

Technical Review Testimony- by Deb Schardt, RDH, PHRDH

Greetings- my name is Deb Schardt, I am a Registered Dental Hygienist and public health permit holder. I currently serve as NDHA Legislative Chair. I have been a registered dental hygienist for nearly 25 years, working in a variety of positions from private practice, educational settings and public health. I want to thank the technical review committee for their attention to detail in this very complex review!

Basic oral health is an important determinant of overall health. Dental health professionals, the states and the public recognize the critical need to have access to preventive, cost-effective oral care for all populations, especially underserved and unserved populations. Twenty Nebraska counties were without a dentist in 2012. The state of Nebraska has designated 44 counties as general dentistry shortage areas. Unfortunately, the number of dentists that want to practice are more inclined to practice in more urban areas and not in our rural communities. The aging population is keeping more of their teeth longer and have a longer life expectancy and our Medicaid eligible patients continue to grow. In addition, with the Affordable Care Act in place there will be a demand on states to provide accessible, safe and quality oral health care. Therefore, the Nebraska Dental Hygienists' Association (NDHA) proposal is a professional and responsible means of expanding the access to oral health care while ensuring the health and safety of the public.

The purpose of the NDHA proposal is to recognize and further promote the work that was done by the task force and, more importantly to address the preventable crisis we face as a state if we fail to explore other models that will provide quality oral health care to Nebraskans.

Criterion one: The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on scope of practice.

A dental hygienist is a primary care oral health professional who has graduated from an accredited dental hygiene program in an institution of higher education and is licensed in dental hygiene to provide education, assessment, research, administrative, diagnostic, preventive and therapeutic services that support overall health through the promotion of optimal oral health. There are many areas of coordinated care that a dental hygienist is an appropriate choice to include in a patient's overall health care.

Criterion two:

In 2009, Nebraska Legislature allowed the department of Health and Human Services to allow a dental hygienist with 3,000 hours of clinical experience to provide direct care access to children

in a public health setting without the presence of a dentist. One state funded program that ran from Jan. 2011 to Aug. of 2012 partnered with local health departments throughout the state providing screenings to nearly 14,000 children, and applied 22,973 fluoride varnish applications to those in need. 48.3% of these children did not have a dental home, 76.9% of families were on Medicaid, and 85.5% of the families did not have dental insurance. (Reference submitted document, “Nebraska Oral Health Access for Young Children Program” summary).

Public Health Dental Hygienists in the last year, have now had the privilege to treat adults in nursing homes and other public health settings, and in doing so, we have opened a door, but we are still finding barriers to care. We are confident that dental hygienists are educated and prepared to deliver quality care directly to patients in schools and nursing homes. The public health setting offers medical oversight from the medical director of the facility and has its own structure to assure that safe and quality care is being provided.

Currently there are 37 states that allow the public to directly access the oral health care services of a dental hygienist. It would seem logical that with some additional education, dental hygienists would be able to service these populations more effectively.

In a dental office setting, hygienists possess the psychomotor skills to quickly learn the limited restorative procedures that would be taught to the level, skill and competency of a licensed dentist with appropriate competency testing. (See “Forsyth Experiment in Training of Advanced Skills Hygienists,” (Journal of Dental Hygiene, vol. 87 pg. 63-66, copyright 2013) This in turn increases the efficiency of the dental practice allowing the dentist to spend more time to do advanced procedures. In short, NDHA believes that the oral health team should work to the top of their education and scope.

Criterion three: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.

Multiple studies and research have been conducted about the safety and effectiveness of advanced practice dental hygienists. Each and every report concurs that “Mid-level” dental providers perform equal standards of care as a dentist for the small scope of procedures they are intensely trained to do. Multiple research reports substantiating the safety and standards of care of Mid Level Dental providers have been put out by The PEW Charitable Trusts, W.K. Kellogg, and Institute of Medicine (IOM) to name a few. With the appropriate education, Expanded Function Dental Hygienists can safely work under the general supervision of a dentist. Currently, all dental hygiene procedures are under general supervision in the statute with the exception of administering local anesthesia and monitoring of nitrous oxide which are under indirect supervision.

NDHA is asking that in accordance with the original Board of Dentistry technical review application that dental hygienists be allowed to administer local anesthesia and reversal agents (an injectable agent that when administered will terminate the numbing effect of local anesthesia and delivered by the same route as local anesthesia) under general supervision to provide pain control to the patients hygienists are allowed to see under general supervision. 31 states currently allow dental hygienists to administer and titrate nitrous oxide and it is currently being taught in both of the dental hygiene schools in the state of Nebraska. This can very easily be a part of the dental hygiene scope of practice under the indirect supervision of a licensed dentist. Similar scope of practice and supervision issues arise in the context of advanced practice registered nurses. The Federal Trade Commission (FTC) emphasizes that overly broad scope of practice restrictions and supervision requirements, unsupported by legitimate health and safety concerns, may limit competition and decrease access without providing any countervailing benefits to health consumers.

Extraction of teeth: The “extraction of human teeth” should be applied to those extractions of teeth that you as a parent would “extract” on your own child who has a very loose tooth. The reason this was mentioned in the task force discussions is because when dental hygienists are working in a school based sealant program, there are some children that have a tooth that is literally hanging on by a thread, and who refuse to pull it out on their own. This causes pain and difficulty in chewing and causes inflammation and a potential for infection from this lingering baby tooth. This also prevents application of a dental sealant to a permanent tooth that is already erupting under the baby tooth. If our principal goal is to expand access to oral health care, while at the same time protecting the public health and safety, it is counterintuitive that a school nurse, coach or teacher may assist a student with “extracting” their loose tooth, but a dental hygienist working in the school providing oral health care is not allowed to remove the tooth. One might think this doesn’t need to be listed in statute. NDHA takes the statutes very literally, if it isn’t in there, we are not allowed to perform the procedure. The NDA/NDAA tends to like the vagueness and grey area as it allows for more speculation and delegating of procedures without requiring proper education.

Administering local anesthesia unsupervised: The NDHA is asking for what was supported by the Nebraska Board of Dentistry in their initial technical review application—allowing dental hygienists to administer local anesthesia “under the general supervision of a dentist.” Currently, dental hygienists are licensed to administer local anesthesia, but the dentist must be physically on the premises. What the NDHA is asking is for a dentist to have the authority to ask his/her dental hygienist to apply a local anesthesia so the patient is “numb” by the time the dentist is available to perform the necessary care regardless of whether he or she is on *or off* the premises.

This may be a good time to note that the local anesthesia courses provided to dental hygienists in dental hygiene programs are the same and sometimes more hours than the dental school courses, and, to the best of our knowledge, the states that allow this under general supervision (meaning that the DDS has to authorize the hygienist to administer the local anesthesia) NONE have had any complaints made to their states' Board of Dentistry about hygienists not performing to the upmost competency. Dr. Malamad also indicated that : he is unaware of any increased risk (morbidity/mortality) associated with the administration of local anesthesia by dental hygienists under general supervision versus indirect supervision. So long as the person injecting the drug is trained to (1) administer properly (aspirate, slow injection); (2) adequately perform a physical evaluation of the patient (review medical history); (3) be able to recognize signs & symptoms of 'problems', and (4) be able to manage those problems, whether or not a doctor is physically present in the office should not make a difference in safety. (referenced as supporting documentation with the NDHA proposal).

Again it is counterintuitive to think that a dental hygienist already licensed to administer local anesthesia would do it differently depending on whether a dentist is physically on the premises or in route to the premises. It is also counterintuitive to take the position that a dentist on premises can trust his or her dental hygienist to administer local anesthesia, but is unable to knowingly direct the hygienist to do so when he or she is not on the premises.

Criterion four: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

Dental Hygienists are formally educated and licensed in an accredited institution and have to pass written and clinical exams in order to apply for a license. Washington State is an example of a state that requires a restorative component to initial dental hygiene licensure. With the path in place for educating mid-level type providers and the model from Washington State, I believe that the future dental hygiene graduates would already have this in their curriculum and be tested both clinically and didactically through third party testing. This would provide the needed education to be competent in both the Registered Dental Hygienist and the Public Health Dental Hygienist scope of practice proposed. Additional coursework would be required to achieve the Expanded Function Registered Dental Hygienist).

For those already licensed and wanting to expand their skills, a combination of online didactic learning would occur with a set amount of clinical hours as described in the Kansas and Minnesota models set out in the NDHA proposal. Competency testing by calibrated faculty in an accredited institution would occur for those acquiring the additional education.

Criterion five: There are appropriate post-professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill of service in a safe manner.

As stated above, many of these procedures will be incorporated into the current dental hygiene curriculum with testing for clinical competency. Many surrounding states are already developing this curriculum and the Commission on Dental Accreditation is drafting the Accreditation Standards for Advanced Dental Therapy Education Programs.

A pharmacist would have to have the state's list of those certified to have prescriptive authority through their National Provider number. In this case, a DEA number would not be required, since the dental hygienist with prescriptive authority would not be writing prescriptions for narcotics. The list of limited authority would be that which was submitted to the committee and would be listed in statute for the Board of Dentistry to promulgate rules and regulations.

Criterion six: There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

Because the dental hygienist would have to prove competency to complete the educational program, take the national board exam and the clinical competency exam by a third party, pass a state jurisprudence exam and receive a credential, this would assure to the public the clinicians competency, just the same as what a dentist has to do to prove competency. There is a requirement of 30 hours of continuing education every two years. If a patient or provider would have a complaint, because dental hygienists are credentialed, they would be subject to discipline and possibly loss of license per the Board of Dentistry.

Dental sealants: The NDHA believes that placement of dental sealants may not require the skill and judgment of a licensed dentist. However, the NDHA does think that it requires at a minimum the skill and judgment of a licensed dental hygienist. We support a dental assistant performing this care, but only with education, competency testing, and a credential in order to protect the public. Our concern is that this issue was brought before the Board of Dentistry in a complaint, but was dismissed by the review committee as not being problematic. Therefore, dentists continue to delegate this procedure to untrained and unlicensed dental assistants.

Of the 33 states that allow sealant placement by dental assistants, 24 of those states require it to be by an expanded function dental assistant with the needed education and training and most of those only allow it under direct supervision, which means the dentist must check the sealant placement after it is placed and before the patient is dismissed to assure proper placement and occlusion.

The NDHA thinks the application of dental sealants by dental assistants is a public health and safety issue that needs to be addressed in statute and rules and regulations.

Education and Credentialing: As the NDA proposal points out, if it is deemed necessary that dentists and dental hygienists have formal education, testing and credentialing to perform services, then the NDHA thinks it disingenuous that the NDA does not endorse that dental assistants must also have some level of standardization to perform the same oral health services. For example, the NDHA is concerned that the NDA proposal recommends allowing a dental assistant to administer nitrous oxide, which is a drug. Such recommendation requires less than the supervision level currently required by a licensed dental hygienist. Even, Dr. Acierno addressed the need for the current dental assistants who are monitoring anesthesia to have more training and education than they currently do in his final report from the dental anesthesia technical review.

NDHA supports a scope of practice for dental assistants to be defined in statute in addition to the appropriate education, licensure and supervision of all parties addressed in the proposals. The concern NDHA has with the Board of Dentistry defining the education requirements for dental assistants is that the majority of the board are dentists. The NDHA's preference, which also better protects the public's health and safety, is to have the scope of practice and educational requirements defined in statute by the Legislature, which then allows the board to promulgate the rules and regulations. This is a more open and transparent process that clearly articulates the scope of practice for all dental professionals, better protects the public's health and safety, and minimizes the medical liability of a dental practice.

All of the expanded procedures that are requested by the dental hygienists would require the same or similar instruction that dentists would receive for the exact same procedure. We too, believe that the traditional dental office can be made more efficient by allowing a defined scope of practice for dental assistants in statute and increasing the scope of practice for dental hygienists to expand their reach to the growing population that does not access dental care through the traditional dental practice, as well as expanding their services within a dental practice.

According to the Healthy People 2020 progress report 14 of the 26 health indicators have either been met or are improving. Other indicators have shown little or no change, and a few remain at baseline. The sole oral health indicator, persons who visited the dentist in the past year, joins suicide and major depressive episodes in adolescents in having gotten worse since baseline. In 2007, 44.5 percent of Americans were visiting dental offices, while 41.8 percent were doing so in 2011. The target percentage for 2020 is 49 percent. We have a growing senior population that is going to long-term care facilities with a full complement of teeth that we, dental professionals, have been successful in helping them maintain in their advanced years.

However, once these seniors enter long-term care facilities, it is difficult to continue providing dental care to this population because very few dentists will treat these patients unless they are transported to their offices. We also know that the growing number of Medicaid patients are having difficulty in finding a dental home. The current model does not serve everyone. The current model is also not sustainable as our underserved and unserved populations continue to grow especially in a state like Nebraska where our demographics are very diverse between eastern and western Nebraska.

A recent report from the University of North Dakota, despite having one of the highest Medicaid dental reimbursement rates in the U.S. is still fighting distribution-of-care issues. Because of the gaps in coverage, only 30% of Medicaid-enrolled children had a dental visit in the last calendar year. The report goes on to inform that two other oral health providers that North Dakota recognizes is the registered dental assistant (RDA) and qualified dental assistants. An RDA has formal training or certification and has a greater scope of practice; a qualified dental assistant is trained chair-side.

In 2012, there were 472 RDAs with a North Dakota address and 107 without an address. Furthermore, 89% reported working the desired amount of hours, while 7% reported working fewer hours than desired.

As part of the goal to improve oral health delivery in the state, the authors of the report made five recommendations that were presented to the Interim Health Services Committee. The recommendations were subsequently passed by the committee and referred to the Interim Management Committee of the Legislative Council:

- Increase funding and reach of safety-net clinics to include providing services in western North Dakota.
- Increase funding and reach of the Seal! North Dakota Dental Sealant Program to include using dental hygienists to provide care and incorporating case management and identification of a dental home, where a patient receives oral healthcare in a coordinated manner on an ongoing basis (includes Medicaid reimbursement for services rendered).
- Expand the scope of dental hygienists and use them at the top of their current scope of practice to provide community-based preventive and restorative services and education to high-need populations.
- Create a system to promote the dentistry profession among state residents and encourage the practice in North Dakota through a consolidated loan repayment program and partnership, and look for student spots at schools of dentistry.
- Increase Medicaid reimbursement.

The NDHA proposal is a systemic solution to what we are currently facing in providing dental services in Nebraska and responsibly expands the care of dental professionals so they will be able to deliver dental services to all populations, but more specifically our underserved and unserved populations.

The NDHA proposal also provides a model that a dentist may incorporate that provides him/her with the flexibility to use dental hygienists that have expanded abilities and education to make a dental office more efficient and by allowing dental hygienists to perform simpler dental procedures so the dentist can focus on the more complex cases. This efficiency is furthered by the NDHA proposal of providing for a licensed dental assistant.

As to the licensed dental assistant, because dental hygienists already have the baseline training and experience needed to provide expanded functions in the dental office, including additional continuing education, the NDHA thinks that dental assistants should first become a licensed profession. After this, the NDHA would support dental assistants participating in the same continuing education and curriculum that dental hygienists complete in order to do certain procedures.

In sum, the NDHA proposal is a responsible means for serving the Medicaid, underserved and unserved populations in Nebraska while at the same time protecting the public's health and safety. The NDHA proposal aligns appropriate supervision with the delegated duties. The NDHA proposal will encourage dental practices to operate more efficiently, thus increasing their capacity to care for more patients. The NDHA proposal will make clear the scope of practice of the dental assistant that will limit the medical liability of the dental practice and better protect the health and safety of the public. Finally, the NDHA proposal reflects the collaborative work of The Future of Teamwork in Dentistry Task Force, a task force with NDA, NDAA and NDHA representatives that came to agreement on: the best solution for dentists, dental hygienists, and dental assistants to offer quality care to patients; how better to utilize the knowledge, skills and existing workforce of dental hygienists and dental assistants; how to help dental practices and other clinics and programs increase efficiency; and how to help increase the access to dental care for *all* Nebraskans.