

## **1) How do you place requirements on a person that is not credentialed? (OJT requirement to have Infection Control/CPR)**

Page 14 of the NDA/NDAA proposal modifies Nebraska Statute §38-1136, allowing the BOD to prescribe regulations governing the duties, including any educational requirements such as infection control and CPR. The BOD previously established Regulations governing dental assistants, not currently credentialed, performing coronal polishing and taking x-rays.

### **§ 38-1136 Dental hygienists; dental assistants; performance of duties; rules and regulations.**

- (a) The department, with the recommendation of the board, shall adopt and promulgate rules and regulations governing the performance of duties by licensed dental hygienists and dental assistants, **including any educational requirements.**
- (b) The board may adopt rules and regulations for the licensure of dental assistants. Every applicant for licensure shall satisfactorily complete an examination approved by the board, which examination shall require the applicant to demonstrate that the applicant is capable of performing the functions of a licensed dental assistant and shall be administered within the State at least once each year at such time and place as the board designates, and (1) have satisfactorily completed and graduated from a training program for dental assistants accredited by the American Dental Association's Commission on Dental Accreditation and approved by the board, or (2) have a high school diploma or its equivalent and at least 1,500 hours of work experience as a dental assistant.
- (c) Dentists delegating expanded-functions duties to licensed dental assistants or licensed dental hygienists shall do so in accordance with rules and regulations set forth by the board. No person shall perform expanded-functions duties in this state unless the board has issued to such person a permit to perform expanded-functions duties in this state.

## **2) Define parameters for RDHs writing prescriptions**

The RDH prescription portion of the proposal needs to be limited to 0.12 percent Chlorhexidine Gluconate and 1.1 percent neutral sodium chloride.

## **3) Any other minimum age requirements in the UCA?**

Section 38-129 of the UCA defines the minimum age of 19 to receive a credential, unless modified by another statute or regulation.

### **§ 38-129. Issuance of credential; qualifications**

No individual shall be issued a credential under the Uniform Credentialing Act until he or she has furnished satisfactory evidence to the department that he or she is of good character *and has attained the age of nineteen years except as otherwise specifically provided by statute, rule, or regulation.* A

credential may only be issued to a citizen of the United States, an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act, or a nonimmigrant lawfully present in the United States who is eligible for a credential under the Uniform Credentialing Act.

§ 38-1221(1) - To be eligible for a license under the Emergency Medical Services Practice Act, an individual *shall have attained the age of eighteen years.*

§ 38-2890(2)(a) **Pharmacy technicians** - To register as a pharmacy technician, an individual shall *(a) be at least eighteen years of age;*

§ 38-2221. **Practical nursing;** *There is no minimum age requirement for licensure as a licensed practical nurse*

§ 38-2220. **Nursing;** *There is no minimum age requirement for licensure as a registered nurse.*

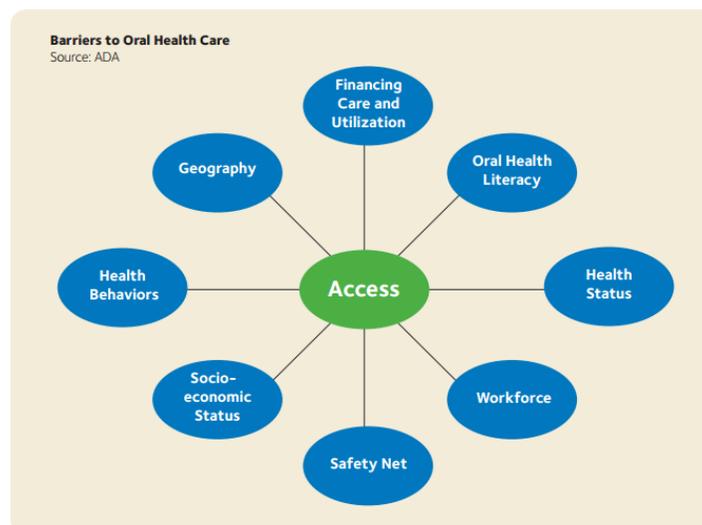
§ 38-10,128(1) **Nail technician or instructor** - *He or she has attained the age of seventeen years on or before the beginning date of the examination* for which application is being made;

#### 4) How will each proposal solve the "access to care" issue?

In short, neither proposal will solve the “access to care” issue. That said, we believe the NDA/NDAA proposal will go further improving the oral health of all Nebraskans.

Access to oral health care is a very complex problem. The ADA Health Policy Institute identified several types of barriers to receiving needed dental care, as is illustrated below. Financial barriers were mentioned most often. The second most common response was that insurance did not cover the procedure. The “not enough dentists” was reported by relatively small percentages of the population and this has declined over time. The full report, *Breaking Down Barriers to Oral Health for All Americans: the Role of Workforce*, is attached.

Breaking Down Barriers to Oral Health for All Americans: The Role of Workforce



The NDA/NDAA is requesting a Scope of Practice change for the practice of hygiene and dental assisting to provide for the education, training, and certification of an Expanded Functions Dental Assistant (EFDA).

An EFDA is a highly trained and skilled dental assistant or dental hygienist who receives additional education to enable them to perform reversible, intraoral procedures, and additional tasks (expanded duties or extended duties), services or capacities, often including direct patient care services, which may be legally delegated by a licensed dentist under the supervision of a licensed dentist. Training programs for EFDA are self-sustaining and can be operated in existing training programs with no additional cost to the educational system.

The EFDA practices under the supervision of a licensed dentist. Connection to the Dental Home ensures that children will have access to comprehensive care, including restorative services to eliminate pain and restore function.

Inclusion of an EFDA in the dental office as a part of the dental team will increase access to care for the underserved citizens in Nebraska, including children, the elderly and those with special needs. Research suggests that the use of EFDAs can increase the capacity of the dental office. Beazoglou, et al (2009), in an economic analysis of EFDAs in Colorado concluded that private general dental practices can substantially increase gross billings, patient visits, value-added, efficiency and practice net income with the delegation of more duties to auxiliaries. Increasing access to services within the context of a dental home will improve the oral health of Connecticut children and adults and will prevent the unnecessary suffering that comes with dental decay and infection. Beazoglou T, Brown LJ, Ray S, Chen L, Lazar V. *An Economic Study of Expanded Duties of Dental Auxiliaries in Colorado*. Chicago: American Dental Association, Health Policy Resources Center; 2009.

**Interesting contrast:** the NDHA proposal *eliminated* the EFDA tier after having supported it for over two years in the Task Force, stating now that “skills already possessed by an available pool of dental hygienists.” The NDHA proposal is more concerned with providing more job opportunities for hygienists and less employment opportunity for assistants than addressing the access to care issue. We know this is true by examining the attached interview with Deb Schardt in the NDHA November 2013 Access, Legislative Success Stories article. When asked how the most recent modification to the hygiene statute §38-1130, will make a difference to dental hygienists, Ms. Schardt responded, “it will provide *much needed job opportunities for under employed or unemployed hygienists in Nebraska*. The opportunities to serve the adult population *will also create much-needed employment.*”

A 2012 study compared the outcomes of restorations placed by restorative function auxiliaries (RFAs) with those placed by dentists. Of 910 restorations, 17 (1.9 percent) had problems potentially related to the filling or crown placement during the first year. Problem rates were not significantly different ( $p = 0.33$ ) for restorations placed by RFAs (1.3 percent, 6 of 455) and those placed by dentists (2.4 percent, 11 of 455). There was no significant difference in problem rates for restorations placed by RFAs versus those placed by dentists. This finding may free dentists to handle more difficult cases, alleviating some of the pressures of daily practice and meeting the need for improved access. *A comparison of dental restoration outcomes after placement by restorative function auxiliaries versus dentists*, J Public Health Dent. 2012 Spring;72(2):122-7. doi: 10.1111/j.1752-7325.2011.00291.x.

Epub 2012 Feb 16, Worley DC<sup>1</sup>, Thoele MJ, Asche SE, Godlevsky OV, Schmidt AM, Yardic RL, Rush WA.

A recent Harris Poll performed on behalf of Oral Health America stated that those with a household income of under \$50,000, including many who live in urban areas and young adults (including students), are more likely to skip or delay a dental visit, with **74 percent** of those surveyed delaying care for financial reasons or due to lack of insurance coverage.

## **5) What is competency and how we are going to measure competency?**

Page 7 of the *Dental Assistant Education Program Standards*, which we have submitted and is linked on the HHS 407 page, defines competency, clinical competency and competency evaluation. Similar CODA standards apply to Hygiene. *Dental Assistant Education Program Standards 2-10* ensures that didactic and preclinical competency is achieved PRIOR to any clinical practice. We also have Standards that all skill evaluations must be objective. We are proposing that all education take place at ADA CODA programs (or Military), so following CODA standards would be appropriate.

During the education phase, the faculty would be evaluating. Current pedagogy for dental education is:

- A. covering the procedures didactically and with written testing to measure that knowledge has been achieved
- B. performing the procedure to a preclinical level (on a mannequin) with faculty evaluation utilizing objective criteria to measure that psychomotor skills have been achieved. This usually involves the faculty observing the entire procedure, not just evaluating the end result.
- C. performing the procedure to a clinical level (on a person)
- D. For some of the functions, numerous performances of the procedure under the supervision of a dentist in a clinical setting will be required

Once the assistant or hygienist is licensed to perform the procedure, the dentist, as head of the dental team, is ultimately responsible for the safety of the patient. For over 20 years, Nebraska has had a very small version of expanded function dental assistant – a dental assistant that could perform coronal polishing or take x-rays. However, the dentist would not allow a dental assistant that was not fully trained as required by Nebraska Regulations, to perform these duties on a patient. We are not aware of any complaints against a dentist's credential due to the poor performance of a dental assistant performing these to duties.