

Application

Credentialing Review for Expanding Scopes of Practice for Dental Hygiene & Assisting:

A Collaborative Model for Teamwork that Promotes Better Cost-Efficiency and Improved Access for Delivery of Dental Care in Nebraska

Submitted by:



August 5, 2014

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Overview of Proposal

Currently, dental care in Nebraska is primarily delivered in private practice settings that are led by a dentist and typically include a team of business staff, dental hygienists, and dental assistants. Dental hygienists and assistants normally are involved in working on the clinical side. The majority of Nebraskans who receive dental care do so through the private practice sector. A smaller portion seek care through community health centers, public health clinics, within our dental schools, and finally through charitable projects. Preventive services are available from private practitioners and on a limited basis through school-based sealant programs, Head Start and/or WIC Clinics, long-term care settings, etc.; although the system is sporadic and highly dependent on the willingness and availability of both dentists and grant funding sources.

Within these dental teams that deliver care, the dentist is the team leader and works with a clinical staff consisting of hygienists and assistants. Typically, most hygienists care for patient's prevention needs. This includes, taking radiographs, cleaning teeth, placing dental sealants, and educating the patient on home care to prevent dental disease. They also do procedures such as deeper cleanings and preventative instruction. Dental assistants can polish the teeth (but only above the gum-line and only with a polishing cup), take radiographs and sterilize instruments. Most dental assistants spend the majority of their time assisting the dentist with restorative and surgical procedures. Nebraska has two levels of supervision of dental team members, general and indirect, defined in **Exhibit B**.

In addition to working in a private practice settings, a small percent of dental hygienists work in public health settings such as schools, prisons, community health centers, WIC Clinics, nursing homes providing their services to populations that may or may not be able to routinely seek the care of a dentist or have a dental home. One example of this would be placing sealants in a school-based dental sealant program. In 2007, the State of Nebraska passed a law that would allow hygienists to obtain a public health permit that allowed them greater autonomy and flexibility to reach these populations without having a dentist on site. In 1996, dental hygienists were granted privileges to anesthetize patients in a dental practice; a procedure previously done only by the dentist. In 2008, hygienists were able to enroll as Medicaid Providers.

All dental hygienists have two years of dental education and a license to practice dental hygiene in Nebraska. Dental assistants are either trained in accredited dental assisting programs or can be "on the job" trained (OJT). Assistants neither are credentialed professionals nor are they registered. However, there are two procedures that dental assistants can perform with Board of Dentistry approved education. These duties are taking radiographs (x-rays of teeth) and coronal polishing (polishing teeth with a polishing cup above the gumline).

In 2008, the Nebraska Dental Assistants Association submitted a 407 Application seeking to create three levels of dental assistants: a Dental Aide, Licensed Dental Assistant, and Expanded Function Assistant. The NDA and NDHA opposed the 407 and the Application did not result in a favorable Technical Review Report or legislative effort

Section 38-1136 allows the Department of Health and Human Services, with the recommendation of the Board of Dentistry, to adopt and promulgate rules and regulations governing the performance of duties by licensed dental hygienists and dental assistants. In 2007, the Attorney General ruled that the Board of Dentistry did not have the statutory authority to define educational requirements for dental assistant duties.

In 2009, the NDA presented legislation (LB 542) to allow the Board of Dentistry to define educational requirements for dental assistant duties. The NDHA and NDAA opposed this bill, resulting in the only bill filibustered in that Legislative Session.

In Nebraska, approximately, 1/3 of Nebraska dentists see Medicaid. While numerous efforts have been made to get more dentists to see this population, the low reimbursement rates, among other administrative barriers, and challenges inherent in this patient population, have had little effect. Therefore, current focus has been on how to take dental practices that have successful models for seeing Medicaid and other high risk, high needs, low resources to pay individuals, and helping them (the dental practices) to become more efficient. It is not cost-effective for the most expensive, highest compensated person of the dental team (the dentist) to be spending their time doing procedures that are low risk and can be taught to be done by an expanded function dental assistant or expanded function dental hygienist. In addition, a dental hygienist has much more value to the overall care of a patient than simply "cleaning teeth" and discussing good brushing habits. The dental assistant in turn, is much more valuable to the team than "sucking out spit of the patient's mouth" and handing instruments to the doctor. With the passing of the Affordable Care Act, it is anticipated that an even greater number of children and adults will be covered by Medicaid and/or private dental insurance, and as a result, demand will increase.

Better utilizing both dental assistants and hygienists to their full extent not only makes sense for efficiency but also for quality of care and job satisfaction for these valuable team members. The measure of safety for both groups has been well documented in the scientific literature (Abramowitz et. al.). Often, assistants and hygienists leave their jobs to look for work that offers more autonomy and upward career mobility. An example of this is hygienists who go on to nursing school. In the Journal of the American Dental Association (JADA Vol 87, Sept 1973), Abramowitz reported a longitudinal study of four years looking at Expanded Function Dental Assistants (EFDAs). Their findings included: 1) The participating dental auxiliaries were able to provide restorations of acceptable quality and 2) the ability to increase the amount of services provided can greatly help to improve the oral health status of a community.

It is worth noting that the NDA and NDAA acknowledge that "access to care is a very complex issue." Expanding the workforce to be able to do more, is only one tool in the toolbox of how to improve access. Other factors affecting access to care include adequate water fluoridation, affordable dental insurance, working through administrative and cultural barriers as well as improved reimbursement within the Dental Medicaid Program, and placing dentists in counties and/or communities where they are lacking. Another issue is improving the oral health literacy of our population so they understand the benefits of receiving preventive dental care and the role the individual plays in their own oral health through proper home care and a diet low in sugar. Simply expanding duties of a dental team is not a stand-alone solution. The NDA has worked tirelessly to convince the Legislature to pass water fluoridation and, and improve the Dental Medicaid Program to no avail. The NDA was successful in passing legislation to fund the State Dental Director position with a full-time dentist. Furthermore, annually the NDA, NDHA, and NDAA have volunteer members who work at the Mission of Mercy as a way to help provide emergency dental care and dental treatment to those that don't have a dental home. However, this is only a "band-aid" approach and not a dental home model.

Dental disease afflicts many Nebraska children. Poor dental health has detrimental effects on children's readiness for school and ability to succeed in the classroom. In one year, more than 51 million hours of class time are missed because of dental-related illness (U.S. Surgeon General's Report 2000). In "The Cost of Delay," (Pew 2010), Nebraska received a grade of "C" because we do not have sealant programs in at least 25% of our high-risk schools and are well below the benchmark of 75% of our population receiving water fluoridation. Nebraska has low Medicaid reimbursement rates paid to dentists. To clarify, the applicant group is not advocating for a new level of dental provider, only an expansion in scope of practice of existing team members (assistants and hygienists) with appropriate education, licensure, and supervision.

In 2009, the President of the NDA asked members of the three associations (NDA, NDAA, and NDHA) to form an interest group of individuals that wanted to work together to find a common solution to delegating expanded functions to dental auxiliaries called The Future of Teamwork in Delivery of Oral Health Services. . The group explored various ways that we could expand the existing dental team to better serve Nebraskans. More specifically, the group studied, "What might be the best possible way that dentists, hygienists, and assistants could work together in a manner that would offer the best quality of care possible to patients, better utilize the knowledge, skills, and existing workforce of assistants and hygienists, help dental practices and other clinics and programs that need to increase efficiency, improve practice productivity, and help the State of Nebraska by increasing access to care."

The group met for over three years. The NDA reported the work of the group in the NDA Newsletters **(Exhibit K)** The group's model was presented to the NDA House of Delegates, the NDHA and NDAA in April of 2013. Each association then commented on what they could support and what they could not. In September of 2013, the NDA House of Delegates unanimously passed an amended version of the original proposal, that eliminated hygienists performing extractions of human teeth and unsupervised administration of local anesthesia. While the amended version was amenable for the most part to the NDAA, it was not to the NDHA. On November 21, 2013, the NDHA submitted further recommendations to the NDA. The progression of the different levels of hygiene and assistant duties in the Task Force charts is contained in **Exhibit F**. The group ended their role and the associations began to plan for the next steps of the 407 process. The NDA and NDAA believe that the proposal in this Application is the best option that has the support of the majority of its members, and has the best chance of making it successfully through the 407 process and onto successful legislation.

The model uses the State's existing workforce of dental assistants and hygienists and the State's existing accredited training programs for their education and continuing education. The model allows those dentists who wish to delegate more to their clinical staff the ability to do so. It also allows dentists who wish to practice the status quo, not to change how they practice. It aligns appropriate supervision with these delegated duties as well. It also preserves the on-the-job-trained (OJT) dental assistant for those dentists practicing in areas of Nebraska where finding trained dental assistants is difficult. Finally, we believe the proposal makes sense for the state. It balances the need for education and credentialing, expanding duties performed by assistants and hygienists. The Application is based upon the proposal contained in the **September 19, 2013 Task Force charts**, detailed in **Exhibit F**.

In summary, we hope the proposed models give dental assistants and hygienists more career stability, opportunities for career growth, and job satisfaction. Second, we hope the proposed model is good for Nebraskans who may have difficulty finding dental care by allowing dental clinics to operate more efficiently, thus potentially being able to increase their capacity to care for more Medicaid and needy populations. Finally, we believe, that by being proactive in looking at expanded models of care, we will better able to more effectively serve all Nebraskans who desire to receive it.

1. Provide the following information for the applicant group(s): a. name, address, telephone number, e-mail address, and website of the applicant group in Nebraska, and any national parent organization; b. composition of the group and approximate number of members in Nebraska; and c. relationship of the group to the occupation dealt with in the application.

Dental Profession	Nebraska Dental Association 990 members American Dental Association	David O’Doherty, Executive Director 7160 S. 29 th St., Ste #1 Lincoln, NE 68516 davidodoherty@windstream.net (402) 406-1704 www.nedental.org
Dental Assistants	Nebraska Dental Assistants Association 214 members American Dental Assistants Association	Crystal Stuhr, NDAA Legislative CoChair 5321 S Bristolwood Pl. Lincoln, NE 68516 402-437-2740 cstuhr@southeast.edu http://www.nebraskadentalassistants.org/ Cindy Cronick NDAA Legislative CoChair 1211 Manley Court Plattsmouth, NE 68048 (402) 738-4676 ccronick@mccneb.edu

2a-c. Identify by title, address, telephone number, e-mail address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of any of the following: a. members of the same occupation or profession as that of the applicant group; b. members of the occupation dealt with in the application; c. employers of the occupation dealt with in the application; d. practitioners of the occupations similar to or working closely with members of the occupation dealt with in the application;

Dental Hygiene Profession	Nebraska Dental Hygienists Association	521 First Street PO Box 10 Milford, NE 68405 (402) 761-2216 www.nedha.org
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2d-e. Identify by title, address, telephone number, e-mail address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of any of the

following: e. educators or trainers of prospective members of the occupation dealt with in the application;

Education Programs for Dentists, Hygienists, and Assistants	UNMC College of Dentistry	40 th and Holdrege St. Box 830740 Lincoln, NE 68583-0740 (402) 472-1301 unmc.edu/dentistry
	Creighton University School of Dentistry	2802 Webster Street Omaha, NE 68178 (402)280-5890 http://www.creighton.edu/dentalschool/
	UNMC College of Dentistry, Dental Hygiene Program	40th & Holdrege St. Lincoln, NE 68583-0740 (800) 626-8431 Program Director: Gwen Hlava
	Central Community College Dental Hygiene Program	P.O. Box 1024 Hastings, NE 68902-1024 (402) 461-2470 Program Director: Wanda Cloet
	Central Community College Dental Assisting Program	P.O. Box 1024 Hastings, NE 68902-102 www.cccneb.edu Program Director: Ms. Marie Desmarais Phone: 402-461-2467 mdesmarais@cccneb.edu
	Metropolitan Community College Dental Assisting Program	P.O. Box 3777 Omaha, NE 68103-0777 www.mccneb.edu Program Director: Ms. Joan Trimpey Phone: 402-738-4675 jtrimpey@mccneb.edu
	SE Community College Dental Assisting Program	8800 'O' Street Lincoln, NE 68520-1299 www.southeast.edu Program Director: Ms. Crystal Stuhr Phone: 402-437-2740 cstuhr@southeast.edu
	Vatterott College, Omaha Campus	11818 "I" Street Omaha, NE 68137 www.vatterott.edu/omaha.asp Program Director: Ms. Roberta Worm Phone: 402-891-9411 x142 roberta.worm@vatterott.edu
	Kaplan University-Omaha Dental Assisting Program	Dental Assisting Program 5425 N. 103rd Street Omaha, NE 68134 www.kaplanuniversity.edu/omaha-nebraska.aspx

		Program Director: Ms. Shannon Roen Phone: 402-431-6185 sroen@kaplan.edu
	Mid-Plains Community College Dental Assisting Program	1101 Halligan Drive North Platte, NE 69101 www.mpcc.edu Program Director: Ms. Lauri Rickley Phone: 308-535-3650 Rickleyl@mpcc.edu

2f-g. Identify by title, address, telephone number, e-mail address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of any of the following: f. citizens familiar with or utilizing the services of the occupation dealt with in the application (e.g., advocacy groups, patient rights groups, volunteer agencies for particular diseases or conditions, etc.); and g. any other group that would have an interest in the application.

Other Non-Dental Related Groups with Interest in Proposal	Nebraska Pharmacists Association	6221 S 58th Street, Suite A Lincoln, Nebraska 68516 Phone: 402-420-1500 Fax: 402-420-1406 info@npharm.org
	Nebraska Healthcare Association	1200 Libra Drive, Suite 100 Lincoln, NE 68512 Phone 402-435-3551 Fax 402-475-6289 E-mail nhca@nehca.org
	Nebraska Hospital Association	3255 Salt Creek Circle, Suite 100 Lincoln, NE 68504-4778 Phone (402) 742-8140 Fax (402) 742-8191
	Nebraska Nurses Association	PO Box 82086 Lincoln, NE 68501 Phone: 402.475.3859
	Nebraska Rural Health Association	John Roberts 2222 Stone Creek Loop South Lincoln, NE 68512 (402) 421-2356 phone (402) 421-2356 fax Email: jroberts@mwhc-inc.com
	Public Health Association of Nebraska	Rita Parris, Executive Director PublicHealthNe@cs.com 1321 South 37th Street Lincoln, NE 68510 Phone - 402.483.1039 Fax - 402.483.0570
	Nebraska Head Start Association	Suzan Obermiller, President PO Box 509

		Loup City, NE 68853 sobermiller@cennecs.org Tel: 308/745-0780
	Nebraska Oral Health Coalition	HHS (but currently no state dental director)
	Nebraska School Nurses Association	Tonja Frank RN North Bend Central Public Schools 1430 Walnut Street North Bend, NE 68649 Direct Line: 402-637-8087 Email: president@nebraskaschoolnurses.com

3. If the profession is currently credentialed in Nebraska, provide the current scope of practice of this occupation as set forth in state statutes. If a change in this scope of practice is being requested, identify that change. This description of the desired scope of practice constitutes the proposal. The application comprises the documentation and other materials that are provided in support of the proposal.

Dental hygienists are licensed oral health professionals who focus on assessing, preventing and treating oral diseases-both to protect teeth and gums, and also protect patients' overall oral health. Dental hygienists provide patient care under the general supervision of licensed dentists. Public Health Registered Dental Hygienists provide a limited scope of services in public health settings and health care facilities without the supervision of a dentist.

(See Exhibit A, Neb. Rev. Stat. §§ 38-1130 and 38-1131).

The changes requested for the dental hygiene profession include:

- 1) An expansion of scope under general supervision which includes administration and titration of nitrous oxide, placing interim therapeutic restorations, and limited prescription writing for preventive products that reduce risk for tooth decay.
- 2) Expansion of the existing Public Health Dental Hygienist scope of practice which would allow a hygienist to place interim therapeutic restorations and write prescriptions for preventive products that reduce risk for tooth decay in public health settings.
- 3) Creation of a new tier called the Registered Dental Hygienist-Expanded Function (RDHEF). The RDHEF would place and finish restorations and under the indirect supervision of a dentist within a dental practice after the dentist has removed the decay/infection from a tooth.

Proposed Modifications (in red)

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

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

§ 38-1130. Licensed dental hygienist; functions authorized; when; department; duties; Health and Human Services Committee; report

(3) (a) The department may authorize a licensed dental hygienist to perform the following functions in the conduct of public health-related services to children in a public health setting or in a health care or related facility: Oral prophylaxis to healthy children who do not require antibiotic premedication; pulp vitality testing; and preventive measures, including the application of fluorides, sealants, and other recognized topical agents for the prevention of oral disease. A licensed dental hygienist may perform Interim Therapeutic Technique and write prescriptions for mouthrinses and fluoride products that help decrease risk for tooth decay upon completion of a course approved by the Board of Dentistry.

(4) (a) The department may authorize a licensed dental hygienist who has completed three thousand hours of clinical experience to perform the following functions in the conduct of public health-related services to adults in a public health setting or in a health care or related facility: Oral prophylaxis; pulp vitality testing; and preventive measures, including the application of fluorides, sealants, and other recognized topical agents for the prevention of oral disease. A licensed dental hygienist may perform Interim Therapeutic Technique and write prescriptions for mouthrinses and fluoride products that help decrease risk for tooth decay upon completion of a course approved by the Board of Dentistry.

Proposed Modification (in red)

TITLE 172 NEBRASKA ADMINISTRATIVE CODE
Chapter 53 RULES AND REGULATIONS
GOVERNING THE PERFORMANCE OF DUTIES
BY LICENSED DENTAL HYGIENISTS AND OTHER DENTAL AUXILIARIES

The licensed dentist assumes full responsibility for all the aforementioned procedures delegated to a

licensed dental hygienist, under his supervision.

002.01H Expanded Function Restorative Dental Hygienist

The Board shall issue an Expanded Function Restorative Dental Hygienist permit upon receipt of a completed application form, payment of the appropriate fee specified in the Uniform Credentialing Act, and proof that the dental hygienist has completed a board approved expanded functions training course. The requirements of this section must be completed within one (1) year of the date of submission of the application form. The board-issued expanded functions permit must be displayed in plain view in any facility where the dental hygienist will be providing expanded functions prior to delegation of expanded functions to that dental hygienist. Dental hygienists shall renew expanded functions permits in accordance with the requirements established by the Board of Dentistry. A licensed dental hygienist may use continuing education hours obtained for license renewal to renew an expanded functions permit. The Restorative Functions listed below may be performed under the indirect supervision of a dentist.

1. Restorative I Permit—

- A. Places liners, bases and varnishes;
- B. Placing, condensing, and carving amalgam for Class I, V, and VI restorations;
- C. Placing composite/ Glass ionomer for Class I, V, and VI restorations; and
- D. Minor palliative care of dental emergencies (place sedative filling).

2. Restorative II Permit—

- A. Holds a current Restorative I Permit;
- B. Placing, condensing, carving, and finishing amalgam for Class II restorations;
- C. Placing and finishing composite/Glass ionomer for Class II, III, IV restorations.

002.02 Other Prohibited Services. A licensed dental hygienist or any other dental auxiliary, under no circumstances, is ever authorized to perform, whether under the supervision of a licensed dentist or not, the following clinical services:

002.02A Diagnosis and treatment planning.

002.02B Surgery on hard or soft tissue.

002.02C Administering of local or general anesthetics.

002.02D Any other irreversible dental procedure or procedures which require the professional judgment and skill of a licensed dentist.

002.03 Prohibited Services. Except in accredited **programs**, licensed dental hygienists and other dental auxiliaries are prohibited from performing the following clinical services:

02.03A Any intra-oral procedure which would lead to the fabrication of any prosthesis, **Unless possessing the required LDA or EFDA permit.**

002.03B Placing or contouring of a final restoration, **unless possessing an Expanded**

Function Restorative Dental Hygienist or Expanded Function Dental Assistant Restorative Permit.

4. If the profession is not currently credentialed in Nebraska, describe the proposed credential and the proposed scope of practice, and / or the proposed functions and procedures of the group to be reviewed. This description of the desired scope of practice and the proposed credential constitute the core of the proposal. Also, please describe how the proposal would be administered. The application comprises the documentation and other materials that are provided in support of the proposal.

By definition a dental assistant, in the Statutes Relating to Dentistry, “means a person, other than a dental hygienist, employed by a licensed dentist for the purpose of assisting such dentist in the performance of his or her clinical and clinical-related duties.”

Only three functions are actually listed in statute or regulations for assistants: taking x-rays, (172 NAC 53.004) coronal polishing, (172 NAC 53.005) and assist with general, parental and inhalation analgesia anesthesia (§ 38-1143). **See Exhibit C.**

The applicants are seeking to propose the following:

- 1) Maintain the basic level of dental assisting which includes both recognizing dental assisting program graduates and OJT dental assistants. Added to their scope of practice would be monitoring nitrous oxide and placing topical local anesthetic.
- 2) Create a new level of dental assisting called the Licensed Dental Assistant (LDA). This credentialed individual would need to have additional education and testing and licensure so the Board of Dentistry has some measure of control over their education and quality of care provided. An LDA would be able to fit and cement crowns on primary (baby) teeth, monitor and titrate nitrous oxide per a dentist order, and take final impressions/records for dental prostheses. This would all be under indirect supervision of a licensed dentist.
- 3) Create a new level of dental assisting, called expanded function dental assistant (EFDA). This type of dental assistant, with appropriate education, credentials, and licensure would be able to place and finish restorations after the dentist removes the tooth decay/infection from the tooth. This level would perform under the indirect supervision of the dentist.

Proposed Modifications (in red)

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

- (a) The department, with the recommendation of the board, shall adopt and promulgate rules and regulations governing the performance of duties by licensed dental hygienists and dental assistants, **including any educational requirements.**
- (b) **The board may adopt rules and regulations for the licensure of dental assistants. Every applicant for licensure shall satisfactorily complete an examination approved by the board,**

which examination shall require the applicant to demonstrate that the applicant is capable of performing the functions of a licensed dental assistant and shall be administered within the State at least once each year at such time and place as the board designates, and (1) have satisfactorily completed and graduated from a training program for dental assistants accredited by the American Dental Association's Commission on Dental Accreditation and approved by the board, or (2) have a high school diploma or its equivalent and at least 1,500 hours of work experience as a dental assistant.

- (c) Dentists delegating expanded-functions duties to licensed dental assistants or licensed dental hygienists shall do so in accordance with rules and regulations set forth by the board. No person shall perform expanded-functions duties in this state unless the board has issued to such person a permit to perform expanded-functions duties in this state.

Proposed Modification (in red)

TITLE 172 NEBRASKA ADMINISTRATIVE CODE
Chapter 53 RULES AND REGULATIONS
GOVERNING THE PERFORMANCE OF DUTIES
BY LICENSED DENTAL HYGIENISTS AND OTHER DENTAL AUXILIARIES

002.02 Other Prohibited Services. A licensed dental hygienist or any other dental auxiliary, under no circumstances, is ever authorized to perform, whether under the supervision of a licensed dentist or not, the following clinical services:

002.02A Diagnosis and treatment planning.

002.02B Surgery on hard or soft tissue.

002.02C Administering of local or general anesthetics.

002.02D Any other irreversible dental procedure or procedures which require the professional judgment and skill of a licensed dentist.

002.03 Prohibited Services. Except in accredited programs, licensed dental hygienists and other dental auxiliaries are prohibited from performing the following clinical services:

02.03A Any intra-oral procedure which would lead to the fabrication of any prosthesis, **unless possessing the required LDA or EFDA permit.**

002.03B Placing or contouring of a final restoration, **unless possessing an Expanded Function Restorative Dental Hygienist or Expanded Function Dental Assistant Restorative Permit.**

003 SCOPE OF PRACTICE OF DENTAL AUXILIARIES.

003.01 Authorized Services. A licensed dentist is authorized to delegate to a dental auxiliary, other than a dental hygienist, only those procedures for which the dentist exercises supervision,

for which he assumes full responsibility and which do not conflict with these regulations. The phrase "other than a dental hygienist" is used in this section of Subsection 003 to specifically differentiate between "dental hygienist" and any other dental auxiliary, and for no other purpose.

003.02 Prohibited Services. Other dental auxiliaries are not authorized to perform any of the clinical services which may be performed by a licensed dental hygienist pursuant to Subsections 002.01A and 002.01C or any of the clinical services which are prohibited to dental auxiliaries pursuant to Subsection 002.03.

003.03 APPLICATION FOR LICENSE TO PRACTICE DENTAL ASSISTING.

(a) An applicant desiring to secure licensure as a dental assistant shall have:

1. Satisfactorily completed and graduated from an educational program for dental assistants approved by the Board and accredited by the Commission on Dental Accreditation and shall have taken the Dental Assistant Certification Examination administered by the Dental Assisting National Board (DANB) and currently be certified prior to the date of application or Board approved equivalent exam; or
2. Successfully completed high school (or its equivalent) and shall have and obtained at least 1,500 hours of chairside work experience as a dental assistant during the five-year period prior to making application for licensure, passed the Dental Assistant Certification Examination administered by DANB and currently be certified prior to the date of the application or Board approved equivalent exam

(b) An applicant for Licensure as a dental assistant shall submit a completed application to the Board which contains the following information and materials:

1. A certification by the board of dentistry in every state or jurisdiction in which the applicant is a registered or licensed dental assistant verifying that the applicant's credential in that state or jurisdiction is in good standing;
2. Proof of the following, if applicable pursuant to (a) above:
 - i. A certificate of graduation from an approved educational program in dental assisting in which the expanded functions or duties listed in 172 NAC 53.003.04 are taught;
 - ii. A certificate of successful completion of an approved program in licensed or expanded functions in dental assisting. The Board shall recognize the following as providers of approved programs in expanded functions:
 - (1) A program accredited by the Commission on Dental Accreditation;
 - (2) In-service training programs conducted by the US military
3. Results from a criminal history background check conducted by the State of Nebraska pursuant to § 38-131; and
4. The application fee set forth in the Uniform Credentialing Act.

003.04 CATEGORIES OF PRACTICE FOR LICENSED DENTAL ASSISTANTS

(A) Upon completion of a course approved by the Board, the following functions delegable to a Licensed Dental Assistant to perform are listed below by category. The supervising dentist shall check all procedures before dismissing the patient. Must meet all the requirement for licensure.

1. Fixed Prosthodontics 1 Permit

- A. Place retraction cord/material in preparation for fixed prosthodontic impressions; and
- B. Making impressions for the fabrication of any fixed prosthesis/appliance.

2. Removable Prosthodontics 1 Permit

- A. Placement of temporary soft liners in a removable prosthesis;
- B. Extra-oral adjustments of removable prosthesis during and after insertion; and
- C. Making impressions for the fabrication of any removable prosthesis/appliance.

3. Pediatric Fixed 1 Permit

- A. fit and cement crowns on deciduous teeth

4. Monitor and Titrate Nitrous Oxide Analgesia Permit

- A. Under indirect supervision if s/he—

1. Has successfully completed formal training in a course approved by the Board; and
2. Has successfully passed an approved competency test regarding the clinical and didactic training; or
3. Has been certified in another state to assist in the administration of and monitor nitrous oxide subsequent to equivalent training and testing. The dental assistant may qualify to perform these functions by presenting proof of competence of this equivalent training and testing to the Board.

003.05 CATEGORIES OF PRACTICE FOR EXPANDED FUNCTION DENTAL ASSISTANTS

(A) A Licensed Dental Assistant, upon completion of a course approved by the Board, may perform the functions listed below by category as an Expanded Function Dental Assistant. The supervising dentist shall check all procedures before dismissing the patient.

1. Fixed Prosthodontics 2 Permit- must be Licensed Dental Assistant with a current Fixed Prosthodontics 1 Permit;

- A. Extra-oral adjustments of fixed prosthesis;
- B. Final cementation of any permanent appliance or prosthesis

2. Restorative I Permit

- A. Places liners, bases and varnishes;
- B. Placing, condensing, and carving amalgam for Class I, V, and VI restorations;
- C. Placing composite/ Glass Ionomer for Class I, V, and VI restorations; and
- D. Minor palliative care of dental emergencies (place sedative filling).

3. Restorative II Permit— must hold a current Restorative I Permit;

A. Placing, condensing, carving, and finishing amalgam for Class II restorations;

B. Placing and finishing composite/Glass ionomer for Class II, III, IV restorations.

003.06 Expanded Functions Course Providers.

(A) The board may approve Licensed Dental Assistant or Expanded Functions Dental Assistant course providers that satisfy the following minimum criteria:

1. Uses course curriculum approved by the board;
2. Demonstrates that faculty at each course include at least one (1) dentist and that the student to faculty ratios do not exceed one (1) faculty member per ten (10) students;
3. Demonstrates that adequate faculty calibration occurs to insure that educational standards are maintained;
4. Demonstrates that adequate testing, monitoring, and evaluation is in place to assure that graduates have attained competent skills of the component concepts in a laboratory setting; and
5. Demonstrates that mechanisms are in place to provide the board with data on the outcomes of expanded functions duty dental assisting training by reporting on follow-up blind surveys of Licensed Dental Assistant or Expanded Functions Dental Assistant, supervising dentists, and patients.

5. Describe in detail the functions typically performed by practitioners of this occupation, and identify what if any specific statutory limitations have been placed on these functions. If possible, explain why the Legislature created these restrictions.

a) Functions typically performed by dental hygienists

The following duties are typically performed by hygienists:

- oral health care assessments that include the review of health history
- dental charting
- oral cancer screening
- hard tissue assessment
- evaluation of gum disease / health
- expose and process dental radiographs (x-rays)
- remove plaque and calculus (“tartar”) from above and below the gum line using dental instruments; including scaling and root planning/ non-surgical periodontal therapy
- apply cavity-preventive agents such as fluorides and sealants to the teeth and sub-gingival agents to treat periodontal disease
- administer local anesthetic
- educate patients on proper oral hygiene techniques to maintain healthy teeth and gums and counsel patients about plaque control and developing individualized at-home oral hygiene programs

- smoking cessation programs
- counsel patients on the importance of good nutrition for maintaining optimal oral health. (American Dental Hygiene Association)

Nebraska Regulation 172 NAC 53.002.02 places limitations placed on services:

002.02 Other Prohibited Services. A licensed dental hygienist or any other dental auxiliary, under no circumstances, is ever authorized to perform, whether under the supervision of a licensed dentist or not, the following clinical services:

002.02A Diagnosis and treatment planning.

002.02B Surgery on hard or soft tissue.

002.02C Administering of local or general anesthetics.

002.02D Any other irreversible dental procedure or procedures which require the professional judgment and skill of a licensed dentist.

002.03 Prohibited Services. Except in accredited colleges of dentistry, licensed dental hygienists and other dental auxiliaries are prohibited from performing the following clinical services:

002.03A Any intra-oral procedure which would lead to the fabrication of any prosthesis.

002.03B Placing or contouring of a final restoration.

b) Functions typically performed by dental assistants

Currently assistants perform duties as delegated to them by a dentist. This varies greatly from office to office and differs in specialty practices. Typically, assistants in all practice settings:

- prepare the room for treatment
- seat patients
- perform all disinfection and sterilization procedures
- mix and pass materials
- suction
- take x-rays (with a permit)
- polish teeth with rubber cup and only above the gumline (with a permit)
- make and cement temporary restorations
- take preliminary impressions
- perform lab work as needed

A more complete list of duties is in **Exhibit D: ADAA Core Competencies.**

Limitations included in **172 NAC 53.002.02** listed above.

6. Identify other occupations that perform some of the same functions or similar functions.

Dental hygienists can do any function that dental assistants can do. Assistants have some common functions with hygienists. Physicians perform smoking cessation programs, oral health screenings and nutrition counseling.

7. What functions are unique to this occupation? What distinguishes this occupation from those identified in question 6?

Question 5 outlines the differences. Essentially, dental hygienists can work independently in public health settings, can do below the gum cleaning and can place sealants. Dental hygienists provide comprehensive assessments, remove hard deposits from above and below the gum line (scaling and root planning), give local anesthetics (with dentist on site), and place sealants. The prophylaxis or scaling and root planning procedures provided by the dental hygienist improves the health of the soft tissue resulting in reduced inflammation. This has a positive impact on the systemic health of patients served, especially those at risk for diabetes, heart disease, stroke, and aspiration pneumonia. The public health dental hygienist may work without the supervision of a dentist in public health settings only.

While hygienists may perform the duties of an assistant, in most cases the hygienist's focus is on preventive dental services and the assistant's focus is on assisting with restorative dental services. Assistants in specialty or general practices assist with endodontics (root canals and tooth pulp diseases and treatment), prosthodontics (crowns, bridges, implants, etc.), oral surgery, periodontics, orthodontics and general dentistry, on a wide variety of patients of all ages.

8. Identify other occupations whose members regularly supervise members of this occupation, as well as other occupations whose members are regularly supervised by this occupation. Describe the nature of the supervision that occurs in each of these practice situations.

Dentists always supervise dental assistants when working together. Dental hygienists are supervised by dentists in private practice settings and may or may not be supervised by a dentist in public health settings.

9. What actions, judgments, and procedures of this occupation can typically be carried out without supervision or orders? To what extent is this occupation, or portions of its practice, autonomous?

a) Dental Hygienists

Registered dental hygienists work under the general supervision of a dentist. General supervision means the directing of the authorized activities of a dental hygienist or dental assistant by a licensed dentist and shall not be construed to require the physical presence of the supervisor when directing such activities. However, some procedures such as titration of nitrous oxide and anesthetizing a patient, the dentist must be present.

The Public Health Registered Dental Hygienist works within the infrastructure of a public health setting or health care facility. Orders from a dentist are not required to provide limited services.; They carry their own liability insurance. Under no circumstances can a hygienist render a diagnosis. They may bill Medicaid for limited preventative codes.

b) Dental Assistants

Dental assistants are not autonomous and perform duties under either indirect or general supervision. Indirect means that the dentist is on the premises.

10. Approximately how many people are performing the functions of this occupation in Nebraska, or are presenting themselves as members of this occupation? To what extent are these people credentialed in Nebraska?

a) Dental Hygienists

Currently there are 1261 registered dental hygienists licensed in Nebraska and 72 dental hygienists holding a Public Health Permit. All dental hygienists are credentialed by licensure.

b) Dental Assistants

Dental assistants are not credentialed in the state of Nebraska and there are no official lists (i.e. registration, certification or license lists) to identify that number. However, according to the 2005 Nebraska Workforce Needs Report, the 351 responding dentists employed 1690 assistants. According to a 2008 Survey of Dental Practice, by the ADA Survey Center- during 2003 to 2007, the average number of chairside assistants per dentist in the primary private practice of independent dentists hovered around 1.6. Specialists during that same time employed an average of 2.6 chairside assistants. Nebraska has approximately 1000 actively licensed dentists. Using these formulas, there would be approximately 2000-4800 full and part-time dental assistants working in Nebraska.

11. Describe the general level of education and training possessed by practitioners of this occupation, including any supervised internship or fieldwork required for credentialing. Typically, how is this education and training acquired?

a) Dental Hygienists

Dental Hygienists are graduates of accredited dental hygiene education programs in colleges and universities which provide didactic and clinical experiences provided by calibrated faculty. Educational programs also provide for rotations in a variety of settings including schools, nursing homes, hospitals etc.. Hygienists must take a written national board examination, a clinical examination, and a jurisprudence test before they are licensed to practice.

b) Dental Assistants

Dental assistants may be trained on the job (OJT), since there are currently no education requirements. In 2008, the NDA surveyed its members regarding dental assistants. 304 dentists responded to the survey, employing a total of 861 dental assistants. 440 of those dental assistants (51%) were trained on-the-job. 272 of those dental assistants (32%) were Certified Dental Assistants through DANB. 446 dental assistants (52%) had been certified to take x-rays pursuant to 172 NAC 53.004. 329 of the dental assistants (38%) had been certified to perform coronal polishing pursuant to 172 NAC 53.005.

Some assistants have attended a one year ADA CODA (Council on Dental Accreditation) accredited program. There are numerous programs nationwide, six in Nebraska. These programs are a minimum of one year in length and require a minimum of 300 hours of supervised internship.

Dental Assisting National Boards, DANB, is a nationwide testing agency for assistants. While not required in Nebraska, assistants have taken the DANB exams (Radiation Health and Safety (RHS), Infection Control (ICE), and General Chairside Assisting (GC). and maintained the credential of "CDA" (Certified Dental Assistant). As of March 1, 2013, there were 331 CDA's in NE. There are 625 NE dental assistants who have passed RHS (DANB X-ray test) and 671 who have passed ICE (DANB Infection Control test) since April 1995.

12. Identify the work settings typical of this occupation (e.g., hospitals, private physicians' offices, clinics, etc.) and identify the predominant practice situations of practitioners, including typical employers for practitioners not self-employed (e.g., private physician, dentist, optometrist, etc.).

a) Dental Hygienists

The majority of dental hygienists' work in private practice as employees of dentists while a few, specifically PHRDH, practice in hospitals, clinics, nursing homes, schools, and other public health settings. In addition to treating patients directly, dental hygienists may also work as educators, researchers, and administrators.

b) Dental Assistants

Dental assistants work in a variety of settings, including private general and specialty dental practices, dental clinics, dental laboratories, public health clinics, out-patient surgical facilities, government clinics, educational institutions, military, insurance companies, and dental supply/product companies. The predominant setting for this occupation is in private dental practices.

13. Do practitioners routinely serve members of the general population? Are services frequently restricted to certain segments of the population (e.g., senior citizens, pregnant women, etc.)? If so, please specify the type of population served.

Yes, both groups routinely care for the general population. This includes children, adults, seniors, developmentally disabled, incarcerated, etc..

14. Identify the typical reasons a person would have for using the services of a practitioner. Are there specific illnesses, conditions or situations that would be likely to require the services of a practitioner? If so, please specify.

One would typically not seek out a dental assistant alone since they always work in conjunction with a dentist. However, public health settings that employ or contract with a hygienist would typically have school nurses or other public health professionals seek them to work with their population. For example, a school nurse might ask a hygienist to screen school children and/or place dental sealants.

15. Identify typical referral patterns to and from members of this occupational group. What are the most common reasons for referral?

Since an overwhelming number of hygienists and dental assistants work in conjunction with a dentist, it is typically the dentist who refers patients to specialists, physicians, or others. However, a hygienist working in a public health setting would typically refer a patient to a dentist or even other health care provider as needed.

16. Is a prescription or order from a practitioner of another health occupation necessary in order for services to be provided?

No.

In the new proposal, an assistant would still be required to receive direction before performing more advanced procedures. A hygienist would need an order to restore a tooth (with a filling, or stainless steel crown on a baby tooth) after the dentist has removed the decay.

A hygienist would also need an order to commence IRT (interim therapeutic restoration). IRT is used when it is more appropriate to stabilize tooth decay in a patient where age, how soon they would lose the tooth, behavior, terminal illness, or other circumstances make a less invasive, traditional "drill and fill" treatment not indicated. An example would be when a hygienist is in a nursing home and evaluates a patient that has minor tooth decay on a front tooth but the individual is limited to their bed and no dentist with traditional dental equipment is caring for that patient. The hygienist would scoop out the soft decay and fill the void with a tooth colored filling that is done primarily with a hand instrument. This is typically done without local anesthesia. This technique is approved by the American Dental Association, American Academy of Pediatric Dentistry and the World Health Organization.

The goal is to “buy time” and stabilize active dental caries (tooth decay) disease until either the patient can seek more definitive treatment or the tooth is lost.

17. How is continuing competence of credentialed practitioners evaluated?

Hygienists, as an already credentialed profession, would continue to seek CE based on current statute as is consistent with the Uniform Credentialing Act. If he/she is providing expanded duties, they would likely choose CE in this area. This is consistent with how dentists acquire CE. Dentists are not required to have specific hours in specific procedures; just a total of 30 credits every two years.

There are no required written or clinic tests for general dentists, hygienists, or assistants to measure continuing competence. Dentists whom are board certified in a specialty undergo testing based on their specialty board organizations’ guidelines. Therefore, the proposal does not require additional testing after initial licensure for hygienists and assistants.

For the two new tiers proposed for dental assistants, this would require licensure. As is consistent with dentists and hygienists, these levels of dental assisting would also require 30 hours of CE every two years. The Dental Assisting National Board (DANB) also has a testing system that states can use to credential dental assistants. The Certified Dental Assisting Exam tests for radiology, infection control, and chairside assisting. DANB has developed an exam for “Expanded Functions Dental Assistants”, called the Certified Restorative Functions Dental Assistant Exam. However, the applicant group is comfortable leaving the specifics of continued competency to be decided by the Board of Dentistry.

Overall, because the majority of new procedures we are proposing require the supervision of the dentist, the dentist must assure the competency of his/her staff that will assure reasonable safety and quality of care. The intent is that the dentist is assuring that all care provided within their practice or clinic setting is done to the standard of care and *the dentist is ultimately responsible for the patient’s dental care*. This is consistent with other states’ statutes that have similar models of care delivery. In addition, when a patient and/or other dental professional believes that the treatment provided was below the standard of care, this can be handled through the current peer review system and/or the judicial system.

Currently, there is no requirement for initial or continuing competence of a dental assistant. Under the proposal:

1. The Licensed DA and EFDA would be subject to the Uniform Credentialing Act and need 30 hours of continuing education every 2 years for license renewal.
2. The dentist employer would be continuously monitoring the quality of the functions performed by the assistant as he/she ultimately has the responsibility for the quality of services performed.
3. Disciplinary action by the Board of Dentistry (HHS) would be possible to restrict incompetent practitioners; which currently does not happen since dental assistants are not licensed professionals by the state.

18. What requirements must the practitioner meet before his or her credentials may be renewed?

All levels of dental hygiene and the second and third levels of dental assisting will require 30 hours of CE every two years in addition to the fees and paperwork requirements outlined in the UCA.

Dental Hygienists are required to have 30 clock hours of continuing competency every two years for license renewal. The UCA and Rules and Regs outline the types of activities allowed for license renewal (see Exhibit E.) Commonly hygienists will attend CE programs sponsored by professional organizations and colleges. Testing is NOT required for CE programs. Home study and online courses may be utilized with testing required.

19. Identify other jurisdictions (states, territories, possessions, or the District of Columbia) wherein this occupation is currently regulated by the government, and the scopes of practice typical for this occupation in these jurisdictions.

Dental assistants are regulated on a state by state basis through state legislation and/or rules and regs of State Dental Boards. All states regulate the practice of dental assisting, but each state is unique in its requirements.

Nineteen states expressly allow placement of restorations by dental assistants and 20 states expressly prohibit that function. Twelve states (AK, CA, KY, MA, MI, MN, MO, NM, OH, OR, VI and WA) have expanded function assistants similar in education and credential to the proposal. Numerous states have functions and credentialing similar to the duties of the licensed assistant. The U.S. Military is the oldest entity known to use expanded duty dental assistants and dental corpsmen. Exhibits G, H, and I includes other states that allow assistants and hygienists to perform some measure of expanded functions.

Additional Questions an Applicant Group Must Answer about their Proposal

1) What is the problem created by not regulating the health professional group under review, or by not changing the scope of practice of the professional group under review?

Because the proposal will allow hygienists and assistants to place direct restorations on teeth, having these groups be regulated is key to public safety. In addition, since dental assistants are not regulated currently, this would allow for the state to regulate the expanded functions of dental assisting, where the assistant is placing dental materials on teeth.

a) Increased risk of potential for harm without regulation

As the role of the dental assistant has expanded to meet access to care and increased capacity issues, dental assistants are providing more patient care. Assistants are now performing functions that they used to assist with as the dentist performed them. Many functions (or steps in functions) delegated to assistants are billable, insurance coded services. The expansion of functions has not been accompanied by any increase in training, continuing education, competency testing or credentialing. Dental assistants without proper education, testing and credentialing could pose a risk to the public from a lack of knowledge and competency testing.

b) Inconsistency without regulation

As no list of duties or associated levels of supervision exists in either statute or rules and regs, it is currently unclear to the patient, supervising dentist and the dental assistant as to which functions the assistant may perform, leading to a wide range of interpretations and inconsistent levels of training and supervision for dental assisting functions throughout the state. All dental functions have some inherent risk of danger or harm if used improperly. If it is deemed necessary that dentists and hygienists have formal education, testing and credentialing to perform services, should the assistant not also have some level of standardization to perform the exact same services? This proposal is attempting to clarify who can do what, with what education, and supervision.

c) No Mechanism to discipline members of the group without regulation

Without regulation there is no mechanism to discipline dental assistants. Currently, only the dentist employer can be disciplined.

2) If the proposal is for the regulation of a health professional group not previously regulated, all feasible methods of regulation, including those methods listed below, and the impact of such methods on the public, must be considered. For each of the following evaluate the feasibility of applying it to the profession and the extent to which the regulatory method would protect the public.

a) Inspection requirements

None. Because the majority of the newly proposed scope of hygiene practice and all the newly proposed scope of dental assisting practice falls under the practices and clinics operated by dentists, inspection is completed as is consistent with the rules/regs of the practice of dentistry. No mechanism is currently in place to inspect all facilities in the state where dental services are performed and this would be cost prohibitive to initiate and maintain.

b) Injunctive relief

The same system would be in place for the awarding of damages should a patient feel they were harmed or not provided with quality care. However, due the typical situation of the dentist having the "deeper pockets," this threat holds the dentist accountable for the care provided by their staff. Dental hygienists do carry malpractice insurance. To regulate dental assistants on a case by case basis in the court system would be costly and not serve to adequately protect the public, only compensate.

c) Regulating the business enterprise rather than individual providers

None. The new scope of duties being proposed is primarily within a dental practice where the dentist is the owner of the practice. In cases where a hygienist is contracting with a public health clinic or other such entity, payment his/her services are spelled out in the contract.

d) Regulating or modifying the regulation of the dentists

None. Dentists are already regulated through the Dental Practice Act and accompanying rules and regs. Ultimately, the dentist is responsible for all patient care that is provided in his/her clinic regardless if they, their hygienist, or assistant is providing that care. The marketplace will take care of poorly placed dental restorations. For example, if a dental filling is leaking or causing the patient discomfort, the dentist, must assume responsibility for making it right, whether they themselves placed it, or a member of their dental team (hygienist or assistant). The dentist has a vested interest in assuring quality of care or patients choose to take their dental care elsewhere. The proposal would enhance the regulation of those who supervise by providing a list of duties, education and supervision, which is currently lacking.

e) Registering the providers under review

None.

f) Certifying the providers under review

This proposal is not seeking to certify any of providers under review. The proposal seeks to license them. Certification is a voluntary credential and would not protect the public.

g) Licensing the providers under review

By licensing expanded functions of dental assisting, the public is assured a reasonable measure of protection, through completion of mandated education initially, applying for a license, and through CE and re-credentialing through the UCA.

3) What is the benefit to the public of regulating the health professional group under review or changing the scope of practice of the regulated health profession under review?

The benefits to the public are many. These include increasing the capacity with private practices and public health dental clinics to serve more people, improved efficiency which leads to more open appointment time and the ability to offset low Medicaid reimbursement, and being treated by dental team members (both assistants and hygienists) that have advanced training in their field. In addition, having dental assistants, who perform more advanced duties will require them to become licensed, which provides a way for them to be regulated by HHS.

Currently, some subgroups of Nebraska's population can have difficulty accessing dental care. These populations tend to include poor children, very young children (typically under 5 y/o), persons living in counties that don't have a dentist, uninsured poor adults, developmentally disabled adults, and counties where there is no dentist seeing new Medicaid-eligible patients.

Approximately, one-third of Nebraska's dentists see Medicaid and within that group, an even smaller percent see Medicaid to any meaningful extent (more than a few patients per month). This is not unique to Nebraska nor is it just a factor of dentists who don't want to see Medicaid. Research on a national level has shown this is a multi-factorial problem related to poor oral health literacy, administrative barriers, low reimbursement, and other factors that make visiting a dentist difficult for those who may have smaller incomes, transportation issues, etc. (GAO Report 2000).

However, many dental practices have been able to overcome these challenges and are able to see a meaningful number of Medicaid eligibles. Still though, reimbursement rates of the Dental Medicaid Program have put increasing pressures on practices to see fewer Medicaid patients. The Nebraska Dental Medicaid Program reimburses about 40 cents on the dollar. By increasing the efficiency of the practice, through better delegation of duties, the same quality of care can be provided at a lower cost. It is much more cost-efficient for a dentist to be diagnosing, completing dental disease risk assessment, consulting with other medical providers, providing surgical treatment and irreversible procedures than it is to be doing simpler ones that have a wide margin of safety. Research has demonstrated a well-trained EFDA can provide a high level of care when his/her scope is limited to a handful of things they do very well (Abramowitz 1973).

According to Domer (2005), he found that in Colorado, when high delegation dentists were asked how delegation had affected their practice, they answered they believed that expanded

delegation had: 1) increased the number of patients seen, 2) increased productivity and income, 3) reduced stress of practicing dentistry, and 4) produced reduced hours without a decrease in practice income.

Allowing assistants with standardized education, testing and credentialing to perform certain duties will increase the access to dental care statewide. Data from Missouri supports, "Since the program's inception, its estimated 1,800 EFDAs have been trained by Missouri Dental Association (MDA) and its trainers. Accordingly, each of these EFDAs, on average, expands the productivity of the dental team by 10% to 15%, which equates to having added the equivalent in dental productivity of 180 to 270 full-time dentists. As part of a comprehensive solution to the state's oral health work force needs, EFDAs may be the most significant component (short-term) to the problems of rural areas" (<http://moefda.org/programoverview.html>).

4) What is the extent to which the proposed regulation or the proposed change in scope of practice might harm the public?

The applicant groups do not believe there is any evidence that supports expanded function dental assistants or hygienists causing harm to the public. The Task Force attempted to discern this information, but the database kept by the American Association of Dental Examiners is incomplete and did not separate out expanded duty dental assistants or hygienists (data available in reference manual). However, there is always a small risk that dentists that could potentially use these models of care to over-treat patients or choose not to appropriately supervise them. The NE Dental Board already has a system in place to address issues of scope of practice and inappropriate supervision. In fact, we believe that by clarifying these duties, it will actually clean up much of the current statutory language that is vague.

Another oversight system that will help keep checks and balances is the Attorney General's Office and the Office of the Inspector General. These entities investigate Medicaid fraud. A dentist who was billing incorrectly or over-billing could trigger an audit in which investigators could also look at delegation practices. The applicant groups do not believe there is any evidence that supports expanded function dental assistants or hygienists causing harm to the public. Several studies have been done to support this. One example is an article entitled "A Comparison of dental restoration outcome after placement by restorative function auxiliaries versus dentists", published in the Spring 2012 Journal of Public Health Dentistry. The conclusion was "There was no significant difference in problem rates for restorations placed by restorative function auxiliaries versus those placed by dentists. This finding may free dentists to handle more difficult cases, alleviating some of the pressures of daily practice and meeting the need for improved access (Worley 2012)."

5) What standards exist or are proposed to ensure that a practitioner of the health professional group under review would maintain competency?

Dental hygienists, as a licensed profession, must maintain 30 hours of continuing education every two years. This is the same for dentists. The proposal includes 30 hours every two years for dental assistants who become licensed (Tiers 2 and 3). Other than examination for initial licensure, there are no testing requirements for either dentists or hygienists and we are not proposing any new rules for this at this time. The American Dental Association is the organization that is currently studying what type of testing is appropriate for continued competency of dentists. We would expect when the dental profession adopts new standards, it would be likely that something similar would be required of licensed hygienists and licensed assistants at some point in time.

6) What is the current and proposed role and availability of third-party reimbursement for the services provided by the health professional group under review?

Dental assistants would not be eligible for any third party payments since they work under the supervision of the dentist who is the one reimbursed. Dental hygienists are primarily paid through the dental practice they work for on an hourly rate. However, for procedures they can bill Medicaid for when working in public health settings, they would bill Medicaid either directly or the contractor would bill Medicaid. In terms of overall Dental Medicaid Expenditures, public health permit hygienists make up a very small percent of the claims paid by the Dental Medicaid Program. Typical procedures they bill for include prophylaxis (dental cleaning) and topical fluoride treatments. It is important to note that the number of RDH public health permits, as reported by HHS is over 50. However, only three hygienists have billed Medicaid.

7) What is the experience of other jurisdictions in regulating the practitioners affected by the proposal? Identify appropriate statistics on complaints, describing actions taken, etc., by jurisdictions where the profession is regulated.

“The trend since 2000 toward enactment of new rules related to the delegation of expanded functions to dental assistants, combined with the increase since 1993 in the number of states recognizing two or more levels of dental assisting, reflects the oral healthcare community’s increasing interest in allowing the delegation of expanded functions to dental assistants (Position Paper of the ADAA/DANB Alliance Addressing a Uniform National Model for the Dental Assisting Profession).” Since the ADA Commission on Dental Accreditation, American Association of Dental Examiners, and the American Dental Education Association are all beginning to get involved in the education and/or testing of expanded duty staff, there will be opportunities to share information, curriculum, and examinations.

According to the Missouri Dental Board, “As part of a comprehensive solution to the state’s oral health work force needs, EFDA’s may be the most significant component (short term) to

the problems of rural areas (<http://moefda.org/programoverview.html>).” Missouri has had expanded function assistants since 1996. (Exhibit J)

Minnesota has had restorative assistants and hygienists since 2003. The March 1, 2007 Journal of Dental Education published an article entitled: “Allied Restorative Function Training in Minnesota, A Case Study” (Cooper and Monison, 2007). The conclusions stated, “Our findings indicate training in restorative functions provides allied dental professionals the confidence and knowledge necessary to perform restorative function procedures, leading to delegation of these procedures by the dentist, which in turn could lead to an increase in the availability of dental care for the public.”

8) What are the expected costs of regulating the health professional group under review, including the impact of registration, certification, or licensure on the costs of services to the public? What are the expected costs to the state and to the general public of implementing the proposed legislation?

There is no expectation that the public would share in the costs to license these new groups except for tax payer support of public university and community colleges that receive state funding for higher education. We assume the Department of Health and Human Services will apply application fees that are similar to what other groups pay for processing a license application. It is likely that for the dentists who have practices that would utilize these expanded scope of practice models, the application fees would be paid by the dental practice.

Fees for licensure would be recommended by the Board of Dentistry and collected by HHS. Fees could be set to ensure that costs are covered. Since this mechanism is in place for dentists and hygienists, we do not anticipate creation of a cumbersome system. It is anticipated that the number of assistants to credential would begin with a small number and grow, representing a small percentage of the total assistants in the state. For example, according to the Missouri Dental Board, EFDAs currently only constitute approximately 25% to 30% of the state's 6,000 dental assistants. We believe this trend in Nebraska will start slowly and gradually increase over a period of years.

9) Is there any additional information that would be useful to the technical committee members in their review of the proposal?

Many states already support dental assistants and dental hygienists providing expanded functions. The key is appropriate education, testing, supervision, and case selection. A dentist would not likely delegate a more difficult placement of a filling on a medically compromised or behaviorally challenged patient. This proposal did not go into detail in regards to the type or extent of education and testing. We believe that the Nebraska Board of Dentistry and our accredited dental education institutions will develop this curriculum and testing. It is important to note that one of the greatest barriers to states allowing expanded duty delegation is dentists' attitudes. Cooper (1993) found that dentists' positive response to delegating decreased with increasing age and years of practice. She also found that larger

practices were more likely to delegate. Gilmore (1976) found that dentists opposed the delegation of irreversible duties, but were favorably disposed to the delegation of a number of reversible procedures. Young dentists favored the concept more than older dentists, and specialists were more in favor than general practitioners. Furthermore, the study found respondents who were informed on research were more likely to delegate irreversible duties than those who were uninformed. Participation in an EFDA program increased the willingness of dental students to delegate procedures such as placing amalgams. The consumers (patients) did not seem overly concerned with who provided the dental care; they just didn't like the services themselves (Gilmore 1976). We recognize that changing attitudes takes time and not until success stories emerge both from practitioners and the public, will more dentists and dental team members see the benefits of better team utilization.

In all of the studies examined by the proponents groups, the quality of clinical outcomes has been shown to be similar when education and years of experience were controlled for regardless of who placed the restoration. Lotzkar 1971 and Sisty, 1979 have done the most extensive work in this area. In addition, the U.S. military is the oldest entity that routinely uses dental assistants and hygienists in expanded roles through dental corpsman in order to care for soldiers and their dependents.

The American Dental Association supports the use of EFDA's as a way to make the dental practice more efficient and as a way to improve access to care. It is the ADA's policy "not to delegate irreversible and/or surgical procedures." This proposal does advocate for the delegation of one irreversible procedure. This procedure is ITT or interim therapeutic technique (scooping out small amounts of decay with a hand instrument and placing a small tooth colored filling when a more definitive mode of treatment is not indicated or possible; such as bed ridden adult or a child in a public health setting that has no access to a dentist). The other procedures added to the proposal are easy to teach, can be redone by the dentist if not satisfactory, have a wide margin of safety, and have low risk for complications to occur.

Finally, the proposal does not propose undue regulation by the state to credential these expanded duties, nor does it impose an entire new education program; but instead, expands existing accredited dental assisting and hygiene programs to meet both the educational needs of those newly entering the profession and accommodates those already out in the workforce that wish to advance their education.

In summary, we believe the proposal is a good balance for all stakeholders including the public, dentists, dental assistants, hygienists, the dental education community, and the Board of Dentistry. While it does not satisfy the wish list for every group that it affects, we believe it was the best place to start. Further delegation of duties can always be addressed in the future.

Exhibit A

Current Statutes for Nebraska Dental Hygienists

38-1130. Licensed dental hygienist; functions authorized; when.

(1) Except as otherwise provided in this section, a licensed dental hygienist shall perform the dental hygiene functions listed in section 38-1131 only when authorized to do so by a licensed dentist who shall be responsible for the total oral health care of the patient.

(2) The department may authorize a licensed dental hygienist to perform the following functions in the conduct of public health-related services in a public health setting or in a health care or related facility: Preliminary charting and screening examinations; oral health education, including workshops and inservice training sessions on dental health; and all of the duties that any dental assistant is authorized to perform.

(3)(a) The department may authorize a licensed dental hygienist with three thousand hours of clinical experience in at least four of the preceding five calendar years to perform the following functions in the conduct of public health-related services in a public health setting or in a health care or related facility: Oral prophylaxis to healthy children who do not require antibiotic premedication; pulp vitality testing; and preventive measures, including the application of fluorides, sealants, and other recognized topical agents for the prevention of oral disease.

(b) Authorization shall be granted by the department under this subsection upon (i) filing an application with the department, (ii) providing evidence of current licensure and professional liability insurance coverage, and (iii) providing evidence of clinical experience as required under subdivision (a) of this subsection. Authorization may be limited by the department as necessary to protect the public health and safety upon good cause shown and may be renewed in connection with renewal of the dental hygienist's license.

(c) A licensed dental hygienist performing dental hygiene functions as authorized under this subsection shall (i) report authorized functions performed by him or her to the department and (ii) advise the patient or recipient of services or his or her authorized representative that such services are preventive in nature and do not constitute a comprehensive dental diagnosis and care.

(4) For purposes of this section:

(a) Health care or related facility means a hospital, a nursing facility, an assisted-living facility, a correctional facility, a tribal clinic, or a school-based preventive health program; and

(b) Public health setting means a federal, state, or local public health department or clinic, community health center, rural health clinic, or other similar program or agency that serves primarily public health care program recipients.

38-1131. Licensed dental hygienist; procedures and functions authorized; enumerated. When authorized by and under the general supervision of a licensed dentist, a licensed dental hygienist may perform the following intra and extra oral procedures and functions:

- (1) Oral prophylaxis, periodontal scaling, and root planing which includes supragingival and subgingival debridement;
- (2) Polish all exposed tooth surfaces, including restorations;
- (3) Conduct and assess preliminary charting, probing, screening examinations, and indexing of dental and periodontal disease, with referral, when appropriate, for a dental diagnosis by a licensed dentist;
- (4) Brush biopsies;
- (5) Pulp vitality testing;
- (6) Gingival curettage;
- (7) Removal of sutures;
- (8) Preventive measures, including the application of fluorides, sealants, and other recognized topical agents for the prevention of oral disease;
- (9) Impressions for study casts;
- (10) Application of topical and subgingival agents;
- (11) Radiographic exposures;
- (12) Oral health education, including conducting workshops and inservice training sessions on dental health;
- (13) Application or administration of antimicrobial rinses, fluorides, and other anticariogenic agents; and
- (14) All of the duties that any dental assistant is authorized to perform.

Exhibit B

§ 38-1109 General supervision, defined.

General supervision means the directing of the authorized activities of a dental hygienist or dental assistant by a licensed dentist and shall not be construed to require the physical presence of the supervisor when directing such activities.

§ 38-1110 Indirect supervision, defined.

Indirect supervision means supervision when the licensed dentist authorizes the procedure to be performed by a dental hygienist or dental assistant and the licensed dentist is physically present on the premises when such procedure is being performed by the dental hygienist pursuant to section 38-1132 or the dental assistant.

Exhibit C

Current Dental Assisting Statutes and Regulations in Nebraska

§ 38-1107 Dental assistant, defined.

Dental assistant means a person, other than a dental hygienist, employed by a licensed dentist for the purpose of assisting such dentist in the performance of his or her clinical and clinical-related duties.

§ 38-1116 (8) Dentistry practice; exceptions. The Dentistry Practice Act shall not apply to: The performance by a dental assistant, under the supervision of a licensed dentist, of duties prescribed in accordance with rules and regulations adopted by the department;

§ 38-1143 -Assistant; certification required.

Any person who assists a dentist in the administration of general anesthesia, parenteral sedation, or inhalation analgesia shall be currently certified in basic life-support skills or the equivalent thereof.

§ 38-1135 Dental assistants; employment; duties performed.

Any licensed dentist, public institution, or school may employ dental assistants in addition to licensed dental hygienists. Such dental assistants, under the supervision of a licensed dentist, may perform such duties as are prescribed in accordance with rules and regulations adopted and promulgated by the department, with the recommendation of the board.

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

The department, with the recommendation of the board, shall adopt and promulgate rules and regulations governing the performance of duties by licensed dental hygienists and dental assistants.

TITLE 172 NEBRASKA ADMINISTRATIVE CODE
Chapter 53 RULES AND REGULATIONS
GOVERNING THE PERFORMANCE OF DUTIES
BY LICENSED DENTAL HYGIENISTS AND OTHER DENTAL AUXILIARIES

003 SCOPE OF PRACTICE OF DENTAL AUXILIARIES.

003.01 Authorized Services. A licensed dentist is authorized to delegate to a dental auxiliary, other than a dental hygienist, only those procedures for which the dentist exercises supervision, for which he assumes full responsibility and which do not conflict with these regulations. The phrase "other than a dental hygienist" is used in this section of Subsection 003 to specifically differentiate between "dental hygienist" and any other dental auxiliary, and for no other purpose.

003.02 Prohibited Services. Other dental auxiliaries are not authorized to perform any of the clinical services which may be performed by a licensed dental hygienist pursuant to Subsections 002.01A and 002.01C or any of the clinical services which are prohibited to dental auxiliaries pursuant to Subsection 002.03.

004 DENTAL ROENTGENOGRAMS. Any licensed dental hygienist, by virtue of training and professional ability, is hereby authorized, under the supervision of a licensed dentist, to take dental roentgenograms. Any other dental auxiliary is hereby authorized under the supervision of a licensed dentist to take dental roentgenograms, but they shall not be authorized to do so, on or after January 1, 1973, unless they have satisfactorily completed a course in dental radiology approved by the Board and the Department.

005 CORONAL POLISHING. A dental auxiliary is hereby authorized, under the *indirect supervision* of a licensed dentist, to polish all exposed tooth surfaces with a rubber cup or brush driven by a conventional slow-speed hand piece, but they shall not be authorized to do so on or after January 1, 1997, unless they have met the following requirements:

005.01 Attained the age of eighteen (18); and

005.02 One of the following:

005.02A Have graduated from a dental assisting training program which is accredited by the American Dental Association (ADA) and includes a coronal polishing course; or

005.02B Have one (1) year (a minimum of 1500 hours) of clinical work experience as a dental assistant and have successfully completed a course in polishing procedures which is approved by the Board and Department.

005.03 Criteria for Approval of a Course on Polishing Procedures for Dental Assistants.

005.03A The institution administering the course on coronal polishing must be accredited by the American Dental Association;

005.03B The course must have a minimum of fourteen (14) contact hours of instruction to include ten (10) hours of didactic instruction and four (4) hours of clinical participation;

005.03C The didactic course content must include, but not be limited to, instruction in dental anatomy and physiology of the hard and soft tissues of the deciduous and permanent oral facial complex, the correct management of the hard and soft tissues during coronal polishing procedures, demonstration of appropriate patient and operator positions, instruction in universal precautions and infection control, laboratory exercises utilizing manikins or extracted teeth, indications and contraindications for coronal polishing, armamentarium, and principles of polishing

agents;

005.03D The clinical course content must include, but not be limited to, four (4) contact hours of rotary coronal polishing on a minimum of two (2) patients;

005.03E The course shall include written and clinical examinations for the purpose of determining competency of the dental assistant, demonstrating the necessary skills and proficiency to perform coronal polishing; and

005.03F Upon successful completion of the course, the sponsoring institution will provide the attendee with written verification of competency.

006 VIOLATIONS. Any violation of these Rules and Regulations by a licensed dentist or by a licensed dental hygienist shall be considered "unprofessional conduct" and due cause for revocation or suspension of a license to practice dentistry or dental hygiene.

SOURCE: Section 71-193.14

Sections 005 Added Approved by the Attorney General on January 9, 1998 Approved by the Governor on February 27, 1998 Filed by the Secretary of State on February 27, 1998 Effective Date: March 4, 1998

Dental Assisting Functions List

The following is a list of 70 dental assisting tasks developed by the ADAA/DANB Alliance in the course of its research. These selected tasks were determined to be representative of a broad range of dental assisting core competencies.

1. Perform mouth mirror inspection of the oral cavity
2. Chart existing restorations or conditions
3. Phone in prescriptions at the direction of the dentist
4. Receive and prepare patients for treatment, including seating, positioning chair, and placing napkin
5. Complete laboratory authorization forms
6. Place and remove retraction cord
7. Perform routine maintenance of dental equipment
8. Monitor and respond to postsurgical bleeding
9. Perform coronal polishing procedures
10. Apply effective communication techniques with a variety of patients
11. Transfer dental instruments
12. Place amalgam for condensation by the dentist
13. Remove sutures
14. Dry canals
15. Tie in archwires
16. Demonstrate knowledge of ethics/jurisprudence/patient confidentiality
17. Identify features of rotary instruments
18. Apply topical fluoride
19. Select and manipulate gypsums and waxes
20. Perform supragingival scaling
21. Mix dental materials
22. Expose radiographs
23. Evaluate radiographs for diagnostic quality
24. Provide patient preventive education and oral hygiene instruction
25. Perform sterilization and disinfection procedures
26. Provide pre- and post-operative instructions
27. Place and remove dental dam
28. Pour, trim, and evaluate the quality of diagnostic casts
29. Size and place orthodontic bands and brackets
30. Using the concepts of fourhanded dentistry, assist with basic restorative procedures, including prosthodontics and restorative dentistry
31. Identify intraoral anatomy
32. Demonstrate understanding of the OSHA Hazard Communication Standard
33. Place, cure and finish composite resin restorations
34. Place liners and bases
35. Place periodontal dressings
36. Demonstrate understanding of the OSHA Bloodborne Pathogens Standard
37. Take and record vital signs
38. Monitor vital signs
39. Clean and polish removable appliances and prostheses
40. Apply pit and fissure sealants
41. Prepare procedural trays/ Armamentaria set-ups
42. Place orthodontic separators
43. Size and fit stainless steel crowns
44. Take preliminary impressions
45. Place and remove matrix bands
46. Take final impressions
47. Fabricate and place temporary crowns
48. Maintain field of operation during dental procedures through the use of retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.
49. Perform vitality tests
50. Place temporary fillings
51. Carve amalgams
52. Process dental radiographs
53. Mount and label dental radiographs
54. Remove dental trays and cements
55. Remove temporary fillings
56. Apply topical anesthetic to the injection site
57. Demonstrate understanding of the Centers for Disease Control and Prevention Guidelines
58. Using the concepts of fourhanded dentistry, assist with basic intraoral surgical procedures, including extractions, periodontics, endodontics, and implants
59. Monitor nitrous oxide/oxygen analgesia
60. Maintain emergency kit
61. Remove permanent cement from supragingival surfaces
62. Remove periodontal dressings
63. Place post-extraction dressings
64. Fabricate custom trays, to include impression and bleaching trays, and athletic mouthguards
65. Recognize basic medical emergencies
66. Recognize basic dental emergencies
67. Respond to basic medical emergencies
68. Respond to basic dental emergencies
69. Remove post-extraction dressings
70. Place stainless steel crown

Exhibit E

Uniform Credentialing Act 38-145. Continuing competency requirements; board; duties.

(1) The appropriate board shall establish continuing competency requirements for persons seeking renewal of a credential.

(2) The purposes of continuing competency requirements are to ensure (a) the maintenance by a credential holder of knowledge and skills necessary to competently practice his or her profession, (b) the utilization of new techniques based on scientific and clinical advances, and (c) the promotion of research to assure expansive and comprehensive services to the public.

(3) Each board shall consult with the department and the appropriate professional academies, professional societies, and professional associations in the development of such requirements.

(4)(a) For a profession for which there are no continuing education requirements on December 31, 2002, the requirements may include, but not be limited to, any one or a combination of the continuing competency activities listed in subsection (5) of this section.

(b) For a profession for which there are continuing education requirements on December 31, 2002, continuing education is sufficient to meet continuing competency requirements. The requirements may also include, but not be limited to, any one or a combination of the continuing competency activities listed in subdivisions (5)(b) through (5)(p) of this section which a credential holder may select as an alternative to continuing education.

(5) Continuing competency activities may include, but not be limited to, any one or a combination of the following:

- (a) Continuing education;
- (b) Clinical privileging in ambulatory surgical center or hospital as defined in sect 71-405 or 71-419;
- (c) Board certification in a clinical specialty area;
- (d) Professional certification;
- (e) Self-assessment;
- (f) Peer review or evaluation;
- (g) Professional portfolio;
- (h) Practical demonstration;
- (i) Audit;
- (j) Exit interviews with consumers;
- (k) Outcome documentation;
- (l) Testing;
- (m) Refresher courses;
- (n) Inservice training;
- (o) Practice requirement; or
- (p) Any other similar modalities.

Rules & Regs regarding Continuing Competency

Chapter 56-005 CONTINUING COMPETENCY REQUIREMENTS: Each dentist and dental hygienist holding an active credential within the state must, on or before the date of expiration of the credential, comply with the continuing competency requirements for his/her profession, unless the requirements are waived in accordance with 172 NAC 56-006.03 and 56-006.04. Individuals that hold a temporary dentist license are not required to comply with continuing competency requirements. Each credentialed individual is responsible for maintaining certificates or records of continuing competency activities. 56-005.01 On or before the expiration date of the credential, the credential holder must complete 30 hours of acceptable continuing competency requirements in the 24-month preceding the expiration date of the credential.

56-005.02 Acceptable Continuing Competency Activities:

1. State and National meetings, i.e., a meeting of the local, state, or American Dental Association, local, state, or American Dental Hygiene Association, National Dental Association, and/or educational programs sponsored by the recognized specialty groups in dentistry of the American Dental Association;
 - a. One hour credit for each hour of attendance, and only the portion of such meeting which meets the definition of continuing education can be accepted for credit. EFFECTIVE NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES 20
2. District meetings and Study Clubs. In order to qualify as a Study Club in the State of Nebraska, the Dental Study Club must have a charter or constitution, officers, and consist of at least four licensed members. The Study Club must submit a list of meetings, including length, date and topics by March 1 of the reporting period;
 - a. One hour credit for each hour of attendance, and only the portion of such meeting which meets the definition of continuing education can be accepted for credit.
3. Formal education courses which relate directly to the practice of dentistry or dental hygiene;
 - a. One hour credit for each hour of attendance.
4. University-sponsored courses in continuing education in dentistry or dental hygiene;
 - a. One hour credit for each hour of attendance.
5. Licensee acting as table clinician or lecturer to licensed dentists, licensed dental hygienists or dental auxiliaries or licensee attending table clinics;
 - a. One hour credit for each hour of presentation or attendance; allowable credit limited to 2 hours within a 24-month renewal period.
6. Home study with testing mechanism. If there is not a testing mechanism or certificate of completion, the licensee must submit an abstract or resume of the material covered to the Board of Dentistry. The abstract or resume must be written by only the licensee and will be reviewed by members of the Board's subcommittee on continuing education;
 - a. One hour credit for each hour of study; allowable credit limited to 10 hours within a 24-month renewal period.

7. Direct clinical observation;

a. One hour credit for each hour of direct clinical observation; allowable credit limited to 2 hours within a 24-month renewal period.

8. Initial Cardiopulmonary Resuscitation (CPR) certification or CPR re-certification;

a. One hour credit for each hour of study;

b. Allowable credit limited to 10 hours for initial CPR certification within a 24-month renewal period; and

c. Allowable credit limited to 4 hours for CPR re-certification within a 24-month renewal period.

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9. Faculty Overseeing Student Dental Clinics;

a. One hour credit for each hour of faculty overseeing student dental clinics; allowable credit limited to 5 hours within a 24-month renewal period.

10. Dental Public Health continuing education;

a. One hour credit for each hour of dental public health continuing education; allowable credit limited to 5 hours within a 24-month renewal period.

11. Ethics and Professionalism continuing education;

a. One hour credit for each hour of ethics and professionalism continuing education; allowable credit limited to 5 hours within a 24-month renewal period.

12. Well-being (Substance Abuse) continuing education;

a. One hour credit for each hour of well-being (substance abuse) continuing education; allowable credit limited to 5 hours within a 24-month renewal period.

Exhibit F

Task Force Charts

Summary for Proposal for Change in Levels of Nebraska Dental Assisting – Exhibit F

Dental Assistant

Functions Not Permitted: Exam, Diagnosis, Treatment Planning, Surgical Procedures (including removal of tooth structure), Prescribing Drugs, Local Anesthesia with Syringe, Scaling and Root planning (removing hard deposits on teeth). **Red**= new duty, rule, or requirement. **Green**= suggested edits after 6-19-13 Task Force and NDA Cmt mtg

Level of Dental Assisting	Requirements/Recommendations	Indirect Supervision (Dentist onsite, authorizes procedure)	General Super vision (Dentist not on-site, but has authorized procedure)
Dental Assistant NDHA Letter November 21, 2013	19 y/o Infection control training (per federal OSHA requirement) Current CPR May be OJT or grad of CODA dental asst prg	Current duties as outlined in state rules/regs Monitor nitrous oxide (per newly proposed anesthesia guidelines, must have CPR) Place topical local anesthesia	Current duties per state rules/regs Take dental xrays (course & certificate required) Coronal polishing (course, certificate, and 1500 hrs experience required)
Dental Assistant NDA BOT/HOD 9/19/2013	19 y/o REMOVE Infection control training (per fed OSHA requirement) CPR (highly recommended) May be OJT or grad of CODA dental asst prg	Current duties as outlined in state rules/regs Monitor nitrous oxide (must have CPR) Place topical local anesthesia	Current duties per state rules/regs Take dental xrays (course & certificate required) Coronal polishing (course, certificate, and 1500 hrs experience required)
Dental Assistant 8/12/2013	19 y/o REMOVE Infection control training (per fed OSHA requirement) CPR (highly recommended) May be OJT or grad of CODA dental asst prg	Current duties as outlined in state rules/regs Monitor nitrous oxide (must have CPR) Place topical local anesthesia	Current duties per state rules/regs Take dental xrays (course & certificate required) Coronal polishing (course, certificate, and 1500 hrs experience required)
Dental Assistant June 2013	19 y/o Infection control training (per fed OSHA requirement) CPR (highly recommended) May be OJT or grad of CODA dental asst prg	Current duties as outlined in state rules/regs Monitor nitrous oxide (per newly proposed anesthesia guidelines, must have CPR) Place topical local anesthesia	Current duties per state rules/regs Take dental xrays (course & certificate required) Coronal polishing (course, certificate, and 1500 hrs experience required)
Dental Assistant March 2012 (On the Job Trained or grad of CODA DA Program)	No Requirements OJT or Grad of Program	Monitor Nitrous with CPR Current DA duties	Radiology 18 yrs with course Coronal polish 18 yrs old, 1500 hrs exp, with course Current DA Duties

Summary for Proposal for Change in Levels of Nebraska Dental Assisting – Exhibit F

LDA

Functions Not Permitted: Exam, Diagnosis, Treatment Planning, Surgical Procedures (including removal of tooth structure), Prescribing Drugs, Local Anesthesia with Syringe, Scaling and Root planning (removing hard deposits on teeth). Red= new duty, rule, or requirement. Green= suggested edits after 6-19-13 Task Force and NDA Cmt mtg

Level of Dental Assisting	Requirements/Recommendations	Indirect Supervision (Dentist onsite, authorizes procedure)	General Super vision (Dentist not on-site, but has authorized procedure)
Licensed Dental Asst. LDA NDHA Letter November 21, 2013	19 y/o CPR Grad of CODA dental asst prg or OJT (must have 3500 hrs chairside experience) Current DANB certification Pass Clinical competency course and testing for additional procedures. Pass NE jurisprudence exam and Become licensed with HHS and complete CE per UCA	Current duties per state rules/regs Place pit and fissure dental sealants (consider moving to Tier 1, if so, add course) Fit and cement crowns on primary teeth Administer nitrous oxide (would conflict with newly proposed anesthesia guidelines) Take final impressions/records (including digital) for dental prostheses (crowns, bridges, etc.)	Current duties per state rules/regs
LDA NDA BOT/HOD 9/19/2013	19 y/o CPR Grad of CODA dental asst prg or OJT (must have 3500-1500 hrs chairside experience) Current DANB certification or a board approved exam covering any one or more specific duties Pass NE jurisprudence exam Become licensed with HHS and complete CE per UCA	Current duties per state rules/regs Place pit and fissure dental sealants REMOVE FROM ENTIRE PROPOSAL Fit and cement crowns on primary teeth Administer and titrate nitrous oxide (per dentist order) Take final impressions/records (including digital) for dental prostheses (crowns, bridges, etc.)	Current duties per state rules/regs
LDA 8/12/2013	19 y/o CPR Grad of CODA dental asst prg or OJT (must have 3500 hrs chairside experience) Current DANB certification or a board approved exam covering any one or more specific duties Pass NE jurisprudence exam Become licensed with HHS and complete CE per UCA	Current duties per state rules/regs Place pit and fissure dental sealants REMOVE FROM ENTIRE PROPOSAL Fit and cement crowns on primary teeth Administer and titrate nitrous oxide (per dentist order) Take final impressions/records (including digital) for dental prostheses (crowns, bridges, etc.)	Current duties per state rules/regs
LDA June 2013	19 y/o CPR Grad of CODA dental asst prg or OJT (must have 3500 hrs chairside experience) Current DANB certification or a board approved exam covering any one or more specific duties Pass NE jurisprudence exam Become licensed with HHS and complete CE per UCA	Current duties per state rules/regs Place pit and fissure dental sealants (consider moving to Tier 1, if so, add course; or intentionally leave out of statutes altogether) Fit and cement crowns on primary teeth Administer nitrous oxide (would conflict with newly proposed anesthesia guidelines)	Current duties per state rules/regs

	UCA	Take final impressions/records (including digital) for dental prostheses (crowns, bridges, etc.)	
<p>LDA March 2012 (On the Job Trained or grad of CODA DA Program)</p>	<p>Grad of CODA DA program or 3500 hours chairside assisting experience AND Current Dental Assisting National Board Certified (DANB certified/CDA) OR EQUIVALENT BOD approved EXAM Pass NE Jurisprudence exam Become a Licensed LDA with NE HHS CEU's per UCA</p>	<p>Place pit & fissure Sealant with Bd approved course Adapt and cement ss,aluminum/ion/ polycarb crown on deciduous tooth Administer & adjust nitrous/ oxygen levels as directed with Bd approved course</p>	<p>Take final impressions/records for fixed and removable prostheses with Bd approved course All DA duties</p> <ul style="list-style-type: none"> •

Summary Proposal for Change in Levels of Nebraska Dental Assisting - Exhibit F

EFDA

Functions Not Permitted: Exam, Diagnosis, Treatment Planning, Surgical Procedures (including removal of tooth structure), Prescribing Drugs, Local Anesthesia with Syringe, Scaling and Root planing (removing hard deposits on teeth).

Level of Dental Assisting	Requirements/Recommendations	Indirect Supervision (Dentist onsite, authorizes procedure)	General Super vision (Dentist not on-site, but has authorized procedure)
Expanded Function Dental Assistant (EFDA) NDHA Letter November 21, 2013	19 y/o CPR Have 1500 hours as LDA Complete Board approved course such as DANB EFDA one Complete DANB EFDA exam or board approved exam (such as CRDTS or another state equivalent) Obtain EFDA license from HHS and complete CE per UCA	Current duties per state rules/regs All duties of LDA Place and finish dental restorations (fillings, crowns, etc.)	Current duties as per state rules/regs
EFDA NDA BOT/HOD 9/19/2013	19 y/o CPR Have 1500 hours as LDA Complete Board approved course such as DANB EFDA one Complete DANB EFDA exam or board approved exam (such as CRDTS or another state equivalent) Obtain EFDA license from HHS and complete CE per UCA	Current duties per state rules/regs All duties of LDA Place and finish dental restorations (fillings, crowns, etc.)	Current duties as per state rules/regs
EFDA 8/12/2013	19 y/o CPR Have 1500 hours as LDA Complete Board approved course such as DANB EFDA one Complete DANB EFDA exam or board approved exam (such as CRDTS or another state equivalent) Obtain EFDA license from HHS and complete CE per UCA	Current duties per state rules/regs All duties of LDA Place and finish dental restorations (fillings, crowns, etc.)	Current duties as per state rules/regs
EFDA June 2013	19 y/o CPR Have 1500 hours as LDA Complete Board approved course such as DANB EFDA one Complete DANB EFDA exam or board approved exam (such as CRDTS or another state equivalent) Obtain EFDA license from HHS and complete CE per UCA	Current duties per state rules/regs All duties of LDA Place and finish dental restorations (fillings, crowns, etc.)	Current duties as per state rules/regs
EFDA March 2012 (On the Job Trained or grad of CODA DA Program)	19 years of age Have 1500 hr experience as a LDA OR Be a current Registered Dental Hygienist (RDH) complete a NE Board-approved EFDA course Pass written and clinical EFDA exam per NE Dental Bd Obtain an EFDA license from the NE Dental Bd	This was listed under Direct Supervision, which disappeared in 2013 All LDA functions + <ul style="list-style-type: none"> • Place/condense/carve direct & indirect permanent restorative materials CEU's per Uniform Credentialing Act	All DA duties

Summary of Change in Levels of RDH Dental Hygiene Practice – Exhibit F

Level of Practice	Requirements/ Recommendations	Indirect Supervision (Dentist authorized procedure and IS on site)	General Supervision (Dentist authorized procedure but is NOT on site)	Public Health Supervision (Dentist may not be present and services provided in public health or related healthcare settings)
Registered Dental Hygienist (RDH) 11/21/13 NHDA Letter	All current ones in statute	Administer nitrous oxide* (per newly proposed anesthesia guidelines)	Current scope of practice Orofacialmyology ¹ * REMOVE Interim Therapeutic Technique ² * Write prescriptions for mouthrinses and fluoride products that help decrease risk for tooth decay* Take Final impressions Administer local anesthesia and reversal agents	
Registered Dental Hygienist (RDH) 9/19/13 NDA BOT	All current ones in statute	Administer and titrate nitrous oxide (per dentist order)*	Current scope of practice Interim Therapeutic Technique ¹ * Write prescriptions for mouthrinses and fluoride products that help decrease risk for tooth decay* Administer local anesthesia (Pt has documented diagnosis and procedure authorized per dentist order)	
Registered Dental Hygienist (RDH) 8/12/13	All current ones in statute	Administer and titrate nitrous oxide*	Current scope of practice Interim Therapeutic Technique ¹ * Write prescriptions for mouthrinses and fluoride products that help decrease risk for tooth decay* Administer local anesthesia (Pt has documented diagnosis and procedure authorized per dentist order)	
Registered Dental Hygienist (RDH) 6/19/2013	All current ones in statute	Administer nitrous oxide* (per newly proposed anesthesia guidelines)	Current scope of practice Orofacialmyology ¹ * REMOVE Interim Therapeutic Technique ² * Write prescriptions for mouthrinses and fluoride products that help decrease risk for tooth decay* Administer local anesthesia and reversal agents	
Registered Dental Hygienist (RDH) August 2012	All current requirements for DH licensure		Current scope Administer local anesthesia nitrous oxide administration and titration ¹ orofacialmyology with national certification Interim Therapeutic Restoration(ITR) /ART ¹ Prescription authority for topical antimicrobial rinses and Fluoride. ¹ Extraction of teeth w/class 4 mobility ^{1,2}	

<p>Registered Dental Hygienist (RDH) 6/29/12</p>	<p>All current requirements for DH licensure</p>	<p>Current scope Administer local anesthesia nitrous oxide administration and titration orofacialmyology# Interim Therapeutic Restoration(ITT) /ART # Prescription authority for topical antimicrobial and Fluoride.# Extraction of teeth w/class 4 mobility* #</p>	
<p>Registered Dental Hygienist (RDH) June 2012</p>	<p>All current requirements for DH licensure</p>	<p>Current scope Administer local anesthesia nitrous oxide administration and titration orofacialmyology# Interim Therapeutic Restoration(ITT) /ART # Prescription authority for topical antimicrobial and Fluoride.# Extraction of teeth w/class 4 mobility* #</p>	
<p>Registered Dental Hygienist (RDH) April 2012</p>	<p>All current requirements for DH licensure</p>	<p>Current scope Administer local anesthesia nitrous oxide administration and titration fissurotomy to enable sealant placement administer anesthetic reversal agents, orofacialmyology Interim Restorative Technique (IRT) Prescription authority for antimicrobial and Fluoride. Extraction of teeth w/class 4 mobility</p>	
<p>Registered Dental Hygienist (RDH) Sept. 2011</p>	<p>Graduate of accredited Dental hygiene Program pass written and clinical competency exam by testing agency. CRDTS or comparable exam. Pass jurisprudence exam Demonstrate continuing competency Obtain RDH License NE DHHS</p>	<p>Current scope Administer local anesthesia (change to general) Topical disease prevention and management. (laser tx of aphthous ADD <ul style="list-style-type: none"> • nitrous oxide administration • fissurotomy, • Atraumatic Restorative Therapy (ART) • anesthetic reversal agents, </p>	<p>Maintain existing Scope</p>

Summary Proposal for Change in Levels of **EFRDH** Dental Hygiene Practice – Exhibit F

Level of Practice	Requirements/ Recommendations	Indirect Supervision (Dentist authorized procedure and IS on site)	General Supervision (Dentist authorized procedure but is NOT on site)	Public Health Supervision (Dentist may not be present and services provided in public health or related healthcare settings)
<p>Expanded Function Restorative Dental Hygienist (EFRDH) 11/21/13 NDHA Letter</p>	<p>Current RDH and have EFDH license Proof of liability Insurance Completion of course (didactic and clinical) within an accredited dental school or completion equivalent exam from another state. DANB developing national exam for restorative procedures. Pass board approved exam (such as CRDTS)</p>	<p>Place and finish dental restorations* (amalgams, composites, stainless steel crowns) Extraction of primary teeth ready to exfoliate.</p>	<p>Current scope of practice Minor denture adjustments* Place and finish dental restorations* (amalgams, composites, stainless steel crowns) Extraction of primary teeth ready to exfoliate*</p>	<p>Minor denture adjustments^{4*}</p>
<p>Expanded Function Restorative Dental Hygienist (EFRDH) 9/19/2013 NDA BOT</p>	<p>Current RDH and have EFDH license Proof of liability Insurance Completion of course (didactic and clinical) within an accredited dental school or completion equivalent exam from another state. DANB developing national exam for restorative procedures. Pass board approved exam (ie CRDTS)</p>	<p>Place and finish dental restorations* (amalgams, composites, stainless steel crowns) Extraction of primary teeth ready to exfoliate.</p>	<p>Current scope of practice</p>	<p>Minor denture adjustments^{4*}</p>
<p>Expanded Function Restorative Dental Hygienist (EFRDH) 8/12/2013</p>	<p>Current RDH and have EFDH license Proof of liability Insurance Completion of course (didactic and clinical) within an accredited dental school or completion equivalent exam from another state. DANB developing national exam for restorative procedures. Pass board approved exam (ie CRDTS)</p>	<p>Place and finish dental restorations* (amalgams, composites, stainless steel crowns) Extraction of primary teeth ready to exfoliate*</p>	<p>Current scope of practice</p>	<p>Minor denture adjustments^{4*}</p>
<p>Expanded Function Restorative Dental Hygienist (EFRDH) June 2013</p>	<p>Current RDH and have EFDH license Proof of liability Insurance Completion of course (didactic and clinical) within an accredited dental school or completion equivalent exam from another state. DANB developing national exam for restorative procedures. Pass board approved exam (such as CRDTS)</p>	<p>Place and finish dental restorations* (amalgams, composites, stainless steel crowns) Extraction of primary teeth ready to exfoliate*</p>	<p>Current scope of practice Minor denture adjustments*</p>	<p>Minor denture adjustments^{4*}</p>

<p>Expanded Function Restorative Dental Hygienist (EFRDH) August 2012</p>	<p>Current Registered Dental Hygienist (RDH) <u>AND</u> Successful completion of an Expanded Function Dental Hygiene course with didactic and clinical course taught by an accredited dental school. <u>AND</u> Pass CRDT or Equivalent Restorative Exam <u>AND</u> Obtain an EFRDH license NE</p>		<p>Proposed RDH scope Place and finish direct restorations ¹ Extraction of primary teeth ¹ (Lincoln District suggested INDIRECT supervision)</p>	
<p>Expanded Function Restorative Dental Hygienist (EFRDH) 6/29/2012</p>	<p>Current Registered Dental Hygienist (RDH) <u>AND</u> Successful completion of an Expanded Function Dental Hygiene course with didactic and clinical course taught by an accredited dental school. <u>AND</u> Pass CRDT or Equivalent Restorative Exam <u>AND</u> Obtain an EFRDH license NE DHHS</p>		<p>Proposed RDH scope Place and finish direct restorations ***INDIRECT SUPERVISION Extraction of primary teeth ***INDIRECT SUPERVISION</p>	
<p>Expanded Function Restorative Dental Hygienist (EFRDH) April 2012</p>	<p>Current Registered Dental Hygienist (RDH) <u>AND</u> Successful completion of an Expanded Function Dental Hygiene course with didactic and clinical course taught by an accredited dental school. <u>AND</u> Pass CRDT or Equivalent Restorative Exam <u>AND</u> Obtain an Expanded Function license NE DHHS</p>		<p>Current proposed RDH scope minor palliative care of dental emergencies Place and finish direct restorations</p>	
<p>Restorative Dental Hygienist Sept 2011</p>	<p>current Registered Dental Hygienist (RDH) <u>AND</u> Successful completion of a Restorative/Expanded Function Dental Hygiene course with didactic and clinical course taught by an accredited dental school. <u>AND</u> Pass CRDT or Equivalent Restorative Exam <u>AND</u> Obtain a Restorative/ Expanded Function license NE DHHS</p>	<p>Current RDH scope Placing, condensing, and carving amalgam restorations Placing composite restorations Placing Glass Ionomer Restorations Extraction of deciduous teeth that are partially exfoliated with class 4 mobility</p>	<p>Current RDH scope Identification and removal of decay using hand instrumentation and placing a temp. filling (ART) including glass ionomer and other palliative materials adjust partials and dentures placing soft. reline in dentures, minor palliative care of dental emergencies</p>	

Proposal for Change in Levels of (PHRDH) Dental Hygiene Practice – Exhibit F

Level of Practice	Requirements/ Recommendations	Indirect Supervision	General Supervision	Public Health Supervision <small>(Dentist may not be present and services provided in public health or related healthcare settings)</small>
Public Health Dental Hygienist (PHRDH) 11/21/2013 NDHA Letter	Current RDH and have public health permit Proof of liability Insurance Authorization from and report to HHS			Current scope of practice Provide a dental hygiene diagnosis Orfacialmyology ¹ REMOVE —with national certification Periodontal debridement Topical anesthetic Local anesthetic and reversal agents with a DDS or MD order. Interim Therapeutic Technique ² * Prescriptions for topical mouthrinses and fluoride that decrease risk for decay* Extraction of primary teeth that meet specific criteria and are ready to exfoliate ³ * Minor denture adjustments and denture reline Palliative care to include, but not limited to, smoothing a rough edge of a tooth Current scope of practice Interim Therapeutic Technique1 * Prescriptions for topical mouthrinses and fluoride that decrease risk for decay* Extraction of primary teeth that meet specific criteria and are ready to exfoliate2*
Public Health Dental Hygienist (PHRDH) 9/19/2013 NDA BOT	Current RDH and have public health permit Proof of liability Insurance Authorization from and report to HHS			Current scope of practice Interim Therapeutic Technique1 * Prescriptions for topical mouthrinses and fluoride that decrease risk for decay* Extraction of primary teeth that meet specific criteria and are ready to exfoliate2*
Public Health Dental Hygienist (PHRDH) 8/12/2013	Current RDH and have public health permit Proof of liability Insurance Authorization from and report to HHS			Current scope of practice Interim Therapeutic Technique1 * Prescriptions for topical mouthrinses and fluoride that decrease risk for decay* Extraction of primary teeth that meet specific criteria and are ready to exfoliate2*
Public Health Dental Hygienist (PHRDH) June 2013	Current RDH and have public health permit Proof of liability Insurance Authorization from and report to HHS			Current scope of practice Orofacialmyology1 REMOVE Interim Therapeutic Technique ² * Prescriptions for topical mouthrinses and fluoride that decrease risk for decay* Extraction of primary teeth that meet specific criteria and are ready to exfoliate ³ *

<p>Public Health Dental Hygienist (PHRDH) August 2012</p>	<p>NE License to practice Dental Hygiene Proof of liability Ins. Authorization from NE DHHS/Report to DHHS</p>			<p>Services to all individuals in a public health or healthcare setting. Periodontal debridement Topical anesthetic Interim Therapeutic Restoration (IRT)/ART¹ Prescription authority for topical antimicrobial and Fluoride Rinses ¹ Ext. of primary teeth ^{1,2,3} Ext. of permanent teeth with standing order of physician or dentist for palliative purposes ^{1,2,3} Orofacialmyology with National Certification</p>
<p>Public Health Dental Hygienist (PHRDH) 6/29/2012</p>	<p>NE License to practice Dental Hygiene Proof of liability Ins. Authorization from NE DHHS/Report to DHHS</p>			<p>Services to all individuals in a public health or healthcare setting. Periodontal debridement Topical anesthetic Interim Therapeutic Restoration (IRT)/ART# Prescription authority for topical antimicrobial and Fluoride # Ext. of primary teeth with class 4 mobility* **# Ext. of permanent teeth with class 4 mobility with standing order of MD * **# Orofacialmyology with National Certification</p>
<p>Public Health Dental Hygienist (PHRDH) April 2012</p>	<p>NE License to practice Dental Hygiene Proof of liability Ins. Authorization from NE DHHS/Report to DHHS</p>			<p>Preventive services to all individuals in a public health or healthcare setting. Prophylaxis, Periodontal debridement; FI- application, sealants, etc. Interim Restorative Techniques (IRT) Prescription authority for antimicrobial and Fluoride Extraction of teeth with class 4 mobility Fissurotomy to enable sealant placement Orofacialmyology with National Certification</p>
<p>Public Health Dental Hygienist (PHRDH) Sept 2011</p>	<p>NE License to practice Dental Hygiene Proof of liability Ins. Authorization from NE DHHS Report to DHHS</p>			<p>Preventive services to individuals in a public health or healthcare setting. Prophylaxis, FI- application, sealants, etc. (reflects LB 330 language)</p>

Exhibit H

Source: DANB Overview of State Requirements for Dental Assistants to Perform Selected Restorative Functions, June 4, 2013

State	Duty Allowed?	Level of Dental Assistant Permitted to Perform Task	Level of Supervision	Education Requirements	Exam Requirements	Work Experience/ On-the-Job Training	Other	
West Virginia	N	A dental assistant may perform only those delegated procedures specified by rule of the board						
Wisconsin	N	Prohibited: Any procedure which may cause damage to patient's teeth or oral cavity which cannot be remedied without professional intervention						
Wyoming	y	Dental Assistant	Direct	Training by the employer or by an accredited school for dental assistants				

States That Expressly Allow Some Level of Dental Assistant to Perform Some Aspect of Placing, Contouring, Finishing, Adjusting and/or Polishing Amalgam and Composite Restorations: 29

Alaska	Georgia*	Massachusetts	Montana*	North Carolina	South Carolina*
Arizona	Idaho*	Michigan	New Hampshire	North Dakota*	Tennessee
California	Illinois	Minnesota	New Jersey	Ohio	Virginia
Colorado*	Kentucky	Mississippi	New Mexico	Oregon	Washington
Florida*	Maine	Missouri	New York	Pennsylvania	

* State expressly allows dental assistants only to polish restorations

States That Do Not Expressly Allow Dental Assistants to Perform and Do Not Expressly Prohibit Dental Assistants from Performing Placing, Contouring, Finishing, Adjusting and/or Polishing Amalgam and Composite Restorations: 4

Indiana	Kansas	Vermont	Wyoming
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States That Expressly Prohibit Dental Assistants from Performing all of these Functions: Placing, Contouring, Finishing, Adjusting and/or Polishing Amalgam and Composite Restorations: 18

(Some additional states allow some but not all of these functions; these are specified with both Y and N in the table and are not included in this list.)

Alabama	District of Columbia	Maryland	Rhode Island	West Virginia
Arkansas	Hawaii	Nebraska	South Dakota	Wisconsin
Connecticut	Iowa	Nevada	Texas	
Delaware	Louisiana	Oklahoma	Utah	

These data are presented for informational purposes and are not intended as a legal opinion about dental practice in any state. Although the information is derived from current state dental practice acts, DANB makes no warranties about the correctness of the information presented herein.

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Analysis of Permission to Delegate Restorative Functions to Dental Assistants: Place, Contour, Finish, Adjust and/or Polish Amalgam and Composite Restorations

Page 23 of 25

Please note: This page contains summary information accompanying a chart prepared by DANB that presents a detailed state-by-state analysis of permission and requirements for delegating the following group of restorative functions to dental assistants: place, contour, finish, adjust and/or polish amalgam and composite restorations. The first list above contains those states that allow some level of dental assistant to perform at least one of the functions in this group. The states where polishing restorations is the only function in this group that dental assistants are permitted to perform are marked with an asterisk. In addition, in the following states, dental assistants are allowed only to place amalgam in a prepared tooth for condensation by the dentist, but may not be permitted to finish the restoration: Arizona, Massachusetts, Mississippi, New Jersey, and North Carolina.

Dental Hygienists: Permitted Functions by State (Dental Practice Acts Overview) Exhibit I

Dental Hygienists Restorative Duties By State

State	Apply Cavity-Liners & Bases	Place & Remove Temporary Restorations	Place/Remove Temporary Crowns	Place/Carve/Finish Amalgam Restoration	Place & Finish Composite Resin Silicate Restoration	Requirements
AK				Allowed*	Allowed*	Board Approved Course WREB or Equivalent Exam
AL	Allowed*	Allowed*	Place Only*	Prohibited	Prohibited	
AR				Prohibited	Prohibited	Program
AZ		Place*				
CA				Allowed*	Allowed*	Requires RDAEF License
CO						
CT		Prohibited		Prohibited	Prohibited	
DC	Prohibited	Allowed		Prohibited	Prohibited	
DE		Prohibited	Prohibited	Prohibited	Prohibited	
FL	Allowed	Allowed	Allowed	Prohibited	Prohibited	
GA	Allowed*		Allowed*			
HI				Prohibited	Prohibited	
IA	Allowed*	Allowed*				
ID	Allowed*		Place Only*	Allowed	Allowed	Restorative Endorsement. WREB or Equivalent Restorative Exam.
IL				Prohibited	Prohibited	
IN						
KS						
KY	Allowed*		Allowed*	Allowed*	Allowed*	Proof of competency.
LA				Prohibited	Prohibited	
MA	Prohibited	Remove Only*	Allowed*	Prohibited	Prohibited	
MD		Allowed	Allowed	Prohibited	Prohibited	
ME		Allowed	Allowed*	Allowed*	Allowed*	Board approved FDH program

*Can do services by virtue of inclusion in dental assistants scope of practice. Please check practice act for education requirements.

1 | Prepared by staff of the American Dental Hygienists' Association, May 2010

Dental Hygienists Restorative Duties By State

State	Apply Cavity-Liners & Bases	Place & Remove Temporary Restorations	Place/Remove Temporary Crowns	Place/Carve/Finish Amalgam Restoration	Place & Finish Composite Resin Silicate Restoration	Requirements
TX	Prohibited	Prohibited	Prohibited	Prohibited	Prohibited	
UT						
VA						
VT						
WA		Allowed*	Allowed*	Allowed*	Allowed*	Trainings expanded function, Restorative services in curriculum of Washington Dental Hygiene programs. WREB restorative required for dental hygiene license.
WI		Place Only				Replacement of temporary restorations in emergency situations only.
WV	Allowed*	Allowed*	Allowed			
WY		Place Only		Allowed (with EP Certificate)	Allowed (with EP certificate)	Expanded function certificate no longer offered, but existing certificates honored.

Disclaimer: Information based on staff research of state statutes and legislation. This document should not be considered a legal document.



*Can do services by virtue of inclusion in dental assistants scope of practice. Please check practice act for education requirements.

3 | Prepared by staff of the American Dental Hygienists' Association, May 2010

Exhibit J

Summary of Missouri Rules and Regulations For Dental Assistant Including Expanded Functions.

All of the expanded functions (EF) for dental assistants are under direct supervision.

Direct supervision:

- The dentist is in the dental office or treatment facility, has personally diagnosed the condition to be treated, personally authorized the procedures
- The dentist remains in the dental office or treatment facility while the procedures are being performed by the dental auxiliary
- The dentist evaluates the performance of the dental auxiliary before the dismissal of the patient.

Expanded functions approved course

-A provider of EF curriculum and competency testing approved by MO Dental Board (MDB)

-EF permit – issued by MDB authorizing a DA, CDA and LDH to perform EF duties upon delegation from a Missouri Licensed dentist.

-EF permits will be issued in the following categories: Restorative I, Restorative II, Removable Prosthodontics, Fixed Prosthodontics, and Orthodontics.

- Missouri Test of Basic DA Skills Test (approved by MDB) includes: terminology, principles of asepsis, disinfection and sterilization, and other concepts of DA deemed necessary to master for advanced skills.
- Proof of competence documentation: diploma, certificate of mastery or letter from an approved course provider or competency testing agent stating that the DA has completed the MDB successfully with competency testing.
 - Proof of certification as CDA from DANB, and showing graduation from accredited DA Program with competency testing in appropriate EF module
 - Proof of competence of Missouri Test of Basic DA skills and that the DA has completed a board approved EF training course
 - Current CPR
 - Permits renewed every 5 years with 16 hours of CE directly related to the EF.

Categories of Expanded Functions

1. Restorative I
 - a. Sizing and cementing of prefabricated crowns
 - b. Placing, condensing and carving amalgam for Class I, V, and VI restorations
 - c. Placing composite for Class I, V, and VI restorations
 - d. Minor palliative care for dental emergencies
2. Restorative II
 - a. Sizing and cementing of prefabricated crowns

- b. Placing, condensing, carving and finishing amalgam for Class I, II, III, IV, V, and VI restorations
 - c. Placing and finishing composite for Class I, II, III, IV, V, and VI restorations
 - d. Minor palliative care of dental emergencies
- 3. Orthodontics
 - a. Preliminary bending of arch-wire
 - b. Removal of orthodontic bands and bonds
 - c. Final cementation of any permanent appliance or prosthesis
 - d. Making impressions for the fabrication of any removable or fixed prosthesis/appliance
 - e. Placement and cementation of orthodontic brackets or band
- 4. Prosthodontics Fixed
 - a. Place retraction cord in preparation for fixed prosthodontics impressions
 - b. Extra-oral adjustments of fixed prosthesis
 - c. Extra-oral adjustment of removable prosthesis during and after insertion
 - d. Final cementation of any permanent appliance or prosthesis
 - e. Making impressions for the fabrication of any removable or fixed prosthesis
- 5. Prosthodontics Removable
 - a. Placement of temporary soft liners in a removable prosthesis
 - b. Extra-oral adjustments of removable prosthesis during and after insertion
 - c. Minor palliative care for dental emergencies
 - d. Making impressions for the fabrication of any removable or fixed prosthesis/appliance

Expanded Functions Providers:

Must be approved by the MDB and satisfy the following requirements:

- 1. Curriculum approved by board
- 2. Faculty at each course must include a dentist with a ratio of 1 to 10
- 3. Adequate faculty calibration
- 4. Adequate testing, monitoring and evaluation
- 5. Provide the board data on the outcomes of EF

Prohibited Acts of an EFDA:

- 1. Diagnosis,
- 2. Cutting of tooth structure
- 3. Surgical procedures on hard or soft tissues
- 4. Prescription, injection and administration of drugs
- 5. Final bending of arch-wires
- 6. Scaling of teeth
- 7. Administration of nitrous

Exhibit K

NDA Newsletters 2010 -2013

President's Message

Change



Dr. Jack Wesch

Many years ago I helped my children set up a stone polisher out in the garage. In the garage because this thing had to run constantly for weeks on end and the noise was objectionable. The principle was simple, you placed a bunch of stones in this drum that rotated on a horizontal axis and as the stones constantly tumbled over each other the friction would wear off the rough edges and acquired outer coating to reveal the beauty of the gem inside.

Not unlike the Task Force dedicated to the Future of Teamwork in the Delivery of Oral Health Services. For the Task Force the container (or drum) is the room we select to hold the meeting in (do we dilute this essential by using conference calls?) Just like my kids always wanting to open the drum and see what's happening (impatience) people inside and outside the Task Force find their impatience bubbling to the surface.

When you bring together people with diverse backgrounds, diverse agendas, diverse personalities, diverse mental models - one sees a lot of rough edges and facades. Time is the only remedy that allows the frictions to abate. Just like stones, each person has their own unique hardness. Some wear away to dust in no time at all and some maintain their sharp edges and façade until you discount or discard them. Success with the stone polisher is to emerge with some real "gems." Success with a container of people (i.e., a Task Force) is to emerge with a group that has molded into a force. A group that has realized we have a lot to learn and we need to learn together. We need to learn how to think and think how to learn.

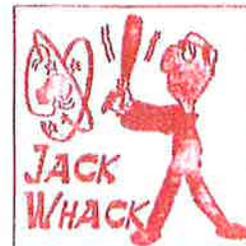
We have learned throughout our lives the old adages about change. Change is inevitable. The only thing constant is change. You can't stop change. Well --- they are all true. How we deal with

change is the variable. When a typical organization is faced with new information about change they react by 1) doing nothing with the information or 2) go on a witch hunt. One of these responses is bad and the other is even worse.

In 1969, Avrom King spoke the final day of our NDA annual session. It was poorly attended and Avrom was not yet well known. Avrom was a "futurist" and spoke about the future for dentistry. He told a story that really impacted me:

In your mind go back to the 13th century. Imagine you were a monk in a monastery on a hillside and in this monastery you were assigned a cubicle in which you slept and worked nearly 24 hours a day. Your job is that of luminary, one who with quill and ink will copy the gospel letter by letter onto paper. Every other day you do the gold embossing on the page you penned the day before. In your lifetime you would possibly complete one bible.

Now picture you wake up one morning and you hear a commotion in the adjoining cubicle. You step up onto your chair and peer over the wall. There sets a brand new Xerox machine. Don't mind the incidentals like electricity just realize there sets a Xerox machine, capable of doing in one day what you spent a lifetime on. Now you can exhibit one of six behaviors. You could exhibit denial, shake your head, think you are dreaming and just go back to your normal routine of business as usual. You could exhibit anger, go into a rage and do something hostile like dump rocks into the machine. You could exhibit apathy, shake your head and mutter "woe is me" as you stumble back to bed and sink into depression. You could demonstrate sublimation and relieve yourself via substitution by taking a bottle of liquor and crawling over the nunnery wall. You could display distorted reality perception, form an organization to oppose this invasion and lobby the people to ban the dang thing or at least regulate it into worthlessness. Or you could adopt the behavior that Carl Menninger called accommodation. You could look with new eyes and say "wow! with this change I have my life back. I have more time to be in touch with myself



and my spiritual side. I can now do more for the ones I serve. I can learn new things. I have a gift of that most precious of all assets - time."

So, how is the Task Force on the Future of Teamwork in the Delivery of Oral Health Service doing? Quite well, thank you! From the inside I can tell you, I observe some real gems beginning to shine. The rotating drum is far from done. There is still some real facades, some real sharp corners, some hardened surfaces unpolished. We are slowly adding some new stones and some stones have set in the corner hoping to not lose their distinguishing sharp edges and hiding behind their facades.

"If we accept that the problem dentistry is facing is the unmet dental needs of our society, we have the opportunity to practice accommodation. We must have an honest answer to the questions "Is our present business model somehow contributing to the problem?" And, "do we have enough reasons to heal?"

So, how do we have these productive conversations that promote learning together? We know "speaking out" is a sure way to thwart progress (i.e., "we all speak our minds here but no one's mind is ever changed" equals worthless conversation.) Posturing and pursuit of individual agendas ultimately will thwart significant innovation. Worse than speaking out is smoothing over. "Terminal politeness" also kills efforts to learn together.

What is necessary is seeing a larger picture than any one of us. Higher levels of trust than we are accustomed to must be built. Willingness to embrace justified change and a good stone polisher will work in time.

NDA Oral Health Task Force

Three Tier Dental Assisting Categories Based on Missouri Model



Dr. Jack Wesch

Task Force Report

ATTN: July 26, 2011 Topeka
Capital Journal headline:

Majority of Kansas counties face dental shortage.

Fourth paragraph in the article:
"Shannon Cotsoradis, president and CEO of Kansas Action for Children, said legislation that would provide better dental care in the state by allowing the training and licensing of registered dental practitioners has been introduced in both chambers of the Kansas Legislature."

"Under the bill, dental practitioners would be able to perform more than 30 procedures, including preparation and restoration of cavities, installation of temporary crowns, and extraction of teeth with a dentist's oversight."

This legislation is backed by three grassroots coalitions and funded by outside NGO dollars.

The Nebraska Dental Association understands we cannot sit still in these changing times or others will gladly make our decisions for us. The task force on the Future of Teamwork



in the Delivery of Oral Health Services has worked diligently to form a team atmosphere which can utilize our current available manpower to answer the needs of Nebraska Citizens.

Our current proposal (with the full backing of the Board of Trustees) is to establish a tiered system of dental assisting. Tier one would be exactly as most people practice today in the relationship of dental assistant and dentist. Tier two would be a licensed dental assistant, would require a level of training and testing and would entail a list of duties they could perform.

Tier three opens the door for Expanded Function Dental Assistants (EFDA's) and as training models are developed would permit the placing of filling materials, etc. I see the Missouri statutes on dental

assisting as a very close match to what we are proposing. Feel free to go to the Missouri website and view in total their dental practice act.

I urge you to extend your comments, suggestions, and concerns to your district delegates so they can bring them to the September 22, House of Delegates meeting for expression.

It is my fervent hope that we realize that our colleagues, the Dental Hygienists, have a key role in developing our answer to the perception of manpower shortage.

Our task force truly believes that acting as a team with all players present and accountable we can design an Oral Health Care Delivery much better than legislatures wading through accusations and innuendos.

President's Message



Dr. Ken Hermesen

As I write this, it is very cold outside with a new layer of snow on the ground and the prospect of spring seems far off. But spring will come as it has since the beginning. It

reminds me that for all of us change is as inevitable as the change of the seasons. Sometimes it is difficult for us to see the change... the guy I see in the mirror looks, more or less, like the guy I saw yesterday. It is only when we have the perspective of time that we see the difference. To illustrate this point, a few days ago a colleague gave me a picture he found of me when I first started teaching some 35 years ago. The guy in the picture bore a resemblance to me except he was about 40 lbs lighter, had a dark brown beard, what hair he had was dark and he looked like he was in pretty good shape. Ugh, I thought, where did that guy go? You have probably heard it said that there are only two things for certain, death and taxes. I think we can add another... change. There was a popular song, *The Times They are a-Changin'*, which describes the struggle involved in change. It was written by singer/songwriter Bob Dylan and certainly could describe the struggle of change in our times. Thing is, that song was written in 1963, some 48 years ago.

The point I am trying to make is that we can't stop change. It is inevitable. But we can make a difference in helping shape the change that is made. Most of you know that over the past two years, Jack Wesch, our former NDA President, has been heading a Task Force to help guide changes in the way we approach expansion of services, particularly services to the underserved populations within our state. Working with representatives from the Nebraska Dental Assistants Association (NDAA), the Nebraska

Dental Hygienists' Association (NDHA) and colleagues from the Nebraska Dental Association, Dr. Wesch has led the Task Force in looking at various practice models that may help address some of the barriers-to-care issues that we face. At the last Board of Trustees meeting Dr. Wesch brought forth a proposal from the Task Force with an important provision for the development of a new level of dental assistant called the "Expanded Functions Dental Assistant" or EFDA. Under the direct supervision of a dentist, the provision would allow a significant expansion of duties performed by highly trained, motivated dental auxiliaries.

EFDA's are not a new concept. When I graduated from dental school in 1975, I started teaching one day a week at Creighton in what they called the Team Clinic. This clinic had six (or perhaps eight) highly trained, very competent dental assistants who performed expanded functions, including placing rubber dams, taking impressions, making temporary restorations and placing amalgam and composite restorations. For example, in the placement of an amalgam or composite restoration, the dental student would diagnose and treatment plan the case, administer the anesthetic, prepare the tooth and check the final product. You can fill in the steps in between that were all accomplished by the dental assistant. The purpose of the Team Clinic was to train the dental students in how to maximize utilization of the expanded function dental assistants. At the time, and remember this was 1975, it was thought that this was the way dental practices would likely be run in the not-too-distant future. Over time, some states moved forward with this practice modality. Others, like Nebraska, did not.

In the coming weeks and months, you will hear more about the work of the Task Force and the development of the EFDA in Nebraska. From my personal, very positive experience with the TEAM

assistants I can see the tremendous help well-trained EFDA's could bring to some of our colleagues, particularly general practices, pediatric practices and Federally Qualified Health Center practices that see a high percentage of Medicaid patients. There may need to be some "tweaking" of the exact provisions brought forward by the Task Force on EFDA's, but I think the time has come for us to move forward to adopt the EFDA model. For those of you who see no benefit to your practice or your patients by utilizing an EFDA, your Board of Trustees are sensitive to your position and will strive to ensure that there will be no change in the way you currently practice. Addition of the EFDA provision would apply only to those who feel it would benefit their patients and practice. For more information, I encourage all of you to talk to your Trustee, District Delegates, any of the Leadership or to contact Jack Wesch to express your opinions on this issue.

The Legislative season is well underway with several bills of interest to the NDA. David O'Doherty testified on our behalf on LB 810, the "non-covered services bill", and was encouraged by the response from the legislators. We are also engaged in educating the legislators regarding the negative effects of eliminating adult Medicaid, a move the NDA strongly opposes. Indications are that our efforts are having a positive effect.

In closing, I want to express my appreciation to the members of the Board of Trustees and House of Delegates for the job they have done this year. One of my goals was to keep the BOT and HOD members better informed of the activities of the Association and to encourage them to be more engaged in the process of governing. I am very pleased to report that they have responded in a big way. If you see your Trustee or House of Delegate members, please thank them for the time and effort they have devoted to governing your Association.

House of Delegates

April 12, 2012 - Embassy Suites

ADA President **Dr. William R. Calnon** attended the NDA's Board of Trustees and House of Delegates session, stressing the importance of organized dentistry to be collaborative, proactive and assertive.



The House of Delegates also debated the proposed dental assisting proposal from the Oral Health Task Force.



Above Left: ADA President Dr. William R. Calnon

Above: Lincoln District Delegates caucusing before discussion of the proposed Task Force dental assisting duties chart.



Left: NDA House of Delegates approves the proposed dental assisting chart shown below. Before moving forward with dental assisting duties, the Task Force will focus on a proposal for expanded hygiene.

The Future of Teamwork in the Delivery of Oral Health Services- Dental Assistant

Functions Not Permitted: Exam, Diagnosis, Treatment Planning, Surgical or Cutting Procedures, Pulp Capping, Prescribing Drugs, Administer Anesthesia (Other than Topical and Nitrous Oxide as listed) & Supra and Sub Gingival Scaling and Root Planning, Extractions

Title	Requirements	Direct Supervision	Indirect Supervision	General Supervision
Dental Assistant (DA)	No Requirements OJT or Grad of Program		Monitor Nitrous with CPR Current DA duties	Radiology 18yrs with course Coronal polish 18yrs old, 1500 hrs exp, with course Current DA Duties
Licensed Dental Assistant (LDA)	Grad of CODA DA program or 3500 hours chairside assisting experience AND Current Dental Assisting National Board Certified (DANB certified/CDA) OR EQUIVALENT BOD approved EXAM Pass NE Jurisprudence exam Become a Licensed LDA with NE HHS CEU's per Uniform Credentialing Act	Place pit & fissure Sealant with Bd approved course Adapt and cement ss/alum/ion/ polycarb crown on deciduous tooth Administer & adjust nitrous/ oxygen levels as directed with Bd approved course	Take final impressions/records for fixed and removable prostheses with Bd approved course All DA duties	All DA duties
Expanded Function Dental Auxiliary (EFDA)	19 years of age 1500 hr experience as a LDA OR Be a current RDH Complete a NE Board-approved EFDA course Pass written and clinical EFDA exam per NE Dental Bd Obtain an EFDA license from the NE Dental Bd CEU's per Uniform Credentialing Act	All LDA functions (with course) + Place/condense/carve direct & indirect permanent restorative materials	All LDA and DA duties	All DA duties

Direct supervision - Dentist is physically present, authorizes the procedure, remains in office while procedure is performed and before dismissal of the patient, evaluates the performance of the procedure.

Indirect supervision - Dentist is physically present, authorizes the procedure, and remains in office while procedure is performed. (Evaluation of the procedure prior to dismissal is optional- at the preference of the dentist)

General supervision - A dentist has authorized the procedure, but is not physically present in the office.

House of Delegates

NDA Expanding Practice Scopes Committee Established

BACKGROUND

The Lincoln District Dental Association (LDDA) would like to acknowledge the dedication, countless hours, meetings, discussions and forethought by this Task Force Committee in regards to the proposed Credentialing Review for Expanding Scopes of Practice for Dental Hygiene & Assisting. We appreciate the proactive nature of this Task Force in the search for a solution that is specific for the needs of Nebraskans. It is our hope to have this issue addressed before some well-financed Foundation(s) propose alternative non-dentist providers for Nebraska. The three tier [Assistant] model, TaskForce March 30th revised 3 tier was approved at the April 2012 House of Delegates.

The LDDA Delegates met and thoroughly discussed the proposed Credentialing Review for Expanding Scopes of Practice for Dental Hygiene & Assisting. It is our belief that it is time to have the NDA refine and come to consensus on this issue, namely Expanding Scopes of Practice for Dental Hygiene & Assisting. With the Nebraska Dental Association role as a leader of the dental team let it be,



10th District ADA Trustee, Dr. James Zenk, swears in the 2013-2014 NDA Officers (l to r): Dr. Deb West - Speaker of the House, Dr. Mike Neal - Secretary, Dr. Gary Westerman - Treasurer, Dr. Henry St Germain - Immediate Past President, Dr. Merlyn Vogt - Vice President, Dr. Scott Wieting - President and Dr. Randy Nordstrom - President-Elect.

Resolved:

a) The House of Delegates create a NDA Committee with one or more member dentist representative(s) from each NDA district along with dentists from the Task Force as ex officio members and in addition the opportunity for representation from each dental specialty. The representatives will be chosen by each district and specialty

b) The responsibility of the NDA Expanding Practice Scopes Committee will be to update the work from the current Task Force including the 407 process, charts and application.

c) The Committee will prepare an updated Proposal to be presented at the September 2013 NDA House of Delegates meeting.



From the Trenches



David J. O'Doherty

Early this summer, the Board of Dentistry (B O D) submitted a 4 0 7 Application to update the Sedation Statutes and Regulations

to comply with the ADA guidelines issued in 2007.

The 407 process involves submitting an Application to modify any statutes that affect the practice of dentistry. A Technical Review Committee (TRC) is selected by HHS and chaired by a member of the Board of Health. Several meetings are held to allow interested parties to testify for or against any or all of the Application. The TRC submits a final report to the Board of Health. The Board reviews the report and submits its own recommendation to the Chief Medical Officer of HHS. The CMO then submits a report to the Legislature HHS Committee. All of this leading up to a proposed piece of Legislation for the upcoming session.

The BOD's Sedation Application included expansion of duties for hygienists and assistants as it related to Inhalation Analgesia. The NDA Board of Trustees thought this section of the BOD's Application should be removed and included with the Expanded Duties Task Force work shown on pages 10 & 11:

You can read the BOD's Application on the HHS website at <http://dhhs.ne.gov/pages/CredReviewDentalAnesthesia.aspx>

The NDA Expanding Practice Scopes Committee met at Wilderness Ridge Lodge on August 12th (above right) to review the charts that you see on pages 10 & 11. If you have any



questions or comments regarding the charts, please contact one of the members of the Committee. These charts will be reviewed, debated and voted on at the September 20th NDA House of Delegates. These charts will also be available on the NDA Member website under the House of Delegates tab.

2013 NDA Expanding Practice Scopes Committee

- Omaha** - Drs. Jenn Hasslen & Chris Foix
- Lincoln** - Drs. Cliff Leffingwell & Chris Haag
- SW** - Dr. Chuck Bauer
- Central** - Dr. Mark Minchow
- Perio** - Dr. Dennis Anderson
- Pros** - Dr. Paul Sheridan
- Endo** - Dr. Ken Hermsen

- Ortho** - Dr. Phil Samuels
- Pedo** - Drs. Brent Johnson & Eric Hodges
- Public Health**: Dr. Karen Bober
- Oral** - Dr. Monte Zysset

As part of the NDA's Strategic Plan, the Board of Trustees has looked into redistricting the NDA. The redistricting research was chaired by **Dr. Tom Fagot**. The map below is the proposed NDA redistricting that the Board of Trustees and House of Delegates will discuss and vote on at the September 20th meeting in Kearney.

We are excited for the permanent tailgating spot at the Grand Manse, show on the map to the right. Hope to see you there August 31!



Expanded Function Auxiliaries

Oral Health Task Force Current Proposals before the NDA

Proposal for Change in Levels of Nebraska Dental Assisting (Aug 12 2013)

Functions Not Permitted: Exam, Diagnosis, Treatment Planning, Surgical Procedures (including removal of tooth structure), Prescribing Drugs, Local Anesthesia with Syringe, Scaling and Root planing (removing hard deposits on teeth). **Red**= new duty, rule, or requirement. **Green**= suggested edits after 6-19-13 and 8-12-13 NDA Cmt Mtg **Blue**= discussion points following NDA/NDHA mtg July 16, 2013)

Level of Dental Assisting	Requirements/Recommendations	Indirect Supervision (Dentist onsite, authorizes procedure)	General Super vision (Dentist not on-site, but has authorized procedure)
Dental Assistant	19 y/o REMOVE Infection control training (per fed OSHA requirement) CPR (highly recommended) May be OJT or grad of CODA dental asst prg	Current duties as outlined in state rules/regs Monitor nitrous oxide (must have CPR) Place topical local anesthesia	Current duties per state rules/regs Take dental xrays (course & certificate required) Coronal polishing (course, certificate, and 1500 hrs experience required)
Licensed Dental Assistant (LDA)	19 y/o CPR Grad of CODA dental asst prg or OJT (must have 3500 hrs chairside experience) Current DANB certification or a board approved exam covering any one or more specific duties Pass NE Jurisprudence exam Become licensed with HHS and complete CE per UCA	Current duties per state rules/regs Place pit and fissure dental sealants REMOVE FROM ENTIRE PROPOSAL. Fit and cement crowns on primary teeth Administer and titrate nitrous oxide (per dentist order) Take final impressions/records (including digital) for dental prostheses (crowns, bridges, etc.)	Current duties per state rules/regs
Expanded Function Dental Assistant (EFDA)	19 y/o CPR Have 1500 hours as LDA Complete Board approved course such as DANB EFDA one Complete DANB EFDA exam or board approved exam (such as CRDTS or another state equivalent) Obtain EFDA license from HHS and complete CE per UCA	Current duties per state rules/regs All duties of LDA Place and finish dental restorations (fillings, crowns, etc.)	Current duties as per state rules/regs

Abbreviations: OJT = on the job trained DANB= Dental Assisting National Board CE=Continuing Education UCA = Uniform Credentialing Act
CPR= cardiopulmonary resuscitation Board = NE Board of Dentistry CODA=Commission on Dental Accreditation

Points the NDA Cmt would like the Task Force to Consider Regarding Dental Assisting Proposal (as of June 19, 2013 mtg):

1. Get a legal opinion on what is the appropriate age for an entry level dental assistant.
2. Much discussion over whether pit and fissure sealants belong in Tier I or II. Final consensus was they should go in Tier I because the goal of sealants is "not to place the perfect sealant." The overarching goal and intent of the entire proposal is to break down barriers to care, create more efficient dental teams, and serve more patients (particularly those that have less access to care).

Healthy People 2020 states as their goals:

OH-7: Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year. Target: 49.0 percent. Baseline: 44.5 percent of persons aged 2 years and older had a dental visit in the past year in 2007. Target setting method: 10 percent improvement. Data source: Medical Expenditure Panel Survey (MEPS), AHRQ.

OH-8: Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year. Target: 29.4 percent. Baseline: 26.7 percent of children and adolescents aged 2 to 18 years at or below 200 percent of the Federal poverty level received a preventive dental service during the past year in 2007. Target setting method: 10 percent improvement. Data source: Medical Expenditure Panel Survey (MEPS), AHRQ.

OH-12.2 Increase the proportion of children aged 6 to 9 years who have received dental sealants on one or more of their permanent first molar teeth. Target: 28.1 percent. Baseline: 25.5 percent children aged 6 to 9 years received dental sealants on one or more of their first permanent molars in 1999-2004.

OH-12.3 Increase the proportion of adolescents aged 13 to 15 years who have received dental sealants on one or more of their permanent molar teeth. Target: 21.9 percent. Baseline: 19.9 percent of adolescents aged 13 to 15 years received dental sealants on one or more of their first permanent molars and one or more second permanent molars in 1999-2004. Target setting method: 10 percent improvement. Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

Medical Data

53% of Nebraska Medicaid eligible children received any dental care in 2010 (Nebraska State Oral Health Plan 2011).

3. Consensus was to keep the 3 Tiers overall. However, much discussion took place about reducing it two. The advantage of keeping the LDA Tier I is because the Board of Dentistry can more easily authorize education and credentialing.
4. The proposal SHOULD include a change in statute that allows the Board of Dentistry to regulate all members of the dental team's need for education and/or permits regardless of licensure.

Expanded Function Auxiliaries

Proposal for Change in Levels of Dental Hygiene Practice (Aug 12, 2013)

Functions not permitted: Diagnosis, preparation of the tooth surface for permanent restorative purposes. **Red** = new duties or requirements. **Green** = New suggestions since Task Force mtg and NDA cmt mtg on 6-19-13 and 8-12-13. **Blue** = discussion at July 16th mtg with NDA and NDHA

Level of Practice	Requirements/ Recommendations	Indirect Supervision (Dentist authorized procedure and IS on site)	General Supervision (Dentist authorized procedure but is NOT on site)	Public Health Supervision (Dentist may not be present and services provided in public health or related healthcare settings. Must have collaborative agreement with dentist)
Registered Dental Hygienist (RDH)	All current ones in statute	Administer and dilute nitrous oxide (per dentist order) □	Current scope of practice Interim Therapeutic Technique ¹ * Write prescriptions for mouthrinses and fluoride products that help decrease risk for tooth decay* Administer local anesthesia (PT has documented diagnosis and procedure authorized per dentist order)	
Public Health Dental Hygienist (PHRDH)	Current RDH and have public health permit Proof of liability insurance Authorization from and report to HHS			Current scope of practice Interim Therapeutic Technique ¹ * Prescriptions for topical mouthrinses and fluoride that decrease risk for decay? Extraction of primary teeth that meet specific criteria and are ready to exfoliate ² *
Expanded Function Restorative Dental Hygienist (EFRDH)	Current RDH and have EFDH license Proof of liability insurance Completion of course (didactic and clinical) within an accredited dental school or completion equivalent exam from another state. *DANB developing national exam for restorative procedures. Pass board approved exam (ie CRDTS)	Place and finish dental restorations* (amalgams, composites, stainless steel crowns) Extraction of primary teeth ready to exfoliate*	Current scope of practice	Minor denture adjustments*

1. Definition of Interim Therapeutic Technique (ITR)

Use of a glass ionomer (tooth colored restoration) where fluoride release is needed. ITR and ART (atraumatic/alternative restorative technique) have similar techniques but different therapeutic goals. ITR may be used in very young patients, uncooperative patients, or patients with special health care needs for whom traditional cavity preparation and/or placement of traditional dental restorations are not feasible or need to be postponed. Additionally, ITR may be used for caries control in children with multiple open carious lesions, prior to definitive restoration of the teeth. ART, endorsed by the World Health Organization and the International Association for Dental Research, is a means of restoring and preventing caries in populations that have little access to traditional dental care and functions as definitive treatment. This typically involves use of a hand instrument or slow speed rotary instrument to remove decay and placing the tooth colored filling with a hand instrument. It does not involve anesthetizing the patient. Also, approved by the World Health Organization, American Dental Association, American Association of Public Health Dentistry, and American Academy of Pediatric Dentistry.

2. Extractions of primary teeth in public health settings:

- Tooth must be ready to exfoliate.
- Patient is without a dental home.
- Tooth is interfering with eating, causing pain, or interfering with eruption of permanent tooth.
- Extraction must appear simple enough to remove without traditional forcep. (NDHA WOULD LIKE NDA TO RECONSIDER THIS POINT)
- Must obtain informed consent from child's legal guardian.
- Hygienist must have a collaborative agreement with a dentist to diagnose need for extraction AND in case of complications.

3. Minor Denture Adjustment Criteria in public health settings:

- Must consult with dentist of record if available
- Must have a collaborative agreement with a dentist in case consultation needed and/or complications arise
- Must document adjustment in patient's dental and/or medical record

Definition of "Dental Home" is the ongoing relationship between the dentist and the patients, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

Other abbreviations:

OJT = on the job trained

UCA = Uniform Credentialing Act

ITR = Interim Therapeutic Technique

DANB = Dental Assisting National Board

CPR = Cardiopulmonary resuscitation

ART = Atraumatic Restorative Technique

CE = Continuing Education

Board = NE Board of Dentistry

* Must take a Board approved course

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