

BEFORE THE DENTAL AUXILIARIES' TECHNICAL REVIEW COMMITTEE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC HEALTH  
STATE OF NEBRASKA

\_\_\_\_\_) )  
IN THE MATTER OF ) ) TRANSCRIPT  
A PUBLIC HEARING REGARDING THE ) ) VOLUME I of I  
NEBRASKA DENTAL ASSOCIATION/ ) ) (Pages 1 through 151)  
NEBRASKA DENTAL ASSISTANTS ) )  
ASSOCIATION PROPOSAL AND THE ) )  
NEBRASKA DENTAL HYGIENISTS ) )  
ASSOCIATION PROPOSAL. ) )  
\_\_\_\_\_) )

Nebraska State Office Building  
301 Centennial Mall South  
Lower Level C  
Lincoln, Nebraska

Convened, pursuant to notice, at 9:00 a.m.,

January 8, 2015,

BEFORE:

Wayne Stuberg, Ph.D., P.T., Chairperson.

COMMITTEE MEMBERS PRESENT:

Linda Black, R.T.; Edmund Bruening; Allison  
Dering-Anderson, PharmD, R.P., Ryan  
McCreery, Ph.D.; Stephen Peters, B.A., M.A.

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DHHS STAFF PRESENT:

Matt Gelvin, Administrator  
Ron Briel, Program Manager  
Marla Scheer, Administrative Staff

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Reporter's Certificate 3

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## REPORTER'S CERTIFICATE:

State of Nebraska            )  
  ) ss  
County of Lancaster        )

I, Wendy C. Cutting, reporter for GENERAL REPORTING SERVICE, certify that I reported the proceedings in this matter; that the transcript of testimony is a true, accurate and complete extension of the recording made of those proceedings; further, that the disposition of the exhibits is referenced in the index hereto.

IN TESTIMONY WHEREOF, I have hereunto set my hand at Lincoln, Nebraska, this \_\_\_\_\_ day of January, 2015.

\_\_\_\_\_  
Reporter

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1 PROCEEDINGS:

2 CHAIRPERSON STUBERG: The next item of business is  
3 our agenda for today. This is a public hearing on the  
4 proposal. We had a coin toss prior to, and the proposal for  
5 the Nebraska Dental Association/Nebraska Dental Assistants  
6 was the winner of the flip, so they will begin. Testimony  
7 by the applicant groups is limited to two hours, one hour  
8 per applicant group. That does not include if the committee  
9 members ask any questions and it takes that time over one  
10 hour of testimony.

11 MR. BRIEL: And we ask that those questions not  
12 interrupt the testimony. Wait until after each testifier  
13 has finished their testimony.

14 CHAIRPERSON STUBERG: Thank you, Ron.

15 Then there will be 30 minutes total, 15 minutes  
16 per applicant group for rebuttal. So, if there is anything  
17 that is said in testimony of the other group, you are  
18 allowed time to be able to speak back to those at that time.

19 Third, then, will be for anyone who is neutral,  
20 any testimony that's unaffiliated with either group, allowed  
21 30 minutes for testimony, concluding the presentations of  
22 each of the groups and the rebuttals, that's limited to five  
23 minutes per testifier. So, that will be our review.

24 Now, I have quite a few names as far as testifiers  
25 for the two groups. If you thought that this was just a

1 sign-in sheet and you all needed to sign in, you didn't need  
2 to sign in. So, I'll be going down the list, and if at the  
3 time I call your name, you're not actually a testifier for  
4 the group, just say, "Pass," and I'll cross you -- cross  
5 them off the list or --

6 MR. BRIEL: Yeah.

7 CHAIRPERSON STUBERG: I'll cross you off the list.

8 MR. BRIEL: There could have been some  
9 misunderstandings. Unless you testify, you don't have to  
10 sign in.

11 CHAIRPERSON STUBERG: All right, so, we are then  
12 going to begin with testimony from the Nebraska Dental  
13 Association and the Nebraska Dental Assistants Association.  
14 I have Scott Morrison as the first testifier.

15 DR. SCOTT MORRISON

16 DR. MORRISON: Mr. Chairman, that list that you  
17 have in front of you, I think the NDA and the NDAA have met  
18 and kind of formulated the chronology of when we want to  
19 testify and who we want to testify. So, you can read  
20 through the list, but I think we kind of know where we want  
21 to be.

22 CHAIRPERSON STUBERG: I'm fine with that.

23 DR. MORRISON: Good morning, everyone. My name is  
24 Scott Morrison. S-c-o-t-t, M-o-r-r-i-s-o-n. And I am a  
25 private practice dentist who specializes in periodontics.

1 Just a little background, periodontics is one of nine  
2 specialties recognized by the American Dental Association.  
3 And it deals with the prevention, diagnosis, and treatment  
4 of diseases affecting the gums and supporting structures of  
5 the teeth, and the placement of implants. I have faculty  
6 appointments as a clinical instructor at the UNMC College of  
7 Dentistry in Lincoln and at the UNMC General Practice  
8 Residency in Omaha. I am the current President of the  
9 Nebraska Dental Association, an association that represents  
10 73 percent of the practicing dentists within the State of  
11 Nebraska.

12 I would like to take a few minutes to discuss with  
13 you the intent of the proposal presented by the Nebraska  
14 Dental Assistants and the Nebraska Dental Association.  
15 While this joint proposal provides for some expansion of  
16 duties for hygienists and assistants, the primary focus is  
17 patient safety. This proposal also serves to improve the  
18 efficiency of the dental team, which increases patient  
19 access to care. It creates the expanded career ladder for  
20 both assistants and hygienists. And it creates a level of  
21 dental assisting that can be licensed and regulated by the  
22 State all while maintaining the highest quality of care that  
23 currently exists for our patients.

24 Expanded function within dentistry is something  
25 that the NDA has been working on with the NDHA and NDAA for

1 over four years. A task force comprised of dentists,  
2 hygienists, and assistants worked to develop a  
3 recommendation for expanded functions for hygienists and  
4 assistants, a recommendation that was then presented for  
5 consideration to each professional association. Through a  
6 series of open meetings and a unanimous vote by the NDA  
7 House of Delegates, i.e., their governing body, the NDA  
8 elected to accept the recommendation of the task force with  
9 the exception of expanded functions for hygienists that's  
10 related to extractions and unsupervised delivery of local  
11 anesthesia, and for assistance related to application of  
12 sealants. While content of the NDA/NDAA proposal does not  
13 include all elements of expanded functions referenced within  
14 that task force, the elements included within our joint  
15 proposal represent the areas of common ground that were, in  
16 fact, supported by all three segments of the dental team,  
17 the dentist, the hygienist, and the assistant.

18 Subsequently, the NDHA developed its own proposal,  
19 which not only added back in the expanded functions for  
20 hygienists related to extractions and unsupervised delivery  
21 of local anesthesia, but also included additional duties for  
22 hygienists while at the same time took away agreed-upon  
23 duties for assistants and tightened the supervision of  
24 duties currently performed by assistants. The inclusion of  
25 additional expanded duties for hygienists could not be left

1 unchallenged by the Dental Association. And specifically,  
2 those duties included dental hygiene diagnosis and cavity  
3 preparation of teeth. The proposal submitted by the NDHA or  
4 Hygiene Association provides for an expanded career ladder  
5 for hygienists only, with an emphasis on expanded duties to  
6 be performed by hygienists in clinical situations in  
7 environments without supervision by a dentist.

8 As stated earlier, the Nebraska Dental Association  
9 and the Nebraska Dental Assistants Association goal is in  
10 their 407 application is patient safety. And let me be  
11 clear in stating that the Nebraska Dental Association does  
12 not support the proposed expanded duties for hygienists  
13 related to extractions, dental hygiene diagnosis, and cavity  
14 preparation, because the expansion does not place patient  
15 care first. The NDHA's proposal, which involves the  
16 drilling of teeth in preparation for the placement of  
17 restorations or sealants allows hygienists to perform  
18 irreversible procedures. The place to learn and become  
19 proficient in performing these procedures is in dental  
20 school.

21 In addition, the NDA only supports the delivery of  
22 anesthesia by a hygienist through injection within an  
23 indirect supervision situation. The dentist must be present  
24 to assist with any problems that may ensue, and again to  
25 protect the patient and to ensure his or her safe care.

1 Common ground with NDA on four duties in the hygiene  
2 proposal, extractions, unsupervised delivery of local  
3 anesthesia, dental hygiene diagnosis, and cavity preparation  
4 does not exist. This proposal also seems to detract from  
5 the provision of comprehensive dental care by the  
6 traditional dental team in that it provides only for scope  
7 expansion for hygienists and does not consider the  
8 importance of the assistants in the process.

9 The purported basis for the NDHA proposal is  
10 improved access to dental care primarily through hygienists  
11 providing limited treatment dental care to seniors and  
12 children. Seniors and children represent two of the most  
13 vulnerable and difficult populations to treat. And the  
14 providing of limited treatment dentistry to these patients  
15 without on-site supervision of a dentist seeks to undermine  
16 the precepts of comprehensive care and patient safety. In  
17 our opinion, the hygiene proposal seeks to create additional  
18 working environments and opportunities for the numbers of  
19 hygienists that are unemployed or underemployed. The NDA  
20 advocates for all persons to receive comprehensive care.  
21 Therefore, the NDA believes that all persons are best served  
22 through the establishment of a dental home and treatment  
23 provided by a dental team consisting of the dentist,  
24 hygienist, and assistant, a position advocated by the ADA.

25 Our proposal is the outcome of years of work and

1        compromise and discussion between the various members of the  
2        dental team. It is a well-thought-out and well-researched  
3        program that will work statewide and allows for increased  
4        access to care through the use of both hygienists and  
5        assistants without placing the patient in harm's way or  
6        subjecting the patient to irreversible procedures being  
7        performed by those with insufficient training or  
8        insufficient supervision. Throughout this process, the  
9        provision of quality care to patients, based on recognized  
10       levels of education, experience, and licensing should serve  
11       as the overriding consideration in evaluating each of these  
12       proposals.

13                We believe that the NDA/NDAA proposal is a  
14       positive step forward in terms of patient safety and quality  
15       of care. Risk is inherent in any expansion or creation of a  
16       scope of practice, but with the dentist as the head of the  
17       dental team, that risk is kept to an acceptable level. It  
18       may not be as far as some would want and it is too far for  
19       others. But the bottom line is that it is a compromise that  
20       has the ability to work well within the state and benefit  
21       patients and care providers across Nebraska. Thank you.

22                CHAIRPERSON STUBERG: Questions from the  
23       committee?

24                (No response.)

25                Dr. Morrison, would you clarify? When you say

1 that the report from the task force was accepted in the  
2 House of Delegates of the Nebraska Dental Association, are  
3 the delegates represented by either dental assistants or  
4 dental hygienists or are they all dentists?

5 DR. MORRISON: They're all dentists representative  
6 of different districts within our state.

7 MR. PETERS: I have two questions. Regarding when  
8 you were in this collaborative issue, because that seems to  
9 be a key point that you're trying to make here, that  
10 everything was moving along pretty swimmingly, and then what  
11 was it that created the break off? Why did it not go to the  
12 end of the river and meet the ocean?

13 DR. MORRISON: Well, the task force finished with  
14 their document, and that was then passed on to the different  
15 associations. The two issues that I mentioned, which were  
16 extractions and unsupervised delivery of local anesthesia  
17 were the two issues for the Dental Association that they  
18 felt they could not move forward with.

19 MR. PETERS: So, had those issues been discussed  
20 at length inside the two committees or withinside this --

21 DR. MORRISON: Withinside our Dental Association,  
22 yes. There were several --

23 MR. PETERS: But not with the hygienists at that  
24 point or --

25 DR. MORRISON: That was done within the context of

1 the task force.

2 MR. PETERS: And so, then, in your opinion, what  
3 was it that they were after? They wanted expansion for both  
4 or just themselves?

5 DR. MORRISON: I'm sorry, I don't --

6 MR. PETERS: If it broke off and then they pursued  
7 this expansion on their own, what was it that they wanted  
8 inside when the committee was formed? What were they after?

9 DR. MORRISON: The goal of the task force, is  
10 that --

11 MR. PETERS: Well, the goal of the task force, it  
12 seems as though within that, then there was a faction that  
13 occurred, because then somebody went one way and somebody  
14 didn't want that.

15 DR. MORRISON: Right. I think the problem came  
16 from, in the NDA's opinion, the hygienists moving too far  
17 beyond their scope of practice.

18 MR. PETERS: Too far beyond their scope or too far  
19 beyond the scope of what the assistants would also be doing?

20 DR. MORRISON: Now, subsequent to what the NDHA  
21 came with in the proposal that you see in front of you,  
22 there were additions that were added into that. And so,  
23 those were obvious -- I can't speak for the Hygiene  
24 Association, but things that they desired from the fact that  
25 they presented that proposal.

1 MR. PETERS: They weren't able to get hammered out  
2 withinside this collective group.

3 DR. MORRISON: I can't really comment on --

4 MR. PETERS: Or were they not brought up in the  
5 collective group?

6 DR. MORRISON: My assumption --

7 MR. PETERS: I'm trying to see what happened in  
8 the collective group.

9 DR. MORRISON: Yeah, I can't comment on what was  
10 happening --

11 MR. PETERS: Because it could have been going on  
12 for six months and then all of a sudden, oops, we just got  
13 this new thing towards the end that said, "We want all these  
14 cool things, too."

15 DR. MORRISON: Well, it went on for about three  
16 years.

17 CHAIRPERSON STUBERG: Dr. Morrison, will there be  
18 another person testifying who could more easily address the  
19 question that's being asked by the committee member?

20 DR. MORRISON: Yes, someone that was on the task  
21 force.

22 MR. PETERS: And then my other question on this is  
23 the dental home. I've heard this brought up several times.  
24 So, the point on the dental home is, is that the hygienists  
25 really don't need pieces of this, because it's being taken

1 care of in other capacities withinside the dental home?

2 DR. MORRISON: Pieces of?

3 MR. PETERS: Of what they're after, the cavity,  
4 the extraction.

5 DR. MORRISON: Well, comprehensive care is taken  
6 within that dental home. And so, you could -- anything  
7 within the dental realm of treatment is done within that  
8 dental home.

9 MR. PETERS: So, no matter what, if the hygienists  
10 don't get this and they're not going to be able to do this,  
11 this stuff still gets done by somebody.

12 DR. MORRISON: Absolutely.

13 MS. BLACK: How does it get done by someone --  
14 maybe a better question would be how do the rural and  
15 underserved find a dental home, and how does your proposal  
16 help them, specifically, do that?

17 DR. MORRISON: Well, our proposal only addresses a  
18 small part of the access to care issue. Access to care runs  
19 in many different directions, monetary, transportation,  
20 language, culture. There's a list of things. And I think  
21 our executive director submitted some information on the  
22 barriers to care as far as dentistry is concerned. But it  
23 allows to be able to do, in any area, whether it's rural or  
24 urban, is it improves the efficiency of, for instance, a  
25 practice that would see only the small percentage of

1 Medicaid patients. They could increase that percentage by  
2 being able to delegate duties that normally would be taken  
3 up timewise by the dentist.

4 MS. BLACK: But would they? Given the current  
5 reimbursement climate, because they're more efficient, would  
6 that then translate to seeing more Medicaid patients?

7 DR. MORRISON: Well, part of efficiency comes with  
8 costs, and so if you can lower your costs in that situation,  
9 then I think you can. I can't speak for every dentist. My  
10 perception would be that, for instance -- and you'll hear  
11 from a pediatric dentist later, that it could be a huge  
12 benefit in the child's situation as far as pediatrics was  
13 concerned to where that could be delegated to be extremely  
14 more efficient. The private practice solo dentist, I'm not  
15 so sure they would look at that as a huge benefit. As you  
16 get into more of the bigger practices, group practices, and  
17 commercial practices -- I'm losing the term, but they would  
18 be more likely, I think, to engage in that kind of practice.  
19 And I understand your concern with the underserved. And the  
20 nursing care facility is a whole different ball of wax.

21 CHAIRPERSON STUBERG: Any other committee members  
22 questions?

23 (No response.)

24 Thank you, Dr. Morrison.

25 DR. MORRISON: Thank you very much.

1 CHAIRPERSON STUBERG: So, given your comments, I  
2 assume there's a next person that's wanting to come up to  
3 testify?

4 DR. MORRISON: Yeah.

5 CHAIRPERSON STUBERG: We won't go in order of the  
6 list, that's fine.

7 CRYSTAL STUHR

8 MS. STUHR: Hi. My name is Crystal Stuhr,  
9 C-r-y-s-t-a-l, my last name is Stuhr, S-t-u-h-r. I am a  
10 past president of the Nebraska Dental Association -- past  
11 president of the Nebraska Dental Assisting Association, and  
12 Nebraska and local. I am currently a program chair of  
13 Southeast Community College Dental Assisting Program. I  
14 have been working on the legislation for dental assistants  
15 for a very long time, approximately started in about 2007.  
16 So, I wanted to thank you guys all for being here today to  
17 listen to all of our testimonies.

18 I just wanted to reiterate, when I started with  
19 the legislation process, the reason why I got involved with  
20 it was because, when I went to Board of Dentistry meetings  
21 as an educator and as the president-elect of the Nebraska  
22 Dental Assisting Association. There was a ton of confusion  
23 addressed constantly about what can a dental assistant do?  
24 What can they not do legally? And I was involved with all  
25 of the trying to figure out if we could write regulations or

1 not for dental assistants to add education to some duties  
2 and functions at that point. And we were trying to move  
3 forward with that. And we found out that we couldn't write  
4 education with those duties. So, through the years, I've  
5 been part of the task force. Dr. Jack Wesch asked me to be  
6 on that task force, so I have been actively on that dental  
7 task force for the last three years as well.

8 So, I don't know if you want me to address the  
9 question that you had regarding --

10 CHAIRPERSON STUBERG: I would suggest you --

11 MS. STUHR: Just stay with my --

12 CHAIRPERSON STUBERG: For all of you, since you're  
13 limited to an hour, I would suggest that you keep your  
14 answers brief. I don't know how many people you plan to  
15 have testify, so that everybody that would like to speak can  
16 speak.

17 MS. STUHR: All right, thank you.

18 So, basically, when we wrote our proposal, I want  
19 to make sure that you understand that our focus was very  
20 simple. The patient safety was a main concern. And as we  
21 wrote our proposal, all of the duties that we put in front  
22 for any dental auxiliary was reversible procedures under a  
23 level of supervision that we felt was very comfortable with  
24 their level of education. So, that was our main focus.  
25 When we looked at the tier approach, we felt like that was

1 the best approach, because, if I'm an on-the-job-trained  
2 dental assistant, I'm going to need more supervision versus  
3 if I'm an educated dental assistant and have a credential, I  
4 would need less supervision, but I still need supervision  
5 under the dentist.

6 We believe that the tier of the dental assistants  
7 is essential and that these tiers allow the dentist to  
8 practice as is or it would allow them to delegate the  
9 simpler duties to the qualified dental auxiliary. As the  
10 dental assistants have moved from assisting, which that's  
11 how we started within the statutes was just assisting with  
12 dental procedures. Now we're moving to performing some of  
13 those simpler dental procedures. We feel that we have to  
14 stair-step the transition with appropriate requirements and  
15 proper regulation. The initial assessment of the dental  
16 assistant would be accomplished through the utilization of  
17 what is already out there, the Dental Assisting National  
18 Board or a board-approved equivalent exam. This exam would  
19 give us the basic knowledge in dental radiography health and  
20 safety, infection control, and general chairside.

21 The dental assistant that has passed the Dental  
22 Assisting Exam, then they would be eligible to complete  
23 additional education and training to move on to the first  
24 tier of the expanded function permits. They would then have  
25 to take additional courses that would include the didactic

1 training, the preclinical, and clinical instruction, and  
2 testing. And then this individual would have continuous  
3 monitoring by their supervising dentist, and ultimately the  
4 Board of Dentistry. All of the credentials for the dental  
5 assistants in the state would be required to complete the  
6 same continuing education requirements as the dentist or the  
7 dental hygienist.

8 And then, I kind of went into the brief details  
9 and I just wanted to clarify that the dental assistant, the  
10 first level that we had or the first tier is the on-the-job-  
11 trained dental assistant, or they could be a graduate of a  
12 CODA-accredited program. They just haven't taken the board  
13 exam. They would be required to have the OSHA infection  
14 control training and we do recommend that everyone would  
15 have CPR.

16 Dental Radiography is something that they can  
17 complete a course that the board has approved. And this is  
18 something that they can currently do under general  
19 supervision. And we want to maintain that. And that has  
20 been maintained in our proposal.

21 Coronal polishing is the second duty that they can  
22 also pursue if they have worked for a dentist for 1,500  
23 hours and have proof of that. Then they can take a course  
24 and get a certificate to complete those duties under  
25 indirect supervision by the dentist.

1           The next tier is the licensed dental assistant,  
2           which is a graduate from accredited program or an on-the-  
3           job-trained dental assistant that has worked for 3,500  
4           hours. And then 1,500 of those hours has to be within the  
5           last five years. They would have to pass the Dental  
6           Assisting National Board or an equivalent exam approved by  
7           the board; pass a jurisprudence exam. And then, if once  
8           they've done that, they could apply for licensure with the  
9           State of Nebraska. Once they've applied for their licensure  
10          and become a licensed dental assistant, if they would like  
11          to do any of those expanded duties in that first level or  
12          that first category, then they would have to take, again, a  
13          course in that expanded duty, take the didactic part, the  
14          preclinical, the clinical instruction with testing. And  
15          again, it would be continually monitored by the supervising  
16          dentist. Those categories are the fixed prosth, the  
17          removable prosth, pediatric fixed, and monitor and  
18          nitrous (sic) nitrous oxide.

19                 And we did put those all separate just due to the  
20          fact that dental assisting is very different in different  
21          offices. If I work for a pediatric dentist, I have no  
22          interest in removable prosth. If I work for a general  
23          dentist, I'm probably not going to be doing a lot of  
24          pediatric duties, and that's really why we did separate all  
25          of those permits and didn't make it an all or nothing.

1           And then, the last tier on that is the expanded  
2           function dental assistant. The dental assistant would have  
3           to have 1,500 hours as a licensed dental assistant first,  
4           and then they would have to complete that first tier, that  
5           first category of the expanded function before they can move  
6           to the second category. So, as we look at all of these  
7           expanded functions, we have really stair-stepped it, allowed  
8           them to get competent, and to be very comfortable in that  
9           lower level before they moved on to the second level and  
10          more extensive procedures. And then the last thing that  
11          they would have to do was pass the restorative functions  
12          test by the Dental Assisting National Board or something  
13          that would be similar and approved by the Board of  
14          Dentistry.

15                 All of the courses that we are offering with the  
16                 expanded functions are going to be given only by CODA-  
17                 accredited programs, Commission on Dental Accreditation  
18                 programs or by the U.S. military, and that's just going to  
19                 ensure that the standards of care and everything is still in  
20                 check with the faculty, with the ratios, and the facilities.

21                 After studying and discussing the topics of the  
22                 task force for three years, we believe that this is the most  
23                 effective way to protect the public. We looked at many  
24                 models from other states and reviewed them, and we found  
25                 that most states still had the tiered effect for dental

1 assistants and was very similar as what we are proposing  
2 today. The on-the-job-trained dental assistant or the  
3 unregulated dental assistant is there to complete the very  
4 simple functions, where the regulated or licensed dental  
5 assistant or credentialed dental assistant is there to  
6 complete the a little more complex functions. We're not  
7 trying to reinvent the wheel. We're just trying to  
8 customize it for Nebraska. And our bottom line is, we want  
9 to make it so we can keep the patients safe and try to make  
10 what will work best with the dental team.

11 Right now, as of 2014, 37 states currently  
12 credential dental assistants, and 24 of them have some level  
13 of restorative dental assistant. These numbers are  
14 definitely increasing as the states look for more effective  
15 ways to serve the patients population.

16 And lastly, when comparing CODA standards, the  
17 curriculum for the dental assisting program versus dental  
18 hygiene program, it's clear that the dental assisting  
19 programs are best suited for restorative functions. Dental  
20 assistant programs cover information in greater depth  
21 regarding operative or restorative procedures, materials,  
22 instruments, set-ups in both a preclinical and clinical  
23 level. We include 30 hours of clinical chairside experience  
24 assisting with operative procedures. This truly makes the  
25 restorative functions a natural progression for qualified

1 dental assistants in both the licensed dental assistant and  
2 the expanded functions. Thank you for your time.

3 CHAIRPERSON STUBERG: Thank you.

4 Would you like to follow up with your question  
5 that she was going to answer?

6 MR. PETERS: Do you remember my question?

7 MS. STUHR: About what happened?

8 MR. PETERS: Yeah, the motivation between the two  
9 groups, what it was and then what was the --

10 MS. STUHR: Well, you know, I did sit on the task  
11 force, you know, pretty much the entire time. And if you  
12 look at Appendix F in the proposal, I think it was an August  
13 date and it was kind of in a gray band.

14 MR. PETERS: Yes.

15 MS. STUHR: That's where we were at with what was  
16 on the table at the task force, and that's what we were in  
17 discussion of. And then, the bottom line was we are not  
18 comfortable -- the dental assistants are not comfortable  
19 with the supervision levels of not having anybody on the  
20 premises. We work with patient care all the time with the  
21 dentist, and I can't imagine trying to do an extraction,  
22 prep a tooth, a lot of the duties that they put on the  
23 table, without anybody else having to be on the premises.  
24 And so, those were really things that we couldn't support.  
25 After we, I guess, the ties broke, their proposal included a

1 lot more duties than that were ever brought to the table.  
2 The prepping the teeth was never on the table at the task  
3 force. That was just one example. So, some of those were  
4 never brought to the task force table.

5 MR. PETERS: So, they changed the supervision.  
6 You're worried about the supervision, but then when they --

7 MS. STUHR: Brought additional duties, yeah.

8 MR. PETERS: Then these additional duties were --

9 MS. STUHR: Yes.

10 MR. PETERS: Now, in your position on that, then,  
11 are these additional duties monumental leaps forward because  
12 they can do it? Or are they monumental leaps forward  
13 because it just sounded like it was the right thing to do,  
14 you know, because we've gone for this before, it would be a  
15 good thing? Because it seems as though your position is  
16 your -- you've gone through this very good progression of, I  
17 start here as a dental assistant. I can go two paths. I  
18 can get trained or I can go on-the-job. We've done this.  
19 And now, we're at a place where we want to keep going on  
20 this sort of logical progression. And you said it's a  
21 stair-step process to get to someplace else because of  
22 changing. But we're not really taking these huge leaps.  
23 I'm taking Step D to Step E. I'm not going to Step F  
24 bypassing Step E. And it seems that when they came back to  
25 this table, they were at -- everybody was on Step E, and

1 then, all of a sudden, you skipped F -- or they skipped F  
2 and went right to G. Where, you're basically saying, "We  
3 think we should keep going along a very progressive path."

4 MS. STUHR: Uh-huh.

5 MR. PETERS: Is that an accurate analogy?

6 MS. STUHR: I think that's accurate, yes.

7 MR. PETERS: Because it seems as though your  
8 position -- you've developed this sort of story that says,  
9 "You know, we're not going to go here. And we're not going  
10 to go here. We're going to go right through the step  
11 process."

12 MS. STUHR: Right.

13 MR. PETERS: And we were all going along that way,  
14 and all of a sudden now, somebody wanted to go to G and we  
15 were still saying, "Let's get through F, first."

16 MS. STUHR: Well, the safety of the -- I mean,  
17 that's the bottom line is, I can't imagine -- there's just a  
18 lot of things that can happen with a patient and being  
19 without anybody else on the premises, that's a huge concern.

20 MR. PETERS: And so, you believe your proposal  
21 keeps you focused on this sort of progressive process.

22 MS. STUHR: Very much so.

23 MR. PETERS: And that the training and everything  
24 that goes along with it, you're looking at maybe not moving  
25 these one hyg- -- I'm sorry, the dental assistants who are

1 not going through this class structure, but have gone  
2 through the on-the-job, you're hoping that they continue  
3 through this sort of --

4 MS. STUHR: Yeah, absolutely, because of, I mean,  
5 Nebraska, that's the way it's built. And so, I think we  
6 have to accommodate needs of everyone. And, you know, we  
7 did include the restorative functions for the hygienists in  
8 our proposal as well. We didn't eliminate that. And they  
9 have reduced the amount of supervision in theirs with us,  
10 and have eliminated a lot of the duties that we had at the  
11 task force for us as well.

12 MR. PETERS: Well, like I said, my concern and my  
13 consistent questions always pertain to what's -- why this  
14 progression that was going along and then all of a sudden,  
15 it's just a leap into some new territory that hadn't have  
16 been explored before. And now, was it -- is it legitimate  
17 along the training that someone has received and their  
18 backing that they're going to get, or is it, "Hey, we think  
19 we can do this now, too."

20 CHAIRPERSON STUBERG: Any other questions --

21 MR. BRUENING: In the interest of time, will we  
22 have an opportunity to raise questions with Crystal after  
23 both testimonies?

24 CHAIRPERSON STUBERG: How many people are planning  
25 to testify on behalf of the Association for the Nebraska

1 Dental --

2 DR. MORRISON: Three more.

3 CHAIRPERSON STUBERG: Three more. And so --

4 MR. BRUENING: Then let's kick that down the road  
5 and we'll try to come back to it.

6 MS. STUHR: Thank you.

7 DAVID O'DOHERTY

8 MR. O'DOHERTY: Good morning. My name is David  
9 O'Doherty. I'm the Executive Director of the Nebraska  
10 Dental Association and I will just be speaking briefly on  
11 the question that the committee raised on how does the  
12 proposal satisfy the criteria. There's focusing mostly on  
13 the dental assisting side, because one of the question we  
14 heard from the committee is, we're not seeing harm here.  
15 And true, there's -- we don't see a clear physical harm to  
16 the citizens of Nebraska, but we're seeing the harm present  
17 itself in other areas, which I think the committee has also  
18 recognized.

19 The current unregulated practice of dental  
20 assisting prohibits the State from licensing dental  
21 assistants, as is done throughout the United States. The  
22 Board of Dentistry can designate a list of duties that  
23 assistants can perform, but they are prohibited from tying  
24 education to any of those duties. Because the State cannot  
25 regulate dental assistants, there is a great uncertainty

1 within the dental profession as to what assistants can or  
2 cannot do in a dental office. The approval and enactment of  
3 our application would allow the State to license dental  
4 assistants and include an EFDA in a dental practice under  
5 the supervision of a dentist and extend the ability of that  
6 dental practice to provide dental services to all  
7 populations, including most at risk for dental disease. So,  
8 that's the harm part of it, which we agree that's a  
9 criterion, but we see the harm showing up in the places I  
10 just described.

11 The second criterion does -- the regulation does  
12 not impose significant economic hardship or significantly  
13 diminish the supply of practitioners. Because we're keeping  
14 the on-the-job-trained position, that preserves what's going  
15 on in dental assisting -- or dental offices throughout the  
16 state. So, because we're keeping that position, we don't  
17 think that diminishes the supply, but actually allows those  
18 who want to be trained and do more procedures in the dental  
19 office to do that.

20 The third criterion, the public needs assurance  
21 from the State of initial and continuing professional  
22 ability. As is currently done with hygienists and dentists,  
23 the State is doing that already within the dental office and  
24 the dental team, so this would just be another person within  
25 the dental team that the State is providing that competency

1 and training and licensing.

2 And the fourth criterion, the public cannot be  
3 protected by a more effective alternative. We think the  
4 public has been well served with the protection that is  
5 currently in place with the Board of Dentistry and the  
6 boards that you all are a part of in the current process of  
7 licensing and monitoring education of dentists and  
8 hygienists. The state credentialing process will protect  
9 the public regarding the licensing of dental assistants.

10 Happy to answer any questions.

11 CHAIRPERSON STUBERG: Questions?

12 DR. McCREERY: So, you hit on it a little bit, but  
13 one question that I have is why not just license all dental  
14 assistants? In terms of public safety and monitoring, and  
15 if the need to monitor -- or to license dental assistants is  
16 there, why not just say we're going to license everybody and  
17 then institute the tiers within licensure?

18 MR. O'DOHERTY: That, actually, in our eyes, tried  
19 to happen in 2007 or 2008 with the dental assisting. That's  
20 how we viewed their application, as requiring effectively  
21 all assistants to be licensed. We had over 40 or 50  
22 dentists show up to that 407 and say, you can't do that. We  
23 have -- you know, we're out in rural Nebraska. We're out in  
24 Valentine. We can't require -- we can't get licensed dental  
25 assistants in our practices. We need to be able to train

1 someone who has prior -- previously a nurse or previously an  
2 EMT or some other profession or occupation to come into our  
3 office and train them to be a dental assistant. So, that,  
4 in theory, would be great, but in Nebraska and a lot of  
5 states, that won't work, that you just have to have the  
6 ability to have an on-the-job-trained dental assistant.

7 CHAIRPERSON STUBERG: Related to that, having two  
8 tracks to become a licensed dental assistant, one,  
9 on-the-job training, and one, that you've taken a  
10 professional education track, do you -- is it your opinion  
11 that it's understood within the dental profession within the  
12 state of Nebraska that once the scope of practice of a  
13 dental assistant would be defined and licensed, that people  
14 that don't have that credential would not be able to do  
15 those duties in a dentist office by having assignment by the  
16 dentist? I.e., by defining what I can do as a dental  
17 assistant, it defines what an on-the-job-trained person that  
18 is not a licensed individual, unless they're in the training  
19 process for becoming that category.

20 MR. O'DOHERTY: Right. Our current statutes and  
21 regs for dental assisting, it says, assistants can do  
22 basically anything under the supervision of a dentist. And  
23 then it goes out and it lists five things that auxiliaries,  
24 which include hygienists, cannot do. So, it's very broad  
25 with some limitations. Now, with our proposal, it'll go

1 back -- it'll go through these two levels and say, only  
2 these people can do these tasks. It'll still leave open  
3 some other areas, but we're addressing things that have been  
4 most prevalent within the profession that need to be  
5 addressed with education.

6 CHAIRPERSON STUBERG: So, again, it's your opinion  
7 that on a defined task --

8 MR. O'DOHERTY: Right.

9 CHAIRPERSON STUBERG: -- that somebody who does  
10 not have that credential --

11 MR. O'DOHERTY: Absolutely.

12 CHAIRPERSON STUBERG: -- should not be doing that  
13 in a dentist's office or that dentist would be in a position  
14 that their license could be --

15 MR. O'DOHERTY: They would be -- right. Just like  
16 it would be now, but there would be more definition to what  
17 they -- on-the-job cannot do.

18 CHAIRPERSON STUBERG: Very good. Thank you.  
19 Are there any other questions?

20 (No response.)

21 Thank you.

22 MR. O'DOHERTY: Thank you.

23 DR. MELANIE STECKELBERG

24 DR. STECKELBERG: Good morning. My name is Dr.  
25 Melanie Steckelberg, M-e-l-a-n-i-e, S-t-e-c-k-e-l-b-e-r-g.

1 I'm a Lincoln dentist, both in private practice for ten  
2 years, concurrently working part-time at the  
3 Lincoln/Lancaster County Health Department for the past  
4 seven years. I was also a part-time clinical instructor at  
5 the dental college for almost five years. During my time as  
6 a clinical instructor, I taught dental students in the  
7 undergraduate periodontics clinic. Within the last months  
8 of each student's four-year dental program, I witnessed  
9 every student drastically improve their diagnostic  
10 abilities, critical thinking skills, clinical techniques,  
11 and chairside manner. The skills necessary to diagnose  
12 require the full length of the program for a dentists  
13 degree. However, the NDA and NDAA are not proposing for  
14 dental hygienists to diagnose nor provide any treatment that  
15 is irreversible.

16 I am asking the committee to move the NDA and NDAA  
17 proposal forward. This proposal will not completely solve  
18 the access to care issue, but it will let us be more  
19 efficient in providing timely treatment to the patients that  
20 desire the dental care. Unfortunately, one third of the  
21 U.S. Population has not seen the dentist within the past  
22 year. I have done dental screenings at two LPS schools for  
23 the past five years. One school is very high needs and the  
24 other is not. The total number of students in screenings  
25 has decreased; however, the number of children with

1 significant dental needs has not decreased. Therefore, I am  
2 screening fewer students, but more of these students have  
3 significant amounts of dental decay.

4 Students identified as having the highest dental  
5 needs are given access to both free dental care and  
6 transportation to the Health Department during the spring  
7 semester every year. Parents are welcome to ride the bus  
8 with their child from the school, but are not required to do  
9 so. Unfortunately, there is still an issue where more than  
10 one family won't consent to dental treatment for their child  
11 even after the nurse has sent home notes and even made home  
12 visits to discuss why this dental treatment is necessary for  
13 their child. We cannot fix the access issue for those that  
14 refuse dental care.

15 Patients must have a dental home, that one  
16 practice or clinic that they go to for their dental care.  
17 If dental treatment is going to occur in a nursing facility,  
18 each one of those facilities will have the same start-up  
19 expenses as my private office. This is why I think those  
20 facilities usually do not have a dental clinic within them.  
21 Nebraska regulations require nursing home facilities to  
22 assist residents in obtaining routine and 24-hour dental  
23 care to meet the needs of each resident. The facility must,  
24 if necessary, assist the resident in making appointments and  
25 arranging transportation to and from the dentist's office.

1           In my private practice in Lincoln, I do not plan  
2 to utilize these expanded functions in the near future;  
3 however, I can see this occurring at the Health Department,  
4 and I appreciate the benefit expanded functions will provide  
5 pediatric practices with a dentist remaining the head of the  
6 dental team and the only dental provider performing any  
7 irreversible procedures.

8           The military has long used EFDAs, expanded  
9 function dental assistants, in dental practice where the  
10 same dental assistant stays with the patient during the  
11 entire appointment while the dentist and expanded function  
12 dental hygienist or assistant rotate positions throughout  
13 the treatment rooms. The dentist would diagnose, prepare  
14 the tooth, and discuss with the patient the dental  
15 auxiliary's role to place and finish today's dental  
16 restoration. This would allow more patients to be treated  
17 in a day. The settings that would likely utilize expanded  
18 functions have more than 50 percent of their practice  
19 patients with the Medicaid program. We need to help our  
20 pediatric dentists treat more of the underserved by  
21 expanding the scope of practice of dental auxiliaries.

22           The committee was concerned regarding our model,  
23 including both regulated and unregulated professionals. We  
24 must retain the ability for our dentists to continue to  
25 train dental assistants on the job, which has no documented

1 safety issues in Nebraska, in order to have dental  
2 assistants available for rural dental offices. The Dental  
3 Practice Act lacks definition of what procedures can be  
4 legally delegated to dental assistants. Advancing our  
5 proposal would give legal parameters that, yes, dental  
6 assistants can do this, and give the Dental Board the  
7 authority to adopt and promulgate rules and regulations,  
8 including educational requirements for those dental  
9 professionals.

10 Expanded function restorative dental hygienists  
11 and expanded function dental assistants would provide dental  
12 treatment such as placing and carving fillings, but  
13 absolutely no preparation. A current diagnosis from a  
14 dentist is required prior to any irreversible procedure as  
15 cavities do not remain stagnant. And that photograph should  
16 kind of give you an idea of why. This is a patient I saw in  
17 my private practice, and the first one is actually the one  
18 that you see teeth on the top and the bottom. And if you  
19 look at the tooth to the right of the dental implant, on  
20 this side here, you can see a little, what we call cervical  
21 burnout, a little dark area, but that's not tooth decay.  
22 But I think that most people could see this dark area right  
23 here, which is nine months later, and this tooth was not  
24 salvageable. This was a Class V cavity.

25 Class I restorations are on the chewing surfaces

1 of the back teeth. They're covered with many nooks and  
2 crannies, which conceal the true depth of decay until the  
3 tooth is opened up, meaning the preparation has already  
4 started. Class V restorations are along the gum line and  
5 unfortunately can wrap around the full circumference of the  
6 tooth.

7 Both of these restoration categories have a higher  
8 chance of undiagnosed pulp exposure than a Class II, III, or  
9 IV restoration, in my personal opinion. Why? It's  
10 complicated, but X-rays will best predict decay depth on  
11 only older patients. Children have much larger pulp  
12 chambers than adults do. The root canal is closer to this  
13 chewing surface, the occlusal of a tooth. So, a much  
14 smaller cavity on a child can easily invade the root canal.  
15 Also, I need 30 percent change for a cavity to show up on an  
16 X-ray, so I cannot expect the depth of a cavity to be  
17 absolutely determined from an X-ray. An X-ray is often not  
18 useful for determining how close the decay is to the pulp on  
19 a Class V restoration, again, those along the gum line,  
20 because the cavity is often superimposed over the pulp  
21 chamber down in here on the radiograph. So, a Class V  
22 cavity can encroach on the pulp when you least expect it.  
23 And when the pulp is exposed, a dentist must make quick and  
24 appropriate treatment in order to save that tooth. Class V  
25 cavities do occur on every tooth in the mouth, and these are

1 especially tricky to treat in the increasing population of  
2 adults with xerostomia, that's dry mouth, a common side  
3 effect from most medications. Unfortunately, Class V  
4 cavities in patients with abnormally dry mouths can progress  
5 to the point where the tooth is not even savable in a matter  
6 of nine months, as I showed you on those X-rays.

7 Did you know that the bur is often moving at  
8 speeds of up to 300,000 rpms entering a space nearly the  
9 same size of my handpiece head, so that most of the  
10 preparation of Class V restorations is by feel, except for  
11 these six teeth. I cannot fathom how any continuing  
12 education course can provide the education and clinical  
13 experiences necessary to prepare a Class I and V decay to  
14 the same standard of care as a dentist. It is the  
15 culmination of dental school that allows dentists to provide  
16 irreversible treatment in a safe, efficient, and respectful  
17 manner.

18 The State of Nebraska should not limit the current  
19 duties of the dental assistant nor add a new level of  
20 supervision to the statute. I respectfully request the  
21 committee to support the NDA/NDAA proposal. I would be  
22 happy to answer any questions that you may have.

23 CHAIRPERSON STUBERG: Thank you.

24 MR. BRUENING: Yeah, I have one. You mentioned  
25 early in your testimony that a large percentage of, I

1 believe it was students or the population have not seen a  
2 dentist in, what, three years I believe you said?

3 DR. STECKELBERG: In the last year.

4 MR. BRUENING: So, what was the demographic of  
5 that percentage?

6 DR. STECKELBERG: That was --

7 MR. BRUENING: Youth or the entire population?

8 DR. STECKELBERG: That was -- sorry, I thought I  
9 had that with me.

10 MR. BRUENING: Well, regardless, and I don't know  
11 that it's relevant here, but isn't -- I mean, that's  
12 almost -- that opens up a whole line of question as to why.  
13 I mean, is it cost?

14 DR. STECKELBERG: As to why? I mean, I have  
15 patients --

16 MR. BRUENING: Why are they refusing dental care?

17 DR. STECKELBERG: At the Health Department, I see  
18 people of all different ethnicities, and there are certain  
19 ethnicities that don't even believe they need dental care.  
20 I mean, that's one issue.

21 MR. BRUENING: So, you --

22 DR. STECKELBERG: So, it's not --

23 MR. BRUENING: -- believe it's substantiate --

24 DR. STECKELBERG: -- it's multi-factorial.

25 MR. BRUENING: -- they're declining based upon

1 just logic --

2 DR. STECKELBERG: And some is --

3 MR. BRUENING: -- their own --

4 DR. STECKELBERG: -- they don't have the finances.

5 MR. BRUENING: -- it's not a financial matter.

6 DR. STECKELBERG: For some it is.

7 MR. BRUENING: But, yeah, okay. And then, your  
8 testimony -- is your testimony in support of the dental  
9 assistant or is it opposed to the hygienists?

10 DR. STECKELBERG: I am in support of the  
11 dentist/dental assistant.

12 MR. BRUENING: Okay, thank you.

13 CHAIRPERSON STUBERG: Any other questions?

14 MR. PETERS: On the tooth situation -- thanks for  
15 the pictures. Everybody likes pictures. The question that  
16 I have on that, though, is how many are we really dealing  
17 with? I mean, how many times will a patient -- I'm sorry, a  
18 dentist see such a situation where, hey, it looks like a I,  
19 but, oh-oh, nine months later, it was a V?

20 DR. STECKELBERG: It's pretty often. I mean, I  
21 will have patients come in who have been diagnosed by one of  
22 the other seven dentists at the Health Department, and  
23 they'll be diagnosed as a Class I, and I get in there and  
24 it's a Class II.

25 MR. PETERS: And so, what happens if I treat it as

1 a Class I and I go in there and just do a basic filling,  
2 like such, and fix that piece of it? Does that buy me any  
3 time or it still just going to go full to Level V at some  
4 point in time?

5 DR. STECKELBERG: Well, when it goes -- they're  
6 not classifications like mobility, I, II, III, IV, V. Class  
7 I is on the chewing surface. Class II goes over to the side  
8 of the tooth. Class III is on front teeth in between the  
9 teeth. Class IV on front teeth goes up to include the  
10 incisal angle. And Class V are the ones at the gum line.  
11 So, Class I and II only occur on the back teeth, III and IV  
12 only on the front teeth, and V on all of the teeth. If that  
13 helps.

14 MR. PETERS: Yeah, that does help. So, it's  
15 pretty common, hard to detect.

16 DR. STECKELBERG: I mean, you can feel it when  
17 you're going around.

18 MR. PETERS: It's extra -- it takes some extra  
19 skill, some extra detail, a real clear understanding of the  
20 X-rays.

21 DR. STECKELBERG: And not only that. You have to  
22 be able to diagnose, and the current statutes are that they  
23 can assess, the hygienist and assistant -- or just the  
24 hygienist, sorry.

25 CHAIRPERSON STUBERG: Other questions?

1 (No response.)

2 Thank you, Dr. Steckelberg.

3 DR. JESSICA MEESKE

4 DR. MEESKE: Good morning. My name is Dr. Jessica  
5 Meeske. My last name is spelled M-e-e-s-k-e. And I'm a  
6 children's dentist in private practice in Hastings and the  
7 Grand Island communities. I also want to let you know I was  
8 one of the two dentists on the original task force. I'm an  
9 adjunct faculty member at the College of Dentistry. I serve  
10 on the American Academy of Dentistry's National Medicaid and  
11 Access to Care Committee. I currently chair the Nebraska  
12 Dental Association's Medicaid Committee, and I'm a former  
13 trustee of the NDA. And I'm a former board member of the  
14 South Heartland District Health Department.

15 I'm in a four-doctor pediatric dental practice.  
16 We employ about five dental hygienists and about 12 to 15  
17 dental assistants. We're also one of the largest providers  
18 of dental care for children eligible for the Medicaid  
19 program in Nebraska.

20 In Nebraska, less than half of the kids who  
21 qualify for Medicaid in 2013 received any preventive dental  
22 service. What's any preventive dental service? Dental  
23 cleaning, dental sealants, fluoride treatments. Having  
24 access to preventive dental care is directly related to  
25 fewer cavities, less pain and suffering with children,

1 nutrition issues, and lots of missed hours of school. It's  
2 also related to lower costs for patient families and costs  
3 to the Nebraska Dental Medicaid Program.

4 I know that if I provide a dental home for kids  
5 regardless of income, I have a better chance of putting them  
6 on the right trajectory for their dental health for the rest  
7 of their life. Thus, not only they have better dental  
8 health, they have better overall health, they're better able  
9 to get jobs, because they have a nice smile. And we keep  
10 costs down for the State's Dental Medicaid Program, roughly  
11 about a \$40 million expenditure for the State.

12 We talked a little bit about barriers for patients  
13 on Medicaid in receiving dental care and also significant  
14 challenges that dental practices face. And these have been  
15 described in the original proposal. It's not uncommon for  
16 families in my practice to drive three and four hours one  
17 way for dental care for their child. Now, it's not just the  
18 amount of driving and the cost to get to the dental  
19 practice. Think about that child missing school for an  
20 entire day or the parents missing an entire day of work.  
21 And these aren't parents that have jobs like yours or mine  
22 where we might have sick leave or benefits. These are  
23 typically parents that have the kind of jobs that don't  
24 provide any kind of pay or benefit. Much of the dental care  
25 is similar to medical care in that a certain portion of

1 patients, they only need preventive care. That middle group  
2 needs very minor restorative care, the kinds of things we're  
3 talking about today with the expanded function, whether with  
4 a dental assistant or a hygienist.

5 And then there's that group of patients that are  
6 complicated. They're complicated medically. They're  
7 complicated dentally, how sick they are in their mouths.  
8 And they have very complicated social issues, family  
9 dynamics, behavior issues. Those aren't the kind of  
10 patients that we're talking about in the NDA and the NDAA  
11 proposal. A team approach works great to take care for all  
12 three of these groups, it really does. With the dentist  
13 being the head of the dental home, I'm the one in charge of  
14 examining the patients, providing the diagnosis, the  
15 treatment plan, and then discerning which patients can be  
16 treated by which individual in my practice. And right  
17 now -- it's very confusing right now what's legal and what's  
18 not legal. We have multiple opinions from the Attorney  
19 General. We have very vague language, and so, this is a  
20 really important role that you're doing is to try to help us  
21 clarify.

22 As you know, dentistry is absolutely decades  
23 behind medicine in how we delegate various duties that would  
24 benefit patients in access to care. And the model of using  
25 somebody like me with four years of college, four years of

1 dental school, three years of pediatric dental residency  
2 training, and a masters in dental public health, you don't  
3 need me to treat a lot of these patients. You need me to  
4 have overall responsibility, but I don't need to be  
5 providing some of these services when I have capable staff  
6 that can do it. The team I employ already, they're very  
7 skilled. They're willing to go back to school. And most  
8 are willing and excited about the possibility of doing more.  
9 And to be very honest with you, many of them are just very  
10 underutilized. And I lose my most ambitious people, both  
11 hygienists and dental assistants, who go on to other  
12 professions because, for some of them, in their mind, it's a  
13 dead end job. There's no opportunity for career growth.

14 The issues that you all have brought up in your  
15 questions are excellent. And as an original member of the  
16 task force, we discussed a lot of these in depth over a long  
17 period of time. And other questions that you've brought up,  
18 we hadn't even thought of. Many of the things you've  
19 brought up from a pharmacy level, they're really good  
20 questions. They're really important questions. Your  
21 questions and debate, they've been thought-provoking and  
22 they've been thoughtful. Having worked on this topic at the  
23 state and national level for more than ten years, this is  
24 the closest that these three groups have ever been to really  
25 making monumental change. I'm not sure we would ever find

1 100 percent agreement. There's always going to be some turf  
2 battles and some differences of opinion. But we have moved  
3 this hugely. And personally, I'm very excited that ten  
4 years ago, most Nebraska dentists didn't even want to think  
5 about this. They would have showed up at a 407 hearing to  
6 talk about how not to change the status quo. It just didn't  
7 make sense to them. Now, we have a critical mass of  
8 Nebraska dentists saying, "I think this is really an  
9 important direction that we could go." And they're keeping  
10 an open mind, even though a lot of them, they don't  
11 understand yet if they would ever use it in their practices  
12 or how they may use it.

13 I'm different. As a pediatric dentist, we're  
14 overwhelmed. We're overwhelmed with the numbers of kids  
15 we're seeing, the numbers of low-income kids we're seeing,  
16 and we need to increase the capacity in our practice to be  
17 able to take care of more of these needy kids while  
18 promoting safety and also promoting patient quality.

19 Finally, our educational institutions, they're on  
20 board with this. We don't need fly-by-night courses. We  
21 don't need to send assistants and hygienists out of state.  
22 We have accredited institutions that are ready now to help  
23 make this happen. I think that's exciting.

24 In closing, I want to thank each of you that has  
25 spent so much time learning about my profession and dental

1 care delivery system and being so diligent in your  
2 proceedings. We are long overdue for change, even if we  
3 need your help figuring out what the framework and the  
4 details of that change is going to be. I look forward to  
5 reading your recommendations, including those that will make  
6 the proposal stronger and more clear for everyone. And I  
7 urge you to support the proposal of the Nebraska Dental  
8 Association and the Nebraska Dental Assistants Association.  
9 Thank you.

10 CHAIRPERSON STUBERG: Thank you.

11 Questions?

12 MS. BLACK: I have one. You said that you have  
13 patients who travel three and four hours to your practice.  
14 And you're in, what would be considered by some, central  
15 Nebraska. Why are they -- do they not have access to  
16 pediatric dentistry closer to home or is --

17 DR. MEESKE: There's a multitude of reasons of why  
18 this happens. Sometimes the child falls into that third  
19 group that I talked about that's medically complicated,  
20 dentally, has a lot going on. So, when I say "dentally  
21 complicated," you might have a two-year-old with 15 bombed  
22 out teeth from tooth decay that requires treatment in a  
23 hospital setting. So, the patient's completely asleep in  
24 surgery. I come in and treat them. Some counties, we don't  
25 have a dentist. Some counties we have a dentist, but that

1 dentist isn't taking new Medicaid. Doesn't mean they're not  
2 taking Medicaid and trying to do their share. But sometimes  
3 there is too many patients in a Medicaid system that I feel  
4 is very broken, and so we just don't have the capacity to do  
5 that. So, that's why they're traveling so far.

6 CHAIRPERSON STUBERG: Any other questions?

7 (No response.)

8 Thank you.

9 Are there any other individuals that desire to  
10 testify? I would notify you that you have, I would say,  
11 approximately ten minutes max. That includes questions.

12 MR. BRIEL: I've got 25 minutes for this group.

13 CHAIRPERSON STUBERG: Twenty-five.

14 MR. BRIEL: And I've even factored in the  
15 questions.

16 CHAIRPERSON STUBERG: As far as the questions?

17 MR. BRIEL: Yeah.

18 CHAIRPERSON STUBERG: Oh, great. There's still  
19 time.

20 MS. BERNEY: I won't need all that time.

21 CHAIRPERSON STUBERG: No problem.

22 NICHOLE BERNEY

23 MS. BERNEY: Nichole Berney, N-i-c-h-o-l-e,  
24 Berney, B-e-r-n-e-y. And I am the current Nebraska Dental  
25 Assisting Association President. I'm also the Lincoln

1 Dental Assisting Association past president. And I'm also  
2 currently an educator in the dental assisting program here  
3 in Lincoln for Southeast Community College. Today, my  
4 testimony will actually be on behalf of the Nebraska Dental  
5 Assistants Association representing their board, their  
6 members, and various committees. And we believe the  
7 proposal -- basically, we're in opposition to the Nebraska  
8 Dental Hygiene Association proposal. We believe the  
9 proposal would not help to ensure the safety of the patient,  
10 because it would allow hygienists to perform extractions,  
11 tooth preparations and fillings, fissurotomies, and delivery  
12 of anesthesia under general supervision, basically, without  
13 a dentist on premises essentially allowing hygienists to  
14 practice dentistry with no supervision. These procedures  
15 are irreversible, thus posing potential harm to a patient.  
16 The NDHA proposal has eliminated dental assistants from the  
17 EFDA, expanded function dental assistant, restoration  
18 procedures. CODA-accredited programs focus on preparing  
19 dental assistants to assist with restorative procedures,  
20 instruments used, setups, supplies, and materials. Also,  
21 the on-the-job-trained assistant or OJT focuses solely on  
22 assisting with restorative procedures. And that's what they  
23 do day in and day out. That's their main purpose. While in  
24 practice, hygienists do not have their main focus on  
25 restorative procedures, but rather on preventative

1 procedures.

2 The Nebraska Dental Hygiene Association proposal  
3 also has no general supervision for dental assistants. This  
4 is a concern since it would limit access to care for  
5 patients by not allowing dental assistants to basically do  
6 the things that we're doing now, such as taking X-rays,  
7 recementing temporary crowns, or even applying wax kind of  
8 to the end of an orthodontic arch wire that may come loose  
9 just for patient, you know, kind of comfort or care. And  
10 then, also, all of these procedures, as I mentioned, are  
11 currently procedures dental assistants right now do under  
12 general supervision. Do you have any questions?

13 CHAIRPERSON STUBERG: Could you help me in what is  
14 the estimated percentage of participation of the dental  
15 assistants in the state of Nebraska that are members of the  
16 NDAA?

17 MS. BERNEY: That's a good question. Estimated  
18 percentage, I would probably say, perhaps around 50 percent.  
19 The number changes quite a bit, but I would say about 50  
20 percent.

21 CHAIRPERSON STUBERG: So, your testimony you feel  
22 would represent a minimum of half of the dental assistants  
23 in the state of Nebraska?

24 MS. BERNEY: I would probably say about half, but  
25 there are different levels of also being a membership now,

1 because they've kind of done some changes with the  
2 structuring with that on a national level. So, I would  
3 probably say, you know, at least 50 to 60 percent.

4 CHAIRPERSON STUBERG: Have you discussed the  
5 proposal that's been put forth by the NDA/NDAA at a meeting  
6 of the dental assistants?

7 MS. BERNEY: Yes, we have with our board members.  
8 And we also talk about it on local levels, too, on the local  
9 societies.

10 CHAIRPERSON STUBERG: Thank you.

11 Any questions?

12 (No response.)

13 MS. BERNEY: Thank you.

14 DR. MORRISON: Mr. Chairman, that concludes the  
15 testimony from the NDA/NDAA.

16 CHAIRPERSON STUBERG: Very good, thank you very  
17 much.

18 MR. PETERS: I do have one --

19 MR. BRIEL: With 23 minutes to spare.

20 MR. PETERS: Well, I do have a question, I'm  
21 sorry, to your name again?

22 DR. MEESKE: Jessica, Dr. Meeske.

23 MR. PETERS: You look like somebody I work with,  
24 so I call you -- it looks like Deb Istas.

25 (Laughter.)

1           Sorry. It was a question regarding -- it came to  
2 me after you were kind of going through your process, inside  
3 your 12 hygienists -- or five hygienists, 12 dental  
4 assistant organization in there, when it comes to the  
5 process of getting these things moved through, is the  
6 hygienist touching every patient, or is the dental assistant  
7 touching every patient?

8           DR. MEESKE: No, it depends on the patient. It  
9 depends on the age of the patient, the level of cooperation,  
10 and the reason that the patient's there. Would you like me  
11 to give you an example?

12           MR. PETERS: Yeah.

13           DR. MEESKE: So, let's say, a patient is coming in  
14 and they're having multiple procedures done with nitrous  
15 oxide or laughing gas. The dental assistant would call the  
16 patient back. She would do the initial charting and then  
17 double check what's being done for the day. The dentist  
18 would come in and say, "I concur. That's what the plan is  
19 for the appointment today." Then I might leave and check  
20 another patient. And if this is a cooperative patient  
21 that's low risk, so not a patient that has complicated  
22 medical issues, one of my five hygienists might come in and  
23 numb the patient up. If there were dental sealants to be  
24 done, the hygienist would do the sealants then, while the  
25 patient's getting numb. Hygienist would leave, go see her

1 next patient. I would come in and provide the restorative  
2 care or drilling on the tooth, taking care of the disease.

3 MR. PETERS: So, you're in the luxury of having 12  
4 and five, whatever that number is. If I were a dentist and  
5 I really was starting out or, look, I wanted to keep my  
6 overhead to a certain place, where would -- what would I do?  
7 Would I have two -- a hygienist and a dental assistant, or  
8 would I just maybe go with a hygienist and not worry about  
9 getting an assistant and I'm covered? Or would I have to  
10 have one or the other or both?

11 DR. MEESKE: Well, I can only speak for pediatric  
12 dentists. There's plenty of general dentists in the room  
13 that I think would better address the question, but if you  
14 were starting out, you probably wouldn't start out with a  
15 hygienist. You'd start off with one or two dental  
16 assistants, and -- for example, when I started in my  
17 practice, we had all dental assistants, no hygienists. As  
18 we saw the value of what the dental hygienists brought to  
19 the team with a higher level of education and expertise, we  
20 went from one hygienist to now five hygienists. So, it just  
21 depends on the type of practice you have. But in our case,  
22 we would utilize them. And when you say 12 assistants, I  
23 actually need 15. I can't hire three more right now,  
24 because it's hard to find, because it is such a low-paying  
25 job for so many.

1                   MR. PETERS: And so, if I did go with this -- with  
2                   the DA route, what would I rather want to -- would I rather  
3                   have them a very expanded scope or, you know, get them to  
4                   the point where they're at least just dealing with  
5                   everything. You know what I mean?

6                   DR. MEESKE: That's a great question. And in my  
7                   practice, so, with having 12 dental assistants, we have some  
8                   assistants that all they will ever be is your bread and  
9                   butter, basic level, dental assistant, what you and I know  
10                  when we go to the dentist, plays the role of the typical  
11                  dental assistant. We have some of those individuals that  
12                  would like to do more, and they're willing to go back to  
13                  school and they're willing to take on the added level of  
14                  responsibility. And that takes an individual that is more  
15                  mature, more committed to staying in the profession, and  
16                  most importantly, somebody that I trust to say to me, "You  
17                  know what, Dr. Meeske, I'm looking at this tooth and I know  
18                  I'm trained to do it, but I'm just not comfortable doing it.  
19                  Would you step in and do it?" To me, that's the number one  
20                  thing, is I can trust them that if they're not comfortable,  
21                  they let me know. And then, I'm really proud to say that  
22                  I've had several dental assistants that have gone as far as  
23                  they can under existing law with their career path and they  
24                  now have applied and been accepted into dental hygiene  
25                  school. And I'm very excited about that as well.

1 MR. PETERS: I'd like to know how much cross-over  
2 we're getting into hygiene. I thank you. Sorry to call you  
3 back up.

4 DR. MEESKE: That's all right.

5 CHAIRPERSON STUBERG: Okay, that concludes the  
6 testimony for the proponents of the Nebraska Dental  
7 Association and Nebraska Dental Assistants Association.  
8 We're now going to move to the proponents of the Nebraska  
9 Dental Hygienists Association, whoever would like to start.  
10 And how many do we have to testify for the -- this proposal  
11 as a proponent? How many of you are planning -- just so  
12 that --

13 MS. SCHARDT: Two, just for the --

14 CHAIRPERSON STUBERG: Okay, very good.

15 JULIE NILES

16 MS. NILES: Good morning.

17 CHAIRPERSON STUBERG: Good morning.

18 MS. NILES: My name is Julie Niles, N-i-l-e-s.  
19 I'm a registered dental hygienist and I'm currently the NDHA  
20 President. I have been a registered dental hygienist for  
21 nearly 28 years and have worked in private practice general  
22 dentistry my whole career. In my years of working in the  
23 dental office, I have collaborated with 36 dental assistants  
24 and 11 different dentists. My point to this information is  
25 this: The most important requirement for working in a

1 successful and safe dental practice is to have quality,  
2 knowledgeable people to work with where each and every  
3 member of the office is vitally important to the day-to-day  
4 safety and for the office to run smoothly.

5 I would like to address the dental assisting  
6 component of the NDHA proposal in Criteria One, unregulated  
7 practice can clearly harm or endanger health, safety, or  
8 welfare of the public.

9 CHAIRPERSON STUBERG: Let me interrupt just a  
10 moment so that we're clear here.

11 MS. NILES: Certainly.

12 CHAIRPERSON STUBERG: You're to be testifying as a  
13 proponent --

14 MS. NILES: Correct.

15 CHAIRPERSON STUBERG: -- of the NDHA proposal.

16 MS. NILES: Correct.

17 CHAIRPERSON STUBERG: Not concerns about the NDA  
18 or NDAA proposal.

19 MS. NILES: Correct.

20 CHAIRPERSON STUBERG: Just so we're clear.

21 MS. NILES: Yes.

22 CHAIRPERSON STUBERG: Go ahead.

23 MS. NILES: Thank you. As dental assisting stands  
24 now, many dental assistants are trained on the job, most  
25 generally by other on-the-job-trained dental assistants with

1 the dentist overseeing the process. If the dental assistant  
2 did graduate from an accredited dental assisting program in  
3 Nebraska, this training is a total of 11 months, nine months  
4 of school work or clinical work, and two months spent in  
5 dental offices observing. And then later, after they've  
6 been there a little while, also participating in the  
7 treatment experience.

8 Over the last four decades, dentistry and dental  
9 assisting have changed dramatically with dental assistants  
10 being delegated more and more responsibilities. This list  
11 outlines many of the duties such as assisting the dentist  
12 with fillings, taking X-rays with certification, polishing  
13 exposed enamel with certification, helping with extractions,  
14 root canals, fillings, crowns, sealants, surgical procedures  
15 such as gingivectomies, tissue grafts, placing implants,  
16 removing excess or protruding bone from denture patients,  
17 and tissue recontouring. They are also responsible for  
18 disinfection and sterilization of the room, operatory  
19 equipment, sterilization of instruments, handpieces, and  
20 disposable armamentarium. Other duties include being  
21 knowledgeable and compassionate when going over a patient's  
22 medical history, staying up to date on HIPAA rules and  
23 regulations, monitoring nitrous oxide, taking impressions,  
24 bite registrations, or current methods of mixing and  
25 dispensing appropriate amounts of dental materials.

1           In Nebraska, statute, rules and regulations,  
2           education has not changed to reflect this trend of  
3           increasing responsibilities of the dental assistant. We are  
4           here today attempting to make changes that first and  
5           foremost safeguard the public and improve access to care for  
6           patients. It is important to regulate or license the  
7           proposed licensed dental assistant who will be providing  
8           direct patient care that if done incorrectly could lead to  
9           negative results, outcomes, or consequences.

10           A dental assistant in Nebraska who is at least 19  
11           years of age at this time, could easily become a licensed  
12           dental assistant by, A, graduating from an accredited dental  
13           assisting school, or have approximately one and a half years  
14           of full-time experience working as an on-the-job-trained  
15           assistant then, taking and passing the Dental Assisting  
16           National Board, a jurisprudence exam. And after becoming a  
17           licensed dental assistant, fulfilling the continuing  
18           education requirements that are required of all of us to  
19           keep up our licensure. This license would then allow  
20           licensed dental assistants to perform expanded functions  
21           including dental sealant placement, which is currently only  
22           allowed to be done by dentists and dental hygienists as part  
23           of their education and licensing. They could also fit and  
24           cement crowns on primary teeth, and take final impressions  
25           or records for dental prosthesis. At this time, only

1 dentists are allowed to provide these services for patients  
2 in Nebraska.

3 Licensure benefits both the public and the  
4 individual dental assistant, because essential  
5 qualifications for dental assistants are identified. A  
6 determination is made as to whether or not the individual  
7 meets those qualifications, and an objective forum is  
8 provided for review of concerns regarding dental assistants'  
9 abilities when needed. Licensure benefits the dental  
10 assistant because clear, legal authorization for the scope  
11 of practice of the profession is established. Licensure  
12 also protects the use of titles. Only a licensed dental  
13 assistant is authorized to use the title of licensed dental  
14 assistant.

15 Once a license is issued, the Board of Dentistry  
16 holds a licensee to provisions defined in statute, and when  
17 necessary, can take action against the license of those  
18 licensed dental assistants who have exhibited unsafe dental  
19 assisting practices. By providing a standard of education  
20 and regulated qualifications set forth by a governing body,  
21 proof can be established of minimum qualifications of  
22 knowledge and ability. This would be very valuable  
23 information in the case of a lawsuit situation that could  
24 occur in a dental practice.

25 You, the technical review committee, have asked

1 for evidence of harm by the work of a dental assistant. It  
2 is difficult to provide evidence, as a supervising dentist  
3 would be disciplined in the event of inferior work by a  
4 dental assistant, as the Board of Dentistry has no authority  
5 to regulate or discipline a dental assistant at this time.  
6 There is a case of *Brown versus Rainbow Dental* where the  
7 jury found the dental assistant had allowed a patient to  
8 swallow impression material, which resulted in surgery to  
9 remove the material from the patient, Brown's, colon. Of  
10 course, accidents happen in the best medical professions.  
11 This case only demonstrates that dental assistants are  
12 providing services that can result in a negative consequence  
13 if done incorrectly. Certainly, the dental literature and  
14 research indicates that if procedures are done incorrectly,  
15 the consequences are numerous and include chemical burns,  
16 dental pain, TMJ pain, headaches, pain upon eating,  
17 additional visits to the dentist, poor self-cleansing of the  
18 tooth, food impaction, dental decay, secondary dental decay,  
19 gingival inflammation, periodontal disease, and possible  
20 tooth loss.

21 It is imperative that all oral health  
22 professionals have necessary knowledge and psychomotor  
23 skills to achieve excellent outcomes when placing dental  
24 restorations. Dental restorations are ideally made to blend  
25 smoothly with the contours of the natural tooth being

1 restored. If the filling is too large or the margins  
2 overhang the edge of the tooth, food and bacterial plaque  
3 can accumulate along the margins. If the filling is too  
4 small and there is space between the teeth, food and  
5 bacteria will accumulate there, as well creating new decay.  
6 Both circumstances will lead to inflammation, can lead to  
7 periodontal disease, systemic health problems, tooth decay,  
8 and eventual tooth loss. As a dental hygienist, one of my  
9 primary roles is to create an environment that the patient  
10 can keep clean. NDHA feels the proposal to allow registered  
11 dental hygienists to take the necessary courses in  
12 accredited institutions and pass a third-party clinical  
13 competency program exam would adequately prepare them to  
14 safely provide this service to the public. We feel a  
15 natural progression will develop to allow dental assistants  
16 to safely provide these services, but feel the step of  
17 licensure with more limited duties should be taken first.  
18 The proposed pathway that the NDAA/NDA has does not require  
19 any accredited education, and this is our concern.

20 Twenty-eight states allow nitrous oxide monitoring  
21 by dental assistants, primarily under direct supervision.  
22 Ten states allow dental assistants with formal education in  
23 expanded functions under direct supervision to administer or  
24 initiate nitrous oxide sedation. Here in Nebraska, when I  
25 looked up the education given to dental assistants in

1 accredited dental assisting programs, I found information on  
2 who it was safe to give nitrous oxide to and who it was not  
3 safe to give nitrous oxide to. But there was no information  
4 provided on what to look for when monitoring a patient on  
5 nitrous oxide. In the dental hygiene clinical practice  
6 handbook, there was a list of signs and symptoms to monitor  
7 for different levels of nitrous oxide sedation, and I have a  
8 copy of that I will hand out to everyone. This monitoring  
9 signs and symptoms list should be mandatory information to  
10 utilize in the process of monitoring patients on nitrous  
11 oxide. Without this information, a patient could easily  
12 become over-sedated creating dangerous situations,  
13 especially in children.

14 In summary, will unregulated practice clearly harm  
15 or endanger the health, safety, or welfare of the public?  
16 It could. As I outlined earlier, harm may come from  
17 services proposed by the NDHA as well as the NDA and NDAA.  
18 The duties to be delegated to dental assistants require  
19 education, demonstrated competency levels to safeguard the  
20 public. Changing statute to require at minimum experience,  
21 passing a written competency exam, and required coursework  
22 will allow the Board of Dentistry to have authority over the  
23 licensed dental assistants.

24 Regulation of this profession does not impose  
25 significant new economic hardship on the public or

1 significantly diminish the supply of qualified practitioners  
2 or otherwise create barriers to services that are not  
3 consistent with public welfare as these regulations are  
4 already in place for dentists and dental hygienists.

5 The NDHA proposal does increase the role of the  
6 dental assistant to include expanded functions of sealant  
7 placement, final impressions for permanent prosthetics, and  
8 to fit and cement crowns on primary teeth. The latter two  
9 are certainly restricted to dentists in Nebraska at this  
10 point. This proposal would increase the capacity of the  
11 dental practice to provide care to more patients at a  
12 cost-effective manner, and that would allow more Medicaid  
13 patients to be seen by members of the dental team with a  
14 lower overhead cost keeping the subsequent reimbursement  
15 levels adequate to cover the cost of treatment.

16 The public needs assurance from the State of  
17 initial and continuing professional ability. We feel that,  
18 indeed, the NDHA proposal does not go too far at this time  
19 in delegating duties to dental assistants. The proposal for  
20 expansion of duties and licensure is natural progression for  
21 dental assistants, and the public will be safeguarded under  
22 this proposal. The Board of Dentistry will have the  
23 authority to require continuing competency under the Uniform  
24 Credentialing Act. In a state where tattoo artists and paid  
25 dining aides who have statute and regulation requiring

1 minimum standards of coursework, competency evaluation, and  
2 their name placed on a state registry just for feeding  
3 another person or marking them with ink, we would sure hope  
4 that using acid etch and sharp instruments in someone's  
5 mouth would garner as much consideration and department  
6 insight (sic).

7           The NDA/NDAA proposal for an expanded function  
8 dental assistant, in our opinion, goes too far in allowing  
9 duties and procedures with a pathway that requires no  
10 accredited formal education at this point. We, NDHA, forced  
11 the subject of education within the task force. It was an  
12 area that became obvious we could not agree on. The  
13 majority of states that allow expanded functions require an  
14 accredited formal education. Due to their formal education,  
15 there is a wealth of knowledge that dentists and hygienists  
16 have. NDHA, as well as most states, see the importance of  
17 requiring formal education for expanded function dental  
18 assistants. The pathway that the NDA/NDAA proposal allowing  
19 on-the-job-trained assistants to progress into an expanded  
20 function dental assistants does not include these  
21 educational parameters.

22           As professionals, we believe in utilizing each  
23 member of the dental team to the highest level of their  
24 education and training. We see value in educated and  
25 trained licensed dental hygienists and licensed dental

1 assistants to provide care in our state and safeguarding the  
2 public by requiring licensure for the dental assistant is  
3 paramount.

4 The public cannot be protected by a more effective  
5 alternative. The work of the task force found that  
6 on-the-job-trained dental assistants were necessary as to  
7 not impose significant new economic hardship on the public.  
8 It will be imperative that the entire dental team then would  
9 understand the role of all licensed and unlicensed team  
10 members. Licensed team members must post their license for  
11 public viewing in the office.

12 And on a final note, I just want to add one more  
13 thought. Dental disease has been at the top of the list for  
14 Medicaid medical afflictions for many years here in the  
15 state of Nebraska. Dental disease is costing our state in  
16 excess of \$25 million a year. A survey that was performed  
17 several years ago assessing the amount of money that could  
18 be saved by preventive services to Medicaid recipients. And  
19 it was determined that for one dollar spent on preventive  
20 services, eight dollars was saved in restorative services.

21 Dental hygienists are specialists in preventive  
22 oral care services. And by being allowed to bring these  
23 preventive services to nursing home, hospitals, assisted  
24 living centers, schools in a manner that allowed more  
25 accessible reimbursement for Medicaid, just think of how

1 much money we could save the State of Nebraska in Medicaid  
2 costs. For example, it is estimated that 60 percent of  
3 inhalation pneumonia cases of the elderly population are due  
4 to the bacteria on the oral cavity. If you have ever looked  
5 into the mouth of a nursing home resident, you would see  
6 exactly how this could happen. By providing oral care  
7 through expanded functions to this group of people,  
8 hygienists could greatly reduce the bacteria levels in their  
9 mouths and reduce the number of residents contracting  
10 inhalation pneumonia. One hospital visit for a pneumonia  
11 case costs Medicaid, on average, \$40,000. This is just one  
12 example of how preventive oral care can greatly affect our  
13 state's Medicaid costs. By allowing dental hygienists to  
14 utilize their full scope of services in public health  
15 arenas, it could reduce the amount of Medicaid costs in our  
16 state significantly. Prevention is the only way to get out  
17 of the disease cycle. The treatment of disease does not  
18 prevent disease. Prevention prevents disease.

19 I want to thank you for you attention and  
20 thoughtful consideration of our proposal.

21 CHAIRPERSON STUBERG: Thank you.

22 Questions from the committee?

23 MR. PETERS: I'm going to pose the same question,  
24 basically. This juncture where everybody was at regarding  
25 the collaborative. I heard from them saying that it was one

1 thing, and I'm curious, do you agree? And what is your  
2 viewpoint on where it was collaborating and the break off  
3 that occurred? Because it seems to be the onus is on the  
4 hygienists who tended, my understanding is, that kind of  
5 broke this off. So, I'd like to understand why that  
6 happened, where it happened, and what were the outcomes of  
7 that if you know, and then, if it goes in alignment with  
8 what they perceive is the problem.

9 MS. NILES: Yes. First of all, I need to clarify  
10 that I did not attend those task force meetings.

11 MR. PETERS: Is there anybody else here that  
12 could?

13 MS. NILES: Yes. The next speaker will be able to  
14 address that.

15 MR. PETERS: Then we'll let that one -- you're off  
16 the hook.

17 (Laughter.)

18 MS. NILES: Okay.

19 CHAIRPERSON STUBERG: Let me reframe that, then.  
20 One of the separations between the proposal of the Dental  
21 Hygienists Association and the other proposal is that you  
22 allow for licensure of a dental assistant, but only for a  
23 person who's gone through a formal training process to get  
24 to licensure is the issue of on-the-job-trained assistants  
25 that you're not allowing as a part of what is in your

1 proposal, and, therefore, a significant departure from the  
2 two proposals, is that correct?

3 MS. NILES: They would still be allowed to take  
4 their licensure for sure, because they -- if they have a  
5 year and a half of experience, they are allowed to take that  
6 exam.

7 CHAIRPERSON STUBERG: Okay, so, refresh my memory,  
8 because your testimony in reference to on-the-job-trained  
9 dental assistants, by your proposal, would be allowed to  
10 become licensed.

11 MS. NILES: Yes.

12 CHAIRPERSON STUBERG: Okay, very good. Because I  
13 didn't think that was clear by your testimony.

14 MS. NILES: Oh, I'm sorry.

15 CHAIRPERSON STUBERG: But it was, in reading some  
16 of the information. Second question I have for you. Is  
17 dentistry reimbursed on a scale depending on who provides  
18 the procedure? So, if going into an office, if I have a  
19 sealant applied by -- well, that's not a good example.  
20 Another procedure. Pick a procedure that's something that  
21 could be done across people that would be in the dentist's  
22 office. So, it might be something that the dentist,  
23 certainly, would always be able to do, a delegatable task to  
24 an assistant or a hygienist, is there a differential in  
25 payment, differential in cost, the reimbursement system,

1       depending on who provides that service? Or is it like in  
2       medicine, there's a common procedure code, a CPT code, and  
3       it makes no difference who provides it, it's the same cost,  
4       and, therefore, the same expense to the system. Is that  
5       true?

6               MS. NILES: Yes. That is true.

7               CHAIRPERSON STUBERG: Then how -- your point of  
8       debate in reference to by having other people provide these  
9       services reducing the cost to society of dental care, how is  
10      that a salient point? It certainly helps me as a dentist to  
11      be able to improve my margin of profit, as a part of what  
12      I'm doing in my practice by having people that are not me  
13      providing that service.

14              MS. NILES: Yeah.

15              CHAIRPERSON STUBERG: How does it reduce the cost  
16      of provision of dental care to Medicaid or any other?

17              MS. NILES: In my view, it would be a savings to  
18      the dentist by his overhead costs in the office, thus  
19      allowing him to see more of the Medicaid patients and being  
20      able to bring those into this office in a business  
21      perspective and still being solvent at the end of the month.

22              CHAIRPERSON STUBERG: I would certainly give you  
23      that if I don't want to maximize my profit margin, I would  
24      be able to charge less.

25              MS. NILES: Right.

1                   CHAIRPERSON STUBERG: But otherwise, I think your  
2 point of this will reduce the cost isn't necessarily --

3                   MS. NILES: It was the cost to --

4                   CHAIRPERSON STUBERG: -- the case, then it's  
5 inherent --

6                   MS. NILES: -- the dentist.

7                   CHAIRPERSON STUBERG: -- upon the behavior of the  
8 dentist and the dental practice as to what happens with  
9 that.

10                  MS. NILES: Correct, yes.

11                  CHAIRPERSON STUBERG: Are there other questions?

12                  MR. PETERS: I still have a couple more. In your  
13 testimony, too, regarding the supervision, because you bring  
14 it up, can you explain to me what your view is on the  
15 supervision issue that, you know, there is this  
16 functionality piece that's going to be left into the  
17 hygienists' hands if this goes through or if it doesn't,  
18 that there is a discrepancy between what is and what is not  
19 deemed supervision. And whether direct or indirect, you  
20 know, this whole process, and I still don't know  
21 whether -- you'd kind of touched on this, but that was  
22 brought up that this -- that their position is that this  
23 would always be under some sort of supervised thing. Yours  
24 is not. Why is that a safety -- why is that safe? Why is  
25 that unsupervised with an increased processes now, with

1 increased services you're going to provide people, why is  
2 that safe?

3 MS. NILES: You're talking about in, like, a  
4 nursing home setting?

5 MR. PETERS: A nursing home or even withinside the  
6 dental -- you know, if the dental isn't there and the  
7 hygienists are actually performing some of these things that  
8 otherwise would be supervised or in someone else's  
9 definition these would have to be supervised, and in your  
10 definition, they're not. How is that safe?

11 MS. NILES: It would be safe in the fact that we  
12 have -- would have to take the exams for -- or have taken  
13 exams that were on an equal level to what is taught in the  
14 dental school.

15 MR. PETERS: So, it's just a matter of the  
16 training that makes it safer?

17 MS. NILES: I believe so.

18 CHAIRPERSON STUBERG: Questions?

19 MS. DERING-ANDERSON: Yes. We heard, during the  
20 previous testimony, that if you were going to perform dental  
21 care in a nursing facility, that to do it on site in the  
22 nursing facility, there are a number of expenses associated  
23 with that. I mean, there virtually needs to be a dentist  
24 office there or an office.

25 MS. NILES: Right.

1 MS. DERING-ANDERSON: Is that practical?

2 MS. NILES: To have a dental office in --

3 MS. DERING-ANDERSON: Right.

4 MS. NILES: I know of no dental offices in nursing  
5 homes.

6 MS. DERING-ANDERSON: So, if those don't exist,  
7 how are we going to prevent inhalation pneumonia with a  
8 statute?

9 MS. NILES: Right.

10 MS. DERING-ANDERSON: Because the reason we  
11 license people who feed other people is because of  
12 aspiration pneumonia.

13 MS. NILES: Right.

14 MS. DERING-ANDERSON: At about an 82 percent rate  
15 when you look at some of the diseases. So, to flipply say,  
16 "We really don't care about aspiration pneumonia until we  
17 care about aspiration pneumonia" -- and I don't think most  
18 tattoo artists are supervised.

19 MS. NILES: I would agree.

20 MS. DERING-ANDERSON: Well, but you didn't agree  
21 when you insisted that their licenses therefore meant that  
22 supervised dental assistants needed to be licensed.

23 MS. NILES: Okay.

24 MS. DERING-ANDERSON: So, I'm confused as to what  
25 we're going to do for nursing homes who can't afford to put

1 in a dental suite that is going to dramatically reduce  
2 aspiration pneumonia. I don't get it.

3 MS. NILES: Okay. What has happened in other  
4 states where they have these services provided in nursing  
5 homes on a regular basis, which is just starting here in  
6 Nebraska, is that the dental hygienist goes in on more of a  
7 monthly or bi-weekly basis to help clean and remove the  
8 plaque, which is the bacteria from the mouth. For that  
9 service, you do not need an entire dental office. You can  
10 do that in their bed. You can do that in -- most nursing  
11 homes have a hairdressing facility, which provides the sink  
12 for rinsing and a chair that would lean back just a little  
13 bit for better access. You can use portable equipment,  
14 which is available readily, and those type of equipments  
15 would offer everything that you need for oral hygiene  
16 services to reduce the amount of plaque in a mouth and  
17 amount of bacteria to help prevent these inhalation  
18 problems.

19 DR. McCREERY: Is the NDHA proposal limited to  
20 those functions that you're currently describing in the  
21 public health setting?

22 MS. NILES: I'm sorry?

23 DR. McCREERY: So, you're describing cleaning  
24 people's teeth.

25 MS. NILES: Correct.

1 DR. McCREERY: Sounds reasonable for me to do in a  
2 nursing home.

3 MS. NILES: Yes.

4 DR. McCREERY: But the NDHA proposal is not  
5 limited to cleaning people's teeth in a public health  
6 setting, is that correct?

7 MS. NILES: Correct.

8 MS. BLACK: So, can the dental assistant -- or the  
9 dental hygienists do that now with their public health?

10 MS. NILES: Authorization, yes.

11 MS. BLACK: So, is that currently -- that's  
12 allowed in your practice.

13 MS. NILES: That is correct. That is currently  
14 allowed.

15 MS. BLACK: Is it how -- cleaning teeth in a  
16 nursing home --

17 MS. NILES: Yes.

18 MS. BLACK: -- is allowed with the public license.

19 MS. NILES: Health authorization, yes.

20 MS. BLACK: So, how much is it being done now?  
21 And if it's not being done very often now, why is it not  
22 being done?

23 MS. NILES: I think probably the biggest barrier  
24 for having dental hygienists go into these services now is  
25 getting some type of reimbursement, which is still being

1 ironed out.

2 CHAIRPERSON STUBERG: That was going to be my  
3 question, is that who pays for that service?

4 MS. NILES: Exactly.

5 CHAIRPERSON STUBERG: If it's not public health.

6 MS. NILES: We are allowed --

7 CHAIRPERSON STUBERG: Can only a dentist bill, or  
8 can a dental hygienist independently bill third-party  
9 reimbursement for those services?

10 MS. NILES: What is happening right now is that we  
11 have had hygienists who are being reimbursed somewhat by  
12 Medicaid. However, in the last couple of months, those  
13 services that we can bill for has been greatly reduced.  
14 Third-party, as far as insurance companies, they say it is  
15 legal for us to bill to them; however, the insurance  
16 companies are not seeing us as a billable entity at this  
17 point and not paying.

18 MS. DERING-ANDERSON: So, is there something in  
19 this proposal that will change that?

20 MS. NILES: I believe that in this proposal, some  
21 of the expanded functions would be created that would help  
22 to -- as far as, like, the removal of a tooth that is  
23 impeding --

24 MS. DERING-ANDERSON: Well, I'm going to ask about  
25 that next, actually.

1 MS. NILES: Exactly.

2 MS. DERING-ANDERSON: But is there something  
3 inherent in here that you believe, because I understand you  
4 can't speak for any insurer. Certainly not CMS. But is  
5 there something in here that you think will make getting  
6 paid more likely.

7 MS. NILES: I'm going to have you, really, ask  
8 that to Deb since she deals more with the public health.

9 MS. DERING-ANDERSON: I would be happy to.

10 MS. NILES: Thank you.

11 MS. DERING-ANDERSON: And I'm actually kind of  
12 cool with cleaning my teeth in the beauty shop. Is it safe  
13 to pull teeth in the beauty shop?

14 MS. NILES: Again, it's just going to be those  
15 teeth that are hanging by a thread. You're going to take a  
16 piece of gauze and literally just kind of twist it out.  
17 They are that loose.

18 DR. McCREERY: How do you know, as a dental  
19 hygienist -- because, from what I understand from previous  
20 testimony, the ability to determine the class of tooth there  
21 requires --

22 MS. NILES: Exactly.

23 DR. McCREERY: -- diagnosis, is that correct?

24 MS. NILES: It would.

25 DR. McCREERY: And so, what about the training of

1 a dental hygienist --

2 MS. NILES: That is all covered in our education  
3 and things that we are tested on in our board examinations.

4 CHAIRPERSON STUBERG: I have one additional  
5 question for you. What portion of the dental hygienists in  
6 the state of Nebraska are members of the Nebraska Dental  
7 Hygienists Association?

8 MS. NILES: I believe at this time it is right  
9 around 50 percent.

10 CHAIRPERSON STUBERG: So, similar to dental  
11 assistants, your testimony represents half of -- by what  
12 your association is speaking to. And what has been done  
13 within your association for purposes of discussing this  
14 proposal? Was there a formal vote at a state meeting to  
15 have you come and testify?

16 MS. NILES: Our last state meeting was held last  
17 April and discussion of these procedures was held in an  
18 issues forum for all hygienists that were present, which was  
19 approximately 400 of the hygienists in the state of  
20 Nebraska. I have also personally sent out letters of  
21 information to hygienists and they are discussed in  
22 component meetings.

23 CHAIRPERSON STUBERG: Thank you.

24 Are there any other questions?

25 (No response.)

1 Thank you for your testimony.

2 MS. NILES: Thank you.

3 DEB SCHARDT

4 MS. SCHARDT: What she's passing around is  
5 actually some of the -- or all of the questions that you  
6 guys had provided us on the list. A lot of those, Julie and  
7 I have tried to cover in our testimony, but those will give  
8 you a little clearer description of the questions that were  
9 asked within the criteria and the questions from the  
10 committee.

11 My name is Deb Schardt, S-c-h-a-r-d-t. I'm a  
12 registered dental hygienist and public health permit holder.  
13 I currently serve as NDHA Legislative Chair. I have been a  
14 registered dental hygienist for nearly 25 years, working in  
15 a variety of positions from private practice, adjunct  
16 clinical faculty at Central Community College, and the  
17 public health departments. I want to thank the technical  
18 review committee for their attention to detail in this very  
19 complex review.

20 Basic oral health is an important determinant of  
21 oral health -- of overall health. Dental health  
22 professionals, the states, and the public recognize the  
23 critical need to have access to preventive, cost-effective  
24 oral care for all populations, especially underserved and  
25 unserved. Twenty Nebraska counties were without a dentist

1 in 2012. The State of Nebraska has designated 44 counties  
2 as general dentist shortage areas. Only one third of  
3 Nebraska dentists even accept Medicaid. And, unfortunately,  
4 the number of dentists that want to practice and are  
5 inclined to practice are focused more in urban areas as  
6 opposed to rural communities. The aging population is  
7 keeping more of their teeth longer and have longer life  
8 expectancy, and our Medicaid-eligible patients continue to  
9 grow. In addition, with the Affordable Care Act in place,  
10 there will be a demand on states to provide accessible,  
11 safe, and quality oral health care. Therefore, the Nebraska  
12 Dental Hygienists Associations' proposal is a professional  
13 and responsible means of expanding the access to oral health  
14 care while ensuring the health and safety of the public.

15 The purpose of the NDHA proposal is to recognize  
16 and further promote the work that was done by the task  
17 force, and more importantly, to address the preventable  
18 crisis that we now face as a state.

19 I want to just try and briefly go through the  
20 criteria and address those. So, under Criterion One, the  
21 health, safety, and welfare of the public are inadequately  
22 addressed by the present scope of practice or limitations on  
23 scope of practice. A dental hygienist is a primary care  
24 oral health professional who has graduated from an  
25 accredited dental hygiene program in an institution of

1 higher education and is licensed in dental hygiene to  
2 provide education, assessment, research, administrative,  
3 diagnostic, preventive, and therapeutic services that  
4 support overall health through the promotion of optimal oral  
5 health. There are many areas of coordinated care that a  
6 dental hygienist is an appropriate choice to include in a  
7 patient's overall health care.

8 Criterion Two, enactment of the proposed change in  
9 scope of practice would benefit the health, safety, or  
10 welfare of the public. In 2009, Nebraska Legislature  
11 allowed the Department of Health and Human Services to allow  
12 a dental hygienist with 3,000 hours of clinical experience  
13 to provide direct care access to children in a public health  
14 setting without the presence of a dentist. One state-funded  
15 program that ran from January 2011 to August of 2012  
16 partnered with local health departments throughout the state  
17 providing screenings to nearly 14,000 children and applied  
18 22,973 fluoride varnish applications to those in need; 48.3  
19 percent of these children did not have a dental home; 76.9  
20 percent of families were on Medicaid; and 85.5 percent of  
21 the families did not have dental insurance. And that is  
22 referenced from the Nebraska Oral Health Access for Young  
23 Children Program.

24 Public health dental hygienists in the last year  
25 have now had the privilege to treat adults in nursing homes

1 and other public health settings. And in doing so, we have  
2 opened a door, but we are still facing barriers to care.  
3 And it is difficult to find a referral source to refer our  
4 patients that we see in the nursing home. I know there was  
5 a letter submitted from a nursing home that tried, even in  
6 the Kearney area, to find several dentists to treat a  
7 patient that had dental needs and no one would.

8 We are confident that dental hygienists are  
9 educated and prepared to deliver quality care directly to  
10 patients in schools and nursing homes. The public health  
11 setting offers medical oversight from the medical director  
12 oversight from the medical director of the facility and has  
13 its own structure to assure that safe and quality care is  
14 being provided. Within that system, we don't just go in  
15 and, you know, "Hi, Mrs. Jones, we're going to clean your  
16 teeth today." There's that whole infrastructure that you go  
17 through in a nursing home, that you're not just -- I mean,  
18 you're direct access, but you have to do it under the safety  
19 of the medical director.

20 MR. PETERS: The medical director of the facility?

21 MS. SCHARDT: Yes. Currently, there are 37 states  
22 that allow the public to directly access the oral health  
23 care services of a dental hygienist. It would seem logical  
24 that with some additional education, dental hygienists would  
25 be able to service these populations more effectively. And

1 in Nebraska, all of the 98 public health hygienists, their  
2 practice is only limited to underserved areas, so -- and  
3 public health settings. We're not setting up a corner on  
4 the street doing services. They're all targeted at public  
5 health settings and for underserved and unserved  
6 communities.

7 In a dental office setting, hygienists possess the  
8 psychomotor skills to quickly learn the limited restorative  
9 procedures that would be taught to the level, skill, and  
10 competency of a licensed dentist with appropriate competency  
11 testing. This, in turn, increases the efficiency of the  
12 dental practice allowing the dentist to spend more time to  
13 do advanced procedures. In short, NDHA believes that the  
14 oral health team should work to the top of their education  
15 and scope.

16 Criterion Three. The proposed change in scope of  
17 practice does not create a significant new danger to the  
18 health, safety, and welfare of the public. Multiple studies  
19 and research have been conducted about the safety and  
20 effectiveness of advanced practice dental hygienists. Each  
21 and every report concurs that a mid-level-type dental  
22 provider performs equal standards of care as dentists for  
23 the small scope of procedures they are intensely trained to  
24 do. Multiple research reports substantiating the safety and  
25 standard of care of mid-level dental providers have been put

1 out by the PEW Charitable Trusts, W.K. Kellogg, and the  
2 Institute of Medicine to name a few. With the appropriate  
3 education, expanded function hygienists can safely work  
4 under the general supervision of a dentist. And I think  
5 that's maybe where there's some issues that aren't quite as  
6 clear when we've heard from the other group, that we are  
7 still under the general supervision of a dentist in this  
8 expanded level that would provide restorative services. So,  
9 the dentist still has the authority to allow or not that  
10 procedure in his or her practice.

11 MR. PETERS: Only in the practice, but not the  
12 nursing home?

13 MS. SCHARDT: Correct. That would be the public  
14 health authorization would be the direct access.

15 Currently, all dental hygiene procedures are under  
16 general supervision in the statute with the exception of  
17 administering local anesthesia and monitoring of nitrous  
18 oxide, which are under indirect supervision.

19 NDHA is asking that in accordance with the  
20 original Board of Dentistry technical review application,  
21 that dental hygienists be allowed to administer local  
22 anesthesia and reversal agents, and that the reversal agents  
23 are an injectable agent that when administered will  
24 terminate the numbing effect of local anesthesia and  
25 delivered by the same route as local anesthesia. We are

1 asking that under general supervision to provide pain  
2 control to the patients hygienists are allowed to see under  
3 general supervision. Thirty-one states currently allow  
4 dental hygienists to administer and titrate nitrous oxide.  
5 And it is currently being taught in both of the dental  
6 hygiene schools in the state of Nebraska. This can very  
7 easily be part of the dental hygiene scope of practice under  
8 the indirect supervision of a dentist, meaning that they are  
9 on the premises when you're administering. Similar scope of  
10 practice and supervision issues arise in the context of  
11 advanced practice registered nurses. The Federal Trade  
12 Commission emphasizes that overly broad scope of practice  
13 restrictions and supervision requirements, unsupported by  
14 legitimate health and safety concerns may limit competition  
15 and decrease access without providing any countervailing  
16 benefits to health consumers.

17 And the extraction of teeth, I know we kind of  
18 talked about that a lot. This should be applied to the  
19 extractions of teeth that you, as a parent, would extract on  
20 your own child who had a very loose tooth. The reason this  
21 was mentioned in the task force discussions is because, when  
22 dental hygienists are working in a school-based sealant  
23 program, there are some children that have a tooth that is  
24 literally hanging on by a thread and who refused to pull it  
25 out on their own. This causes pain and difficulty in

1 chewing, causes inflammation, and a potential for infection  
2 from the lingering baby tooth. This also prevents  
3 application of a dental sealant to a permanent tooth that is  
4 already erupting under the baby tooth. If our principal  
5 goal is to expand access to oral health care, while at the  
6 same time protecting the public's health and safety, it is  
7 counterintuitive that a school nurse, coach, or teacher may  
8 assist the student with extracting their loose tooth, but a  
9 dental hygienist working in the school providing oral health  
10 care is not allowed to remove the tooth. One might think  
11 this doesn't really need to be in statute. NDHA takes the  
12 statutes very literally. If it isn't in there, we're not  
13 allowed to do it. The NDA/NDAA tends to like the vagueness  
14 and the gray area that it allows more speculation and  
15 delegating of procedures without requiring proper education.

16 Administering local anesthesia. The NDHA is  
17 asking for what was supported, again, by the Nebraska Board  
18 of Dentistry initially in their technical review. It would  
19 allow the dental hygienists to administer local anesthesia  
20 under the general supervision of a dentist, meaning the  
21 dentist still has to authorize the procedure. If you work  
22 for a doctor that doesn't want you to do that, you won't be  
23 doing it, so it's still under the discretion of the dentist.  
24 Currently, dental hygienists are licensed to administer  
25 local anesthesia, but the dentist must be physically on the

1 premises. What the NDHA is asking is for a dentist to have  
2 the authority to ask his or her dental hygienist to apply a  
3 local anesthetic so the patient is numb by the time the  
4 dentist is available to perform the necessary care,  
5 regardless of whether he or she is on or off the premises.

6 This may be a good time to note that the local  
7 anesthesia courses provided to dental hygienists in dental  
8 hygiene programs are the same and sometimes more hours than  
9 the dental school courses. And to the best of our  
10 knowledge, the states that allow this under general  
11 supervision have not had any complaints made to their state  
12 dental boards about hygienists not performing to the utmost  
13 competency. Dr. Malamad, an instructor of anesthesia, also  
14 indicated that he is unaware of any increased risk,  
15 morbidity or mortality, associated with the administration  
16 of local anesthesia by dental hygienists under general  
17 supervision versus indirect. So long as the person  
18 injecting the drug is trained to administer properly, which  
19 includes aspirating and injecting slowly; adequately perform  
20 a physical evaluation of the patient, with a review of the  
21 medical history; be able to recognize signs and symptoms of  
22 problems; and be able to manage those problems whether or  
23 not a doctor is physically present in the office should not  
24 make a difference in safety.

25 Again, it is counterintuitive to think that a

1 dental hygienist already licensed to administer local  
2 anesthesia would do it differently depending on whether a  
3 dentist is physically on the premises or en route to the  
4 premises. It is also counterintuitive to think the position  
5 that a dentist on premises can trust his or her hygienist to  
6 administer local anesthesia, but is unable to knowingly  
7 direct the hygienist to do so when he or she is not on the  
8 premises.

9 Criterion Four. The current education and  
10 training for the health profession adequately prepares  
11 practitioners to perform the new skill or service. Dental  
12 hygienists are all formally educated and licensed in an  
13 accredited institution and have to pass written and clinical  
14 exams in order to apply for licensure. Washington State is  
15 an example of a state that requires a restorative component  
16 to initial dental hygiene licensure. With the path in place  
17 for educating mid-level-type providers and the model from  
18 Washington State, I believe that the future dental hygiene  
19 graduates would already have this in their curriculum and be  
20 tested both clinically and didactically through third-party  
21 testing. This would provide the needed education to be  
22 competent in both the registered dental hygienist and the  
23 public health dental hygienist scope of practice.

24 Additional coursework would be required to achieve the  
25 expanded function registered dental hygienist, the one that

1 would be placing fillings.

2 For those already licensed and wanting to expand  
3 their skills, a combination of online learning -- as well as  
4 a set amount of clinical hours, as described in the Kansas  
5 and Minnesota models that were set out in the NDHA proposal.  
6 Competency testing by calibrated faculty in an accredited  
7 institution would occur for those acquiring the additional  
8 education.

9 Criterion Five. There are appropriate post-  
10 professional programs and competence assessment measures  
11 available to assure that the practitioner is competent to  
12 perform the new skill of service in a safe manner. As  
13 stated above, many of these procedures will be incorporated  
14 into the current dental hygiene curriculum with testing for  
15 clinical competency. Many surrounding states are already  
16 developing this curriculum and the Commission on Dental  
17 Accreditation is drafting the accreditation standards for  
18 advanced dental therapy education programs.

19 A pharmacist would have to have the state's list  
20 of those that would be certified to prescriptive authority  
21 through their national provider number. In this case, a DEA  
22 number would not be required since the dental hygienist with  
23 prescriptive authority would not be writing any  
24 prescriptions for narcotics. The list of limited authority  
25 would be that which was submitted to the committee and would

1 be listed in statute for the Board of Dentistry to  
2 promulgate the rules and regulations.

3 Criterion Six. There are adequate measures to  
4 assess whether practitioners are competently performing the  
5 new skill or service and to take appropriate action if they  
6 are not. Because the dental hygienist would have to prove  
7 competency to complete the educational program, take the  
8 national board exam and clinical competency by a third  
9 party, pass a state jurisprudence exam, and receive a  
10 credential, this would assure to the public the clinicians  
11 are competent just the same as it does for a dentist. There  
12 is a requirement of 30 hours of continuing education every  
13 two years. And if a patient or provider would have a  
14 complaint, because dental hygienists are credentialed, they  
15 would be subject to discipline and possible loss of  
16 licensure per the Board of Dentistry.

17 Dental sealants. The NDHA believes that placement  
18 of dental sealants may not require the skill and judgment of  
19 a licensed dentist. However, the NDHA does think that it  
20 requires, at a minimum, the skill and judgment of a licensed  
21 dental hygienist. We support a dental assistant performing  
22 this care, but only with education, competency testing, and  
23 a credential in order to protect the public. Our concern is  
24 that this issue was brought before the Board of Dentistry in  
25 a complaint, but was dismissed by their review committee as

1 not being a problematic situation. Therefore, dentists  
2 continue to delegate this procedure to untrained and  
3 unlicensed dental assistants.

4 Of the 33 states that allow sealant placement by  
5 dental assistants, 24 of those states require it to be an  
6 expanded function dental assistant with the needed education  
7 and training, and most of those only allow it under direct  
8 supervision, which means the dentist must check the sealant  
9 placement after it is placed and before the patient is  
10 dismissed to assure proper placement and occlusion. And  
11 just to kind of clarify that, 33 -- I know we've struggled  
12 with definitions a little bit, but as I was looking, 33  
13 states define direct supervision the same that we have in  
14 our proposal, that the dentist would have to check the  
15 procedure once it was completed, not that they have to be in  
16 the room while the procedure is being done. The NDHA thinks  
17 the application of sealants by dental assistants is a public  
18 health and safety issue that needs to be addressed in  
19 statute and rules and regs.

20 Education and credentialing. As the NDA proposal  
21 points out, if it is deemed necessary that dentists and  
22 dental hygienists have formal education, testing, and  
23 credentialing to perform services, then the NDHA thinks it  
24 disingenuous that the NDA does not endorse that dental  
25 assistants must also have some level of standardization to

1 perform the same oral health services. For example, the  
2 NDHA is concerned that the NDA proposal recommends allowing  
3 a dental assistant to administer nitrous oxide, which is a  
4 drug. Such recommendation requires less than the  
5 supervision level currently by a licensed dental hygienist.  
6 Even Dr. Acierno addressed the need for the current dental  
7 assistants who are monitoring nitrous oxide to have more  
8 training and education than they currently do in his final  
9 report from the dental anesthesia technical review.

10 NDHA supports a scope of practice for dental  
11 assistants to be defined in statute in addition to the  
12 appropriate education, licensure, and supervision of all  
13 parties addressed in that proposals. The concern NDHA has  
14 with giving the Board of Dentistry the ability just to  
15 define all the education requirements for assistants is that  
16 the majority of the Board are dentists and the make-up of  
17 the Board changes over time. The NDHA's preference, which  
18 also better protects the public's health and safety, is to  
19 have the scope of practice and educational requirements  
20 defined in statute by the Legislature, which also allows the  
21 Board to promulgate the rules and regs. This is a more open  
22 and transparent process that clearly articulates the scope  
23 of practice for all dental professionals, better protects  
24 the public's health and safety, and minimizes the medical  
25 liability to a dental practice.

1 All of the expanded procedures that are requested  
2 by the dental hygienist would require the same or similar  
3 instruction that dentists would receive for the exact same  
4 procedure, just like we do with giving local anesthesia.  
5 We, too, believe that the traditional dental office can be  
6 made more effective by allowing a defined scope of practice  
7 for dental hygienists and dental assistants. This will  
8 allow us to reach the growing population that does not  
9 access dental care through the traditional dental practice  
10 as well as expanding the services within a dental practice.

11 According to the Healthy People 2020 Progress  
12 Report, 14 of the 26 health indicators have either been met  
13 or are improving. Other indicators have shown little or no  
14 change, and a few remain at baseline. The sole oral health  
15 indicator, persons who visited the dentist in the past year,  
16 joins suicide and major depressive episodes in adolescents  
17 in having gotten worse since baseline. In 2007, 44.5  
18 percent of Americans were visiting dental offices, while  
19 41.8 percent were doing so in 2011. The target percentage  
20 for 2020 is 49 percent. We have a growing senior population  
21 that is going to long-term care facilities with a full  
22 complement of teeth. We, as dental professions, have been  
23 successful in helping them to maintain their oral health  
24 over their advanced years. However, once these seniors  
25 enter long-term care facilities, it is difficult to continue

1 providing dental care to this population, because very few  
2 dentists will treat these patients unless they are  
3 transported to their offices. We also know that the growing  
4 number of Medicaid patients are having difficulty in finding  
5 a dental home.

6 The current model does not serve everyone. The  
7 current model is also not sustainable as our underserved and  
8 unserved populations continue to grow, especially in a state  
9 like Nebraska where our demographics are very diverse  
10 between eastern and western Nebraska.

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

17 The NDHA proposal also provides a model that a  
18 dentist may incorporate that provides him or her with the  
19 flexibility to utilize dental hygienists that have expanded  
20 abilities and education to make a dental office more  
21 efficient and by allowing dental hygienists to perform  
22 simpler dental procedures so the dentist can focus on the  
23 more complex cases. This efficiency is further enhanced in  
24 the NDHA proposal by providing for a licensed dental  
25 assistant.

1           To the licensed dental assistant, because  
2           hygienists already have the baseline training and experience  
3           needed to provide expanded functions in the dental office,  
4           including additional continuing education, the NDHA thinks  
5           that dental assistants should first become a licensed  
6           profession. After this, the NDHA would support dental  
7           assistants participating in the same continuing education  
8           and curriculum that dental hygienists complete in order to  
9           do those same procedures.

10           In sum, the NDHA proposal is a responsible means  
11           for serving the Medicaid, underserved, and unserved  
12           populations in Nebraska while at the same time protecting  
13           the public's health and safety. The NDHA proposal aligns  
14           appropriate supervision with the delegated duties. The NDHA  
15           proposal will encourage dental practices to operate more  
16           efficiently, thus increasing their capacity to care for more  
17           patients. The NDHA proposal will make clear the scope of  
18           practice for dental assistants that will limit the medical  
19           liability of the dental practice and better protect the  
20           health and safety of the public. Finally, the NDHA proposal  
21           reflects the collaborative work of the Future in Teamwork in  
22           Dentistry Task Force, a task force with the NDA, NDAA and  
23           NDHA representatives that came to agreement on the best  
24           solution for dentists, dental hygienists, and dental  
25           assistants to offer quality care to patients; how better to

1 utilize the knowledge, skills, and existing workforce of  
2 dental hygienists and dental assistants; how to help dental  
3 practices and other clinics and programs increase  
4 efficiency; and how to help increase the access to dental  
5 care for all Nebraskans. We believe the NDHA proposal  
6 addresses these very issues and urge your support of that  
7 proposal. Questions?

8 CHAIRPERSON STUBERG: Thank you. Yes, could you  
9 address the question that's previously been asked about  
10 where was the point of departure from your perspective of  
11 the task force in having to have a separate proposal? And  
12 then, secondarily, which additional duties have been added  
13 into your proposal that were not things that were confirmed  
14 by the task force as that recommendation was coming forward?

15 MS. SCHARDT: I would say the main deal breaker,  
16 if you will, for the hygienists was when the dental sealants  
17 were removed from being a course -- being a procedure that  
18 was required to have a license. So, the license and  
19 education that is part of the dental hygiene scope of  
20 practice seems to, through Board opinions and stuff, has  
21 seemed to be able to be delegated by an on-the-job-trained  
22 dental assistant with no formal education. And we think  
23 that's a safety issue. And if a dentist and a hygienist  
24 need to have the education and skill set, psychomotor skills  
25 to do that procedure, we would think that an assistant would

1 also need to have that same level of competency. So, that  
2 was probably the main deal breaker.

3 A lot of the same things, as far as the public  
4 health supervision, I would say the one thing that was added  
5 that was not necessarily in the discussions going back,  
6 like, from four years ago, was the actual prepping of teeth  
7 by an expanded registered dental hygienist in that next tier  
8 that would require the education similar to what a dentist  
9 would do. If I can just kind of briefly touch on -- do you  
10 want me to touch on some of the things in the public health?  
11 We're very --

12 CHAIRPERSON STUBERG: Do committee members desire  
13 to have that? I'm familiar with the list.

14 MR. PETERS: My only question on the public health  
15 thing, though, is, how is a private nursing home company,  
16 contracts with a dentist -- how does that fall under a  
17 public health auspices, that I have the right to do that?  
18 Or does it not?

19 MS. SCHARDT: In the statutes, public health  
20 hygienists prove 3,000 hours of clinical experience and have  
21 liability insurance, because of the nature of our education  
22 and licensure, are allowed to be able to go into nursing  
23 homes. But within that setting, it's more of a partnership  
24 for health for that patient, so you're working under a  
25 medical director. You would never extract a tooth that was

1 hanging on by a thread without an order from a DDS or an MD.

2 MR. PETERS: Plus Medicare or Medicaid situations  
3 apply here, too, because they're under a government  
4 insurance program. So, then, public health has some role in  
5 that area. But would you work with a private paid -- a  
6 person who's in a nursing home who's a private pay and some  
7 dentist says, "Go in and get this guy in shape"? Does that  
8 fall under public health?

9 MS. SCHARDT: If a dentist -- I think part of the  
10 reason the creation of this public health permit initially  
11 happened was that hygienists really had the desire to serve  
12 the underserved populations. However, the way the statute  
13 is written, if you work for a dentist, and they allow you  
14 general supervision to be able to go out and do this type of  
15 thing, which we would kind of look at the public health  
16 permit being like that, it would put that burden back on  
17 that dentist to also be responsible for the total oral  
18 health care of that patient. And then, when we're seeing  
19 Medicaid patients, and we have the limited number of  
20 dentists in the state, but don't take Medicaid, they're not  
21 necessarily wanting all of the referrals that we would see  
22 in that setting to go to their office.

23 MR. PETERS: So, let me ask this question. The  
24 one thing I see here as an odd thing, and I don't know if  
25 it's real or not, but is it possible for a group of dental

1       hygienists to open up their own clinic and then have a  
2       dentist, you know, have some sort of overview of them down  
3       the road where without any real business other than that  
4       they've got their own -- you know, like a physical therapy  
5       group, you know, that's just a dental hygienists group and  
6       this is what we do under this expanded scope?

7               MS. SCHARDT: No.

8               MR. PETERS: And under following some public  
9       health rule, is this a vision that's unreal or real?

10              MS. SCHARDT: I would say it would not be a  
11       realistic view of that. We're very place-based, and so,  
12       just like yesterday I was at a public school and screened  
13       and provided fluorides for over 300 kids. And, you know, I  
14       saw a handful of abscesses that, you know, we refer, we've  
15       sent documentation home to the parents that these children  
16       have immediate needs.

17              MR. PETERS: What role did your dentist have in  
18       any of that?

19              MS. SCHARDT: They didn't. I contacted with the  
20       school. I worked through the health department, and contact  
21       with the schools directly, their school nurses. There's a  
22       requirement in the state now for dental screenings for  
23       kindergarten through fourth grade, seventh and tenth. And a  
24       lot of these nurses realize the needs and want us to screen  
25       all of their kids. And so that's that collaboration that it

1 happened and where we're also allowed to do the fluoride and  
2 sealants in those settings. Those are things that we can  
3 provide as well.

4 MS. BLACK: But you basically send information  
5 home to the parents and it's up to the parents, then, to  
6 notify a dentist to take care of those issues?

7 MS. SCHARDT: To get care. And we also have  
8 dental day coming up, so we also try to source people  
9 through those avenues to be able to help them get the care  
10 that they need. And the school nurses are very good at  
11 follow-up and stuff, too. You know, it's kind of -- it's a  
12 joint effort on everybody's part.

13 MR. PETERS: So, currently, under the public  
14 health model, you are allowed to go into the nursing homes.

15 MS. SCHARDT: Yes.

16 MR. PETERS: And do what you want to do.

17 MS. SCHARDT: We can provide cleanings and  
18 fluoride varnish. You wouldn't do sealants. But the things  
19 that, like the -- what we call interim therapeutic technique  
20 would be -- probably you could stretch the -- it is a  
21 temporary restoration and we're allowed, under general  
22 supervision, to place temporary restorations. So,  
23 technically, you know, that could probably fall under that.  
24 We're just very systematic in that we want that  
25 detailed -- we want people to have that extra training. We

1 don't want them to think that they can just go in and do  
2 that.

3 MS. DERING-ANDERSON: The previous testifier said,  
4 "Could you hold this question," so I did. What language in  
5 here would lead you to believe it is more likely that you  
6 will be paid than you currently are?

7 MS. SCHARDT: We are able to be reimbursed  
8 directly from Medicaid, and that's the populations,  
9 primarily, that we're working with. Does that -- I'm not  
10 really sure I'm grasping your question.

11 MS. DERING-ANDERSON: Well, no, that makes sense,  
12 actually. But the argument was, we're not getting paid.  
13 And so, we need this law so that we get paid, so that we can  
14 improve access. And my question was, show me where in the  
15 language you anticipate that your payment rate will improve,  
16 that's the rate of getting paid, not the per/procedure  
17 payment.

18 MS. SCHARDT: Right. I would say, under -- and I  
19 think the dental hygiene diagnosis has kind of been  
20 misconstrued, also, as far as we're not, like, diagnosing  
21 the dental stuff that only dentists diagnose. We're  
22 involved more with the treatment that we provide directly,  
23 periodontal scaling and root planing, which, in theory, if  
24 you were in the public health setting, would you be able to  
25 bill for that, if you didn't diagnose that that person had

1 gum disease? You know, so that it allows us to be able to  
2 do what we do.

3 MS. DERING-ANDERSON: And you treated 300 children  
4 yesterday.

5 MS. SCHARDT: It was a long day.

6 MS. DERING-ANDERSON: Assuming you worked a  
7 10-hour day, that's two minutes per kid.

8 MS. SCHARDT: Well, we did screenings --

9 MS. DERING-ANDERSON: You treated 300 and  
10 screened?

11 MS. SCHARDT: We screened 300. We did fluoride  
12 treatment on probably 40 of those, but it was elementary  
13 through high school.

14 MS. DERING-ANDERSON: Right, but I'm trying to  
15 grasp, in two minutes, and this is assuming a 10-hour day  
16 with no breaks, no bathrooms, no lunch.

17 MS. SCHARDT: No lunch is right.

18 MS. DERING-ANDERSON: You've got 300 kids in ten  
19 hours, which is 30 kids an hour and there's 60 minutes in an  
20 hour. So, that's two minutes per kid. You looked in their  
21 mouth, you found kids who had abscesses, you treated kids in  
22 two minutes per patient.

23 MS. SCHARDT: We didn't treat anyone that has  
24 abscesses. That is only a dental --

25 MS. DERING-ANDERSON: Right, I'm not saying this

1 right. I'm assuming that to apply fluoride takes more than  
2 two minutes. So, if you can do 300 kids in ten hours, I  
3 don't understand why you're not making all kinds of money.  
4 I don't get it. I mean, I can't fill a prescription in two  
5 minutes.

6 MS. SCHARDT: Right. I'm working through --

7 MS. DERING-ANDERSON: But you can look in their  
8 mouth, decide whether or not you can treat them and treat  
9 them in two minutes.

10 MS. SCHARDT: These are basic screenings that the  
11 school nurses would typically provide; however, they  
12 contract or currently we're working under a grant that  
13 allows us to be able to go in and work with the schools.  
14 And so, the school nurse prefers having a dental  
15 professional to look and screen the kids for any major oral  
16 health. We're not taking X-rays, it's just looking for  
17 major concerns. And so, if they need -- the fluoride  
18 varnish, any child can receive. And so, the ones that had  
19 consent forms sent back by parents are the ones that we put  
20 the fluoride varnish on. And, yes, we had a system and a  
21 team so that it -- I mean, I wasn't charting and all of  
22 that.

23 MS. DERING-ANDERSON: So, you weren't the only  
24 person involved in the care of these 300 people.

25 MS. SCHARDT: Right.

1 MS. DERING-ANDERSON: That's the piece I missed.

2 MS. SCHARDT: Okay.

3 MS. DERING-ANDERSON: And if it's possible, I  
4 would like a list of the 33 states with the exact same  
5 definition of direct supervision.

6 MS. SCHARDT: Okay.

7 MS. DERING-ANDERSON: Thank you.

8 CHAIRPERSON STUBERG: All right, I think in the  
9 sake of time, we're going to have to go ahead and call this  
10 phase. We're going to take a 10-minute recess. We'll  
11 reconvene, when we reconvene from the recess and we will  
12 allow for rebuttal from the proponents of the Nebraska  
13 Dental Association's proposal with NDHA proposal.

14 MR. BRIEL: And I will have to comment.  
15 Obviously, we're going to run beyond noon. It was our hope  
16 to finish in three hours, but that, obviously, won't happen,  
17 so fair warning, it's going to go on into the noon hour.

18 (Off the record from 11:25 a.m. until 11:35 a.m.)

19 CHAIRPERSON STUBERG: I misspoke at the end of the  
20 previous session in that the next order of business would be  
21 for anyone who would like to testify that's signed up as a  
22 neutral or unaffiliated testifier. I don't know if these  
23 folks just were, "I'm here," and thought that this was to be  
24 roll call or if there's somebody on this list that would  
25 like to testify from a neutral perspective. Neutral, and if

1 so, if that individual or individuals would come forward.

2 MR. BRIEL: We were going to do the rebuttal  
3 first, weren't we?

4 CHAIRPERSON STUBERG: Oh, we haven't --

5 MR. BRIEL: Yeah, we haven't done the rebuttal.

6 CHAIRPERSON STUBERG: Oh, that's correct. We do  
7 need the rebuttal. Yeah, we need to go with the rebuttal  
8 before we go with neutral.

9 MR. BRIEL: We need to do the rebuttal, summary  
10 and/or rebuttal.

11 CHAIRPERSON STUBERG: Yeah.

12 DR. MORRISON: Do you want to change the agenda?

13 MR. BRIEL: No.

14 CHAIRPERSON STUBERG: No, let's stay the order  
15 that was intended as is. So, please, this is time for the  
16 rebuttal to the proponent testimony for the NDHA proposal.  
17 Please.

18 DR. ANTHOLZ: I have a question for clarification.

19 CHAIRPERSON STUBERG: Please.

20 DR. ANTHOLZ: The neutral testimony, are we  
21 allowed to give any rebuttals during that neutral testimony?

22 MR. BRIEL: That's not what that's about.

23 CHAIRPERSON STUBERG: No.

24 MR. BRIEL: That's for any person who might have  
25 been interested in this issue and speak to it from a very

1 different perspective, like we've got some people here who  
2 represent rural health, for example. They might have an  
3 insight or a comment they might want to make. But it isn't  
4 supposed to be used by those who represent the parties  
5 involved.

6 DR. ANTHOLZ: Well, then, two of our names, the  
7 first two names on the neutral, we thought that was for if  
8 we were representing a different organization that also had  
9 a stake in this. So, we've mis-signed up, so we'll go  
10 during the rebuttals.

11 CHAIRPERSON STUBERG: That'd be fine.

12 Please.

13 MS. SHARDT: Are you by-passing all of those --  
14 because I know there were health directors that had signed  
15 up -- after?

16 CHAIRPERSON STUBERG: After this, yes.

17 DR. SCOTT MORRISON

18 DR. MORRISON: Again, my name is Scott Morrison  
19 with the Nebraska Dental Association. I wanted to address a  
20 couple things in nursing care facilities right up front,  
21 is -- and my background comes from having invested money in  
22 a mobile dental clinic that serves only nursing care  
23 facilities. That was something that was undertaken about  
24 seven years ago, so I've been doing that for about six or  
25 seven years. I, myself, do not do the treatment, but I've

1 put together a group that brought monies together to have a  
2 dentist -- two dentists, actually, a hygienist and sometimes  
3 two hygienists, assistant and a business manager within a  
4 mobile van and treat patients in a nursing care facility.  
5 My biggest point, I guess, to that end is that comprehensive  
6 care in a nursing care facility is extremely difficult. So,  
7 if you have a patient that's bedridden, to try and clean  
8 their teeth to even try and place fluoride on those patients  
9 extremely difficult.

10 So, when we talk about comprehensive dental care,  
11 I don't think that exists within the confines of a nursing  
12 care facility. The concern that was talked about a little  
13 bit was, is a nursing care facility going to outlay the  
14 money to have a dental chair in their facility, and I don't  
15 think that's the case.

16 The other issue is, you know, the hygienists spoke  
17 of the medical director being the overseer, but I don't  
18 think, if you ask the medical director of a medical -- or of  
19 a nursing care facility, my assumption would be that the  
20 assistant -- or I'm sorry, the hygienist or the dentist  
21 that's in that facility is under their own liability. And  
22 their treatment is brought forth under their own auspices.

23 So, many of the things that were addressed that  
24 can be done now, are not being done now in a nursing care  
25 facility. And somebody will address that in just a little

1 bit.

2 The other thing, I wanted to mention was that  
3 there was a comment about nitrous oxide monitoring and the  
4 letter from Dr. Acierno, the Chief Medical Director. And  
5 that report was based on sedation dentistry, not analgesia  
6 dentistry, and there's a difference. Nitrous oxide doesn't  
7 even -- or isn't even included within that report, so that  
8 was a change in scope of practice of the dental -- or  
9 dentist in regards to sedation. So, that comment really had  
10 nothing to do with -- or the comment of Dr. Acierno had  
11 nothing to do with nitrous oxide.

12 The other thing I wanted to address was  
13 unsupervised anesthesia. And it's counterintuitive, to  
14 steal a phrase there, to think that if a dentist wanted  
15 unsupervised delivery of local anesthesia in their office  
16 that they wouldn't be here touting it. And you don't see  
17 that in our proposal. So, to use that as an inference to  
18 say I'm at lunch and I call my hygienist and say, "Numb them  
19 up, because I'll be there five minutes late," I don't think  
20 is professional, and I don't think it's the way you treat  
21 people or do dentistry.

22 I think that's pretty much what I had. That's it.

23 CHAIRPERSON STUBERG: Thank you.

24 DR. MORRISON: I'm sure there will be others that  
25 will follow me here.

1 CHAIRPERSON STUBERG: Thank you.

2 Any other individuals that would like to make a  
3 rebuttal? Understanding, you are all limited to 15 minutes.  
4 So, if there's more than 15 minutes will allow, you need to  
5 be conferring with one another to get your points made.

6 CRYSTAL STUHR

7 MS. STUHR: I just have one correction that I want  
8 to make that we talked about the numbers of members that we  
9 have that were represented for dental assistants when we had  
10 spoke before. It is in the proposal on page 21, 10(b).  
11 Since dental assistants are unregulated, we don't have a  
12 huge population of membership. And right now, I think we  
13 have about 265 dental assisting members in the state of  
14 Nebraska. And we don't really know the number of dental  
15 assistants that are currently in the state of Nebraska. We  
16 know that there's around 1,000 dentists licensed, and  
17 typically, they have -- the last survey talks about they  
18 have 1.6 to 2.6 assistants per dentist. So, I just wanted  
19 to clarify that we have about 265.

20 DAVID O'DOHERTY

21 MR. O'DOHERTY: David O'Doherty, Nebraska Dental  
22 Association Executive Director. What I'm passing out now is  
23 a map of the public health permits. Ten years ago, we went  
24 through this 407 before where hygiene wanted their entire  
25 scope of practice in the public health setting. We had a

1 407, went through a couple legislative bills. It resulted  
2 in the statute that now allows them to go out in public  
3 health settings unsupervised to do limited preventative  
4 services.

5 In 2008, hygienists were granted the ability to  
6 bill Medicaid. And so, what this map shows is where those  
7 permit holders are located in what counties, because that's  
8 how the State lists them. So, as of about a month ago,  
9 there were 77 active public health permits in Nebraska. Of  
10 those 77 permits, only 16 were located in a designated  
11 shortage area. And of those, only three were billing  
12 Medicaid. So, a lot has been said about how dentists don't  
13 take Medicaid and it wasn't ten years ago, you know, "We'll  
14 do Medicaid." Well, that's not happening. Just wanted to  
15 let you know that's where they are and how many are billing.

16 Another number that was of concern was the  
17 percentage of membership for the NDHA. Non-profits file a  
18 Form 990 that lists certain things, and one of those items  
19 is membership dues. So, if you take the NDHA 990 for  
20 membership dues divided by how much of it is per dues-paying  
21 member, for 2014, it'd be 328 hygienists, paid members,  
22 divided by 1,271 licensed hygienists in the state, that  
23 would come up to 25 percent. I think the number that was  
24 quoted earlier was much higher.

25 MS. DERING-ANDERSON: Can you answer one question?

1 This work in long-term care under public health, you can't  
2 designate long-term care as a shortage area, because it's a  
3 CMS mandate. So, is it shortage areas and nursing home -- I  
4 mean I --

5 MR. O'DOHERTY: Right.

6 MS. DERING-ANDERSON: I'm missing the --

7 MR. O'DOHERTY: The definition is fairly broad --

8 MS. DERING-ANDERSON: -- statutory construct.

9 MR. O'DOHERTY: -- under the public health permit.  
10 The statute definition for public health defines two areas,  
11 I mean, two sentences that define the areas. Schools,  
12 nursing homes. It doesn't have to be a shortage area. It  
13 could be a nursing home in Omaha.

14 MS. DERING-ANDERSON: Thank you.

15 MR. BRUENING: Question. Help me interpret this.  
16 So, State designated shortage areas. So, a county,  
17 Franklin, number one, so they are short one or they have  
18 one?

19 MR. O'DOHERTY: That means there's one person with  
20 a public health hygienist permit in that county, active. I  
21 think there have been over 100 issued, but the active  
22 permits are 77.

23 MR. PETERS: Of the 77.

24 MR. O'DOHERTY: Of those 77, one is in Franklin.

25 CHAIRPERSON STUBERG: Thank you.

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MONTE ZYSSET

DR. ZYSSET: My name is Monte Zysset, M-o-n-t-e, last name's spelled Z-y-s-s-e-t. I'm an oral maxillofacial surgeon here in Lincoln. I'm also a board-certified oral maxillofacial surgeon, and I'm a board examiner for the American Association of Oral Maxillofacial Surgeons. I'm an adjunct clinical professor at the University of Nebraska Medical Center.

I surveyed the oral maxillofacial surgeons in the state of Nebraska, and they really support the Nebraska Dental Association proposal for -- that you have all heard about, and they'd like to thank you guys for hearing these proposals. They do not support the hygienists' proposal. And on surveying of the oral maxillofacial surgeons, which we represent 100 percent of them in the state, they don't support the diagnosis of any kind of pathology, performing irreversible procedures or removal of any type of teeth under any kind of supervision.

The problems with removal of teeth is it's not just removing the teeth. It's that there's a patient connected to these teeth. So, most of the way that dentists are trained and if you do a residency, you're trained to evaluate this and you have to be able to treat the complications. Even though they may be very, very remote, you have to be able to diagnose those things and treat them.

1 So, dentists with their training are trained this way -- in  
2 order to get licensed, you have to be able to treat these  
3 things. The potential complications, as we see them, with  
4 removal of teeth is there's always going to -- there could  
5 be infection in the process. You have to be able to  
6 diagnose that infection. And infections are really --  
7 they've changed through the past ten years I've been doing  
8 this. There is a lot more resistant infections. How are  
9 you going to treat those? What antibiotics? Are you going  
10 to give antibiotics? And those things would have to be  
11 diagnosed and treated by a dentist. You can have bleeding.  
12 There's undiagnosed bleeding problems, multiple new  
13 anti-coagulant medicines that these patients could be on.  
14 You go into the nursing home, they'll be on multiple  
15 medications that interact between the medications, and so it  
16 can be very dangerous to just take out a very mobile tooth  
17 that you can have a lot of bleeding. And then you have to  
18 treat that if you produce that bleeding.

19 You can fracture roots off, and then that can be  
20 left and you can have infection with those. Then that turns  
21 that into a surgical procedure where you have to retrieve  
22 those roots. You can take out a very easy tooth and you can  
23 slip and you can aspirate it. And that would be the  
24 worst-case scenario in a nursing home where you don't know  
25 where that tooth went. You don't have X-rays. You don't

1 have the ability to figure out what has happened with that.  
2 And some of these teeth that are loose, that's a problem.  
3 You can grab a hold of them and they just come shooting out,  
4 because there's not much holding them in.

5 There's -- you can have unrecognized and  
6 undiagnosed pathologies. You go in and somebody's sent to  
7 your office or you go into a nursing home to adjust a  
8 denture, and this will look like a denture sore, but it's  
9 actually a squamous cell carcinoma. So, if you don't have  
10 the ability to recognize that, you can adjust that denture  
11 for a long time and that won't go away. And that's very  
12 detrimental to the patients long term.

13 In the past, oh, probably ten years, we have a  
14 real problem with bisphosphonate therapy, which is a drug  
15 that's promoted for osteoporosis. And so, on those -- the  
16 patients will be on those and it interacts with other drugs.  
17 And then they can have a necrosis where they lose bone. So,  
18 you take out a very, very easy tooth and then that stays  
19 open and that bone shows through and they start losing  
20 pieces of bone or they get an infection in the bone with  
21 those. So, all that, how you take out those very mobile and  
22 easy teeth has changed and it's changing all the time for  
23 the betterment of the patient. But you can look at a  
24 patient and say, "That's an easy extraction," but it will  
25 bite you. It can be a very big problem with that.

1           As far as the diagnosis, you know, we're unaware  
2 of anything -- we don't know what a hygiene diagnosis is,  
3 what they propose in that. And our proposition is that  
4 if -- a diagnosis is all inclusive. You can't just say,  
5 "Okay, I'm going to diagnose this for the hygienist, but I'm  
6 going to ignore the rest of it." It has to be done  
7 thoroughly. General supervision, you know, a nursing home  
8 has a big potential for misdiagnosis with, you know, cancers  
9 or anything like that looking like denture sores or  
10 just -- I mean, it's not just decayed teeth that can be  
11 there.

12           The medical compromised patients in these nursing  
13 homes and the multiple medications they're on make this very  
14 complex for them to be able to be treated in the nursing  
15 home. Most all of patients that we see, we get a call, they  
16 haven't been diagnosed by the physician, so then they call  
17 and then we will see them in the office. And sometimes that  
18 takes treatment in the hospital. It can't be treated even  
19 in your office. And even sometimes your diagnosis changes.  
20 When you're taking out a tooth, that diagnosis may be  
21 ongoing, and you say, "Okay, there's infection here,"  
22 whatever, so it's not -- you have to have that ability to  
23 diagnose and treat that.

24           And the last thing is, you know, if the criteria  
25 for credentialing review for the change of scope of practice

1 of a regulated health profession states that the proposed  
2 change of scope of practice does not create a significant  
3 new danger to the health, safety, or welfare of the public.  
4 We believe, as oral maxillofacial surgeons, that the State  
5 of Nebraska -- we feel that these proposed changes would  
6 present a danger to the health, safety, and welfare of the  
7 public as it is put forth thus far. Thank you.

8 CHAIRPERSON STUBERG: For the record, your  
9 comments, how many licensed oral maxillofacial surgeons are  
10 there in the state of Nebraska?

11 DR. ZYSSET: Thirty-one.

12 CHAIRPERSON STUBERG: And you interviewed and  
13 received response back from all 31, that is the basis upon  
14 your --

15 DR. ZYSSET: Yeah, all but two.

16 CHAIRPERSON STUBERG: All but two, okay.

17 MR. BRIEL: And that's the time for that  
18 particular side. So, now it's the other side, NDHA.

19 CHAIRPERSON STUBERG: It is now time for rebuttal  
20 for the NDHA.

21 DARLENE CARRITT

22 MS. CARRITT: Forgive me. I wasn't prepared to  
23 rebut, but I've made some comments here. My name is Darlene  
24 Carritt. I'm a dental hygienist. I've practiced for 36  
25 years. I've served as past NDHA President. I've been on

1 the Board of Examiners for ten years in the '90s. I still  
2 examine for dental hygiene licensure, and I've been an  
3 educator for over 25 years at the Medical Center College of  
4 Dentistry here in Lincoln. I'm here because, and I think  
5 we're here because of access to care, basically, our  
6 organization. And that's why I'm in the audience today.  
7 I'm blessed to be an educator and to be able to share some  
8 experiences with our students that I didn't get when I was a  
9 student 36 years ago. Little did I know 36 years ago, we'd  
10 still be seeing children in schools with severely decayed  
11 mouths, with fluoride that's readily available, and the  
12 situations that we see with abscesses, painful conditions.  
13 But we have such a diverse population group these days,  
14 little did I know back then that we'd be seeing those  
15 things. Also, when I first started practicing and I'd do  
16 presentations in nursing homes, maybe five people had their  
17 teeth. And so, direct care providers didn't pay attention.  
18 But now, when we're taking our students to these nursing  
19 home facilities, at least three fourths of the population  
20 have their teeth. And they're not all old people in the  
21 nursing homes, we've discovered. You know, there's people  
22 younger than you and I there due to mental illness, due to  
23 brain trauma injuries, due to obesity, you know, places them  
24 in long-term care facilities. The other reason they're  
25 there is because they don't have the finances to put them

1 anywhere else. And so, again, they are Medicaid-dependent.  
2 So, we're just beginning to learn a lot by taking our  
3 students into these facilities. This law has existed for  
4 one year as far as a public health provider dental hygienist  
5 being able to provide care in the nursing home. And we've  
6 needed 3,000 hours of clinical practice plus liability  
7 insurance to be able to do that.

8 So, what we are seeing is a travesty in these  
9 facilities. And I think that's what precipitated some of  
10 the things that we are proposing today. Cleaning teeth,  
11 absolutely. But, we're not there just to clean teeth and to  
12 prevent decay. The biggest reason we're there is to reduce  
13 the bacteria in the mouths, train personnel, and to prevent  
14 aspiration pneumonias and other problems that contribute to  
15 the problems that they've already got. Just the  
16 polypharmacy problems that exist in those nursing homes is  
17 outrageous. And when you try to open a person's mouth and  
18 their lips stick to their teeth so badly that they can't  
19 chew and function, that's a travesty. And the silver  
20 tsunami is coming. That's us, the baby boomers. And so,  
21 we're on the beginning step of what needs to happen in the  
22 future.

23 So, we're blessed to be able to go into the homes,  
24 but here's some barriers. Getting a Medicaid provider  
25 number is a barrier. It takes months. It's not lucrative

1 as far as financially lucrative. So, again, dental  
2 hygienists have to maintain their jobs and their private  
3 practice to be able to live. And then maybe on their day  
4 off, give a half a day here and there to a nursing home  
5 until, maybe we're reimbursed for some other codes to make  
6 it at least financially feasible that we can do some of  
7 these things.

8 The biggest thing that we're providing right now  
9 is education to the direct care providers. We've got a  
10 grant from the State of Nebraska to do that. We've trained  
11 some hygienists that have gone into over 40 facilities  
12 currently, and again, training direct care providers to  
13 provide daily care. Then, a new grant is being offered and  
14 they want to expand that, not to just care in nursing homes,  
15 but other entities have seen what we can provide as far as  
16 prevention. And they're saying, why can't we provide to  
17 patients home bound or where there's direct care providers  
18 at home and how can we train them? So, we're investigating  
19 those possibilities, but it's going to explode.

20 Delivering care bedside. That's all we do when we  
21 go into the nursing homes. We don't have a fancy facility  
22 or portable equipment. We're literally scaling, cleaning  
23 teeth, doing assessments, providing fluoride varnishes  
24 bedside. When they're 4- to 500 pounds, we can't move them  
25 into a chair, and so we're leaning, bending over, scaling,

1 and piping very crudely. But we are reducing the bacteria  
2 in the mouth, working with staff to prevent further decay,  
3 further bacterial involvement.

4 Sealant programs. Again, as an educator, we're  
5 blessed to be able to provide sealant programs in, right  
6 now, the Lincoln and Omaha areas in the 90 percent free and  
7 reduced lunch facilities, and then in the Panhandle where we  
8 have an extended site. And I wish you could see what we see  
9 in the children that are there. We've placed over 30,000  
10 sealants a year with our students. And lots of referrals.  
11 The nurses are begging for more. We don't have -- we can't  
12 take the students out. So, the need is there.

13 Yes?

14 CHAIRPERSON STUBERG: I need you to direct your  
15 comments to what is it about the proposal that the NDA and  
16 NDAA are putting forward that will not allow this to happen  
17 if this continues to happen, that it's currently available,  
18 but there's not enough of it. Does that make sense?

19 MS. CARRITT: The previous testifier from the NDA,  
20 Executive Director, was talking about how many public health  
21 hygienists existed, the low numbers. And again, one of the  
22 barriers to that is the 3,000 hours of required private  
23 practice. Our students are being trained, but then, when  
24 they graduate, they're not allowed to do it for two or three  
25 years to get that experience. But I want to let this

1 committee know that they are being trained to do these  
2 things. There's just some barriers. And so not all the  
3 hygienists in Nebraska are public health hygienists.  
4 There's barriers there.

5 MR. BRUENING: So, that comment would dilute how I  
6 interpret this data here?

7 MS. CARRITT: What does that --

8 MR. BRUENING: It says that there are 77 active  
9 public health.

10 MS. CARRITT: We currently have 98 public health  
11 providers.

12 MR. BRUENING: Yeah, okay, so what about the .23  
13 percent registered dental hygienists that are billing  
14 Medicaid?

15 MS. CARRITT: Again, that's a barrier. I'm still  
16 waiting for my Medicaid provider number.

17 MR. BRUENING: So, you're saying your comment that  
18 it's less than a year old --

19 MS. CARRITT: Yes.

20 MR. BRUENING: -- the public health law dilutes  
21 this, this data.

22 MS. CARRITT: Right. I mean, we're still in the  
23 process. It's just -- it's in its infancy. But what we  
24 have done is provide education and trying to reduce these  
25 barriers. We're talking with Medicaid to try to reduce

1 those barriers.

2 MS. DERING-ANDERSON: So, what in this proposal  
3 makes it more likely that Medicaid will issue you a provider  
4 number?

5 MS. CARRITT: Dental hygiene diagnosis. Now,  
6 again, it's not for dental diagnosis. Dental hygiene  
7 diagnosis. To quote from another state in their statutes,  
8 "performs dental hygiene assessment," which we already do,  
9 "dental hygiene diagnosis, dental hygiene treatment planning  
10 for dental hygiene services, and to refer and identify  
11 dental abnormalities for immediate referral to a dentist."  
12 We're doing these things, but it would put it in statute  
13 that then Medicaid might recognize those things, then to  
14 allow some assessment codes to be reimbursed.

15 DR. McCREERY: Is that a pattern that's been  
16 observed in the other states that have --

17 MS. CARRITT: Again, this is just beginning. And,  
18 yes, I get to quote the State of Colorado that they're  
19 trying to do those things.

20 DR. McCREERY: I mean, but can you provide  
21 evidence that that's happening as a result of the expanded  
22 scope of practice for dental hygienists? Because this issue  
23 of access, as we've heard about it, is really multi-faceted,  
24 and so, what I would appreciate and what I haven't seen is  
25 some evidence to show in the 33 other states that have

1 expanded this -- you know, we heard about Healthy People  
2 2020. It doesn't seem like we're making progress despite  
3 the fact that 33 states already have this. So, it raises  
4 questions to me as to whether or not this expanded dental  
5 hygiene is going to have an impact on that access issue.  
6 That's really important for this proposal.

7 MS. CARRITT: And what statistics are you wanting,  
8 then?

9 DR. McCREERY: You would think that if -- in  
10 states that have adopted this expanded scope of practice for  
11 dental hygienists, that you would see a different trend than  
12 you would see in states that have it in terms of access, in  
13 terms of those sorts of things. And that's why I'm asking  
14 that.

15 MS. CARRITT: Very few states are as blessed as  
16 Nebraska as far as the access laws. A lot of the states are  
17 similar to our general supervision. They ask for  
18 collaborative practice of a dentist. Well, if your dentist  
19 doesn't have Medicaid, you aren't able to provide that  
20 service. I've had a hygienist from South Dakota call to see  
21 how we approach it. They can't get dentists to collaborate  
22 with them. But our state does allow us to do that. And  
23 again, we're in our infancy as far as providing that care.

24 DR. McCREERY: But, if 33 states have adopted what  
25 you're proposing, you would think, in those states, if this

1 will address the issue of access, that you would see trends  
2 of improving access in those states. Are there data to  
3 support that conclusion?

4 MS. SCHARDT: I can look for you --

5 MS. CARRITT: But a lot of those states demand the  
6 collaboration with the dentist. If their dentist does not  
7 provide Medicaid, then it doesn't happen.

8 MS. SCHARDT: I think the needs are increasing so  
9 much that --

10 CHAIRPERSON STUBERG: I think we need to be  
11 careful here. We're -- this discussion is to be directed  
12 for your rebuttal to the opposite proposal.

13 MS. CARRITT: Okay. Local anesthesia. As an  
14 educator, I can assure you that the local anesthesia course  
15 taught to the dental hygienists is equal to at least what  
16 the dental students receive today. They graduate with being  
17 watched and monitored with over 150 injections before they  
18 graduate. We're used routinely in private practice. I'm  
19 administering injections for the dentists all the time. I  
20 think -- and we have to address accreditation issues. We  
21 have to prove competency.

22 The dentist's letter that was provided for you by  
23 Deb Schardt points out, from Dr. John Alden, and at the  
24 bottom of that letter, he talks about dental hygienists  
25 providing local anesthesia in the offices. "The current

1 proposal would allow services presently endorsed in the  
2 presence of a dentist to continue to be available if the  
3 dentist is absent." When the dentist is absent, I'm not  
4 able to treat all the patients that I need to treat. We're  
5 limited. Lots of patients come in that need local  
6 anesthetic. I've practiced with this for over 20 years. Is  
7 my care going to be delivered differently whether they're in  
8 the office or not?

9 The question is, as I see it, quoting the dentist,  
10 "Does a dentist's confidence in a dental hygienist's skills  
11 diminish in their absence? Are hygienist's skills  
12 diminished? Are their services less conscientious? Are are  
13 their concern for patient's welfare changed due to a dentist  
14 not being on site?" We're licensed. We abide under the  
15 governance of the Dental Board. If we do something wrong,  
16 we're going to be disciplined.

17 I would also like to address very quickly, the  
18 education levels for the dental assistant. We felt that by  
19 the things that we submitted in our proposal that we were  
20 expanding the functions of the dental assistant. Placing  
21 dental sealants requires psychomotor skills, as with doing  
22 anything that's in the mouth. I teach a coronal polishing  
23 course to dental assistants, and those dental assistants  
24 have had at least a minimal of 1,500 hours of practice.  
25 Some of the assistants that have come to my course have

1 practiced 10 or 15 hours. When you put a mirror in a  
2 non-dominant hand, and a handpiece in the dominant hand and  
3 expect them to do psychomotor skills in a mouth on the other  
4 side of the chair, it's a different story. The difference  
5 is psychomotor skills. Can they learn how to do these  
6 things? Yes. With proper education and clinical competency  
7 and licensure and regulation like we proposed earlier. So,  
8 again, it's forgetting what we were like when we first  
9 started to practice. Anything takes repetition with  
10 psychomotor skills. And so, again, the education that we're  
11 supporting for sealant placement, we feel is critical.

12 CHAIRPERSON STUBERG: Thank you.

13 How are we for time?

14 MR. BRIEL: I think that's the end of the  
15 rebuttal.

16 CHAIRPERSON STUBERG: Next item of agenda, then,  
17 now that the rebuttals are completed, if there was anyone  
18 who is neutral or unaffiliated with either of the two groups  
19 that they would like to give testimony?

20 MR. PETERS: I do have one quick question that I'd  
21 like answered. Would the anesthesia be delivered at the  
22 nursing home under your proposal?

23 MS. CARRITT: No.

24 DR. MORRISON: There is a caveat. If you look at  
25 an FDHRDH, that says --

1 MR. PETERS: It would be.

2 DR. MORRISON: Right.

3 MR. PETERS: I saw that.

4 MS. CARRITT: It also gives the exception of if  
5 you have supervision --

6 MR. PETERS: So, there is an exception to it.

7 MS. CARRIT: There's got to be supervision.

8 MR. PETERS: And it could be delivered in the  
9 nursing home.

10 MS. CARRITT: If you have the supervision of the  
11 dentist.

12 CHAIRPERSON STUBERG: Go ahead.

13 DR. EMILY WILLETT

14 DR. WILLETT: My name is Emily Willett. I'm an  
15 orthodontic resident at the College of Dentistry in Lincoln  
16 and a general dentist at Summit Dental Health in Omaha. I'm  
17 a recent graduate of the Doctoral Dental Surgery Program at  
18 the UNMC College of Dentistry, and I was an active local,  
19 regional, and national leader for the American Student  
20 Dental Association. I'd like to share some information  
21 about the academic and licensure process for providing  
22 dental care in the state of Nebraska as a dentist. I will  
23 describe the didactic and clinical training I received at  
24 UNMC, which adequately allows me to perform diagnosis and  
25 irreversible dental procedures, which is applicable

1 statewide, as approximately 85 percent of dentists in rural  
2 Nebraska are graduates of UNMC.

3 Dental school graduates have earned a minimum of a  
4 four-year bachelor's degree prior to acceptance to dental  
5 school, which is accredited by a national body, the  
6 Commission on Dental Accreditation, under the jurisdiction  
7 of the American Dental Association. After completion of  
8 prerequisite science courses, and admissions test, and an  
9 application and interview process, dental students are  
10 welcomed into a four-year doctoral program. The dental  
11 school curriculum is front-loaded with instructive,  
12 lecture/test-style coursework as the foundation is important  
13 to understand the development and growth of the head and  
14 neck structures, in addition to the development,  
15 progression, prevention, diagnosis, and treatment of oral  
16 diseases and conditions. In other words, the widespread  
17 concept that a dentist is merely one who fixes teeth is  
18 descriptive of only one area of the dentist's  
19 responsibility. The dentist is, in fact, a person dedicated  
20 to the highest standards of health through the prevention,  
21 diagnosis, and treatment of all oral diseases and  
22 conditions.

23 The dental school education is a four-year, full-  
24 time job, plus additional hours required for review of  
25 material and study. In all four years of dental school, we

1 have have either didactic or clinical coursework from  
2 approximately 8:00 to 5:00 Monday through Friday, ten or  
3 plus months of the year, and equally, as many hours required  
4 to review and learn the material outside of the framework of  
5 formal instruction. The curriculum is designed to develop  
6 the academic foundation and practice the hand skills to  
7 safely and effectively operate our dental equipment and  
8 perform dental procedures.

9 CHAIRPERSON STUBERG: Excuse me. I'm going to  
10 interrupt here for the sake of time. There's no one, I  
11 believe, up here that questions the training or ability of a  
12 dentist to carry out procedures in dental practice of what a  
13 dentist does. I need your comments to specifically go  
14 towards issues related to these two proposals that are  
15 sitting in front of us and our ability to recommend or not  
16 recommend one or both -- we're not going to recommend both,  
17 one or the other or neither, to the Board of Health.

18 DR. WILLETT: Understood.

19 CHAIRPERSON STUBERG: Yeah, if you could focus  
20 your comments there, that's where we need them.

21 DR. WILLETT: Then I will electronically, the rest  
22 of my comments will be provided to you. I sent it to Mr.  
23 Ron --

24 CHAIRPERSON STUBERG: That's great, because we  
25 will read that testimony.

1 DR. WILLETT: Perfect. Well, then, I guess just  
2 in summary, it's just -- I hope to emphasize to you that the  
3 type of training that a dentist receives is very extensive.  
4 In the last months of our dental education, we're in the  
5 clinic treating patients approximately 26 hours a week. And  
6 so, that's experience that can't be replaced in a less  
7 formal setting. I think there are some procedures -- and I  
8 would like you to acknowledge that if certain procedures are  
9 desired to be performed by an individual, that person is  
10 invited to go to dental school to receive that proper  
11 education.

12 MS. DERING-ANDERSON: I have a single question.  
13 When did you do basic pharmacology and anesthesia? Like,  
14 give me a -- five years ago? Within the last five years?

15 DR. WILLETT: In my second year of dental school,  
16 which would have been four years ago.

17 MS. DERING-ANDERSON: Sweet. When you talked  
18 about reversal agents, did that include the huge dramatic  
19 increased risk of bleeding because they don't affect nerve?  
20 They are, in fact, vasodilators.

21 DR. WILLETT: Yes, ma'am.

22 MS. DERING-ANDERSON: So, was that a piece then or  
23 is that a sort of new --

24 DR. WILLETT: That was a component in my education  
25 four years ago.

1 MS. DERING-ANDERSON: Four years ago. Thank you  
2 very much.

3 CHAIRPERSON STUBERG: But you're not done. What  
4 is included in the dentistry instruction as it relates to  
5 the proposal that's being brought forth to us from the NDA  
6 and the NDAA is that it's going to allow for on-the-job  
7 training. What was included in your academic preparation to  
8 allow fidelity in what you teach somebody in a practice that  
9 is off the street, as opposed to the opposing proposal is  
10 that you only really need to -- you should be credentialed  
11 through an academic process, testing, et cetera?

12 DR. WILLETT: To answer that -- so, I think we've  
13 mentioned that we're unsure as to how many practices or how  
14 many dentists will incorporate these types of expanded  
15 functions. In my opinion, if I were to employ expanded  
16 functions, I would be, you know, I guess, be teaching a  
17 procedure that I'm comfortable performing myself. And if I  
18 were to teach it to an on-the-job-trained assistant, I  
19 would, personally, refer back to the types of education  
20 materials I had received when I learned the procedure. In  
21 pediatric dentistry there's a common process called "tell,  
22 show, do," where you instruct, you know, tell a patient what  
23 you're going to do. You demonstrate it. And then, you  
24 observe the patient, or in this case you would observe the  
25 dental assistant performing that function. So, I think an

1 on-the-job-training type of credentialing or, I guess,  
2 providing them with authorization to perform that duty, you  
3 know, would be appropriately applied, you know, when the  
4 dentist can do that kind of tell, show, do, instruct and  
5 demonstrate and then monitor the success of those  
6 procedures.

7 CHAIRPERSON STUBERG: Thank you.

8 Anyone else from a neutral or unaffiliated  
9 perspective?

10 ROGER WIESE

11 MR. WIESE: Good morning. It's still morning,  
12 isn't it? My name's Roger Wiese. It's afternoon already?  
13 Then I hope you had a good morning. Good afternoon to you.

14 My name is Roger Wiese. I'm the Director with the  
15 North Central District Health Department. We're located out  
16 of O'Neill, Nebraska. I'll try to provide you some comments  
17 that will assist you in your recommendation process by  
18 delivering a little bit of life experience that we have had  
19 with our public health office so far.

20 A little bit of demographics of where we are.  
21 North Central District Health Department, we cover nine  
22 counties. We're a very large district, 15,000 square miles,  
23 49,000 people. We cover all the way from Cherry County on  
24 our western end to Rock, Brown, Keya Paha, Boyd, Holt,  
25 Antelope, Pierce, and Knox. Our largest community within

1 our district is 3,700 people, O'Neill, Nebraska. O'Neill is  
2 an hour and 15 minutes from Norfolk, two hours from Grand  
3 Island. It kind of gives you a little bit of a geographic  
4 distance with what we deal with within our area. We will  
5 roughly estimate run anywhere from about 33 to 38 percent  
6 Medicaid within our district. It depends on the year and  
7 which statistic you're looking at over the last ten years.

8 Our Board of Health dentist is Dr. Kenneth Tusha.  
9 He is out of Creighton and Therese Sullivan is our hygienist  
10 and she is on our Board of Health as well. I mention those  
11 two, because we have started, in the last three years, a  
12 Miles of Smiles program. That's what it's entitled. It is  
13 preferably a revenue-generating program as best we can.  
14 Some of the other programs that hygienists have talked about  
15 have been grant-funded. We are striving to develop a  
16 program that's mainly revenue-generating, so in two years  
17 we're not dismissing the program and dismissing the need  
18 that is still present within our health district.

19 We have a Miles of Smiles program where we take a  
20 dental hygienist or a number of dental hygienists out to a  
21 school and provide the screenings for a varnish treatment  
22 and education, not only education to the students or the  
23 youth client, but also education to take home to the  
24 families. They use mouth mirrors, explorers, probes, et  
25 cetera. Our screening is more than the question was time

1 before, it's very diligent. It's definitely more than two  
2 minutes per kid. We're going in on an approach that it's  
3 however long it takes us during the day. We started this  
4 program in 2012. We initiated seven schools within our  
5 health district. We climbed up to 17 two years ago, and in  
6 the last three semesters, we are in 38 of our 39 grade  
7 schools. Our teachers love it. Our school nurses love it.  
8 I do not have a single dentist in our district that does not  
9 like it. And I have numerous dental hygienists that we  
10 contract with that work wonders in our district.

11 End with just a few numbers, if I can to kind of  
12 paint you a general picture of --

13 CHAIRPERSON STUBERG: This is not helping between  
14 our job of making a decision on these two proposals, the  
15 breadth and scope of your program that I'm sure is  
16 wonderful.

17 MR. WIESE: Can I get to some numbers that might  
18 help you?

19 CHAIRPERSON STUBERG: Please.

20 MR. WIESE: Some of the numbers --

21 CHAIRPERSON STUBERG: Well, what I'm needing is  
22 information from you as far as our moving forward one or the  
23 other of these two proposals. That's what our job is. So,  
24 we have to recommend one or the other of these two  
25 proposals.

1 MR. WIESE: Moving forward with the RDH proposal?

2 CHAIRPERSON STUBERG: Or the RDA.

3 MR. WIESE: Yes, the hygienists' proposal, because  
4 I believe it's going to benefit public health, and I believe  
5 it's going to benefit overall the youth that are going to be  
6 seen within our district. We have done sealant programs,  
7 we've done two sealant programs within our schools, high  
8 priority needs. You mentioned a little bit of a cost  
9 savings before, and there was relatively a point in time  
10 cost savings. We have been able to, in Boyd County alone,  
11 in a two-day span, working with the College of Dentistry, we  
12 were able to have a 95 percent participation rate within  
13 Boyd County Schools. We saw 209 children and provided 562  
14 sealants. That would never have happened so much in a  
15 clinic setting in a day or in a two-day program.

16 MS. DERING-ANDERSON: But both proposals would  
17 allow that.

18 MR. WIESE: To continue, yes. And I guess I'm  
19 just trying to bring a perspective of how the hygienists  
20 work in a public health setting. And some of the comments  
21 that I've been hearing is what would be a disadvantage  
22 into -- what's slowing them down. I think part of the  
23 Medicaid billing, at least that we're able to manage and run  
24 out of our office, hopefully helps a little bit with the  
25 ability to get out and see a vast number of children and to

1 be able to not only increase our referrals to our providers,  
2 but also to care for a number of the kids.

3 MR. PETERS: Okay, I have a specific question for  
4 you. How many extractions did your hygienists --

5 MR. WIESE: None.

6 MR. PETERS: -- recommend back to a dentist?

7 MR. WIESE: Oh, I thought you were going to say  
8 "do." That, I do not know the specifics of what was  
9 recommended. I can get you numbers --

10 MR. PETERS: No, I'm good. I just --

11 MR. WIESE: -- for that, but I don't know what --

12 MR. PETERS: See, these are the questions that I  
13 need to know. Out of 211, how many extractions could have  
14 been done sitting there, because somebody had the ability to  
15 do it or they didn't have the ability to do it right there.

16 MR. WIESE: That I don't know, but I can get you  
17 that data. I do know our referrals for our health care  
18 providers in the first year range from around 20 percent,  
19 and now after we've been doing this program for two years,  
20 we're down to about 14 to 12 percent of a referral rate.

21 MR. PETERS: Because see that's the granular stuff  
22 that really --

23 MR. WIESE: That I understand.

24 MR. PETERS: If you would have brought that, you  
25 know, I mean, that's great. That's good information. We

1 get that, because that's what their proposal's talking  
2 about, extractions, fillings, you know, all this sort of  
3 stuff. Because that's where they want to go. We know where  
4 they are.

5 MR. WIESE: That, I don't have those numbers.  
6 It'd be non-diligent if I provided information on that.

7 MR. PETERS: But see, that's what I'm interested  
8 in. I wanted to know how many of those 250 kids -- 20 of  
9 them needed an extraction that could have been done right  
10 there with a simple extraction device called the finger --

11 MR. WIESE: Absolutely, I understand that  
12 question.

13 MR. PETERS: -- and pulled out.

14 MR. WIESE: I understand that. I could have been  
15 a little bit more prepared --

16 MR. PETERS: That's okay.

17 MR. WIESE: -- to be able to provide that specific  
18 data. So, I understand that.

19 MR. PETERS: You didn't know what we were after.

20 MR. WIESE: What questions do you have for me,  
21 since this is coming back for questions? I mean, I can  
22 continue to kind of provide some data and statistics to what  
23 we're doing.

24 CHAIRPERSON STUBERG: Well, if it's things that  
25 are already currently able to be done and are being done,

1 there isn't anything in either of these two proposals that's  
2 going to take that away. Both of the proposals are going to  
3 help to enhance that.

4 MR. WIESE: The billing codes, especially, for  
5 hygienists to be able to get in and do screenings. You  
6 can't run a program that's non-grant-funded if you aren't  
7 able to bill.

8 MS. DERING-ANDERSON: And is that a statutory  
9 coding issue or a payer coding issue? I mean, is there  
10 something in the statute that says you may not bill Medicaid  
11 for?

12 MR. WIESE: No. Right now it is --

13 MS. DERING-ANDERSON: It's just that Medicaid's  
14 currently not paying for it.

15 MR. WIESE: -- a Medicaid acceptance of the codes.

16 MS. DERING-ANDERSON: Okay.

17 MR. WIESE: As I understand it.

18 MS. DERING-ANDERSON: Okay.

19 CHAIRPERSON STUBERG: Are there any other  
20 questions?

21 MR. WIESE: I just think the ability for us to be  
22 able to get our hygienists out and working -- we talked  
23 public health so much, public health certification, to be  
24 able to get our hygienists out, outside of the clinical  
25 setting and moving in a public health realm. I mean, that's

1 the whole premise behind the Affordable Care Act. Nuts and  
2 bolts. That's why hospitals have to report to the Internal  
3 Revenue Service. You got to be able to show that you're  
4 providing more prevention and more education outside of your  
5 clinical setting. And in public health, we're working  
6 dramatically with that in this area in oral health.

7 MS. DERING-ANDERSON: I'm sorry, I don't mean to  
8 be rude and make this meeting last longer, but what's not  
9 clinical about taking care of a kid in school?

10 MR. WIESE: It's a public health setting.

11 MS. DERING-ANDERSON: Right, but when you deal  
12 with a patient, it's clinical.

13 MR. WIESE: A larger population. Maybe the word  
14 definition, I probably shouldn't have said that.

15 MS. DERING-ANDERSON: I can live with that. I can  
16 live with out-of-office service --

17 MR. WIESE: Population base.

18 MS. DERING-ANDERSON: -- but I can't live with  
19 non-clinical service, because patients are clinical. That's  
20 just how it is.

21 MR. WIESE: Population base is a little bit  
22 better, might be better words for that.

23 MS. DERING-ANDERSON: Okay.

24 MR. WIESE: I apologize.

25 CHAIRPERSON STUBERG: Any other questions or

1 anything else that you felt was -- you wanted to make a  
2 point that you have not been able to germane to us choosing  
3 a proposal?

4 MR. WIESE: Nothing that I have right now. I just  
5 don't think we'd see our screening rates and number of kids  
6 being seen if we wouldn't be doing what we're doing.

7 CHAIRPERSON STUBERG: I think we would all agree  
8 with that.

9 MS. DERING-ANDERSON: I would agree with that.

10 CHAIRPERSON STUBERG: Thank you for your time.

11 MR. WIESE: Thank you.

12 CHAIRPERSON STUBERG: Anyone else?

13 How are we doing for time?

14 MR. BRIEL: About ten minutes.

15 JANE FORD WITTHOFF

16 MS. FORD WITTHOFF: I'm Jane Ford Witthoff, and  
17 I've been in an administrative position in the public health  
18 setting for too many years and probably shouldn't even be  
19 here. But I supervised Lincoln/Lancaster County Health  
20 Department and their dental program for 17 years. We had a  
21 wonderful relationship with the dentists. And,  
22 incidentally, I hope I'm not going to be saying things you  
23 don't want to hear, you know, that aren't pertinent, but  
24 it's just what I've wanted to say. Anyway, we had a  
25 wonderful relationship with the dental community. They

1 supported us. We always did with all of them. So, much  
2 care was provided. And then, I retired for a while, but I  
3 couldn't stay retired. And I wanted to come back and serve  
4 the rural area, because that's always been my love. So,  
5 I've been at Public Health Solutions District Health  
6 Department now for eight years. And we have two offices,  
7 one in Crete and one in Beatrice. We have five counties.  
8 We're kind of a -- we're concerned about dental health, but  
9 I think the important thing I want to tell you is that it's  
10 not just dental health that we're concerned about. We look  
11 at the whole person and we look at the whole system. It's  
12 not just the provision of those preventative services, but  
13 what is the impact for the future for anyone that we touch?  
14 Incidentally, we have 58,000 people. But, you know, the  
15 situation is, is that this is a shortage area. I saw that  
16 map and I hate that map, because it -- sorry, because I know  
17 Marnie very well, but the map shows a geographic shortage.  
18 A lot of my area is within that. And I think they're saying  
19 that basically, it should be okay for you to travel two  
20 hours to a dentist and whatever.

21 When you think about how things are now, you know,  
22 the limited transportation, the income problems, et cetera,  
23 et cetera, et cetera, and also wanting to keep your rural  
24 areas vital. That's not a really workable thing. I don't  
25 want to go two hours for a dentist, particularly if I have

1 kids in school. So, I guess I'm making the point that there  
2 is need beyond the geographic definition. And certainly,  
3 there's a problem with the cost. I mean, I think it's  
4 pathetic what the dentists are paid, awful. And also, it's  
5 unfortunate, too, that people have no value for their dental  
6 care. You know, when they say, "Oh, medicine goes out the  
7 window first when they have money problems." It's not true.  
8 Dental already went out a thousand years ago.

9           Anyway, so there are many different reasons why.  
10 And then people have bad attitudes about dental care. Many  
11 reasons why dental care isn't provided or that people don't  
12 have healthy teeth and aren't healthy. So, we look at all  
13 of those problems. To me, the important things are that I  
14 believe that the dental hygienists and the dentists must  
15 work together. To me, that's the only way we're going to be  
16 able to resolve the problem.

17           CHAIRPERSON STUBERG: Okay, ma'am, again, we are  
18 needing --

19           MS. FORD WITTHOFF: I know.

20           CHAIRPERSON STUBERG: -- comments to help us make  
21 a decision between these proposals and not generalities.

22           MS. FORD WITTHOFF: I understand.

23           CHAIRPERSON STUBERG: We can discuss the sharing  
24 of generalities when this meeting is over. Be happy to do  
25 so.

1 MS. FORD WITTHOFF: Well, I'm not going to go  
2 into --

3 CHAIRPERSON STUBERG: We've got a lot of people  
4 that I want to move us forward on what we're here to do.

5 MS. FORD WITTHOFF: I understand. One point was  
6 made about supervision, and I don't want to get involved in  
7 all of that. I just want to tell you how we do it at -- in  
8 a public health setting.

9 CHAIRPERSON STUBERG: Ma'am, that is not germane  
10 to our activity here.

11 MS. FORD WITTHOFF: Just hold on. It's the  
12 provision of preventative services by a dental hygienist.  
13 We have a quality assurance program. It's one of the things  
14 that we do. We have involvement of our dentists, and, you  
15 know, it's kind of an open process. So -- see, you rattled  
16 me. I can't even think. But anyway, I wanted to make sure  
17 that -- oh, the other thing is, yeah, there is Medicaid to  
18 reimburse for services, but many people don't have Medicaid  
19 and that's the problem. You can't operate any of these  
20 programs with just reimbursements. You have to have some --  
21 unless there's going to be, you know, reimbursement  
22 increased at some point.

23 Anyway, that's all, I guess, I have. If you have  
24 any questions, I'd be glad to answer them.

25 CHAIRPERSON STUBERG: Any questions from the

1 committee?

2 MS. DERING-ANDERSON: No, but thank you. This  
3 process -- I'm one of those creepy policy wonk people. This  
4 process wouldn't exist without you. I mean, it was you and  
5 Gina Dunning and Don Wesely, and we all know that. And we  
6 actually call it the 407 process, because that happened to  
7 be the bill number. And I don't want to lose that history,  
8 because we don't tell you thank you enough.

9 MS. FORD WITTHOFF: Thank you.

10 CHAIRPERSON STUBERG: Nor the importance of the  
11 connection with the public health pieces.

12 MS. FORD WITTHOFF: I just wanted to make sure  
13 that the people are the ones that are the focus, the people  
14 we serve.

15 CHAIRPERSON STUBERG: Thank you.

16 Do we have time for anyone else?

17 MR. BRIEL: About five minutes.

18 CHAIRPERSON STUBERG: Five minutes.

19 You, I believe, are affiliated, because we've  
20 heard from you a number of times in relationship to the NDA  
21 proposal.

22 DR. ANTHOLZ: I'm going to testify on the Academy  
23 of General Dentistry stance on the two proposals.

24 CHAIRPERSON STUBERG: Two and a half minutes. Is  
25 there anyone else to testify?

1 DR. ANTHOLZ: I'll summarize and you can read the  
2 handouts.

3 MS. DERING-ANDERSON: We'll read it.

4 CHAIRPERSON STUBERG: If you want two and a half  
5 minutes, you've got it, because I don't want to cut people  
6 off. It's just that --

7 DR. TRAVIS ANTHOLZ

8 DR. ANTHOLZ: I gave a handout, since I only have  
9 two and a half minutes, on the Academy of General Dentistry  
10 stance. My name is Travis Antholz, A-n, as in Nancy, t, as  
11 in Tom, h-o-l-z, as in zebra. I'm a general dentist here in  
12 Lincoln, Nebraska. I'm also an adjunct professor in the  
13 Department of Surgical Specialties. I maintain a full-time  
14 private practice on top of that, and I'm the immediate past  
15 president of the Academy of General Dentistry. The opinions  
16 that I'm giving are the opinions of the Academy of General  
17 Dentistry. I also happen to share those opinions, but they  
18 are the opinions of the organization.

19 With regard to the two proposals, you can read the  
20 AGD stance on there. Since I only have two minutes, I'm not  
21 going to spend a lot of time going through it. The things  
22 that were taken out of the proposal from the task force with  
23 regards to the NDA and the NDAA's proposal. Those were two  
24 proposals that the Academy of General Dentistry largely  
25 objected to, two of the three. The sealants was independent

1 of us. The reason that we objected in the Academy of  
2 General Dentistry to those two things, one being  
3 extractions, two being administration of local anesthetic  
4 under general supervision. No one questions, and as was  
5 very well presented by the Hygiene Association, their  
6 ability to administer local anesthetic and achieve  
7 anesthesia. That's not the crux of what the debate is  
8 about. According to the *Journal of American Dental*  
9 *Association*, the number one cause of an adverse or dental  
10 emergency in a dental office, whether directly or  
11 indirectly, is the administration of local anesthetic. And  
12 it is the ability to deal with that medical emergency that  
13 ranges anywhere from as small as a hematoma or a syncope all  
14 the way up to a TIA or heart attack or tachycardia or  
15 anything in between. We want to be on site to be able to  
16 manage that to determine if it's tachycardia and we need to  
17 put the patient in a supine position, potentially administer  
18 oxygen, wait for it to pass, or if it's something we need to  
19 call 911 on a TIA, both of which have happened in my office  
20 under my supervision.

21 As far as the extractions, there seems to be some  
22 confusion, because the extractions first were a class that  
23 doesn't exist. Then they were primary teeth. Then they  
24 were teeth in nursing homes. I don't know a lot of primary  
25 teeth that are existing in a nursing home. And I can tell

1 you guys who don't know dentistry, what few primary teeth  
2 still exist in a nursing home, I, as a general dentist,  
3 don't want to mess with, because they're ankylosed and  
4 they're there and they're very difficult to extract.

5 So, if we're to assume, then, that that also  
6 includes permanent teeth, I would share with you a short 30-  
7 second story from two months ago. This is just the most  
8 recent episode when I was overseeing students at the Dental  
9 College. We had an elderly gentleman come in with an  
10 extensive medical history. He had a central incisor that  
11 any one of you could take out with a two-by-two of gauze.  
12 That's how mobile this tooth was. Student went through,  
13 everything was updated on the health history, took the tooth  
14 out, and the patient started to bleed. We initially applied  
15 pressure. We knew some of his medications, like aspirin, he  
16 was going to have more bleeding. He continued to bleed, and  
17 he continued to bleed, and he continued to bleed at an  
18 increasing rate. We finally -- he said, "You know, go ask  
19 my wife. I think they put me on something new that I forgot  
20 to tell you guys about." We walked out in the waiting room  
21 and he's been on Coumadin for three weeks. We had no idea.  
22 We didn't know what his INR was. We very quickly placed a  
23 collagen plug, put an X suture over it, and problem was  
24 solved, bleeding is stopped. That's not something that's  
25 going to happen if you don't have the proper training to be

1 able to administer the emergency treatment under those  
2 procedures. It's not about how easy the extraction is.  
3 It's not whether you can or can't take it out with a  
4 two-by-two of gauze. It's can you deal with the  
5 complications when they arise, as they come up.

6 The sealants, as the Academy of General Dentistry,  
7 we believe dental assistants should also be able to do  
8 sealants. I'll quit. She's calling me time out. So, the  
9 floor is yours.

10 (Laughter.)

11 CHAIRPERSON STUBERG: Thank you.

12 LINDSAY HAYS

13 MS. HAYS: Hello. My name is Lindsay Hays,  
14 L-i-n-d-s-a-y, H-a-y-s. I may have misunderstood as far as  
15 what the neutral position meant. I am neither for nor  
16 against either proposal.

17 CHAIRPERSON STUBERG: Your background?

18 MS. HAYS: My background is, I graduated in 2005  
19 with a bachelor's degree from the University of Nebraska in  
20 Omaha. I then decided to pursue dentistry in 2006, and I  
21 graduated in 2007 from Central Community College dental  
22 assisting program. Then went on to graduate in 2009 from  
23 Iowa Western dental hygiene program.

24 CHAIRPERSON STUBERG: So, you're a hygienist and  
25 an assistant.

1           MS. HAYS: I am a hygienist and an assistant, yes.  
2 I had been practicing dental hygiene in Omaha for most of my  
3 career, and in 2013, my husband accepted a position with a  
4 company in rural Nebraska. I started my job search  
5 immediately, as most would, in the anticipation of making a  
6 move. It quickly became apparent that the job search was  
7 not going to be easy in rural Nebraska. I looked week after  
8 week, delivered several resumés, and after six months, I had  
9 only had two interviews with practices that offered me one  
10 to two days of work per week.

11           I found myself questioning my chosen profession.  
12 Why is the dental profession so much different than that of  
13 the medical profession? The answer to my question was  
14 simple. There are no career advancement opportunities for a  
15 hygienist or an assistant. I had, in a sense, already  
16 reached the pinnacle of my career after only practicing for  
17 five years. For example, in the nursing profession, there  
18 are several avenues for career advancement. We can go ASN,  
19 LPN, RN, BSN, APRN. The list goes on. A medical doctor can  
20 easily delegate duties and base their hiring practices on  
21 what level of training they prefer in their staff. In the  
22 dental world, there is only a dental assistant and a  
23 registered dental hygienist. The dentist cannot delegate  
24 certain duties, and they do not have the option to, due to  
25 the restrictions of our current statutes. All of this

1 equals less access to care in rural Nebraska and far less  
2 job opportunities in my profession.

3 I love what I do, but I am starting to wonder what  
4 the future will hold. Having the ability to work side by  
5 side with my dentist doing minor restorative procedures,  
6 which is consistent with both proposals is ideal. I realize  
7 that not every hygienist will have the desire to take their  
8 skills to the next level, nor will every dentist feel  
9 comfortable delegating such duties. I am fortunate to  
10 currently work at a practice setting that puts hygienists in  
11 a position with a high level of responsibility. I  
12 absolutely agree that when adding clinical duties to any  
13 health profession, advanced training and education is  
14 paramount. I would be eager to advance my career and  
15 provide better service to my patients and the community  
16 should the opportunity arise. Thank you for listening to my  
17 story.

18 CHAIRPERSON STUBERG: So, can I summarize your  
19 testimony that you want this committee to do something with  
20 one of these two proposals --

21 MS. HAYS: Yes, absolutely.

22 CHAIRPERSON STUBERG: -- but not to do anything  
23 would be --

24 MS. HAYS: Yes, exactly. I would like you to do  
25 something.

1 CHAIRPERSON STUBERG: Very good.

2 Any other questions?

3 MS. DERING-ANDERSON: I just wanted to say thank  
4 you. For the first time, I get it when people talk to me  
5 about career advancement and -- you put it in a context that  
6 even this fat old woman can figure out. And I really  
7 appreciate that, thank you.

8 MS. HAYS: Thank you.

9 MR. BRUENING: You may be talking about a  
10 conversation around higher education in general. We won't  
11 go there. I guess I'm confused. So, we've heard testimony  
12 that there is a need for dental care in rural Nebraska.

13 MS. HAYS: Yes.

14 MR. BRUENING: You couldn't get an interview. I  
15 don't understand. Something doesn't jibe.

16 MS. HAYS: The problem is --

17 MR. BRUENING: And I don't think it's relevant to  
18 these discussions, but we've gone this far.

19 MS. HAYS: Quite honestly, I never thought I was  
20 going to have to worry about it. I thought I would be in  
21 the Omaha metro area for the rest of my career. Then, this  
22 job opportunity arose for my husband --

23 MR. BRUENING: I can get you a job tomorrow in IT,  
24 if you want one.

25 (Laughter.)

1           MS. HAYS: Great. So, I had to go out to rural  
2 Nebraska and try to find something. The problem is, as you  
3 see in the map that they gave you, here you are, one dentist  
4 per county. Well, that dentist has, maybe, one hygienist.  
5 And guess what, that hygienist will practice 40 years there,  
6 which is what happened to my old dentist. Forty years, and  
7 she retires. So, where do I go?

8           MR. BRUENING: That explains.

9           MS. HAYS: I don't have any opportunity to go  
10 anywhere else, because I'm stuck where I am in my career.

11          CHAIRPERSON STUBERG: Thank you.

12                 Were there any other individuals? If so, I  
13 apologize, because we are out of time. As far as business  
14 is concerned, than you for submitting your testimonies in  
15 writing, because it's good for us to be able to sit down and  
16 read through those. The next meeting of this group is on  
17 February 12<sup>th</sup> from 9:00 until 12:00 in the morning here in  
18 one of the rooms. And other than that, are there any other  
19 items of business before we adjourn?

20          MR. BRIEL: You will receive a transcript within  
21 approximately two and a half weeks. We will get it and  
22 we'll get it to you electronically.

23          CHAIRPERSON STUBERG: We thank you for the time.  
24 Those of you that came that did not testify, for helping.  
25 I'm sure there's going to be a lot of discussion. And

