHP.
School Based Dental Clinics

Background:

Multiple school based programs currently exist in Connecticut. These programs can be classified as mobile clinics, stand alone clinics in schools, and clinics that work with local safety net facilities to provide care to the underserved children. Dentists and hygienists provide care under the supervision of the dentist. In 2008, the CSDA HOD adopted Resolution #10-2008, identifying school based programs as the cornerstone of its access to care policies relative to children in Connecticut.

ADOPTED
RES. #10-2008
RESOLVED, that the CSDA supports the concept of school-based dental services, under the appropriate supervision of a dentist, as an effective means of addressing the issue of limited access to oral health care for uninsured and underinsured children.

Recently the CSDA convened a seminar with oral health care stakeholders who manage these programs, to better understand how these programs work and affect access to care. As a result, the CSDA learned the important role it can play by expanding its participation in school based programs and maintaining policy as a major piece of its access to care agenda. This will be the most important tool as it has the greatest chance of increasing utilization of oral health services by the target population in the shortest period of time. The CSDA sees its role as encouraging member participation in providing care and expertise in the programs, as well as for increased funding by the legislature. A sub-committee of the Access Committee has also been formed to move forward the CSDA agenda.

Advantages:

1. Treats patients in a place they can access easily
2. Eliminates transportation issues
3. Children miss less time from school
4. Working parents, especially those with low-paying jobs, miss less work
5. It takes place in a culturally sensitive setting
6. There is positive peer modeling experience
7. An absent student can be easily replaced in the schedule
8. Administrative support enhances the success of the program
9. Portable equipment can be used in multiple sites
10. Schools can be linked to community health centers, private offices or other safety net facilities
11. A 2 year DHAT may work well under indirect supervision of a dentist
Disadvantages:

1. Lack of administrative support undermines the success of the program
2. It can be difficult to find dentists to work in these programs
3. Need support of local dentists
**Glossary of Terms:**

**RTI-UNC Evidence-Based Practice Center**
RTI International, in collaboration with the five health professions schools and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, operates the RTI-UNC Evidence-Based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ). The Center is one of 14 EPCs sponsored by the AHRQ.

Available as a resource to the entire health care community, the RTI-UNC EPC produces systematic reviews and analyses of the scientific evidence (evidence reports and updates) on a variety of health care and health policy topics. It also builds on these reports to create materials and messages for patients and clinicians relating to health care decisions. EPC personnel also conduct research into the best practices and methods for conducting reviews of the scientific literature.

The Center prepares AHRQ reports and technology assessments as well as reports for other public and private health care organizations on topics of their choosing. Center staff design and conduct customized literature searches and quantitative analyses.

**ANTHC**
The Alaska Native Tribal Health Consortium (ANTHC) is a non-profit health organization based in Anchorage, Alaska, which provides health services to about 130,000 Alaska Natives and American Indians in Alaska. Established in 1997, ANTHC is owned and managed by Alaska Native tribal governments and their regional health organizations. ANTHC is part of the Alaska Tribal Health System and is one of 22 co-signers of the Alaska Tribal Health Compact, a self-governance agreement with the Indian Health Service. The Community Health Aide (CHA) Program was developed in the 1950s in response to several health concerns. In 1968, the CHA Program received formal recognition and congressional funding. The long history of cooperation and coordination between federal and state governments and Native tribal health organizations has facilitated improved health status in rural Alaska.

The CHA Program is now a network of about 500 Community Health Aides/Practitioners (CHA/Ps) in more than 170 rural Alaska villages. CHA/Ps work within the guidelines of the Alaska Community Health Aide/Practitioner Manual, 1998 Revised Edition, which outlines assessment and treatment protocols. CHA/P are part of an established referral relationship that includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians, and dentists visit villages to see clients in collaboration with the CHA/Ps.

The Alaska Area Native Health Service has the responsibility for provision of medical and health-related services to Indian Health Service beneficiaries residing in Alaska. These services are provided by tribal organizations within the Alaska Tribal Health System. The village-based CHA/Ps are a vital link in the delivery system.
MEDEX

MEDEX Northwest is a regional program that educates physician assistants and Dental Health Aide Therapists (DHAT) in a proven tradition of excellence. MEDEX Northwest, the University of Washington School of Medicine's Physician Assistant Program, is committed to educating experienced health personnel from diverse backgrounds to practice medicine with physician supervision.

The program provides a broad, competency-based curriculum that focuses on primary care with an emphasis on underserved populations. MEDEX encourages life-long learning to meet ever-changing health care needs. As a pioneer in PA education, MEDEX continues to be innovative in identifying, creating, and filling new niches for PAs as a strategy for expanding health care access.

DHAT

Dental Health Aide Therapist. The Alaska Native Tribal Health Consortium, in partnership with the University of Washington School of Medicine's MEDEX program provides a narrowly focused, competency based, primary care curriculum that emphasizes community level dental disease prevention for the underserved Alaska Native populations. Services include restorative, prophylaxis, pulpal and simple oral surgery.

Kellogg Foundation

The W.K. Kellogg Foundation was founded in June 1930 as the W.K. Kellogg Child Welfare Foundation by breakfast cereal pioneer Will Keith Kellogg. In 1934, Kellogg donated more than $66 million in Kellogg Company stock and other investments to the W.K. Kellogg Trust. As with other endowments, the yearly income from this trust funds the foundation.

The foundation is now the 7th largest philanthropic foundation in the U.S. In 2005, the foundation reported that the total assets of the foundation and its trust were US$7.3 billion; about US$5.5 billion of this was in Kellogg Company stock. The foundation funded US$243 million in grants and programs in its 2005 fiscal year. 82% of this was spent in the United States; 9% in southern Africa; and 9% in Latin America and the Caribbean. In 1996 it supplied a multi-year grant worth $750,000 to start mass salt fluoridation programs which were then carried out by the Pan American Health Organization (PAHO), covering 350 million people in Bolivia, Dominican Republic, Honduras, Nicaragua, Panama and Venezuela. The project was part of a multi-year plan launched by PAHO in 1994 to “fluoridate the entire Region of the Americas”.

Pew Foundation

The Pew Charitable Trusts is an independent non-profit organization and non-governmental organization, founded in 1948 with over US$5 billion in assets. Its current mission is to serve the public interest by "improving public policy, informing the public, and stimulating civic life. The Trusts also funds the Pew Research Center, the third-largest think tank in Washington DC, after the Brookings Institution and the Center for American Progress.
**Ford Foundation**

The Ford Foundation is a private foundation incorporated in Michigan and based in New York City created to fund programs that were chartered in 1936 by Edsel Ford and Henry Ford. The foundation makes grants through its New York headquarters and through twelve international field offices. In fiscal year 2007, it reported assets of $13.7 billion and approved $530 million in grants for projects that focused on strengthening democratic values, community and economic development, education, media, arts and culture, and human rights. The Ford Foundation's grant making teams work in three broad program areas. The teams were set up to advance the core elements of the foundation's mission: strengthen democratic values, reduce poverty and injustice, promote international cooperation and advance human achievement.

**R. W. Johnson Foundation**

Based in Princeton, New Jersey, the Robert Wood Johnson Foundation (RWJF) is the United States' largest philanthropy devoted exclusively to health and health care. The foundation’s sole purpose is to help people in the U.S. live healthier lives and get the health care they need. The foundation has significant resources—$10 billion in assets, generating grants approaching $500 million a year—to address the nation’s most complex health and health care issues. The Foundation aims to use these private resources in the service of the public, and in a way that prompts new public policy, inspires action from the private sector, and changes systems for delivering the best health care to the most people.