

January 12, 2015

Wayne Stuberg, PT (Chair)
Members, 407 Technical Review Committee
c/o Ronald Briel
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Dear Dr. Stuberg and Members of the Committee:

Please find attached the written testimony provided by Dr. Melanie Steckelberg at the hearing on January 8, 2015. I represent the Lincoln District as their Trustee to the Nebraska Dental Association.

I am a Lincoln dentist both in private practice for 10 years, concurrently working part-time at the Health Department for the last 7 years. I was also a part-time clinical instructor at the dental college for almost 5 years. During my time as a clinical instructor, I taught dental students in the undergraduate periodontics clinic. Within the last months of each student's 4-year-dental program, I witnessed every student drastically improve their diagnostic abilities, critical thinking skills, clinical techniques, and chairside manner. The skills necessary to DIAGNOSE require the full length of the program for a dentist degree. However, the NDA and NDAA are NOT proposing for dental hygienists to diagnose NOR provide any treatment that is irreversible. I am asking the Committee to move the NDA and NDAA Proposal forward. - This proposal will not completely solve the access to care issue, but it will let us be more efficient in providing timely treatment to the patients that desire the dental care. Unfortunately one-third of the U.S. population has not seen a dentist within the past year. I have done dental screenings at two LPS schools for the past 5 years, one school is very high needs and the other is not. The total number of students in my screenings has decreased; however, the number of children with significant dental needs has not decreased. Therefore, I am screening fewer students, but more of those students have significant amounts of dental decay. Students identified as having the highest dental needs, are given access to both FREE dental care and transportation to the health department during the spring semester each year. Parents are welcome to ride the bus with their child from the school, but are not required to do so. Unfortunately, there is still an issue where more than one family won't consent to dental treatment for their child, even after the nurse has sent home notes and even made home visits to discuss why this dental treatment is necessary for their child. We cannot fix the access issue for those that refuse dental care.

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

In my private practice in Lincoln, I do not plan to utilize these expanded functions in the near future. However, I can see this occurring at the health department and I appreciate the benefit expanded functions will provide pediatric practices, with a dentist remaining the head of the dental team and the only dental provider performing any irreversible procedures. The military has long used EFDAs (the Expanded Function Dental Assistants) in dental practice, where the same dental assistant stays with the patient during the entire appointment, while the dentist and expanded function dental hygienist or assistant rotate positions through the treatment rooms. The dentist would diagnose, prepare the tooth, and discuss with the patient the dental auxiliary's role, to place and finish today's dental restoration. This would allow more patients to be treated in a day. The settings that would likely utilize expanded functions, have more than 50% of their practice patients within the Medicaid program. We need to help our pediatric dentists treat more of the underserved, by expanding the scope of practice of dental auxiliaries.

The Committee was concerned regarding our model including both regulated and unregulated professionals. We must retain the ability for dentists to continue to train dental assistants on-the-job, which has no documented safety issues in Nebraska, in order to have dental assistants available for rural dental offices. The dental practice act lacks definition of what procedures can be legally delegated to dental assistants. Advancing our proposal would give legal parameters that "yes, Dental Assistants can do this," and give the Dental Board the authority to adopt and promulgate rules and regulations, including educational requirements for those dental professionals.

Expanded Function Restorative Dental Hygienists (EFRDHs) and Expanded Function Dental Assistants (EFDAs) would provide dental treatment, such as placing and carving fillings, but absolutely no preparation.

A current diagnosis from a dentist is required prior to any irreversible procedure, as cavities do not remain stagnant. Here is why: showed photos 9 months apart with significant caries rendering the tooth no longer salvageable.

Class I restorations are on the chewing surfaces of the back teeth; these areas are covered with many nooks and crannies, which conceal the true depth of decay until the tooth is opened up, meaning the preparation has already started. Class V restorations are along the gumline, and unfortunately can wrap around the full circumference of the tooth. Both of these restoration categories have a higher chance of undiagnosed pulp exposure than a Class II, III, or IV restoration, in my opinion. Why? It is complicated, but x-rays will best predict decay depth on only older patients. Children have much larger pulp chambers than adults do - the root

canal is closer to the chewing surface (the occlusal) of the tooth. So a much smaller cavity on a child can easily invade the root canal. Also, I need 30% change for a cavity to show up on an xray, so I cannot expect the depth of a cavity to be absolutely determined from an x-ray. An x-ray is often not useful for determining how close the decay is to the pulp on a Class V restoration, those ones along the gumline; the cavity is usually superimposed over the pulp chamber on a radiograph. So, a Class V cavity can encroach on the pulp when you least expect it. And when the pulp is exposed, a dentist must make quick and appropriate treatment in order to save that tooth. Class V cavities do occur on every tooth in the mouth and these are especially tricky to treat in the increasing population of adults with xerostomia (that's dry mouth, a common side effect from most medications). Unfortunately, Class V cavities in patients with abnormally dry mouths can progress to the point where the tooth is not even saveable in a matter of 9 months!

Did you know that the bur is often moving at speeds up to 300,000 RPMs entering a space nearly the same size of the handpiece head, so that most of the preparation of Class V restorations is by feel, except for these 6 teeth [*top front teeth*]. I cannot fathom how any continuing education course can provide the education and clinical experiences necessary to prepare Class I and V decay to the same standard of care as a dentist. It is the culmination of dental school that allows dentists to provide irreversible treatment in a safe, efficient and respectful manner.

The State of Nebraska should NOT limit the current duties of the dental assistant, nor add a new level of supervision to statute.

I respectfully request the Committee to support the NDA/NDAA proposal.

I would be happy to answer any questions that you may have.

I am including my written testimony to supplement my spoken testimony in support of the NDA/NDAA's 407.

Sincerely,

Melanie A. Steckelberg, D.D.S.