STATE OF IOWA

IOWA DENTAL BOARD

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

REVISED 10-22-12

IOWA DENTAL HYGIENE COMMITTEE

AGENDA

October 25, 2012
10:00 a.m.

Location: Iowa Dental Board, 400 SW 8th St., Suite D, Des Moines, Iowa
Committee Members: *Mary Kelly, R.D.H., Chair; Nancy Slach, R.D.H., Vice Chair; Steve Bradley, Secretary*

***New information in red**

I. OPEN SESSION *Mary Kelly*

1. Call to Order, Roll Call
2. Approval of Open Session Minutes
   - July 12, 2012 minutes

II. ADMINISTRATIVE RULES

1. Follow-Up Re: Rulemaking History For Rule 650—10.5, Public Health Supervision
   - Public Health Supervision - Report to the Dental Hygiene Committee & Historical Documents
2. Follow-Up Re: Rules and Fluoride Varnish Under General Supervision
3. Committee Recommendation Re: Proposed Amendments to Chpt. 10, "General Requirements " (Amends the definition of "public health setting")
4. Committee Recommendation re: Next Steps for Expanded Functions Rule Amendments for RDHs and RDAs

III. REMEDIAL EDUCATION PLAN REVIEW

1. Submitted by Shaunda Clark, R.D.H., Kirkwood Community College

IV. *APPLICATIONS FOR LICENSURE & OTHER REQUESTS

1. Application for Dental Hygiene License from Joan van Vliet, D.H.
2. Application for Dental Hygiene License from Jessica Koster, D.H.

V. * CLOSED SESSION

VI. RECONVENE IN OPEN SESSION

VII. OPEN SESSION ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS

VIII. PUBLIC COMMENT

IX. OTHER BUSINESS

X. ADJOURN

If you require the assistance of auxiliary aids or services to participate in or attend the meeting because of a disability, please call the office of the Board at 515/281-5157.

*This portion of the meeting may be conducted in closed session to discuss confidential matters that may concern examination information, peace officers' investigative reports, attorney records related to litigation, patient records and reports on the condition, diagnosis, care or treatment of a patient, or investigation reports and other investigative information which is privileged and confidential under the provisions of Sections 22.7(2), 22.7(4), 22.7(5), 22.7(9), 22.7(19), and 272C.6(4) of the 2011 Code of Iowa.

These matters constitute a sufficient basis for the committee to consider a closed session under the provisions of section 21.5(1), (a), (c), (d), (f), (g), and (h) of the 2011 Code of Iowa. These sections provide that a governmental body may hold a closed session only by affirmative public vote of either two-thirds of the members of the body or all of the members present at the meeting to review or discuss records which are required or authorized by state or federal law to be kept confidential, to discuss whether to initiate licensee disciplinary investigations or proceedings, and to discuss the decision to be rendered in a contested case conducted according to the provisions of Iowa Code chapter 17A.

DENTAL HYGIENE COMMITEE

OPEN SESSION MINUTES

July 12, 2012
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Committee Members	**July 12, 2012**
Mary C. Kelly, R.D.H.	Present
Nancy A. Slach, R.D.H.	Present
Steven P. Bradley, D.D.S.	Present

Staff Members
Melanie Johnson, Christel Braness, Brian Sedars, Phil McCollum, Janet Arjes

Attorney General's Office
Theresa Weeg, Assistant Attorney General

CALL TO ORDER FOR JULY 12 2012
Ms. Kelly called the meeting of the Dental Hygiene Committee to order at 10:16 a.m. on Thursday, July 12, 2012. A quorum was established with all members present.

Roll Call:

Member	Kelly	Slach	Bradley
Present	x	x	x
Absent			

APPROVAL OF MINUTES

- *April 24, 2012 Open Session Minutes*

  - MOVED by BRADLEY, SECONDED by SLACH, to approve the April 24, 2012, minutes of the Dental Hygiene Committee meeting as submitted. Motion APPROVED unanimously.

- *May 18, 2012 Open Session Minutes*

  - MOVED by BRADLEY, SECONDED by KELLY, to approve the May 18, 2012, minutes of the Dental Hygiene Committee teleconference meeting with the correction that Ms. Slach is vice-chairperson and Dr. Bradley is secretary. Motion APPROVED unanimously.

EXPANDED FUNCTIONS FOR DENTAL HYGIENISTS & DENTAL ASSISTANTS

Ms. Kelly stated that the topic of expanded functions would also be discussed at the meeting scheduled for the next day. Ms. Kelly wanted to ensure that all related items would be discussed, including those suggested by the Iowa Dental Hygiene Association (IDHA). Ms. Johnson reported that all comments received by the Board office were forwarded to the Board and interested parties.

Mr. Cope, IDHA, indicated that at the expanded functions meeting in January 2012 it was suggested that a number of other suggestions could be addressed. Mr. Cope feels that it would be consistent to include the discussion of atraumatic restorative treatment (ART) as this is function not currently allowed under the scope of practice of a dental hygienist in Iowa. Ms. Johnson reiterated that she did not want to limit the discussion on this matter; however, she wants to be sure that the discussion is limited to expanded functions, whatever those may include.

Ms. Johnson stated that the Board can determine what to include in the discussion the next day. The Board members have all of the information available to them as a reference.

DAY CARE SETTINGS – PUBLIC HEALTH SUPERVISION

Ms. Kelly reported that this discussion was a follow-up from the prior Board meeting. The Iowa Department of Public Health (IDPH) provided the 2010 data related to the public health supervision agreements on file. The data for 2011 had not yet been compiled at the time of this meeting. At the April 2012 Board meeting, the question was raised as to whether the current rules regulating public health supervision agreements allow services to be provided at day care settings under a public health supervision agreement.

Ms. Kelly stated that she would like to add day care settings to the provisions for public health supervision. Dr. Bradley indicated that some in-home day cares would be included in that language. Ms. Slach clarified that, while some in-home day cares are licensed, others are not.

Dr. Bradley expressed some disagreement to the proposal of adding day cares to the provisions of public health supervision; specifically, Dr. Bradley's concern relates to in-home day cares. Dr. Bradley, indicated, however, that he would need to review a more specific proposal prior to making a final decision.

Ms. Weeg suggested that the Board and/or the Dental Hygiene Committee look at the requirements for licensing of day cares before submitting a proposal for rule change.

Mr. Cope, IDHA, pointed out that all schools and nursing homes are covered under the current rule. Mr. Cope stated that this allows for services to be provided to a large number of minors that may require them.

Ms. Kelly reported that, based on her prior practice experience, a large number of children ages one through four, are not currently covered. Dr. Bradley stated that he sees some of these children prior to Kindergarten. Ms. Kelly stated that a number of these children may not be seen by dentists.

Mr. Cope agrees with Ms. Weeg that the licensure standards for day cares would be a good starting point in reviewing this matter and trying to propose suggestions for change.

Ms. Johnson indicated that any changes made to the public health supervision regulations would require a rule amendment. Ms. Johnson stated that the committee can propose language to the Board for consideration as they see fit.

Ms. Kelly proposed adding day cares, with the exclusion of in-home day care, to the allowed sites for public health supervision agreements.

Ms. Slach inquired as to the reasons why the Board might exclude groups such as in-home day cares. Ms. Slach stated that she was aware of at least one individual with an in-home day care who would possibly embrace these services. Ms. Slach could not find a logical reason to deny services to these in-home day care providers if the same services were to be provided to other day care settings.

- MOVED by KELLY, SECONDED by BRADLEY, to direct staff to draft language to propose a rule amendment adding day care facilities to the rule. Motion APPROVED unanimously.

EXAMINATION REQUIREMENTS FOR PUBLIC HEALTH SUPERVISION

Mr. McCollum referred to the current language in Iowa Administrative Code 650 regarding treatment. Mr. McCollum reminded the committee members that the public health supervision agreements are to stipulate the period of time before an examination must be completed prior to further hygiene services being provided under the public health supervision agreement.

Ms. Weeg feels that the current language in rules is unclear in terms of establishing a baseline. The rule is unclear as to when an examination must occur prior to dental hygiene services being continued. However, Ms. Weeg's not certain that an examination must always occur in between each set of services provided by a public health hygienist. The public health supervision agreement should clearly define this as established by the supervising dentist.

Ms. Kelly thought that the rules allowed the supervising dentist to determine when an examination would be required prior to resuming services. Ms. Kelly believed that the rule had been changed to allow ongoing services to patients, who might not otherwise receive any dental

treatment. Ms. Kelly stated that, as a public health hygienist, it is sometimes difficult to determine when an examination has occurred.

Mr. McCollum agreed that the rule is not clear but that his understanding of the rule is that an examination must be conducted at some point before services continue indefinitely.

Ms. Cacioppo stated that she was on the Board at the time the public health supervision rules were approved. Ms. Cacioppo's recollection is also that the determination should be made by the supervising dentist.

Mr. McCollum stated that he was aware of a rule change as it related to services provided under general supervision. However, Mr. McCollum does not recall if this change also applied to the public health supervision rules. Ms. Weeg stated that it would be a good idea to look at clarifying the rule so as to remove some of the confusion in this area.

Mr. Cope, IDHA, recalls that that the some of the former language was stricken from the rule regarding the 12-month examination requirement; however, the question is how to interpret the current language and how to move forward at this point in time. Mr. Cope feels that it may be better to come back to this issue at a later date. This would allow more time to review the change in language in the rule and to attempt to ascertain the intended impact of the rule.

Dr. Bradley stated that he was comfortable with leaving the determination as to the timeline regarding examination up to the supervising dentist. Ms. Slach inquired as to how to best address the examination when patients may not always see the same practitioner(s).

Ms. Rodgers, IDPH, stated that the sample agreement, provided by their office, was updated to reference time frames as established between the dentists and dental hygienists who enter into these agreements. Ms. Rodgers interpretation of the form is that the dentist is to set the timeline for requiring an examination before hygiene services could continue. However, Ms. Rodgers pointed out that the form provided by IDPH is only a sample document. Licensees do not have to use their form, and rather, could develop their own written supervision agreement. Ms. Johnson asked about the maintenance of those written agreements and whether access could be provided to them. Ms. Rodgers indicated that IDPH maintains the agreements and that they could certainly be made available for further review.

The decision was made to table further discussion on this matter.

FLUORIDE VARNISH UNDER GENERAL SUPERVISION

Ms. Kelly asked for clarification on the matter of fluoride varnish and the level of supervision required. Ms. Kelly recollected that public health supervision agreements would be inclusive of prior-existing services and programs. Ms. Kelly indicated that Mr. McCollum clarified, previously, that general supervision provisions do not necessarily apply to public health supervision.

Ms. Weeg recommended that staff research this matter further to see how this matter may have treated historically. The former staff member who managed this information previously is no longer employed by this office. It might be best to revisit this later at a later date when further research can be completed. Ms. Johnson reminded the committee, that licensees are obligated to operate under the current rule. The committee, however, could propose a change to the rules if the members feel that it is appropriate.

Ms. Kelly would like to see what the language was regarding these services prior to the addition of public health supervision agreements in rule.

PUBLIC COMMENT

Ms. Kelly allowed the opportunity for public comment.

No comments were received.

CLOSED SESSION

- MOVED by BRADLEY, SECONDED by SLACH, to go into closed session pursuant to Iowa Code 21.5(d) to discuss and review complaints and other information required by state law to be kept confidential.

Roll Call:

Member	Kelly	Slach	Bradley
Present	x	x	x
Absent			

Motion APPROVED by ROLL CALL.

- The Dental Hygiene Committee convened in closed session at 10:53 a.m.

OPEN SESSION

- MOVED by SLACH, SECONDED by BRADLEY, to return to open session. Motion APPROVED unanimously.

The Committee reconvened in open session at 10:56 am.

The meeting of the Dental Hygiene Committee was adjourned at approximately 10:56 a.m. on July 12, 2012.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Dental Hygiene Committee is scheduled for October 25, 2012, in Des Moines, Iowa.

Respectfully submitted,

Melanie Johnson, J.D.
Executive Director

MJ/cb

REPORT TO THE DENTAL HYGIENE COMMITTEE

ACTION

DATE OF MEETING: October 25-26, 2012

RE: **Rules: Proposed Amendments to Chapter 10, "General Requirements"**

SUBMITTED BY: Melanie Johnson, Executive Director

ACTION REQUESTED: Committee Recommendation to the Board

These proposed amendments expand the definition of "public health settings" to include programs affiliated with the Early Childhood Iowa (ECI) initiative authorized by Iowa Code Chapter 256I and day care centers (excluding home-based day care centers).

Attached for Review

- Draft Notice of Intended Action, Chapter 10
- Current Public Health Supervision administrative rules, 650—chpt.10
- Information about the Early Childhood Iowa Initiative
  - Iowa Code Chapter 256i, Early Childhood Iowa Initiative
  - Fact sheet from IDPH website

DENTAL BOARD[650]

Notice of Intended Action

Pursuant to the authority of Iowa Code section 147.76, the Dental Board hereby gives Notice of Intended Action to amend Chapter 10, "General Requirements," Iowa Administrative Code.

These proposed amendments expand the definition of "public health settings" to include programs affiliated with the Early Childhood Iowa (ECI) initiative authorized by Iowa Code Chapter 256I and day care centers (excluding home-based day care centers).

Written comments about the proposed amendments will be accepted through January 8, 2013. Comments should be directed to Melanie Johnson, Executive Director, Iowa Dental Board, 400 SW 8th Street, Suite D, Des Moines, Iowa 50309-4687; or by e-mail to Melanie.Johnson@iowa.gov.

A public hearing will be held on January 8, 2013, at 2:30 p.m.at the office of the Iowa Dental Board located at 400 SW 8th Street, Suite D, Des Moines, Iowa. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendments.

Any person who plans to attend the public hearing and who may have special requirements, such as those related to hearing or mobility impairments, should contact the Board office and indicate what specific assistance is needed.

These proposed amendments were approved at the October 25, 2012, meeting of the Dental Board.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code sections 153.33 and 153.39.

The following amendments are proposed.

ITEM 1. Amend subrule 10.5(1) as follows:

10.5(1) Public health settings defined. For the purposes of this rule, public health settings are limited to schools; Head Start programs; programs affiliated with the Early Childhood Iowa (ECI) initiative authorized by Iowa Code Chapter 256I; day care centers (excluding home-based day care centers); federally qualified health centers; public health dental vans; free clinics; nonprofit community health centers; nursing facilities; and federal, state, or local public health programs.

CHAPTER 256I

EARLY CHILDHOOD IOWA INITIATIVE

[SP] Initial early childhood Iowa state board membership to be composed of Iowa empowerment board membership; transition from community empowerment areas and boards to early childhood Iowa areas and boards; rules adopted to implement community empowerment initiative under former chapter 28 applicable until superseded; transition of contracts and remission of unobligated or unexpended community empowerment initiative funds to early childhood Iowa initiative; 2010 Acts, ch 1031, §310

256I.1 Definitions.
256I.2 Desired results — purpose and scope.
256I.3 Early childhood Iowa state board created.
256I.4 Early childhood Iowa state board duties.
256I.5 Early childhood Iowa coordination staff.
256I.6 Early childhood Iowa areas.
256I.7 Early childhood Iowa area boards created.
256I.8 Early childhood Iowa area board duties.
256I.9 School ready children grant program.
256I.10 Early childhood Iowa internet site.
256I.11 Early childhood Iowa fund.
256I.12 Early childhood stakeholders alliance.

256I.1 Definitions.

For the purposes of this chapter, unless the context otherwise requires:

1. *"Department"* means the department of management.

2. *"Desired results"* means the set of desired results for improving the quality of life in this state for young children and their families identified in section 256I.2.

3. *"Early care"*, *"early care services"*, or *"early care system"* means the programs, services, support, or other assistance made available to a parent or other person who is involved with addressing the health and education needs of a child from zero through age five. *"Early care"*, *"early care services"*, or *"early care system"* includes but is not limited to public and private efforts and formal and informal settings.

4. *"Early childhood Iowa area"* means a geographic area designated in accordance with this chapter.

5. *"Early childhood Iowa area board"* or *"area board"* means the board for an early childhood Iowa area created in accordance with this chapter.

6. *"Early childhood Iowa state board"* or *"state board"* means the early childhood Iowa state board created in section 256I.3.

2010 Acts, ch 1031, §278

256I.2 Desired results — purpose and scope.

1. It is intended that through the early childhood Iowa initiative every community in Iowa will develop the capacity and commitment for using local, informed decision making to achieve the following set of desired results for improving the quality of life in this state for young children and their families:

a. Healthy children.

b. Children ready to succeed in school.

c. Safe and supportive communities.

d. Secure and nurturing families.

e. Secure and nurturing early learning environments.

2. The purpose of creating the early childhood Iowa initiative is to empower individuals, communities, and state level partners to achieve the desired results. The desired results will be achieved as private and public entities work collaboratively. This initiative creates a partnership between communities and state level partners to support children zero through age five and their families. The role of the early childhood Iowa state board, area boards, and other state and local government agencies is to provide support, leadership, and facilitation of the growth of individual, community, and state responsibility in addressing the desired results.

3. To achieve the desired results, the initiative's primary focus shall be on the efforts of

the state and communities to work together to improve the efficiency and effectiveness of early care, education, health, and human services provided to families with children from zero through age five.

2010 Acts, ch 1031, §279

256I.3 Early childhood Iowa state board created.

1. The early childhood Iowa state board is created to promote a vision for a comprehensive early care, education, health, and human services system in this state. The board shall oversee state and local efforts. The vision shall be achieved through strategic planning, funding identification, guidance, and decision-making authority to assure collaboration among state and local early care, education, health, and human services systems.

2. *a.* The board shall consist of twenty-one voting members with fifteen citizen members and six state agency members. The six state agency members shall be the directors or their designees of the following departments: economic development authority, education, human rights, human services, public health, and workforce development. The designees of state agency directors shall be selected on an annual basis. The citizen members shall be appointed by the governor, subject to confirmation by the senate. The governor's appointments of citizen members shall be made in a manner so that each of the state's congressional districts is represented by at least two citizen members and so that all the appointments as a whole reflect the ethnic, cultural, social, and economic diversity of the state. A member of the state board shall not be a provider of services or other entity receiving funding through the early childhood Iowa initiative or be employed by such a provider or other entity.

b. The governor's appointees shall be selected from individuals nominated by area boards. The nominations shall reflect the range of interests represented on the area boards so that the governor is able to appoint one or more members each for early care, education, health, human services, business, faith, and public interests. At least one of the citizen members shall be a service consumer or the parent of a service consumer. The term of office of the citizen members is three years. A citizen member vacancy on the board shall be filled in the same manner as the original appointment for the balance of the unexpired term.

3. Citizen members shall be reimbursed for actual and necessary expenses incurred in performance of their duties. Citizen members shall be paid a per diem as specified in section 7E.6.

4. In addition to the voting members, the state board shall include four members of the general assembly with not more than one member from each chamber being from the same political party. The two senators shall be appointed one each by the majority leader of the senate and by the minority leader of the senate. The two representatives shall be appointed one each by the speaker of the house of representatives and by the minority leader of the house of representatives. Legislative members shall serve in an ex officio, nonvoting capacity. A legislative member is eligible for per diem and expenses as provided in section 2.10.

5. The state board shall elect a chairperson from among the citizen members and may select other officers from the voting members as determined to be necessary by the board. The board shall meet regularly as determined by the board, upon the call of the board's chairperson, or upon the call of a majority of voting members. The board shall meet at least quarterly.

2010 Acts, ch 1031, §280; 2011 Acts, ch 118, §87, 89

[P] Confirmation; see §2.32

[SP] Initial early childhood Iowa state board membership to be composed of Iowa empowerment board membership; transition from community empowerment areas and boards to early childhood Iowa areas and boards; 2010 Acts, ch 1031, §310

[T] Code editor directive applied

256I.4 Early childhood Iowa state board duties.

The state board shall perform the following duties:

1. Provide oversight of early childhood Iowa areas.

2. Manage and coordinate the provision of grant funding and other moneys made available to early childhood Iowa areas by combining all or portions of appropriations or other revenues as authorized by law.

3. Approve the geographic boundaries for the early childhood Iowa areas throughout the state and approve any proposed changes in the boundaries.

4. Create a strategic plan that supports a comprehensive system of early care, education, health, and human services. The strategic plan shall be developed with extensive community involvement. The strategic plan shall be annually updated and disseminated to the public. Specific items to be addressed in the strategic plan shall include but are not limited to all of the following:

a. Provisions to strengthen the state structure including interagency levels of collaboration, coordination, and integration.

b. Provisions for building public-private partnerships.

c. Provisions to support consolidating, blending, and redistributing state-administered funding streams and the coordination of federal funding streams. The strategic plan shall also address integration of services provided through area boards, other state and local commissions, committees, and other bodies with overlapping and similar purposes which contribute to redundancy and fragmentation in early care, education, health, and human services programs provided to the public.

d. Provisions for improving the efficiency of working with federally mandated bodies.

e. Identification of indicators that measure the success of the various strategies that impact communities, families, and children. The indicators shall be developed with input from area boards.

5. Adopt common performance measures and data reporting requirements, applicable statewide, for services, programs, and activities provided by area boards. The data from common performance measures and other data shall be posted on the early childhood Iowa internet site and disseminated by other means and shall also be aggregated to provide statewide information.

6. Assist with the linkage of child welfare and juvenile justice decategorization projects with early childhood Iowa areas.

7. Coordinate and respond to requests from an area board relating to any of the following:

a. Waiver of existing rules, federal regulation, or amendment of state law, or removal of other barriers.

b. Pooling and redirecting of existing federal, state, or other public or private funds.

c. Seeking of federal waivers.

d. Consolidating community-level committees, planning groups, and other bodies with common memberships formed in response to state requirements.

8. Develop and implement a levels of excellence rating system for use with the state board's designation process for area boards. Allow for flexibility and creativity of area boards in implementing area board responsibilities and provide authority for the area boards to support the communities in the areas served. The levels of excellence rating system shall utilize a tiered approach for recognizing the performance of an area board. The system shall provide for action to address poor performing areas as well as higher performing areas. Subject to the funding requirements and other requirements established in law, if an area board achieves the highest rating level, the state board may allow special flexibility provisions in regard to the funding appropriated or allocated for that area board. The state board shall determine how often area boards are reviewed under the system.

9. Adopt rules pursuant to chapter 17A as necessary for the designation, governance, and oversight of area boards and the administration of this chapter. The state board shall provide for area board input in the rules adoption process.

10. Develop guidelines for recommended insurance or other liability coverage and take other actions to assist area boards in acquiring such coverage at a reasonable cost. Moneys expended by an area board to acquire necessary insurance or other liability coverage shall be considered an administrative cost.

11. In January each year, submit an annual report to the governor and general assembly that includes but is not limited to all of the following:

a. Any updates to the strategic plan.

b. The status and results of the early childhood Iowa initiative efforts to engage the public

regarding the early care, education, health, human services, and other needs of children zero through age five.

c. The status and results of the efforts to develop and promote private sector involvement with the early care system.

d. The status of the early childhood Iowa initiative and the overall early care system in achieving the set of desired results.

e. The data and common performance measures addressed by the strategic plan, which shall include but is not limited to funding amounts.

f. The indicators addressed by the strategic plan along with associated data trends and their source.

12. Integrate statewide quality standards and results indicators adopted by other boards and commissions into the state board's funding requirements for investments in early care, health, education, and human services.

13. Ensure alignment of other state departments' activities with the strategic plan.

14. Develop and keep current memoranda of agreements between the state agencies represented on the state board to promote system development and integration and to clarify the roles and responsibilities of partner agencies.

15. Work with the early childhood Iowa office in building public-private partnerships for promoting the collaborative early care, education, health, and human services system.

16. Support and align the early childhood Iowa internet site with other agencies and improve internet communication.

17. Except for the fiscal oversight measures to be adopted by the department, adopt rules to implement this chapter. The rules shall include but are not limited to the following:

a. Indicators of the effectiveness of early childhood Iowa areas, area boards, and the services provided under the auspices of the area boards. The indicators shall be developed with input from area boards and shall build upon the core indicators of effectiveness for the school ready children grant program.

b. Minimum standards to further the provision of equal access to services subject to the authority of area boards.

c. Core functions for family support services, parent education programs, preschool services provided under a school ready children grant, and other programs and services provided under this chapter. The state board shall also develop guidelines and standards for state-supported family support programs, based upon existing guidelines and standards for the services.

18. Address other measures to advance the initiative. The measures may include any of the following:

a. Advance the development of integrated data systems.

b. Expand efforts to improve quality and utilize evidence-based practices.

c. Further develop kindergarten assessment approaches that are tied to state early learning standards.

2010 Acts, ch 1031, §281

256I.5 Early childhood Iowa coordination staff.

1. The department shall provide administrative support for implementation of the early childhood Iowa initiative and for the state board. The department shall adopt rules in consultation with the state board to provide fiscal oversight of the initiative. The fiscal oversight measures adopted shall include but are not limited to all of the following:

a. Reporting and other requirements to address the financial activities employed by area boards.

b. Regular audits and other requirements of fiscal agents for area boards.

c. Requirements for area boards to undertake and report on fiscal and performance reviews of the programs, contracts, services, and other functions funded by the area boards.

2. An early childhood Iowa office is established in the department to provide leadership for facilitation, communication, and coordination for the early childhood Iowa initiative activities and funding and for improvement of the early care, education, health, and human services systems. An administrator for the early childhood Iowa office shall be appointed by the

director of the department. Other staff may also be designated, subject to appropriation made for this purpose.

3. The state agencies represented on the state board may designate additional staff, as part of the early childhood Iowa initiative, to work as a technical assistance team with the office in providing coordination and other support to the state's comprehensive early care, education, health, and human services system.

4. The office shall work with the state and area boards to provide leadership for comprehensive system development. The office shall also do all of the following:

a. Enter into memoranda of agreement with the departments of education, human rights, human services, public health, and workforce development and the economic development authority to formalize the respective departments' commitments to collaborating with and integrating a comprehensive early care, education, health, and human services system. Items addressed in the memoranda shall include but are not limited to data sharing and providing staffing to the technical assistance team.

b. Work with private businesses, foundations, and nonprofit organizations to develop sustained funding.

c. Maintain the internet site in accordance with section 256I.10.

d. Propose any needed revisions to administrative rules based on stakeholder input.

e. Provide technical support to the state and area boards and to the early childhood Iowa areas through staffing services made available through the state agencies that serve on the state board.

f. Develop, collect, disseminate, and provide guidance for common performance measures for the programs receiving funding under the auspices of the area boards.

g. If a disagreement arises within an early childhood Iowa area regarding the interests represented on the area's board, board decisions, or other disputes that cannot be locally resolved, upon request, provide state or regional technical assistance as deemed appropriate by the office to assist the area in resolving the disagreement.

2010 Acts, ch 1031, §282; 2011 Acts, ch 118, §87, 89

[T] Code editor directive applied

256I.6 Early childhood Iowa areas.

1. The purpose of an early childhood Iowa area is to enable local citizens to lead collaborative efforts involving early care, education, health, and human services on behalf of the children, families, and other citizens residing in the area. Leadership functions may include but are not limited to strategic planning for and oversight and managing of such programs and the funding made available to the early childhood Iowa area for such programs from federal, state, local, and private sources. The focus of the area shall be to achieve the desired results and to improve other results for families with young children.

2. An early childhood Iowa area shall be designated by using existing county boundaries to the extent possible.

3. The designation of an early childhood Iowa area's boundaries and the creation of an area board are both subject to the approval of the state board. The state board shall determine if a proposed area board can efficiently and effectively administer the responsibilities and authority of the area to be served. The state board may apply additional criteria for designating areas and approving area boards, but shall apply all of the following minimum criteria:

a. An area cannot encompass more than four counties.

b. The counties encompassing a multicounty area must have contiguous borders.

c. A single county area shall have a minimum population of children zero through age five in excess of five thousand, based on the most recent population estimates issued by the United States bureau of the census.

4. If the state board determines exceptional circumstances exist, the state board may waive any of the criteria otherwise specified in subsection 3.

2010 Acts, ch 1031, §283

256I.7 Early childhood Iowa area boards created.

1. *a.* The early childhood Iowa functions for an area shall be performed under the authority of an early childhood Iowa area board. The members of an area board shall be elected officials or members of the public who are not employed by a provider of services to or for the area board. In addition, the membership of an area board shall include representation from early care, education, health, human services, business, and faith interests, and at least one parent, grandparent, or guardian of a child from zero through age five.

b. Terms of office of area board members shall be not more than three years and the terms shall be staggered.

2. An area board may designate an advisory council consisting of persons employed by or otherwise paid to represent an entity listed in subsection 1 or other provider of service. However, the deliberations of and documents considered by such an advisory council shall be public.

3. An area board shall elect a chairperson from among the members who are citizens or elected officials.

4. An area board is a unit of local government for purposes of chapter 670, relating to tort liability of governmental subdivisions. For purposes of implementing a formal organizational structure, an area board may utilize recommended guidelines and bylaws established for this purpose by the state board.

5. All meetings of an area board or any committee or other body established by an area board at which public business is discussed or formal action taken shall comply with the requirements of chapter 21. An area board shall maintain its records in accordance with chapter 22.

2010 Acts, ch 1031, §284; 2010 Acts, ch 1183, §18

256I.8 Early childhood Iowa area board duties.

1. An early childhood Iowa area board shall do all of the following:

a. Designate a public agency of this state, as defined in section 28E.2, a community action agency as defined in section 216A.91, an area education agency established under section 273.2, or a nonprofit corporation, to be the fiscal agent for grant moneys and for other moneys administered by the area board.

b. Administer early childhood Iowa grant moneys available from the state to the area board as provided by law and other federal, state, local, and private moneys made available to the area board. Eligibility for receipt of early childhood Iowa grant moneys shall be limited to those early childhood area boards that have developed an approved community plan in accordance with this chapter. An early childhood area board may apply to the state board for any private moneys received by the early childhood Iowa initiative outside of a state appropriation.

c. Develop a comprehensive community plan for providing services for children from zero through age five. At a minimum, the plan shall do all of the following:

(1) Describe community and area needs for children from zero through age five as identified through ongoing assessments.

(2) Describe the current and desired levels of community and area coordination of services for children from zero through age five, including the involvement and specific responsibilities of all related organizations and entities.

(3) Identify all federal, state, local, and private funding sources including funding estimates available in the early childhood Iowa area that will be used to provide services to children from zero through age five.

(4) Describe how funding sources will be used collaboratively and the degree to which the sources can be combined to provide necessary services to young children and their families.

(5) Identify the desired results and the community-wide indicators the area board expects to address through implementation of the comprehensive community plan. The plan shall identify community-specific, quantifiable performance measures to be reported in the area board's annual report and integration with the strategic plan adopted by the state board.

(6) Describe the current status of support services to prevent the spread of infectious diseases, prevent child injuries, develop health emergency protocols, help with medication,

and care for children with special health needs that are being provided to child care facilities registered or licensed under chapter 237A within the early childhood Iowa area.

d. Submit an annual report on the effectiveness of the community plan in addressing school readiness and children's health and safety needs to the state board and to the local government bodies in the area. The annual report shall indicate the effectiveness of the area board in addressing state and locally determined goals.

e. Function as a coordinating body for services offered by different entities directed to similar purposes within the area.

f. Assume other responsibilities established by law or administrative rule.

g. Cooperate with the state board, department of education, and school districts and other local education agencies in securing unique student identifiers, in compliance with all applicable federal and state confidentiality provisions.

2. An area board may do any of the following:

a. Designate one or more committees to assist with area board functions.

b. Utilize community bodies for input to the area board and implementation of services.

2010 Acts, ch 1031, §285

256I.9 School ready children grant program.

1. The state board shall develop and promote a school ready children grant program which shall provide for all of the following components:

a. Identify the performance measures that will be used to assess the effectiveness of the school ready children grants, including the amount of early intellectual stimulation of very young children, the basic skill levels of students entering school, the health status of children, the incidence of child abuse and neglect, the level of involvement by parents with their children, and the degree of quality of an accessibility to child care.

b. Identify guidelines and a process to be used for determining the readiness of an early childhood Iowa area board for administering a school ready children grant.

c. Provide for technical assistance concerning funding sources, program design, and other pertinent areas.

2. The state board shall provide maximum flexibility to grantees for the use of the grant moneys included in a school ready children grant, including but not limited to authorizing an area board to use grant moneys to pay for regular audits required pursuant to section 256I.5, subsection 1, if moneys distributed to an area board for administrative costs are insufficient to pay for the required audits.

3. A school ready children grant shall, to the extent possible, be used to support programs that meet quality standards identified by the state board. At a minimum, a grant shall be used to provide all of the following:

a. Preschool services provided on a voluntary basis to children deemed at risk.

b. (1) Family support services and parent education programs promoted to parents of children from zero through age five. Family support services shall include but are not limited to home visitation. Of the state funding that an area board designates for family support programs, at least sixty percent shall be committed to programs with a home visitation component.

(2) It is the intent of the general assembly that priority for home visitation program funding be given to programs using evidence-based or promising models for home visitation.

c. Other services to support the strategic plan developed by the state board.

d. Services to improve the quality and availability of all types of child care. The services may include but are not limited to making nurse consultants available to support quality improvement.

4. *a.* A school ready children grant shall be awarded to an area board annually, as funding is available. Receipt of continued funding is subject to submission of the required annual report and the state board's determination that the area board is measuring, through the use of performance measures and community-wide indicators developed by the state board with input from area boards, progress toward and is achieving the desired results and other results identified in the community plan. Each area board shall participate in the levels of excellence rating system to measure the area's success. If the use of performance measures

and community-wide indicators does not show that an area board has made progress toward achieving the results identified in the community plan, the state board shall require a plan of corrective action, withhold any increase in funding, or withdraw grant funding.

b. The state board shall distribute school ready children grant moneys to area boards with approved comprehensive community plans based upon a determination of an early childhood Iowa area's readiness to effectively utilize the grant moneys. The grant moneys shall be adjusted for other federal and state grant moneys to be received by the area for services to children from zero through age five.

c. An area board's readiness shall be determined by evidence of successful collaboration among public and private early care, education, health, and human services interests in the area or a documented program design that supports a strong likelihood of a successful collaboration between these interests. Other criteria which may be used by the state board to determine readiness and funding amounts for an area include one or more of the following:

(1) The levels of excellence rating received by the area.

(2) Evidence of the area's capacity to successfully implement the services in the area's community plan.

(3) Local public and private funding and other resources committed to implementation of the community plan.

(4) The adequacy of plans for commitment of local funding and other resources for implementation of the community plan.

d. The provisions for distribution of school ready children grant moneys shall be determined by the state board.

e. The amount of school ready children grant funding an area board may carry forward from one fiscal year to the succeeding fiscal year shall not exceed twenty percent of the grant amount for the fiscal year. All of the school ready children grant funds received by an area board for a fiscal year which remain unencumbered or unobligated at the close of a fiscal year shall be carried forward to the succeeding fiscal year. However, the grant amount for the succeeding fiscal year shall be reduced by the amount in excess of twenty percent of the grant amount received for the fiscal year.

2010 Acts, ch 1031, §286; 2011 Acts, ch 132, §10, 11, 106

[SP] If sufficient funding is available, eligibility for preschool tuition assistance may be extended to children with a family income in excess of the basic income eligibility requirement; 2011 Acts, ch 132, §5, 102, 106

[T] Subsection 2 amended

[T] Subsection 3, paragraph b amended and editorially internally redesignated

256I.10 Early childhood Iowa internet site.

1. The department shall provide for the operation of an internet site for purposes of widely distributing information regarding early care, education, health, and human services and other information provided by the departments represented on the state board and the public and private agencies addressing the comprehensive system for such services.

2. Information provided on the internet site shall include but is not limited to all of the following:

a. Information about the early childhood Iowa initiative for state and local use. The information shall include data from the indicators of success and performance measures adopted by the state board and fiscal information and other data developed by the department.

b. A link to a special internet site directed to parents, including parent-specific information on early care, education, health, and human services and links to other resources available on the internet and from other sources.

c. Program standards for early care, education, health, and human services that have been approved by state agencies.

3. The department shall provide to the state board information regarding the extent and frequency of usage of the internet site or sites and this information shall be included in the board's annual report to the governor and general assembly.

2010 Acts, ch 1031, §287

256I.11 Early childhood Iowa fund.

1. An early childhood Iowa fund is created in the state treasury. The moneys credited

to the fund are not subject to section 8.33 and moneys in the fund shall not be transferred, used, obligated, appropriated, or otherwise encumbered except as provided by law. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys deposited in the fund shall be credited to the fund.

2. A school ready children grants account is created in the fund under the authority of the director of the department of education. Moneys credited to the account are appropriated to and shall be distributed by the department in the form of grants to early childhood Iowa areas pursuant to criteria established by the state board in accordance with law.

3. Unless a different amount is authorized by law, up to three percent of the school ready children grant moneys distributed to an area board may be used by the area board for administrative costs.

4. *a.* An early childhood programs grant account is created in the fund under the authority of the director of the department of human services. Moneys credited to the account are appropriated to and shall be distributed by the department of human services in the form of grants to early childhood Iowa areas pursuant to criteria established by the state board in accordance with law. The criteria shall include but are not limited to a requirement that an early childhood Iowa area must be designated by the state board in order to be eligible to receive an early childhood programs grant.

b. The maximum funding amount an early childhood Iowa area is eligible to receive from the early childhood programs grant account for a fiscal year shall be determined by applying the area's percentage of the state's average monthly family investment program population in the preceding fiscal year to the total amount credited to the account for the fiscal year.

c. An early childhood Iowa area receiving funding from the early childhood programs grant account shall comply with any federal reporting requirements associated with the use of that funding and other results and reporting requirements established by the state board. The department of human services shall provide technical assistance in identifying and meeting the federal requirements. The availability of funding provided from the account is subject to changes in federal requirements and amendments to Iowa law.

d. The moneys distributed from the early childhood programs grant account shall be used by early childhood Iowa areas for the purposes of enhancing quality child care capacity in support of parent capability to obtain or retain employment. The moneys shall be used with a primary emphasis on low-income families and children from zero to age five. Moneys shall be provided in a flexible manner and shall be used to implement strategies identified by the early childhood Iowa area to achieve such purposes. The department of human services may use a portion of the funding appropriated to the department under this subsection for provision of technical assistance and other support to the early childhood Iowa areas developing and implementing strategies with grant moneys distributed from the account.

e. Moneys from a federal block grant that are credited to the early childhood programs grant account but are not distributed to an early childhood Iowa area or otherwise remain unobligated or unexpended at the end of the fiscal year shall revert to the fund created in section 8.41 to be available for appropriation by the general assembly in a subsequent fiscal year.

5. A first years first account is created in the fund under the authority of the department of management. The account shall consist of gift or grant moneys obtained from any source, including but not limited to the federal government. Moneys credited to the account are appropriated to the department to be used for the early childhood-related purposes for which the moneys were received.

2010 Acts, ch 1031, §288; 2010 Acts, ch 1183, §19

256I.12 Early childhood stakeholders alliance.

1. *Alliance created.* An early childhood stakeholders alliance is created to support the state board in addressing the early care, health, and education systems that affect children ages zero through five in Iowa.

2. *Purpose.* The purpose of the early childhood stakeholders alliance is to oversee and provide broad input into the development of a high quality Iowa early childhood system that meets the needs of children zero through age five and their families and integrates the early

care, health, and education systems. The alliance shall advise the governor, general assembly, state board, and other public and private policy bodies and service providers in coordinating activities throughout the state to fulfill its purpose.

3. *Vision statement.* All system development activities addressed by the early childhood stakeholders alliance shall be aligned around the following vision statement for the children of Iowa: "Every child, beginning at birth, will be healthy and successful."

4. *Membership.* The early childhood stakeholders alliance membership shall include a representative of any organization that touches the lives of young children in the state zero through age five, has endorsed the purpose and vision statement for the alliance, has endorsed the guiding principles adopted by the alliance for the early childhood system, and has formally asked to be a member and remains actively engaged in alliance activities. The alliance shall work to ensure there is geographic, cultural, and ethnic diversity among the membership.

5. *Procedure.* Except as otherwise provided by law, the early childhood stakeholders alliance shall determine its own rules of procedure and operating provisions.

6. *Steering committee.* The early childhood stakeholders alliance shall operate with a steering committee to organize, manage, and coordinate the activities of the alliance and its component groups. The steering committee may act on behalf of the alliance as necessary. The steering committee membership shall consist of the co-chairpersons of the alliance's component groups, the administrator of the early childhood Iowa office, and other leaders designated by the alliance.

7. *Component groups.* The early childhood stakeholders alliance shall maintain component groups to address the key components of the Iowa early childhood system. Each component group shall have one private and one public agency co-chairperson. The alliance may change the component groups as deemed necessary by the alliance. Initially, there shall be a component group for each of the following:

a. Governance planning and administration.

b. Professional development.

c. Public engagement.

d. Quality services and programs.

e. Resources and funding.

f. Results accountability.

8. *Duties.* The early childhood stakeholders alliance duties shall include but are not limited to all of the following regarding the Iowa early childhood system:

a. Coordinate with the early childhood Iowa state board.

b. Serve as the state advisory council required under the federal Improving Head Start for School Readiness Act of 2007, Pub. L. No. 110-134, as designated by the governor.

9. *Staffing.* Staff support for the early childhood stakeholders alliance shall be provided by the department.

2010 Acts, ch 1031, §289

Early Childhood

Division of Health Promotion & Chronic Disease Prevention
Phone: 1-800-383-3826 or 515-281-4911
www.idph.state.ia.us/hpcdp/family_health.asp

Promoting & Protecting the Health of Iowans

IDPH Iowa Department of Public Health

Ellen's Story…

Our daughter, Ellen, was attending preschool at Heartland Child Development Center. They indicated that the Lions Club would be giving a free vision screening at the school and asked for permission to have her screened. We hadn't noticed any problems with her vision whatsoever, but thought it was a good idea to have her vision checked. Even though I am a nurse, I never detected any problems. I would not have had her vision checked until just before kindergarten.

Her results suggested that she be evaluated for a possible astigmatism. I made an appointment and her doctor was very surprised that her left eye had not turned in, as her vision was so poor in that eye. She wanted her in corrective lenses immediately to prevent any strabismus. When Ellen got her first pair of glasses, she cried; so did we! She was so surprised that she could see things that were far away. It was just before Christmas and when she saw the Christmas lights on the trees during the ride home, she said, "I never knew there were separate lights on the trees!" Initially, her vision would only correct to 20/40 with lenses. During the next year, we began patching her right eye in an effort to force the left eye to work harder. She progressed well and under the constant direction of her doctor, she was finally able to correct to 20/20. Also, both eyes have remained conjugate. She looks so cute in her little glasses.

Thank you for the work the Iowa KidSight Program does. If not for the screening, we may have waited too long, and her vision would have been forever impaired.

Did you know?

In Iowa, there are over 240,000 young children ages 0-5. Of these approximately:

- 20% live in poverty[1].
- 16% have parents with compromised mental health status including depression or anxiety[2].
- 40% have mothers with **less** than "excellent or very good" physical or mental health[3].

Why are Early Childhood programs important to promoting and protecting the health of Iowans?

- Despite a recent decline, 2009 data reported an 11% increase of reported child abuse.
- More than 3,000 Iowa children with a known developmental delay or health condition that puts them at risk for future developmental problems are helped each year through the Early ACCESS program. This number has more than doubled since 2001.
- Unintended injury is the leading cause of death and disability for children over age 1. Preventing injuries in early child care and education settings has a large impact on the health, school readiness, and lifelong potential of Iowa's children.

Which Iowa Public Health Goals are we working to achieve?

Strengthen the public health infrastructure

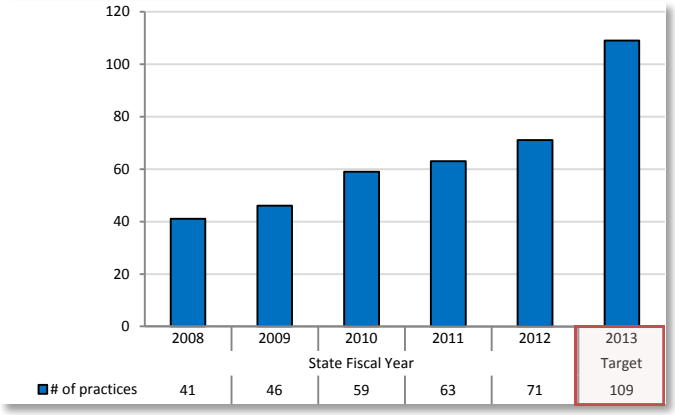
Promote healthy behaviors

What do we do?

- Early Childhood Iowa (ECI) has developed a comprehensive plan that serves as the framework for Iowa's early childhood system.
- The 1st Five program partners with primary healthcare providers to ensure quality social, emotional, and developmental screenings of children under age 5 and helps practices by offering enhanced care coordination to families in need of diverse community resources.
- Healthy Child Care Iowa (HCCI) supports the health and safety of children enrolled in early care and education programs through nurse consultation, health education, and facilitating health services referrals.
- Project LAUNCH seeks to develop the necessary infrastructure and system integration to assure Iowa children from birth to age 8 are thriving in safe, supportive environments, enter school ready to learn, and are able to succeed. Project LAUNCH targets traditionally underserved children and their families in Des Moines with a focus on low-income and minority populations.
- With the Iowa Department of Education, IDPH coordinates the Early ACCESS program, providing developmental evaluations and services for children from birth to age 3, and coordinates services for children with or at risk for developmental delays.

How do we measure our progress?

❶ Number of medical practices engaged in 1st Five screenings.



Data source: 1st Five Title V Child Health Agencies. Data are available annually.

How are we doing? Between FY06 to FY12, the number of known practices in Iowa working to integrate a standardized surveillance tool during well child exams that includes assessing for social/emotional development and family risk factors increased from two to 71. During this same timeframe, the number of children birth to 5 served by this surveillance method increased from approximately 3,000 in FY06 to 75,000 in FY11. For FY13, it is estimated that approximately 38 more practices will be added. Evaluation of referrals shows that for every one referral from a medical practice, three additional referrals are identified when care coordinators work with families.

❷ Number of onsite visits in early childhood and education settings by a Child Care Nurse Consultant

Data Source: ECI Annual Reports and HCCI records. Data are available annually.

How are we doing? In state fiscal year 2011, there were 4,154 onsite visits in early childhood and education settings by a Child Care Nurse Consultant. This is a new statewide performance measure for Early Childhood Iowa in SFY11 and is a change from total service requests. In SFY2012, the number of onsite visits will be counted on a per classroom basis, which is a change from SFY2011. HCCI will use the new 2012 data as a baseline to set targets for future years.

What can Iowans do to help?

1. Go to www.earlychildhoodiowa.org and the parent's page (www.parents.earlychildhoodiowa.org) to learn more about the Early Childhood Iowa project.
2. Check www.idph.state.ia.us/1stfive/ for information on children's social-emotional development and to search a current statewide map of clinics partnering with 1st Five.
3. All Iowans can make sure their babies are screened for hearing loss. Iowa law requires screening all babies before leaving the hospital. To learn more, go to www.idph.state.ia.us/iaehdi/default.asp.
4. If you have a concern about a child's development, make a referral to Early ACCESS by calling 1-888-IAKIDS1 or an email to earlyaccessia@vnsdm.org.
5. All Iowans can support and encourage funding for quality evidence-based early childhood programs.

Expenditures

Federal funds & intra state receipts* (Dept of Human Services & Education): 0153-0536/0548/0676/0980. **1st Five**: general fund, health care trust, & intra state receipts* (Dept of Human Services): K05-0691; K56-5661. **Early ACCESS**: federal funds & intra state receipts* (Dept of Education): 0153-0708/AR18. **HCCI**: intra state receipts* (Dept of Human Services & Management): 0153-0540/0662. **Vision Screening:** general fund K09-0931

	State Fiscal Year 2010 Actual	State Fiscal Year 2011 Actual	State Fiscal Year 2012 Estimate
State funds	$225,380	$366,652	$429,885
Health care trust	$159,057	$0	$0
Federal funds	$561,312	$1,261,542	$1,013,196
Other funds*	$502,025	$596,428	$470,905
Total funds	**$1,447,774**	**$2,224,622**	**$1,913,986**
FTEs	6.69	8.36	7.05

Note: Funding information is intended to provide an overview of funding related to the program area. It does not include all federal and state requirements and/or restrictions for the use of funds. Contact the program area for more detailed budget information.

Iowa Department of Public Health ◆ Division of Health Promotion & Chronic Disease Prevention ◆ Early Childhood

Phone: 1-800-383-3826 or 515-281-4911 ◆ www.idph.state.ia.us/hpcdp/family_health.asp

4th & 5th Floors, Lucas Building ◆ 321 E. 12th Street ◆ Des Moines, IA 50319-0075

Early ACCESS (4th floor)
Phone: 515-242-6167 Fax: 515-242-6013
www.state.ia.us/earlyaccess

1st Five (5th floor)
Phone: 515- 281-8284 Fax: 515-242-6013
www.iowaepsdt.org

Healthy Child Care Iowa (5th floor)
Phone: 281-7519 Fax: 515-242-6013
www.idph.state.ia.us/hcci

[1] Kids Count Data Center, Annie E. Casey Foundation.
[2] Iowa Child and Family Household Health Survey, 2005.
[3] Maternal and Child Health Bureau. (2007).The health and well-being of children: A portrait of states and the nation. *US Department of Health and Human Services.* Retrieved from: http://mchb.hrsa.gov/nsch07/state/iowa.html

650—10.5 (153) Public health supervision allowed. A dentist who meets the requirements of this rule may provide public health supervision to a dental hygienist if the dentist has an active Iowa license and the services are provided in public health settings.

10.5(1) *Public health settings defined.* For the purposes of this rule, public health settings are limited to schools; Head Start programs; federally qualified health centers; public health dental vans; free clinics; nonprofit community health centers; nursing facilities; and federal, state, or local public health programs.

10.5(2) *Public health supervision defined.* "Public health supervision" means all of the following:

a. The dentist authorizes and delegates the services provided by a dental hygienist to a patient in a public health setting, with the exception that hygiene services may be rendered without the patient's first being examined by a licensed dentist;

b. The dentist is not required to provide future dental treatment to patients served under public health supervision;

c. The dentist and the dental hygienist have entered into a written supervision agreement that details the responsibilities of each licensee, as specified in subrule 10.5(3); and

d. The dental hygienist has an active Iowa license with a minimum of three years of clinical practice experience.

10.5(3) *Licensee responsibilities.* When working together in a public health supervision relationship, a dentist and dental hygienist shall enter into a written agreement that specifies the following responsibilities.

a. The dentist providing public health supervision must:

(1) Be available to provide communication and consultation with the dental hygienist;

(2) Have age- and procedure-specific standing orders for the performance of dental hygiene services. Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of dental hygiene services;

(3) Specify a period of time in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement; and

(4) Specify the location or locations where the hygiene services will be provided under public health supervision.

b. A dental hygienist providing services under public health supervision may provide assessments; screenings; data collection; and educational, therapeutic, preventive, and diagnostic services as defined in rule 10.3(153), except for the administration of local anesthesia or nitrous oxide inhalation analgesia, and must:

(1) Maintain contact and communication with the dentist providing public health supervision;

(2) Practice according to age- and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient;

(3) Provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs;

(4) Have each patient sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services; and

(5) Specify a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist, including where these records are to be located.

c. The written agreement for public health supervision must be maintained by the dentist and the dental hygienist and must be made available to the board upon request. The dentist and dental hygienist must review the agreement at least biennially.

d. A copy of the agreement shall be filed with the Oral Health Bureau, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

10.5(4) *Reporting requirements.* Each dental hygienist who has rendered services under public health supervision must complete a summary report at the completion of a program or, in the case of an ongoing program, at least annually. The report shall be filed with the oral health bureau of the Iowa department of public health on forms provided and include information related to the number of patients seen and services provided to enable the department to assess the impact of the program. The department will provide summary reports to the board on an annual basis.

This rule is intended to implement Iowa Code section 153.15.

[**ARC 7767B**, IAB 5/20/09, effective 6/24/09]

FYI

10/22/12 Supplemental

REPORT TO THE DENTAL HYGIENE COMMITTEE

DATE OF MEETING: October 25-26, 2012

RE: **Rule Making History of Public Health Supervision Rule**

SUBMITTED BY: Melanie Johnson

ACTION REQUESTED: FYI Only.

Background

At the July 2012 meeting of the Dental Hygiene Committee a discussion was held concerning the Board's administrative rules regarding public health supervision settings and agreements. The Committee requested staff to review the Board's files and provide information at the October meeting about the Board's rulemaking history for public health supervision. The Committee also requested that staff get copies from IDPH of the current public health supervision agreements and review the terms in the contract that address how much time is allowable following the initial examination by a dentist and subsequent examinations.

On the Board's October meeting agenda are proposed rule amendments that apply to public health settings. These materials are provided for reference purposes.

Attached for Review

- Board's Formal Rule Making re PHS (2003-2009))
- File Documents re: Public Health Supervision (1999- 2009) Included:
  - 2003 Regulatory Analysis by Board
  - Comments received
  - Information regarding other states'
  - 2008 Rule Making Petition filed by IDHA

IOWA ADMINISTRATIVE BULLETIN

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ARC 2327B

DENTAL EXAMINERS BOARD[650]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 147.76, the Board of Dental Examiners hereby gives Notice of Intended Action to amend Chapter 1, "Administration," and Chapter 10, "General Requirements," Iowa Administrative Code.

These amendments change the definition of "general supervision of a dental hygienist" and add a new definition of "collaborative agreement." These amendments would allow a dental hygienist who has 2,500 hours of clinical practice or who is employed as a public health hygienist as of June 1, 2003, to perform preventive services in settings other than a private dental office without the patient's first being examined by a dentist. The hygienist must have entered into a collaborative agreement with a dentist who authorizes and accepts responsibility for the services provided by the hygienist. The collaborative agreement must contain protocols or standing orders for the hygienist to follow.

At their January 23, 2003, regular meeting, the Board approved a petition for rule making submitted by the Iowa Dental Hygienists' Association to amend the rules as proposed in this Notice.

These amendments are subject to waiver at the sole discretion of the Board in accordance with 650—Chapter 7.

Any interested person may make written comments or suggestions on the proposed amendments on or before April 1, 2003. Such written comments should be directed to Jennifer Hart, Executive Officer, Board of Dental Examiners, 400 SW 8th Street, Suite D, Des Moines, Iowa 50309-4687. E-mail may be sent to jhart@bon.state.ia.us.

Also, there will be a public hearing on April 1, 2003, beginning at 10 a.m. in the Conference Room, 400 SW 8th Street, Suite D, Des Moines, Iowa. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendments. Any person who plans to attend the public hearing and who may have special requirements, such as hearing or mobility impairments, should contact the Board and advise of specific needs.

These amendments were approved at the February 4, 2003, teleconference meeting of the Board of Dental Examiners.

These amendments are intended to implement Iowa Code chapters 17A, 147, 153, and 272C.

The following amendments are proposed.

ITEM 1. Amend rule **650—1.1(153)** as follows:

Adopt the following **new** definition:

"Collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for services performed by the dental hygienist. The agreement shall contain protocols or standing orders for the dental hygienist to follow when providing services within the scope of dental hygiene as established in 650—10.3(153). The dental hygienist must ensure that the patient has been examined by a dentist prior to providing additional hygiene services.

Amend the definition of "general supervision of a dental hygienist" as follows:

"General supervision of a dental hygienist" means that a dentist has examined the patient and has prescribed authorized services to be provided by a dental hygienist. The dentist need not be present in the facility while these services are being provided. If a dentist will not be present, the following requirements shall be met:

1. Patients or their legal guardians must be informed prior to the appointment that no dentist will be present and therefore no examination will be conducted at that appointment.
2. The hygienist must consent to the arrangement.
3. Basic emergency procedures must be established and in place and the hygienist must be capable of implementing these procedures.
4. The treatment to be provided must be prior prescribed by a licensed dentist and must be entered in writing in the patient record. *In settings other than a private dental office, such as schools, public health agencies, and health care facilities, a dental hygienist who has a minimum of 2,500 hours of clinical practice during the previous five years of employment or who is employed as a public health hygienist as of June 1, 2003, may perform preventive services without the patient's first being examined by a licensed dentist, if the dental hygienist has entered into a collaborative agreement with one or more dentists.*

ITEM 2. Amend subrule 10.3(3) as follows:

10.3(3) All other authorized services provided by a dental hygienist shall be performed under the general supervision of a dentist currently licensed in the state of Iowa in accordance with 650—1.1(153). *In settings other than a private dental office, such as schools, public health agencies, and health care facilities, a dental hygienist who has a minimum of 2,500 hours of clinical practice during the previous five years of employment or who is employed as a public health hygienist as of June 1, 2003, may perform preventive services without the patient's first being examined by a licensed dentist, if the dental hygienist has entered into a collaborative agreement with one or more dentists. The dental hygienist must ensure that the patient has been examined by a dentist prior to providing additional hygiene services.*

ARC 2325B

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 68B.32A, the Iowa Ethics and Campaign Disclosure Board hereby gives Notice of Intended Action to rescind Chapter 4, "Campaign Disclosure Procedures," Iowa Administrative Code, and adopt a new Chapter 4 with the same title.

This proposed amendment renumbers the current rules on campaign disclosure procedures to eliminate rules that have been previously rescinded and reserved. Two rules are left reserved to reflect anticipated future rule makings. No

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ARC 2788B

ADMINISTRATIVE SERVICES DEPARTMENT[11]

Notice of Intended Action

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Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of 2003 Iowa Acts, House File 534, section 4, the Department of Administrative Services proposes to rescind 401—Chapter 1, "Department Organization," 471—Chapter 1, "Organization and Operation," and rule 581—19.1(19A), "State System of Personnel"; and to adopt 11—Chapter 1, "Department Organization," Iowa Administrative Code.

The purpose of this new chapter is to convert rules regarding department organization from the former departments of General Services, Personnel, and Information Technology and the accounting function of the Department of Revenue and Finance to the new Department of Administrative Services and consolidate common rules into a single chapter that sets forth the organization and mission of the new Department.

Public comments concerning the proposed amendments will be accepted until 3:30 p.m. on October 7, 2003. Interested persons may submit written, oral or electronic comments by contacting Carol Stratemeyer, Department of Administrative Services, Hoover State Office Building, Level A, Des Moines, Iowa 50319-0104; telephone (515) 281-6134; fax (515)281-6140; E-mail Carol.Stratemeyer@iowa.gov.

These amendments were also Adopted and Filed Emergency on August 29, 2003, and are published herein as **ARC 2780B**. The content of that submission is incorporated by reference.

These amendments are intended to implement 2003 Iowa Acts, House File 534, sections 2, 3, 4, 18, 29, 58 and 84.

ARC 2781B

AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 159.5(11), the Department of Agriculture and Land Stewardship gives Notice of Intended Action to rescind Chapter 59, "Sorghum," Iowa Administrative Code.

The purpose of this rule making is to eliminate an obsolete chapter which is not necessary and is largely unenforceable.

Any interested person may make written suggestions or comments on the proposed amendment prior to 4:30 p.m. on October 7, 2003. Such written material should be directed to Ron Rowland, Consumer Protection and Animal Health Division Director, Department of Agriculture and Land Stewardship, Wallace State Office Building, Des Moines, Iowa 50319. Comments may also be submitted by fax to (515) 281-4282 or by E-mail to Ron.Rowland@idals.state.ia.us.

This amendment is intended to implement Iowa Code section 159.5(11).

The following amendment is proposed.

Rescind and reserve **21—Chapter 59**.

ARC 2784B

DENTAL EXAMINERS BOARD[650]

Notice of Termination

Pursuant to the authority of Iowa Code section 147.76, the Board of Dental Examiners terminates the rule making initiated by its Notice of Intended Action published in the Iowa Administrative Bulletin on March 5, 2003, as **ARC 2327B**, amending Chapter 1, "Administration," and Chapter 10, "General Requirements," Iowa Administrative Code.

The Notice proposed to amend the definition of "general supervision of a dental hygienist" and adopt a new definition of "collaborative agreement."

The Board is terminating the rule making commenced in **ARC 2327B** based on written and oral comments. The Board is proposing an alternative rule to address hygiene services provided in public health settings. Notice of Intended Action on the new proposed rule is published herein as **ARC 2783B**.

ARC 2783B

DENTAL EXAMINERS BOARD[650]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 147.76, the Board of Dental Examiners hereby gives Notice of Intended Action to amend Chapter 10, "General Requirements," Iowa Administrative Code.

This amendment allows a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting. The amendment defines public health settings and details the responsibilities of each licensee operating under public health supervision.

Both the dentist and the dental hygienist working under public health supervision are responsible for maintaining contact and communication with each other. The dentist and the dental hygienist must also have a written supervision agreement that provides age- and procedure-specific standing orders for the performance of dental hygiene services. The standing orders must include consideration for medically compromised patients and medical conditions for which no services can be provided prior to a dental exam. The spe-

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ARC 2788B

ADMINISTRATIVE SERVICES DEPARTMENT[11]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of 2003 Iowa Acts, House File 534, section 4, the Department of Administrative Services proposes to rescind 401—Chapter 1, "Department Organization," 471—Chapter 1, "Organization and Operation," and rule 581—19.1(19A), "State System of Personnel"; and to adopt 11—Chapter 1, "Department Organization," Iowa Administrative Code.

The purpose of this new chapter is to convert rules regarding department organization from the former departments of General Services, Personnel, and Information Technology and the accounting function of the Department of Revenue and Finance to the new Department of Administrative Services and consolidate common rules into a single chapter that sets forth the organization and mission of the new Department.

Public comments concerning the proposed amendments will be accepted until 5:30 p.m. on October 7, 2003. Interested persons may submit written, oral or electronic comments by contacting Carol Stratemeyer, Department of Administrative Services, Hoover State Office Building, Level A, Des Moines, Iowa 50319-0104; telephone (515) 281-6134; fax (515)281-6140; E-mail Carol.Stratemeyer@iowa.gov.

These amendments were also Adopted and Filed Emergency on August 29, 2003, and are published herein as **ARC 2780B**. The content of that submission is incorporated by reference.

These amendments are intended to implement 2003 Iowa Acts, House File 534, sections 2, 3, 4, 18, 29, 58 and 84.

ARC 2781B

AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 159.5(11), the Department of Agriculture and Land Stewardship gives Notice of Intended Action to rescind Chapter 59, "Sorghum," Iowa Administrative Code.

The purpose of this rule making is to eliminate an obsolete chapter which is not necessary and is largely unenforceable.

Any interested person may make written suggestions or comments on the proposed amendment prior to 4:30 p.m. on October 7, 2003. Such written material should be directed to Ron Rowland, Consumer Protection and Animal Health Division Director, Department of Agriculture and Land Stewardship, Wallace State Office Building, Des Moines, Iowa 50319. Comments may also be submitted by fax to (515) 281-4282 or by E-mail to Ron.Rowland@idals.state.ia.us.

This amendment is intended to implement Iowa Code section 159.5(11).

The following amendment is proposed.

Rescind and reserve **21—Chapter 59**.

ARC 2784B

DENTAL EXAMINERS BOARD[650]

Notice of Termination

Pursuant to the authority of Iowa Code section 147.76, the Board of Dental Examiners terminates the rule making initiated by its Notice of Intended Action published in the Iowa Administrative Bulletin on March 5, 2003, as **ARC 2327B**, amending Chapter 1, "Administration," and Chapter 10, "General Requirements," Iowa Administrative Code.

The Notice proposed to amend the definition of "general supervision of a dental hygienist" and adopt a new definition of "collaborative agreement."

The Board is terminating the rule making commenced in **ARC 2327B** based on written and oral comments. The Board is proposing an alternative rule to address hygiene services provided in public health settings. Notice of Intended Action on the new proposed rule is published herein as **ARC 2783B**.

ARC 2783B *

DENTAL EXAMINERS BOARD[650]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 147.76, the Board of Dental Examiners hereby gives Notice of Intended Action to amend Chapter 10, "General Requirements," Iowa Administrative Code.

This amendment allows a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting. The amendment defines public health settings and details the responsibilities of each licensee operating under public health supervision.

Both the dentist and the dental hygienist working under public health supervision are responsible for maintaining contact and communication with each other. The dentist and the dental hygienist must also have a written supervision agreement that provides age- and procedure-specific standing orders for the performance of dental hygiene services. The standing orders must include consideration for medically compromised patients and medical conditions for which no services can be provided prior to a dental exam. The spe-

DENTAL EXAMINERS BOARD[650](cont'd)

cific location where services will be provided must be specified. The agreement must also limit the length of time in which further hygiene services can be provided to a patient unless a dental exam has taken place.

The application of initial pit and fissure sealants by a dental hygienist under public health supervision prior to a dental exam shall also follow the supervising dentist's age- and procedure-specific protocols and be based on a dental hygiene assessment.

The dental hygienist must provide each patient, parent, or guardian a written plan for referral to a dentist. Patients must also sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups and are meant for people who otherwise would not have access to services. The supervision agreement must also specify a procedure for creating and maintaining dental records for patients, including where these records are to be located.

The dentist and dental hygienist must maintain the supervision agreement and review the agreement at least biennially. A copy of the agreement must be available to the Board upon request. To facilitate public health programs, a copy of the agreement must also be filed with the Oral Health Bureau of the Iowa Department of Public Health. The hygienist is also responsible for providing summary reports to the Department of Public Health to enable the Department to assess the impact of public health supervision to public health programs.

This amendment is subject to waiver at the sole discretion of the Board in accordance with 650—Chapter 7.

Any interested person may make written comments or suggestions on the proposed amendment on or before October 7, 2003. Such written comments should be directed to Jennifer Hart, Executive Officer, Board of Dental Examiners, 400 SW 8th Street, Suite D, Des Moines, Iowa 50309-4687. E-mail may be sent to jhart@bon.state.ia.us.

Also, there will be a public hearing on October 16, 2003, beginning at 10 a.m. in the Conference Room, 400 SW 8th Street, Suite D, Des Moines, Iowa. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendment. Any person who plans to attend the public hearing and who may have special requirements, such as hearing or mobility impairments, should contact the Board and advise of specific needs.

This amendment was approved at the August 21, 2003, regular meeting of the Board of Dental Examiners.

This amendment is intended to implement Iowa Code chapter 153.

The following amendment is proposed.

Renumber **650—10.5(147,153,272C)** as **650—10.6(147,153,272C)**, and adopt the following **new** rule 650—10.5(153):

650—10.5(153) Public health supervision allowed. A dentist who meets the requirements of this rule may provide public health supervision to a dental hygienist if the dentist has an active Iowa license and the services are provided in public health settings.

10.5(1) Public health settings defined. For the purposes of this rule, public health settings are limited to schools; Head Start programs; federally qualified health centers; public health dental vans; free clinics; nonprofit community health centers; and federal, state, or local public health programs.

10.5(2) Public health supervision defined. "Public health supervision" means all of the following:

a. The dentist authorizes and delegates the services provided by a dental hygienist to a patient in a public health setting, with the exception that hygiene services may be rendered without the patient's first being examined by a licensed dentist;

b. The dentist is not required to provide future dental treatment to patients served under public health supervision;

c. The dentist and the dental hygienist have entered into a written supervision agreement that details the responsibilities of each licensee, as specified in subrule 10.5(3); and

d. The dental hygienist has an active Iowa license with a minimum of three years of clinical practice experience.

10.5(3) Licensee responsibilities. When working together in a public health supervision relationship, a dentist and dental hygienist shall enter into a written agreement that specifies the following responsibilities.

a. The dentist providing public health supervision must:

(1) Be available to provide communication and consultation with the dental hygienist;

(2) Have age- and procedure-specific standing orders for the performance of dental hygiene services. Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of dental hygiene services;

(3) Specify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement; and

(4) Specify the location or locations where the hygiene services will be provided under public health supervision.

b. A dental hygienist providing services under public health supervision may provide assessments; screenings; data collection; and educational, therapeutic, preventive, and diagnostic services as defined in rule 10.3(153), except for the administration of local anesthesia or nitrous oxide inhalation analgesia, and must:

(1) Maintain contact and communication with the dentist providing public health supervision;

(2) Practice according to age- and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient;

(3) Provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs;

(4) Have each patient sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services; and

(5) Specify a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist, including where these records are to be located.

c. The written agreement for public health supervision must be maintained by the dentist and the dental hygienist and must be made available to the board upon request. The dentist and dental hygienist must review the agreement at least biennially.

d. A copy of the agreement shall be filed with the Oral Health Bureau, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

DENTAL EXAMINERS BOARD[650](cont'd)

10.5(4) Reporting requirements. Each dental hygienist who has rendered services under public health supervision must complete a summary report at the completion of a program or, in the case of an ongoing program, at least annually. The report shall be filed with the oral health bureau of the Iowa department of public health on forms provided and include information related to the number of patients seen and services provided to enable the department to assess the impact of the program. The department will provide summary reports to the board on an annual basis.

This rule is intended to implement Iowa Code section 153.15.

ARC 2785B

DENTAL EXAMINERS BOARD[650]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 147.76, the Board of Dental Examiners hereby gives Notice of Intended Action to amend Chapter 29, "Deep Sedation/General Anesthesia, Conscious Sedation and Nitrous Oxide Inhalation Analgesia," Iowa Administrative Code.

Item 1 of the amendments adds a new definition of "monitoring nitrous oxide inhalation analgesia." Item 2 of the amendments establishes minimum training standards for a dental hygienist who monitors a patient under nitrous oxide inhalation analgesia. A dentist must delegate the task, provide direct supervision, and dismiss the patient following completion of the procedure. The hygienist must also immediately report any adverse reactions to the supervising dentist.

These amendments are not subject to waiver or variance as the rules establish minimum training standards and supervision requirements that must be followed in order to protect public health, safety, and welfare.

Any interested person may make written comments or suggestions on the proposed amendments on or before October 7, 2003. Such written comments should be directed to Jennifer Hart, Executive Officer, Board of Dental Examiners, 400 SW 8th Street, Suite D, Des Moines, Iowa 50309-4687. E-mail may be sent to jhart@bon.state.ia.us.

Also, there will be a public hearing on October 7, 2003, beginning at 10 a.m. in the Conference Room, 400 SW 8th Street, Suite D, Des Moines, Iowa. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendments. Any person who plans to attend the public hearing and who may have special requirements, such as hearing or mobility impairments, should contact the Board and advise of specific needs.

These amendments were approved at the August 21, 2003, regular meeting of the Board of Dental Examiners.

These amendments are intended to implement Iowa Code chapters 147 and 153.

The following amendments are proposed.

ITEM 1. Amend rule **650—29.1(153)** by adopting the following **new** definition:

"Monitoring nitrous oxide inhalation analgesia" means continually observing the patient receiving nitrous oxide and recognizing and notifying the dentist of any adverse reactions or complications.

ITEM 2. Adopt **new** subrule 29.6(5) and renumber subrules **29.6(5)** and **29.6(6)** as **29.6(6)** and **29.6(7)**.

29.6(5) A dental hygienist may monitor a patient under nitrous oxide inhalation analgesia provided all of the following requirements are met:

a. The hygienist has completed a board-approved course of training or has received equivalent training while a student in an accredited school of dental hygiene;

b. The task has been delegated by a dentist and is performed under the direct supervision of a dentist;

c. Any adverse reactions are immediately reported to the supervising dentist; and

d. The dentist dismisses the patient following completion of the procedure.

ARC 2755B

ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code sections 15.104 and 15.106, the Iowa Department of Economic Development hereby gives Notice of Intended Action to amend Chapter 7, "Iowa Jobs Training Program," and Chapter 20, "Accelerated Career Education (ACE) Program," Iowa Administrative Code.

The proposed amendments update the rules to incorporate legislative changes enacted during the 2003 Session of the General Assembly. The amendments to Chapter 7 add two new components: job retention and projects funded with moneys from the Grow Iowa Values Fund. The amendments to Chapter 20 add new rules applicable to applications for projects funded with moneys from the Grow Iowa Values Fund.

Public comments concerning the proposed amendments will be accepted until 4:30 p.m. on October 8, 2003. Interested persons may submit written or oral comments by contacting Mike Fastenau, Bureau of Business Finance, Iowa Department of Economic Development, 200 East Grand Avenue, Des Moines, Iowa 50309; telephone number (515) 242-4831; E-mail mike.fastenau@ided.state.ia.us.

A public hearing to receive comments about the proposed amendments will be held on October 8, 2003, at 3 p.m. at the above address in the northwest conference room on the second floor.

These amendments are intended to implement Iowa Code chapters 260F and 260G as amended by 2003 Iowa Acts, House File 692, and House File 683.

The following amendments are proposed.

ITEM 1. Amend 261—Chapter 7 by renumbering rules **261—7.28(260F)** to **7.33(260F)** as **261—7.30(260F)** to **7.35(260F)** and adopting the following **new** rules:

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DENTAL EXAMINERS BOARD[650]

Adopted and Filed

Pursuant to the authority of Iowa Code section 147.76, the Board of Dental Examiners hereby amends Chapter 10, "General Requirements," Iowa Administrative Code.

This amendment allows a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting. The amendment defines public health settings and details the responsibilities of each licensee operating under public health supervision.

Both the dentist and the dental hygienist working under public health supervision are responsible for maintaining contact and communication with each other. The dentist and the dental hygienist must also have a written supervision agreement that provides age- and procedure-specific standing orders for the performance of dental hygiene services. The standing orders must include consideration for medically compromised patients and medical conditions for which no services can be provided prior to a dental exam. The specific location where services will be provided must be specified. The agreement must also limit the length of time in which further hygiene services can be provided to a patient unless a dental exam has taken place.

The application of initial pit and fissure sealants by a dental hygienist under public health supervision prior to a dental exam shall also follow the supervising dentist's age- and procedure-specific protocols and be based on a dental hygiene assessment.

The dental hygienist must provide each patient, parent, or guardian a written plan for referral to a dentist. Patients must also sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups and are meant for people who otherwise would not have access to services. The supervision agreement must also specify a procedure for creating and maintaining dental records for patients, including where these records are to be located.

The dentist and dental hygienist must maintain the supervision agreement and review the agreement at least biennially. A copy of the agreement must be available to the Board upon request. To facilitate public health programs, a copy of the agreement must also be filed with the Oral Health Bureau of the Iowa Department of Public Health. The hygienist is also responsible for providing summary reports to the Department of Public Health to enable the Department to assess the impact of public health supervision on public health programs.

This amendment is subject to waiver at the sole discretion of the Board in accordance with 650—Chapter 7.

Notice of Intended Action was published in the Iowa Administrative Bulletin on September 17, 2003, as **ARC 2783B**. A public hearing on the amendments was held on October 16, 2003. Numerous written and oral comments on the proposed amendments were received. The amendment is identical to that published under Notice.

This amendment was unanimously approved at a December 2, 2003, teleconference meeting of the Board of Dental Examiners.

This amendment is intended to implement Iowa Code chapter 153.

This amendment will become effective on January 28, 2004.

EDITOR'S NOTE: Pursuant to recommendation of the Administrative Rules Review Committee published in the Iowa Administrative Bulletin, September 10, 1986, the text of this amendment [10.5, 10.6] is being omitted. This amendment is identical to that published under Notice as **ARC 2783B**, IAB 9/17/03.

[Filed 12/4/03, effective 1/28/04]
[Published 12/24/03]

[For replacement pages for IAC, see IAC Supplement 12/24/03.]

ARC 3026B

ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]

Adopted and Filed

Pursuant to the authority of Iowa Code sections 15.104 and 15.106, the Iowa Department of Economic Development adopts new Chapter 46, "Endow Iowa Grants Program," Iowa Administrative Code.

Notice of Intended Action was published in the Iowa Administrative Bulletin on September 17, 2003, as **ARC 2753B**.

The rules implement the Endow Iowa Grants Program as authorized by 2003 Iowa Acts, First Extraordinary Session, House File 692. The rules establish application procedures, evaluation criteria, form of award, and the contractual and compliance components of the Program.

A public hearing to receive comments about the proposed rules was held on October 16, 2003. The following comments were received:

- The Director of the Greater Des Moines Foundation offered support for the rules as written, but encouraged the Department to be sensitive to the smaller donors and rural donors in the administration of the Program. The Director also suggested that a definition for "permanent endowment fund" be included in Chapter 46.
- The Director of the Community Vitality Center offered two suggestions: (1) that the rules incorporate a statement of guaranteed portability for affiliate community foundations that are required to make their deposits in the nationally certified foundations, and that those that are the affiliate groups receive some sort of guarantee that they would be allowed to make a change in depository affiliations should they choose to do so; and (2) that there be administrative rules to establish a point of ex-officio liaison from the Community Vitality Center that would work with the lead philanthropic board and attend the lead philanthropic board meetings.

Based on these comments, the following changes have been made:

- Grammatical changes and changes for the purpose of clarification have been made to the proposed rules.
- A definition for "permanent endowment fund" has been added.

The Iowa Department of Economic Development adopted these rules on November 20, 2003.

These rules are intended to implement 2003 Iowa Acts, First Extraordinary Session, House File 692, division VIII.

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DENTAL BOARD[650]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)*"b."*

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 147.76, the Iowa Dental Board hereby gives Notice of Intended Action to amend Chapter 10, "General Requirements," Iowa Administrative Code.

The amendment modifies licensee responsibilities under public health supervision by eliminating the provision that a public health supervision agreement must specify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to provision of further hygiene services by the hygienist. The amendment is proposed in response to a petition for rule making filed by the Iowa Dental Hygienists' Association seeking to remove barriers to access to dental care. The amendment allows the dentist and hygienist to determine the appropriate interval for a dental examination based on the needs of the patients in a public health setting.

This amendment is subject to waiver at the sole discretion of the Board in accordance with 650—Chapter 7.

Any interested person may make written comments or suggestions on the proposed amendment on or before March 3, 2009. Such written comments should be directed to Jennifer Hart, Executive Officer, Iowa Dental Board, 400 SW 8th Street, Suite D, Des Moines, Iowa 50309-4687. E-mail may be sent to Jennifer.Hart@iowa.gov.

Also, there will be a public hearing on March 3, 2009, beginning at 10 a.m. in the Board Conference Room, 400 SW 8th Street, Suite D, Des Moines, Iowa. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendment. Any person who plans to attend the public hearing and who may have special requirements, such as those related to hearing or mobility impairments, should contact the Board and advise of specific needs.

This amendment was approved at the January 15, 2009, regular meeting of the Iowa Dental Board.

This amendment is intended to implement Iowa Code section 153.15.

The following amendment is proposed.

Amend subparagraph **10.5(3)"a"(3)** as follows:

(3) Specify a period of time~~, no more than 12 months,~~ in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement; and

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DENTAL BOARD[650]

Adopted and Filed

Pursuant to the authority of Iowa Code section 147.76, the Iowa Dental Board hereby amends Chapter 10, "General Requirements," Iowa Administrative Code.

The amendment modifies licensee responsibilities under public health supervision by eliminating the provision that a public health supervision agreement must specify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to provision of further hygiene services by the hygienist. The amendment is adopted in response to a petition for rule making filed by the Iowa Dental Hygienists' Association seeking to remove barriers to access to dental care. The amendment allows the dentist and hygienist to determine the appropriate interval for a dental examination based on the needs of the patients in a public health setting.

Notice of Intended Action was published in the Iowa Administrative Bulletin on February 11, 2009, as **ARC 7555B**. A public hearing on the amendment was held on March 3, 2009. Numerous written and oral comments were received. This amendment is identical to that published under Notice.

This amendment was approved at the April 15, 2009, regular meeting of the Iowa Dental Board.

This amendment is intended to implement Iowa Code section 153.15.

This amendment will become effective on June 24, 2009.

The following amendment is adopted.

Amend subparagraph **10.5(3)"a"(3)** as follows:

(3) Specify a period of time~~, no more than 12 months,~~ in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement; and

[Filed 4/21/09, effective 6/24/09]
[Published 5/20/09]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/20/09.

ARC 7790B

DENTAL BOARD[650]

Adopted and Filed

Pursuant to the authority of Iowa Code section 147.76, the Iowa Dental Board hereby amends Chapter 11, "Licensure to Practice Dentistry or Dental Hygiene," and Chapter 12, "Dental and Dental Hygiene Examinations," Iowa Administrative Code.

The purpose of these amendments is to remove the examination administered by the American Board of Dental Examiners, Inc. (ADEX) from the list of examinations that dental hygiene applicants may complete to qualify for licensure by examination. The ADEX examination is no longer administered by the Central Regional Dental Testing Service, Inc. (CRDTS), of which Iowa is a member. Applicants for dental hygiene licensure by examination may take either the CRDTS examination or the Western Regional Examining Board, Inc. (WREB) examination to qualify for licensure.

These amendments are subject to waiver at the sole discretion of the Board in accordance with 650—Chapter 7.

Notice of Intended Action was published in the Iowa Administrative Bulletin on February 11, 2009, as **ARC 7567B**. A public hearing on the amendments was held on March 3, 2009. No oral or written comments were received. One change to the noticed rules has been made. In Item 3, subrules 12.4(1) to 12.4(3) have been amended to clarify procedures for retaking a failed examination. Previously, the

Current Rules

10.3(3) Under the general or public health supervision of a dentist, a dental hygienist may provide educational services, assessment, screening, or data collection for the preparation of preliminary written records for evaluation by a licensed dentist. A dentist is not required to examine a patient prior to the provision of these dental hygiene services.

10.3(4) The administration of local anesthesia or nitrous oxide inhalation analgesia shall only be provided under the direct supervision of a dentist.

10.3(5) All other authorized services provided by a dental hygienist to a new patient shall be provided under the direct or public health supervision of a dentist. An examination by the dentist must take place during an initial visit by a new patient, except when hygiene services are provided under public health supervision.

10.3(6) Subsequent examination and monitoring of the patient, including definitive diagnosis and treatment planning, is the responsibility of the dentist and shall be carried out in a reasonable period of time in accordance with the professional judgment of the dentist based upon the individual needs of the patient.

10.3(7) General supervision shall not preclude the use of direct supervision when in the professional judgment of the dentist such supervision is necessary to meet the individual needs of the patient.

This rule is intended to implement Iowa Code section 153.15.

650—10.4(153) Unauthorized practice of a dental hygienist. A dental hygienist who assists a dentist in practicing dentistry in any capacity other than as an employee or independent contractor supervised by a licensed dentist or who directly or indirectly procures a licensed dentist to act as nominal owner, proprietor, director, or supervisor of a practice as a guise or subterfuge to enable such dental hygienist to engage in the practice of dentistry or dental hygiene or who renders dental service(s) directly or indirectly on or for members of the public other than as an employee or independent contractor supervised by a licensed dentist shall be deemed to be practicing illegally.

10.4(1) The unauthorized practice of dental hygiene means allowing a person not licensed in dentistry or dental hygiene to perform dental hygiene services authorized in Iowa Code section 153.15 and rule 650—10.3(153).

10.4(2) The unauthorized practice of dental hygiene also means the performance of services by a dental hygienist that exceeds the scope of practice granted in Iowa Code section 153.15.

10.4(3) A dental hygienist shall not practice independent from the supervision of a dentist nor shall a dental hygienist establish or maintain an office or other workplace separate or independent from the office or other workplace in which the supervision of a dentist is provided.

This rule is intended to implement Iowa Code sections 147.10, 147.57 and 153.15.

650—10.5(153) Public health supervision allowed. A dentist who meets the requirements of this rule may provide public health supervision to a dental hygienist if the dentist has an active Iowa license and the services are provided in public health settings.

10.5(1) *Public health settings defined.* For the purposes of this rule, public health settings are limited to schools; Head Start programs; federally qualified health centers; public health dental vans; free clinics; nonprofit community health centers; nursing facilities; and federal, state, or local public health programs.

10.5(2) *Public health supervision defined.* "Public health supervision" means all of the following:

a. The dentist authorizes and delegates the services provided by a dental hygienist to a patient in a public health setting, with the exception that hygiene services may be rendered without the patient's first being examined by a licensed dentist;

b. The dentist is not required to provide future dental treatment to patients served under public health supervision;

c. The dentist and the dental hygienist have entered into a written supervision agreement that details the responsibilities of each licensee, as specified in subrule 10.5(3); and

d. The dental hygienist has an active Iowa license with a minimum of three years of clinical practice experience.

10.5(3) *Licensee responsibilities.* When working together in a public health supervision relationship, a dentist and dental hygienist shall enter into a written agreement that specifies the following responsibilities.

a. The dentist providing public health supervision must:

(1) Be available to provide communication and consultation with the dental hygienist;

(2) Have age- and procedure-specific standing orders for the performance of dental hygiene services. Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of dental hygiene services;

(3) Specify a period of time in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement; and

(4) Specify the location or locations where the hygiene services will be provided under public health supervision.

b. A dental hygienist providing services under public health supervision may provide assessments; screenings; data collection; and educational, therapeutic, preventive, and diagnostic services as defined in rule 10.3(153), except for the administration of local anesthesia or nitrous oxide inhalation analgesia, and must:

(1) Maintain contact and communication with the dentist providing public health supervision;

(2) Practice according to age- and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient;

(3) Provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs;

(4) Have each patient sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services; and

(5) Specify a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist, including where these records are to be located.

c. The written agreement for public health supervision must be maintained by the dentist and the dental hygienist and must be made available to the board upon request. The dentist and dental hygienist must review the agreement at least biennially.

d. A copy of the agreement shall be filed with the Oral Health Bureau, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

10.5(4) *Reporting requirements.* Each dental hygienist who has rendered services under public health supervision must complete a summary report at the completion of a program or, in the case of an ongoing program, at least annually. The report shall be filed with the oral health bureau of the Iowa department of public health on forms provided and include information related to the number of patients seen and services provided to enable the department to assess the impact of the program. The department will provide summary reports to the board on an annual basis.

This rule is intended to implement Iowa Code section 153.15.

[**ARC 7767B**, IAB 5/20/09, effective 6/24/09]

650—10.6(147,153,272C) Other requirements.

10.6(1) *Change of address or name.* Each person licensed or registered by the board must notify the board, by written correspondence or through the board's online system, of a change of legal name or address within 60 days of such change. Proof of a legal name change, such as a notarized copy of a marriage certificate, must accompany the request for a name change.

10.6(2) *Child and dependent adult abuse training.* Licensees or registrants who regularly examine, attend, counsel or treat children or adults in Iowa must obtain mandatory training in child and dependent adult abuse identification and reporting within six months of initial employment and subsequently every five years in accordance with 650—subrule 25.2(9).

IOWA DENTAL ASSOCIATION

A Constituent of the American Dental Association

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Executive Director
Robert W. Harpster

December 30, 1999

Constance L. Price
Executive Director
Iowa Board of Dental Examiners
400 SW 8th Street, Suite D
Des Moines, Iowa 50309-4687

RE: Proposed Changes to Implement Iowa Code Section 153.15

Dear Ms. Price:

In November, the Iowa Board of Dental Examiners (IBDE) gave notice of intended action to amend Chapter 1, "Definitions", Iowa Administrative Code. This followed ratification of recommendations from the Dental Hygiene Committee by the IBDE to proceed with rulemaking. Those recommendations were in turn circulated to a random sample (250) of the dentists currently practicing in the state.

The comments received by this office were varied, however, the majority of comments raised questions about clarification of item "c" under "therapeutic" and whether such changes would allow a dental hygienist to work independent of the dentist.

Regarding item "c" under therapeutic, clarification is sought on "removing and polishing hardened excessive restorative materials". Does this mean that a hygienist could "contour" a tooth?

Regarding the issue of independence and supervision. The intent of the proposed rules is to affirmatively allow dental hygienists to perform activities described in the rules, including educational, therapeutic, diagnostic and preventive.

It is also our understanding that the intent of the rules was to allow the performance of such activities under the supervision of a dentist who had delegated the activities, especially those of a therapeutic, clinical and preventive nature.

On the face of the proposed amendments, we fail to understand how said activities are under the supervision of a dentist who has delegated such activities.

The issue is not whether the practice of dental hygiene includes the activities so outlined but that there is a clear and distinct linkage with supervision and delegation of those functions from the dentist. Without such linkage we believe there is a distinct possibility that a hygienist could perform or choose to perform these functions without the supervision of a dentist and without such activities being delegated.

State licensing laws exist to protect the public and the separation of one dental service from another is not in the patient's best interest. In theory we believe these changes could be interpreted as allowing a dental hygienist to work in any setting without the supervision of a delegating dentist. We do not believe that this is the intent of the proposed changes and urge the board to carefully review, and, to the extent necessary, correct this oversight.

A case can be made for consistency in the following citations:

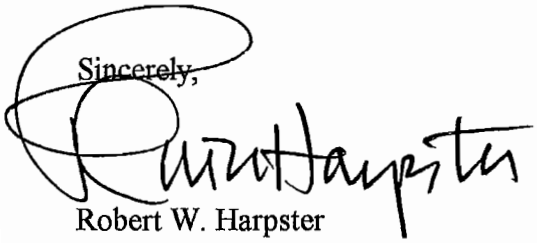
Section 153.15, Iowa Code states that "services shall be performed under supervision of a licensed dentist....".

IAC 650.10.3(3) states " a dental hygienist shall not practice independent from the supervision of a dentist nor shall a dental hygienist establish or maintain an office or other workplace separate or independent from the office or other workplace in which the supervision of a dentist is provided".

Although the proposed amendments are intended to implement Iowa Code section 153.15 we believe that the unintended consequence of adopting such rules could impact the scope of practice and be interpreted as authorizing independent practice of dental hygiene. For that reason we urge the IBDE to clarify and tie supervision and delegation of functions and activities to the proposed definitions. Without such changes we believe that a case be made for the Board make a specific written finding (650.5.6) that the recommendation exceeds the jurisdiction of the committee beyond the authority granted in subrule 5.6(2).

We appreciate the opportunity to comment on the proposed rules.

Sincerely,



Robert W. Harpster
Executive Director

cc. Officers and Trustees

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

IOWA BOARD OF DENTAL EXAMINERS
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

COPY

September 30, 2002

Sheila Temple, RDH
President, Iowa Dental Hygienists' Association
2565 Buckeye Ave
Keota, IA 52248-9487

Dear Ms. Temple:

Pursuant to the rules governing a petition for rulemaking contained at 650 IAC Chapter 7, the Board of Dental Examiners requests a written response concerning the following questions and concerns that have been raised regarding the petition.

1. In your proposed definition of public health supervision, you refer to protocols approved by the Bureau of Oral Health of the Iowa Department of Public Health. At your appearance before the Dental Hygiene Committee you indicated that the only protocols in place are for the fluoride varnish, fluoride prescription, and the sealant programs. However, the Bureau of Oral Health has indicated that no protocols exist for the sealant program and that the program follows grant guidelines. Are there any other protocols approved by the Bureau of Oral Health for providing other types of care?

2. Please provide a written response for Board review concerning how the Bureau's existing protocols are adopted and approved. In addition, how would future protocols be written, adopted, and approved?

3. Does the Bureau of Oral Health have the existing staff/capacity to oversee and enforce the provisions of the proposed amendment? Is there a requirement that a licensed dentist direct the Bureau of Oral Health?

4. Your response to the Dental Hygiene Committee dated September 23, 2002, indicated that the educational and experience criteria were based on a review of those states with less restrictive supervision requirements. What are those states? What are the requirements in those states? How do those requirements differ from those proposed in your petition? Ms. Brown indicated that your Association could provide copies of the requirements in these other states.

5. Your petition would create two pathways for qualification to work under public health supervision. Do you have an estimate of how many hygienists would be "grandfathered" into the standard (currently employed in a public health setting)? Is there a definition of a "public health setting?"

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PHONE:515-281-5157 FAX:515-281-7969 http://www.state.ia.us/dentalboard

6. Could you please provide the definition of "dentally underserved" and "at risk populations" used by the Health Resources and Services Administration of the U.S. DHHS. Your response indicated these definitions should be used for the petition.

7. Are there any other programs in place to provide access to services for these dentally underserved and at risk populations?

8. Would the proposed amendment apply to any care that is provided by a hygienist outside of a private dental office in the 72 of 99 counties referred to as federally designated dental health professional shortage areas? Would this proposed rule allow a hygienist to practice outside of either a dentist office or a public health agency as long as the "dentally underserved" criteria were complied with?

9. Board rules currently allow licensed hygienists, working under the general supervision of a dentist, to provide educational services, assessment, screening, and data collection, what additional services would be provided that are not currently allowed under Board rule?

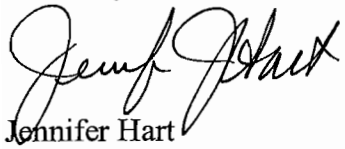
10. Would the Medicaid reimbursement be available to this practice, or does it have to be for care rendered by a dentist? If this is the case, are there any restrictions on what the hygienist could charge? If no reimbursement is available, will this actually result in additional preventive services being provided to the dentally underserved population?

11. How will patients requiring further care be referred to a dentist?

12. Please provide documentation to support the statistics cited in your petition.

If you have any additional information that would address these questions or further assist the Board in their review of this petition, please forward it to the Board office. Your written response will be copied for review at the October 17, 2002, regular meeting of the Board of Dental Examiners.

Sincerely,



Jennifer Hart
Executive Officer

Cc: Board members
Constance L. Price, Executive Director
File

October 7, 2002

RECEIVED
OCT 10 2002
IOWA BOARD OF
DENTAL EXAMINERS

Iowa Board of Dental Examiners
Executive Hills West
1209 E Court Ave
Des Moines, IA 50319

Dear Iowa Board of Dental Examiners:

I appreciate the opportunity to respond to the questions and concerns that have been raised regarding our rulemaking petition. The Iowa Dental Hygiene Association is not asking for independent practice or unsupervised practice. Instead, we are trying to find a way to help solve the problem that Surgeon General David Satcher calls a "silent epidemic of dental and oral diseases that are affecting some population groups." Fourteen other states have developed rules or laws to enable dental hygienists to provide care in settings outside the private dental office. Enclosed in this packet is a listing of these states and their current criteria for this level of practice. Public health supervision can be accomplished in many ways. Specific sites could be listed where hygienists may practice under public health supervision. The dental hygienist could apply for a permit and meet the educational and experience criteria as established by the Dental Hygiene Committee and approved by the IBODE. We are bringing this issue to the Iowa Board of Dental Examiners in hopes that you can work with us to arrive at a way to address this problem in Iowa. The following is substitute wording that might make the rule clearer.

"Public health supervision" of a dental hygienist means that the dental hygienist is following protocols approved by the Oral Health Bureau of the Department of Public Health when providing care for the dentally underserved and at risk patients of permitted settings as listed in 153.15 other than the private dental office. The dental hygienist must apply for a permit and meet the educational and experience criteria as established by the Dental Hygiene Committee and approved by the Iowa Board of Dental Examiners. The dental hygienist may provide services within the scope of dental hygiene practice as established in 650-10.3(1) except for the administration of local anesthetic and nitrous oxide inhalation analgesia and must refer to a dentist for dental planning and treatment. For purposes of this rule, a public health setting is a program sponsored by a state, county or local health department, a community clinic or federally qualified health clinic (FQHC) or a FQHC look alike clinic, a nonprofit or charitable clinic, a nursing home that receives public money , a school based health program or a Headstart program.

The Iowa Department of Public Health defines public health setting to be suggestive of entities that receive tax dollars to deliver a service to those who can not access them otherwise. It is not suggestive of the facility where a service is provided, but rather the vehicle with which tax dollars are funneled (i.e. screening centers). The number of hygienists currently working in these public health settings is approximately 30. This number does not include those hygienists currently employed through federally qualified health centers.

We agree that a referral plan must be in place and we think that this does exist in protocols

developed by the Oral Health Bureau of the Public Health Department. We are enclosing those protocols for existing programs for your review. These protocols were written by the Oral Health Bureau staff or committee and then approved by the Bureau Chief or Division Director.The protocols would just need to be revamped to include additional hygiene services by the Iowa Department of Public Health in conjunction with the IBODE. The question was raised as to whether there was a requirement that a licensed dentist direct the Bureau of Oral Health. I have enclosed documentation of the job description for the Public Health Dental Director in Iowa. The final wording of the job description states that licensure to practice dentistry in the state of Iowa is necessary to fill this position.

It would be ideal if prevention and treatment could occur simultaneously for all persons in the state. That has not been possible for at risk populations to date because of many unresolved factors. The orginal letter we wrote to petition the Dental Hygiene Committee spoke of 72 of the 99 counties in Iowa as being federally designated dental health professional shortage areas. The Health Resources and Services Administration of the U.S. Department of Health and Human Services look at many factors when making this determination. The number of dentists versus population, the number serving the at risk populations (i.e. Medicaid and Medicare), and the distance or logistics of where these at risk populations would need to travel to receive service are all factors considered. Until these problems are solved, it seems prudent to arrive at a workable solution that will allow preventive and comfort measures to be accessible until further dental treatment is available. Enclosed is the map that identifies these counties and also the percentages in all counties that have received preventative and restorative dental treatment through Medicaid. Most of the counties that have had increases in dental preventative and restorative treatment have hygienists that are actively coordinating many of the preventative programs and are utilizing follow-up procedures for treatment planning. I have included the Washington County referral protocols for reference, also.

The proposed amendment would allow dental hygienists the ability to provide preventative care, within our scope of practice, in settings within the state of Iowa for dentally underserved and at risk populations. Most of the states that allow less restrictive supervision or public health supervision specify settings. If the BODE would be more comfortable listing sites or defining agencies or programs where these populations are served, IDHA would be agreeable to that possibility. The greatest need appears to be among children, the elderly, and the Medicaid or uninsured Maternal Health populations. The programs that are in place at this time are through the public health agencies, federally qualified health centers, teaching institutions, or grants from the federal and state level to implement school or nursing home-based programs. The dental hygiene services that would be allowed with support of this rule would be prophylaxis and sealant programs without a initial exam by a dentist. All patients would be referred for treatment planning and exam at this time.

Dental hygienists are not eligible for Medicaid reimbursement. However, the agencies who utilize dental hygienists are Medicaid providers and do receive compensation for the services provided by dental hygienists. Dental hygienists are either employees of an agency or act as independent contractors. For example, the Des Moines Health Center employs four dental hygienists who provide screening, educational programs, and sealants

in the Des Moines Schools. Other public health programs may contract with dental hygienists for various programs such as screening, fluoride varnish or sealants. Even though direct reimbursement is not possible, as long as the agencies where the hygienist provides care are reimbursed for hygiene services, additional preventive service could be provided to the dentally underserved population. Programs for the dentally underserved and at risk populations receive funding from a variety of sources, not just Medicaid. They include money from federal, state, and counties, as well as, grants, and from participants via sliding fee scales.

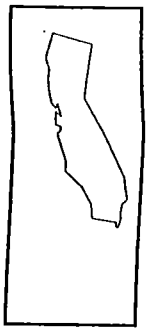
In closing, I hope this letter clears up any questions that you may have when addressing this petition. Dr. Hayley Harvey, Dr. Cathy Watkins, and myself will all be present at the IBODE meeting on the 17th of October and I respectfully request time for each of us to address the Board. I have also enclosed letters of support from Dr. Hayley Harvey (Dental Director-IDPH), Dr. Cathy Watkins (Geriatrics), Dr. Micheal Kanellis (Pediatrics), Marcia Manter (Region VII Head Start Health Specialist), Cecelia Nassif (Mid-Iowa Community Action, Inc.), VaLinda Parsons, RDH, BS (Project Director, Story County Community Dental Clinic), Mike DeAnda (Executive Director-Des Moines Health Center) and Jean Phillips (Health Services Facilitator-Des Moines Public Schools).

Sincerely,

Sheila Temple, RDH
President-Iowa Dental Hygienists' Association
2565 Buckeye Ave.
Keota, IA 52248-9487
Fax and Phone-641/636-3719

States Permitting Unsupervised Practice/Less Restrictive Supervision

For purposes of this document, unsupervised practice means that the dental hygienist can initiate treatment based on his or her assessment of patient needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and can maintain a provider-patient relationship without the participation of the patient's dentist of record.



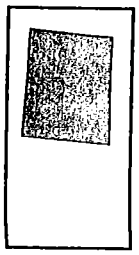
California 1998

Sec. 1768, 1770

Dental hygienists endorsed as RDHAPs (registered dental hygienist in alternative practice) may provide services without supervision for homebound persons or at schools, residential facilities, institutions and in dental health professional shortage areas if the patient has a prescription from a dentist or physician. May own an alternative dental hygiene practice.

Special Requirements: Bachelors degree equivalent, 3 years clinical practice, completion of 150 clock hour special course and exam.

Services: those services permitted under general supervision (which include prophylaxis, root planing, pit and fissure sealants, charting and examination of soft tissue).



Colorado - 1987

Sec. 12-35-122.5

Unsupervised practice in all settings for all licensed dental hygienists for the prophylaxis and several other services. May also own a dental hygiene practice.

Special Requirements: None.

Services--remove deposits, accretions, stains, curettage, apply fluorides and other recognized preventive agents, oral inspection and charting, topical anesthetic. However, x-rays require general supervision and local anesthesia requires direct supervision.

Connecticut 1999

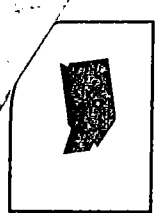
Section 20-126l.

Dental hygienists with 2 years experience may practice without supervision in institutions, public health facilities, group homes and schools.

Special Requirements: 2 years experience.

Services: Complete prophylaxis, remove deposits, accretions and stains, root planing,

sealants, assessment and treatment planning.

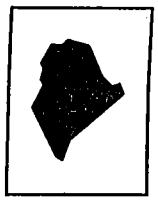


Indiana 1992
Sec. 25-13-1-10

A licensed dental hygienist may provide dental hygiene instruction and in-service training without restriction on location. Dental hygienist may also provide dental prophylaxis for children up to and including grade 12 without supervision if the hygienist is employed by the state department of health, the state department of education or an elementary or secondary school. In any public health setting, may also do screenings and referrals.

Special requirements: Licensed for two years.

Services: Prophylaxis, screenings, (sealants must be done under direct supervision).



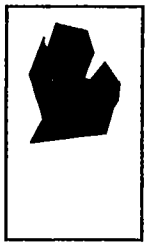
Maine 2001
Rule 02 313 Chap. 1. Sec. 4

A dental hygienist may practice in a public or private school, hospital or other non-traditional practice under "public health supervision status" granted by the dental board on a case-by-case basis. The hygienist may perform the duties they can do under general supervision.

The dentist should have specific standing orders and procedures to be carried out, although the dentist need not be present when the procedures are being performed. A written plan for referral or an agreement for follow-up shall be provided by the public health hygienists, recording all conditions that should be called to the attention of the dentist. The supervising dentist shall review a summary report at the completion of the program or once a year.

Special Requirements: A dental hygienist must apply to the board to practice providing such information the board deems necessary. The board must take into consideration whether the program will fulfill an unmet need, whether a supervising dentist is available and that the appropriate public health guidelines and standards of care can be met and followed.

Services: Services that can be provided under general supervision. Dentist diagnosis for sealants not needed in public health or school sealant programs.



Michigan 1991
Sec. 333.16625

A dental hygienist may perform dental hygiene services under the "supervision" of a dentist as part of a program for dentally underserved populations conducted by a local, state or federal grantee health agency which has been approved by the department of health. Approval good for 2 years.

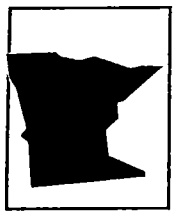
Special Requirements: No special requirements for dental hygienists. Agency must obtain

more than 50% of its funding from public or non-profit sources, employ or contract with at least one dentist and one dental hygienist and

cannot be associated with any private dental practice. No special requirements for the dentist.

Supervision: Dentist must on a regularly scheduled basis review the performance of the dental hygienist, review records and provide consultation. Must be available through one of the following ways:
a) direct communication in person or by radio, telephone or telecommunication
b) periodic consultation to review records and further educate the performance of the individual's functions
c) the provision of predetermined procedures and drug protocol

Services: Services that can be provided under general supervision.



Minnesota 2001
Section 150A.10, subd. 1a

Limited authorization for dental hygienists. A dental hygienist may be employed or retained by a health care facility to perform dental hygiene services without the patient first being examined by a licensed dentist if the dental hygienist has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

Health care facility means hospital, nursing home, home health agency, disabled/juvenile home, federal/state/local public health facility, community clinic, prison, tribal clinic or state-operated facility licensed by the commissioner of human services

A collaborative agreement means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services may be performed without the presence of a licensed dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without the dentist's diagnosis/treatment plan unless specified in the agreement.

Special Requirements: 2 years of clinical experience within the preceding 5 years.

Services: Removal of deposits and stains from the surfaces of the teeth, application of topical preventive and prophylactic agents, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking x-rays, root planing and soft tissue curettage. Dental hygienist shall not place sealants unless the patient has been examined and the treatment planned by a licensed dentist.

** Dental Access Advisory Committee will be developing additional laws and regulations to be completed by late 2002/early 2003*

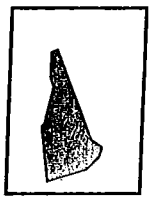
Missouri 2001

Statute 332.311.2

Dental hygienists may provide services without supervision in public health settings to Medicaid eligible children and be reimbursed by Medicaid.

Special Requirements: 3 years experience.

Services: prophylaxis, sealants, fluorides.



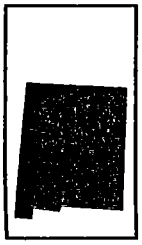
New Hampshire 1993

Rule 101.11(d)

Under "public health supervision" dental hygienists may provide procedures authorized by a dentist in a public or private school, hospital or institution, provided the dentist reviews patient records once in a 12 month period.

Special Requirements: None.

Services: Instruction in oral hygiene, topical fluorides, prophylaxis, assess medical/dental history, periodontal probing/charting.



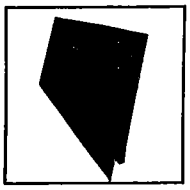
New Mexico 1999

Sec 61-5A-4D
Rule 16.5.17

Collaborative practice is based on a written agreement between the dental hygienist and one or more "consulting dentist(s)." Dental hygienists may treat patients according to a protocol with collaborative dentist or may obtain a diagnosis from dentist based on a hygienist report to dentist. May own or manage a dental hygiene practice in any setting. Must refer patient for dental exam yearly.

Special Requirements: 2400 hours active practice in past 18 months or 3000 hours in 2 of past 3 years.

Services: Each "collaborative practice agreement" must contain "protocols for care." For example, they must provide for standing orders allowing the dental hygienist to perform routine services such as preliminary assessment, x-rays, a prophylaxis and fluoride treatment without prior authorization. Case-by-case authorization will include such procedures as sealants and root planing.



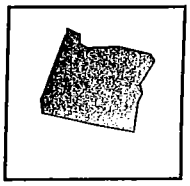
Nevada 1998

Rule 631.210.5

A dental hygienist who has special board authority may perform services in a health facility, school, or place designated by the board without supervision.

Statute 631.287

2001 law allows dental hygienists to obtain approval from the board to work as public health dental health hygienists in schools, community centers, hospitals, nursing homes and such other locations as the state dental health officer deems appropriate. No rules at this time.



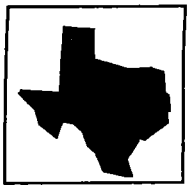
Oregon 1997

Sec. 680.200
Rule 818-035-0065

Dental hygienists who have obtained a limited access permit may initiate services for patients in a variety of limited access settings such as extended care facilities, facilities for the mentally ill or disabled, correctional facilities, schools and pre-schools, and job training centers. RDH must refer the patient annually to a licensed dentist available to treat the patient.

12 hours of CE every two years (in addition to the 24 hours required for all dental hygienists) to renew permit.

Services--All dental hygiene services, except that some (local anesthesia, pit and fissure sealants, denture soft lines, temporary restorations, radiographs and nitrous oxide) must be authorized by a dentist.



Texas 2001

Statute 262.1515

A dentist may delegate services without seeing the patient first to a dental hygienist practicing in a nursing facility or school based health center. The hygienist must refer the patient to a dentist following treatment. The hygienist may not perform a second set of services until the patient has been examined by a dentist.

Special Requirements: 2 years practice experience.

Services: No limitations.

Washington 1984
Sec. 18.29.056

Unsupervised practice in hospitals, nursing homes, home health agencies, group homes (for the elderly, handicapped or youth), state institutions under department of health and human services, jails and public health facilities, provided the hygienist refers to a dentist for dental treatment and planning.

Special requirements: Two years clinical experience within the last five years.

Services -- removal of deposits and stains, application of topical preventive or prophylactic agents, polishing and smoothing restorations, root planing and curettage. (The dental board has ruled that sealants are not included, but require general supervision).

WA 2001
Statute 18.29.220

Dental hygienists who are school endorsed may assess for and apply sealants and fluoride varnishes in community-based sealant programs carried out in schools.

Special Requirements: None for dental hygienists licensed as of April 19, 2001. Rules pending on educational requirements for dental hygienists licensed after that date.

Division of Governmental Affairs *July, 2002*

Class Code: 02515

STATE OF IOWA - DEPARTMENT OF PERSONNEL

PUBLIC HEALTH DENTAL DIRECTOR

DEFINITION

Plans and directs all work activities of the statewide public health dental program, developing comprehensive dental initiatives for prevention activities, evaluating program content and personnel effectiveness; performs related work as required.

The Work Examples and Competencies listed are for illustrative purposes only and not intended to be the primary basis for position classification decisions.

WORK EXAMPLES

Supervises and evaluates the work of subordinate staff; effectively recommends personnel actions related to selection, disciplinary procedures, performance, leaves of absence, grievances, work schedules and assignments, and administers personnel and related policies and procedures.

Administers the state public health dental program in order to prevent and control dental disease and promote good dental health practices by planning, budgeting, monitoring and providing technical assistance.

Evaluates procedures used in the public health dental program in order to revise present programs and develop new initiatives to increase program effectiveness by reviewing statistics of program reports and conducting evaluation site visits.

Coordinates the activities of the dental health section with other units of the Department of Health in order to promote dental health by integrating dental health into other health programs conducted by the Department.

Explains the program and its goals and objectives in order to promote and encourage interest in the public health dental program by talking to officials of public and private agencies.

Coordinates the development of instructional materials in order that the staff may utilize these in various programs conducted by the dental health section by providing advice and direction as required.

Collects and analyzes dental health statistics in order to plan, evaluate, and determine program needs, priorities, and effectiveness by reviewing dental staff activity reports, Maternal and Child Health Project reports, and various dental health survey data.

Performs public relations activities by preparing and giving speeches to dental hygiene students and interested civic groups to inform the public on general dental health.

Represents the Department by attending seminars, conferences, and other meetings, and by giving speeches as requested in order to discuss activities of the dental health unit as well as to gain knowledge useful to developing improved programs of dental public health for the State of Iowa.

COMPETENCIES REQUIRED

Knowledge of the principles and practices of modern dentistry and dental hygiene.

Knowledge of agency program functions, activities, and organization as they relate to the public health dental program.

Knowledge of the principles, problems, and methods of public and business administration, including organization, personnel, and fiscal management.

Knowledge of the methods and media used in health education.

Ability to plan, organize, control and effectively supervise the work of subordinates.

Ability to understand and interpret laws and regulations as they apply to the Department of Health and federally funded Maternal and Child Health projects.

Displays high standards of ethical conduct. Exhibits honesty and integrity. Refrains from theft-related, dishonest or unethical behavior.

Works and communicates with internal and external clients and customers to meet their needs in a polite, courteous, and cooperative manner. Committed to quality service.

Displays a high level of initiative, effort and commitment towards completing assignments efficiently. Works with minimal supervision. Demonstrates responsible behavior and attention to detail.

Responds appropriately to supervision. Makes an effort to follow policy and cooperate with supervisors.

Aligns behavior with the needs, priorities and goals of the organization.
Encourages and facilitates cooperation, pride, trust, and group identity. Fosters commitment and team spirit.
Expresses information to individuals or groups effectively, taking into account the audience and nature of the information. Listens to others and responds appropriately.

EDUCATION, EXPERIENCE, AND SPECIAL REQUIREMENTS
Graduation from an approved school of dentistry with a degree of Doctor of Dental Surgery or Doctor of Medical Dentistry, and two years of administrative experience in a public dental health program;

OR

substitution of a Master's degree in public health for one year only of the administrative experience required above.

NECESSARY SPECIAL REQUIREMENTS
Licensure to practice dentistry in the State of Iowa.
Effective Date: 12/99 BW

Protocol for Dental Assessment, Screening, and Educational Services by Licensed Dental Hygienists in public health settings

In accordance with 10.3(153) and 10.3(2) of the Iowa Board of Dental Examiner (IBDE) rules, a licensed dental hygienist is authorized to provide educational services, assessment, screening, or data collection for the preparation of preliminary written records for evaluation by a licensed dentist and is also authorized to provide services under the general supervision of a dentist. The Bureau of Oral Health considers these rules and encourages their compliance.

1. The Iowa Department of Public Health (IDPH) contracts with public health agencies to provide a variety of dental services. These agencies are required to either employ or subcontract with appropriate dental professionals. Dental hygienists employed in these settings provide dental screenings, fluoride varnish applications, oral health education and counseling, and referrals to local dentists.

2. Licensed dental hygienists providing care in a dental health professional shortage area or public health setting must do so in accordance with IBDE rules.

3. Contracts for specific dental programs monitored by the Bureau of Oral Health incorporate these rules into the **Description of Work section** of those contracts.

   For Example: Within IDPH school-based dental sealant programs, an Iowa-licensed dentist must examine all participating children and determine those children that would benefit from dental sealant application. Following such identification, licensed dental hygienists are utilized to provide dental sealant application under the general supervision of a dentist.

4. Public health agencies contracted by IDPH must have a plan for dental referrals and provision of care coordination services for low-income families to assist in scheduling dental appointments. Licensed dental hygienists shall utilize appropriate licensed dentists to provide dental examinations, monitoring, definitive diagnosis and treatment planning of those low-income individuals that benefit from dental assessment, screenings, and educational services provided by a licensed dental hygienist.

IOWA DEPARTMENT OF PUBLIC HEALTH
FLUORIDE VARNISH PROTOCOL

Fluoride Varnish Facts

Background

Fluoride varnishes have been used in Europe for more than 30 years, and have recently been approved for use in the United States. They received approval in the United States as cavity varnishes and desensitizing agents, however one of the most promising uses for fluoride varnishes is in the prevention of tooth decay. The use of fluoride varnish by dentists for this purpose is referred to as "off-label" use.

Fluoride Content and Uptake into Enamel

There are 3-4 fluoride varnishes available for use in the United States. Cavity Shield, Duraflor and Duraphat are brands commonly used. All contain 5% NaF. The varnishes contain 2.26% by weight fluoride ion in a colophony base. This forms a sticky layer on the tooth following application, which hardens on contact with saliva. Fluoride is then absorbed into the enamel of the tooth. It is recommended that the varnish be allowed to remain on the teeth for up to four hours for optimal absorption. A study by Koch and Petersson measured the levels of fluoride in extracted teeth following application of Duraflor, and found concentrations between 2,250 and 3,800 ppm in the enamel. It was also determined that increasing the time the varnish remained on the teeth from one to six hours more than doubled the fluoride level in the enamel.

Caries Prevention

Most studies have shown 25-45% reductions in the decay rate with the use of fluoride varnish. Of special note is the reduction of decay in pits and fissures, as well as on smooth surfaces of teeth. A two-year study by Holm using 225 3-year-olds resulted in a 44% caries reduction rate following semi-annual varnish applications.

Safety

The concentration of fluoride in varnishes is much higher than that of APF gels or other topical fluorides, however, due to the sticky form of the varnish and the small amount used per application, risk of ingestion and toxicity is very low. Less than 0.5 ml of varnish is usually required to coat the teeth of a young child.

Application of Fluoride Varnish

1. Criteria for the use of fluoride varnish include the presence of factors that put a person at risk for caries, including carious lesions, white-spot lesions, and a history of decay. An additional risk factor for young children is the presence of visible plaque on the primary incisors. Socio-economic status (especially income) can also be an indicator of risk, as low-income children and adults tend to experience more caries than higher-income children and adults.

2. Clean the teeth. The teeth need to be "toothbrush clean" before fluoride varnish is applied. Application after a dental prophylaxis is also acceptable.

3. Have the varnish ready. Use one small drop of varnish (.3 ml is enough for a child and .4 ml is enough for an adult), dispensing it on a tray cover or in a small cup.

Some fluoride varnishes are now packaged with the pre-measured varnish in a well.

4. Isolate and dry the quadrant to be treated. This can be accomplished with gauze or air. Drying should be thorough, but not excessive.

5. Apply the varnish with any convenient applicator to all exposed surfaces of the teeth, including the chewing and interproximal surfaces. Disposable brushes are very effective, or cotton-tipped applicators can be used.

6. Repeat for all remaining quadrants.

7. Ask the patient not to brush their teeth for four hours following the application. Adult patients and parents of children should be informed that the patient's teeth will look yellow until the varnish is brushed off. Manufacturers of fluoride varnish recommend a patient wait 30 minutes after application before eating or drinking.

8. Fluoride varnish should be applied at least twice a year. Applications 3 times a year or 3 times during a 1-week period are also effective.

Personnel Required for Fluoride Varnish Application

Fluoride varnish may only be applied by a licensed dentist, licensed dental hygienist, licensed physician or other health professional functioning within their scope of practice or licensure as provided under Iowa Medicaid rules.

Any amendment to the Title V budget must be approved by the Family Health Bureau prior to implementation.

PROTOCOLS FOR FOLLOW-UP SEALANT PROGRAM
WASHINGTON COUNTY

1. **Letter is mailed home to parents or guardians with results of dental screening and identifying which teeth were sealed. Included on these are contact persons and numbers including 1-800 number. Stamped, self addressed envelopes are included with those needing further treatment so parent/guardian can sign and mail back to public health for further referral also.**

2. **If emergency situations are diagnosed, the school nurse, social worker or dental program coordinator makes phone calls to the child's emergency contact person immediately. Emergency referrals are sent to family dentist or University of Iowa Dental College. Funding eligibility is also determined at this time.**

3. **Names of children needing further treatment or referrals are given to the school nurse and also to the public health social worker for further follow-up.**

4. **Once Public Health social worker receives the chart with necessary referral information, the family is contacted within three weeks of the child receiving the service. Social worker attempts to contact the family by telephone two-three times to explain reason for call. Messages will be left on answering machines. If telephone attempts are not successful then a letter explaining the reasons for follow up is sent. In the letter it is explained to the family the assistance our office is able to provide. Also it is explained that if the social worker does not hear from the family in two weeks then we will assume that our assistance is not necessary and that they are able to take care of the matter on their own.**

5. **In speaking with the family an attempt is made to identify resources the family needs such as, transportation or funding assistance. The social worker attempts to work directly with the family to provide resource and referral.**

6. **If the family accepts the assistance of the social worker then arrangements will be made for necessary appointments. The family is notified of the appointment that is scheduled. Two days prior to the scheduled appointment the social worker contacts the family to offer a reminder of the scheduled appointment.**

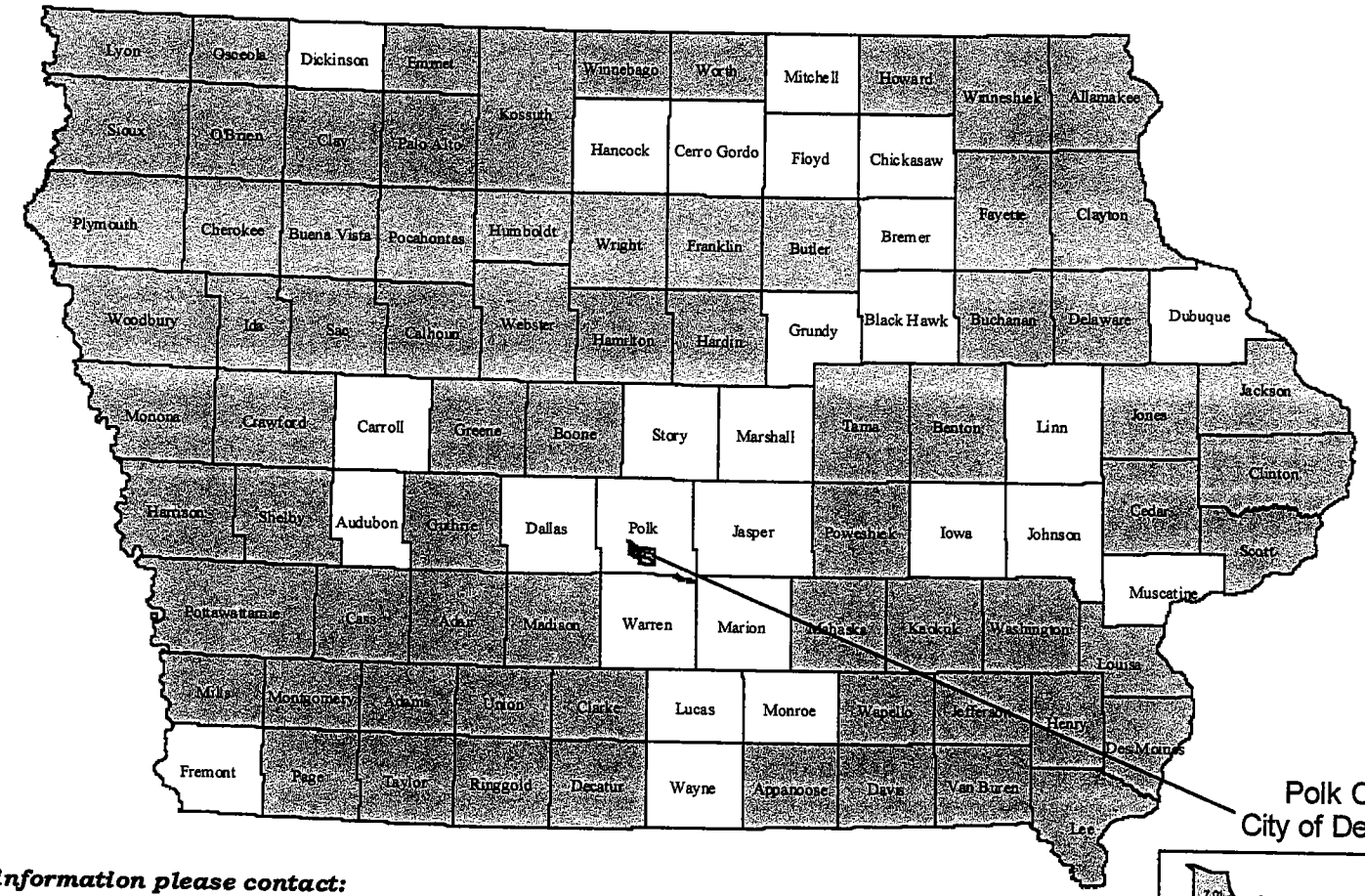
7. **After the child's scheduled appointment the social worker follows up with the dental office directly to a) make sure the child attended the appointment, b) to follow up on other scheduled appointments so reminders can be made to the family. If other appointments are scheduled then reminder of**

appointment and follow up after scheduled appointment is completed by social worker.

8. **If the family does not accept the assistance of social worker then this is noted in the child's chart. The social worker is prepared to offer names and phone numbers for the family to reach to meet the child's identified need.**

9. **All activities are documented in the child's chart so the dental program coordinator is able to refer to all notes then next year when sealant retention exams occur.**

Dental Health Professional Shortage Areas (HPSAs)
November 2001



For further information please contact:

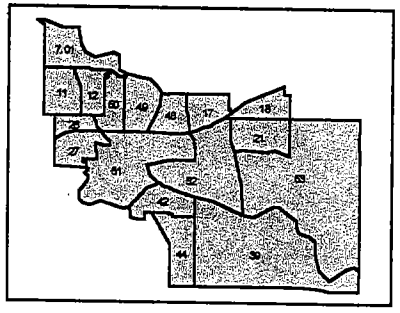
Iowa Department of Public Health
Division of Community Health
Bureau of Health Care Access
Lucas State Office Building, 5th Floor SE
321 East 12th Street
Des Moines, Iowa 50319-0075
www.idph.state.ia.us

Carl Kulczyk, 515 281-7223
ckulczyk@idph.state.ia.us

Lloyd Burnside, 515 242-6879
lburnsid@idph.state.ia.us

N

Iowa County Boundaries
HPSA Designation
Population-Low Income



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FY 2001 Dental Screens

County Number	County Name	Agency Number	Total Eligible Age 1-20	Total Receiving Any Dental Services (00100-09999) Age 1-20	Percent Receiving Any Dental Services (00100-09999) Age 1-20	Total Receiving Preventative Dental (01000 - 01999) Age 1-20	Precent Receiving Preventative Dental (01000 - 01999) Age 1-20	Total Receiving Dental Treatment (02000 - 09999) Age 1-20	Precent Receiving Dental Treatment (02000 - 09999) Age 1-20
1	Adair	127	368	140	38.04%	117	31.79%	67	18.21%
2	Adams	112	303	87	28.71%	60	19.80%	40	13.20%
3	Allamakee	124	642	326	50.62%	280	43.61%	147	22.90%
4	Appanoose	101	1208	465	38.49%	377	31.21%	195	16.14%
5	Audubon	107	302	105	34.77%	63	20.86%	46	15.23%
6	Benton	125	967	423	43.74%	332	34.33%	182	18.82%
7	Black Hawk	102	9794	4063	41.46%	2976	30.39%	1698	17.34%
8	Boone	105	1226	387	31.57%	294	23.98%	115	9.38%
9	Bremer	102	903	385	42.64%	289	32.00%	159	17.61%
10	Buchanan	102	1226	587	47.88%	488	39.80%	269	21.94%
11	Buena Vista	113	1256	422	33.60%	317	25.24%	176	14.01%
12	Butler	111	643	290	45.10%	193	30.02%	109	16.95%
13	Calhoun	107	579	196	33.85%	160	27.63%	102	17.62%
14	Carroll	107	880	376	42.73%	311	35.34%	196	22.27%
15	Cass	123	812	284	34.98%	216	26.60%	125	15.39%
16	Cedar	103	699	221	31.62%	171	24.46%	87	12.45%
17	Cerro Gordo	111	2674	1185	44.32%	946	35.38%	477	17.84%
18	Cherokee	122	567	255	44.97%	170	29.98%	105	18.52%
19	Chickasaw	124	656	285	43.45%	226	34.76%	113	17.23%
20	Clarke	126	663	202	30.47%	158	23.83%	90	13.57%
21	Clay	113	868	329	37.90%	244	28.11%	135	15.55%
22	Clayton	124	739	331	44.79%	281	38.02%	143	19.35%
23	Clinton	134	3908	1341	34.31%	956	24.46%	601	15.38%
24	Crawford	123	1173	366	31.20%	244	20.80%	161	13.73%
25	Dallas	107	1375	424	30.84%	314	22.84%	165	12.00%
26	Davis	101	452	180	39.82%	152	33.63%	68	15.04%
27	Decatur	126	616	206	33.44%	154	25.00%	104	16.88%
28	Delaware	108	741	324	43.72%	279	37.65%	143	19.30%
29	Des Moines	110	3247	1022	31.48%	747	23.01%	386	11.89%
30	Dickinson	113	583	219	37.56%	144	24.70%	102	17.50%
31	Dubuque	108	4310	2416	56.06%	2200	51.04%	984	22.37%
32	Emmet	113	664	281	42.32%	204	30.72%	160	24.10%
33	Fayette	124	1424	656	46.06%	609	42.77%	318	22.33%
34	Floyd	111	1076	491	45.63%	404	37.55%	211	19.61%
35	Franklin	111	572	208	36.36%	167	29.20%	60	10.49%

FY 2001 Dental Screens

County Number	County Name	Agency Number	Total Eligible Age 1-20	Total Receiving Any Dental Services (00100-09999) Age 1-20	Percent Receiving Any Dental Services (00100-09999) Age 1-20	Total Receiving Preventative Dental (01000 - 01999) Age 1-20	Precent Receiving Preventative Dental (01000 - 01999) Age 1-20	Total Receiving Dental Treatment (02000 - 09999) Age 1-20	Precent Receiving Dental Treatment (02000 - 09999) Age 1-20
36	Fremont	126	569	183	32.16%	133	23.37%	89	15.64%
37	Greene	107	592	235	39.70%	201	33.95%	102	17.23%
38	Grundy	102	288	108	37.50%	72	25.00%	46	15.97%
39	Guthrie	107	636	242	38.06%	205	32.39%	128	20.28%
40	Hamilton	115	811	222	27.37%	167	20.58%	96	11.84%
41	Hancock	111	525	239	45.52%	218	41.52%	106	20.19%
42	Hardin	125	1128	386	34.22%	286	25.35%	145	12.85%
43	Harrison	123	965	430	43.65%	351	35.63%	189	19.19%
44	Henry	117	1090	472	43.30%	421	38.62%	175	16.05%
45	Howard	124	453	204	45.03%	175	38.63%	78	17.22%
46	Humboldt	115	423	169	39.95%	114	26.95%	79	18.68%
47	Ida	122	351	147	41.88%	104	29.63%	69	19.66%
48	Iowa	130	645	176	27.29%	130	20.16%	60	9.30%
49	Jackson	103	1111	493	44.37%	415	37.35%	217	19.53%
50	Jasper	133	1452	534	36.78%	321	22.11%	225	15.50%
51	Jefferson	101	997	411	41.22%	340	34.10%	179	17.95%
52	Johnson	130	3615	1252	34.63%	986	27.28%	504	13.94%
53	Jones	103	873	381	43.64%	302	34.59%	185	21.19%
54	Keokuk	101	759	297	38.62%	246	31.99%	117	15.21%
55	Kossuth	111	724	307	42.40%	246	33.98%	136	18.78%
56	Lee	135	3060	930	30.39%	636	20.78%	372	12.16%
57	Linn	131	9585	3940	41.11%	3260	34.01%	1676	17.49%
58	Louisa	106	956	263	27.51%	195	20.40%	133	13.91%
59	Lucas	126	722	275	38.09%	226	31.30%	139	19.25%
60	Lyon	122	458	137	29.27%	100	21.37%	67	14.32%
61	Madison	127	611	239	39.12%	196	32.08%	86	14.08%
62	Mahaska	133	1359	580	42.69%	480	35.32%	211	15.53%
63	Marion	126	1351	402	29.76%	290	21.47%	167	12.36%
64	Marshall	125	2774	912	32.88%	706	25.45%	329	11.86%
65	Mills	128	882	331	37.53%	254	28.80%	151	17.12%
66	Mitchell	111	393	198	51.70%	157	40.99%	84	21.93%
67	Monona	123	630	237	37.62%	193	30.63%	110	17.46%
68	Monroe	126	596	245	41.11%	191	32.05%	113	18.96%
69	Montgomery	112	896	321	35.83%	222	24.78%	159	17.75%
70	Muscatine	106	3181	897	28.20%	619	19.46%	363	11.41%

EPSDT HCFA 416 Rpt

FY 2001 Dental Screens

County Number	County Name	Agency Number	Total Eligible Age 1-20	Total Receiving Any Dental Services (00100-09999) Age 1-20	Percent Receiving Any Dental Services (00100-09999) Age 1-20	Total Receiving Preventative Dental (01000 - 01999) Age 1-20	Precent Receiving Preventative Dental (01000 - 01999) Age 1-20	Total Receiving Dental Treatment (02000 - 09999) Age 1-20	Precent Receiving Dental Treatment (02000 - 09999) Age 1-20
71	O'Brien	113	598	209	34.95%	163	27.26%	108	18.06%
72	Osceola	113	252	62	24.60%	42	16.67%	30	11.90%
73	Page	112	1175	375	31.89%	287	24.40%	173	14.71%
74	Palo Alto	113	430	155	36.05%	108	25.12%	71	16.51%
75	Plymouth	122	919	272	29.60%	205	22.31%	128	13.93%
76	Pocahontas	113	433	145	33.26%	111	25.46%	68	15.60%
77	Polk	132	22958	8492	36.99%	6909	30.10%	3623	15.78%
78	Pottawattamie	126	6817	2571	37.71%	1989	29.18%	1191	17.32%
79	Poweshiek	133	760	283	37.24%	202	26.58%	120	15.79%
80	Ringgold	127	349	116	33.24%	64	18.34%	45	12.89%
81	Sac	107	589	222	37.69%	155	26.32%	105	17.83%
82	Scott	120	12656	4784	37.80%	3585	28.33%	2090	16.51%
83	Shelby	123	517	225	43.52%	167	32.30%	105	20.31%
84	Sioux	122	1173	392	33.42%	293	24.98%	209	17.82%
85	Story	105	2127	673	31.64%	558	26.23%	241	11.33%
86	Tama	125	883	268	30.35%	200	22.65%	113	12.80%
87	Taylor	112	541	184	34.01%	137	25.32%	80	14.79%
88	Union	127	751	251	33.42%	188	25.03%	107	14.25%
89	Van Buren	101	490	168	34.29%	142	28.98%	56	11.43%
90	Wapello	101	3312	1387	41.88%	1183	35.72%	518	15.64%
91	Warren	126	1332	506	37.99%	396	29.73%	200	15.02%
92	Washington	117	964	399	41.39%	339	35.17%	148	15.35%
93	Wayne	126	453	164	36.20%	126	27.81%	77	17.00%
94	Webster	115	2882	1084	37.6[illegible]%	864	29.96%	446	15.48%
95	Winnebago	111	547	209	38.2[illegible]%	156	28.55%	88	16.09%
96	Winneshiek	124	673	281	41.75%	224	33.28%	110	16.34%
97	Woodbury	116	8518	2486	29.19%	1703	19.99%	1220	14.32%
98	Worth	111	241	107	44.40%	77	31.95%	47	19.50%
99	Wright	115	797	279	35.01%	214	26.85%	133	16.69%
	State		167746	63061	37.59%	49192	29.33%	26945	16.06%

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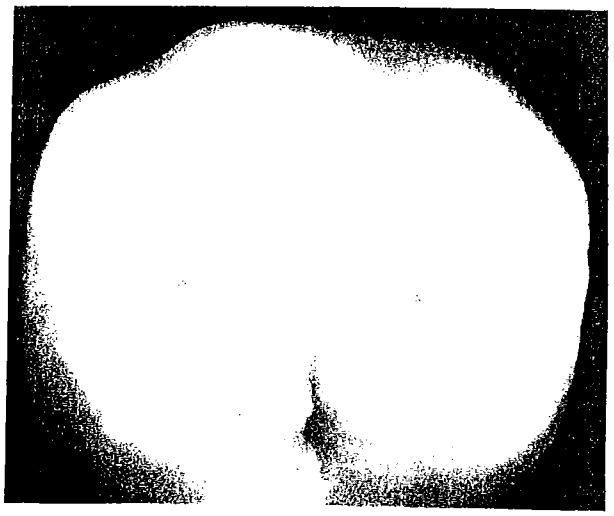
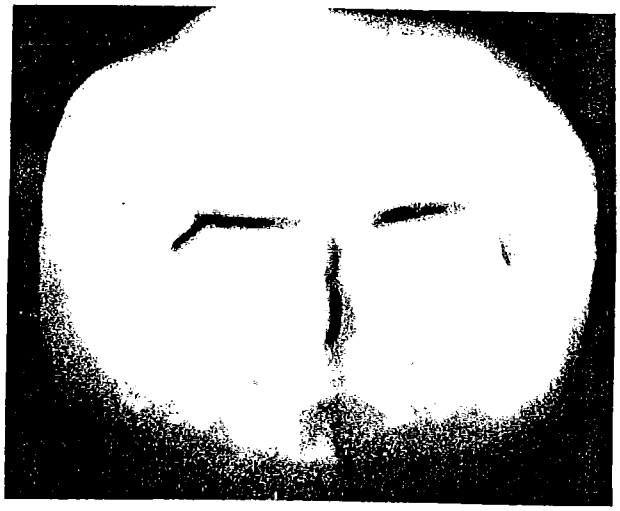
Journal of Public Health Dentistry 199

FIGURE 3
Clinical Presentation of Pit and Fissure Tooth Surfaces According to Category of Dental Caries: Caries free, Enamel Caries, Dentin Caries
(photos courtesy of Professor Ivar Espelid, University of Bergen, Norway)



Caries free

Enamel caries



Dentin caries

ies activity in the mouth (Figure 2).

Pit and Fissure Morphology: Pit and fissure morphology has been shown to be a significant factor in predicting caries risk (30). Previous guidelines have stated clearly that teeth with well-coalesced pits and fissures and wide, easily cleaned grooves usually do not require sealing (7,49-51). Teeth with deep pits and fissures that catch an explorer are ideal candidates for sealants.

Permanent molars have the most susceptible pits and fissures. Premolars are much less susceptible to occlusal caries than permanent molars (8-10,38). Therefore, fewer premolars will be indicated for sealant application than permanent molars. The need for sealant use in first and second primary molars also is determined by the pit and fissure morphology and the life expectancy of the tooth. Primary molars, particularly second molars, can demonstrate deep pits and fissures. Sealants may be indicated on primary molars with clear evidence of pit and fissure caries activity or deep and/or stained fissures, particularly if proximal tooth contact does not exist. In such cases, sealant application is indicated consistent with the overall assessment of the individual's risk and the life expectancy of the tooth.

Questionable Caries: Sometimes it is difficult to distinguish sound pits and fissures from those with caries limited to enamel. In this situation, commonly referred to as questionable caries (7), a tooth would be considered at risk for dental caries and should receive a sealant. A sealant placed over a carious lesion limited to enamel will prevent the progression of undiagnosed caries, should it be present. This approach is justified, since it has been shown that if a diagnostic error occurs and caries is sealed, the lesion will not progress, but will arrest, provided the sealant remains intact (17-20).

Eruption Status: Previous guidelines have stressed the need to seal the tooth immediately after eruption (7,49,50). However, studies have suggested that adequate isolation is essential for sealant retention and that sealant success is positively associated with the eruption status of the teeth and the operator's ability to maintain a dry field (13). Whenever possible, therefore, it is recommended that the sealant placement be delayed until the tooth is sufficiently erupted.

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

DEPARTMENT OF PUBLIC HEALTH
STEPHEN C. GLEASON, D.O., DIRECTOR

September 19, 2002

Shelia Temple, RDH
Iowa Dental Hygiene Association, President
Washington Co. PHN Service
314 McCreedy Drive
Washington, IA 52353

Dear Ms. Temple:

I am writing to congratulate you on the innovative approach to improving access to oral health care in the State of Iowa. Specifically, the matter of allowing registered dental hygienists to perform standard dental hygiene duties in public health settings or dental health professional shortage areas.

As you well know a number of people, particularly children are without dental homes in Iowa. This number is disproportionately high for children from low-income families or who are enrolled in the Medicaid or hawk-I health insurance programs. The same is true for low-income elderly living in long term care facilities.

In an attempt to insure that every child/senior has access to preventive dental services such as dental sealants and fluoride varnish applications it is imperative that dental hygienists be included as part of the solution to providing this care. This does not exclude the need of having a dentist to perform initial examinations, diagnosis and treatment planning. Rather it is to suggest that we can no longer withhold preventive and routine oral health care traditionally performed by dental hygienist where dentist are unable or unwilling to provide theses services.

As Dental Director for the Department of Public Health, I am confident that both the committee members and board members will make every effort to give careful consideration to your proposal for word change to 650-1.1 (153) that will benefit Iowa's most vulnerable populations.

Respectfully Submitted,

Hayley L. Harvey, DDS MS
Public Health Dental Director

LUCAS STATE OFFICE BUILDING / 321 E. 12TH ST. / DES MOINES, IOWA 50319-0075
DEAF RELAY (HEARING OR SPEECH IMPAIRED) 1-800-735-2942 / INTERNET: HTTP://WWW.IDPH.STATE.IA.US/

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THE UNIVERSITY OF IOWA

October 8, 2002

Sheila Temple, RDH
Iowa Dental Hygiene Association, President
Washington County, PHN Service
314 McCreedy Drive
Washington, IA 52353

Dear Ms. Temple,

I am writing to extend my personal support for your efforts to improve oral health access in Iowa. It is my understanding that the Iowa Dental Hygiene Association is seeking approval of the Iowa Board of Dental Examiners to allow registered dental hygienists to provide preventive dental services and referral recommendations to underserved and vulnerable populations. From my perspective as a geriatric dentist, this effort could be nationally viewed as continued leadership from the state of Iowa on the dental access issue.

As you and many of the members of the Iowa Dental Board are aware, Senator Grassley led the national investigation to determine why nursing home residents were among the groups identified in the Surgeon General's report as having poor access to oral care. Senator Grassley was the first to request national nursing home data of oral care in nursing homes. I worked with several others at the University of Iowa, College of Dentistry to provide information for the first national oral health education program for nursing home surveyors. The Iowa Department of Inspections and Appeals led the nation in providing mandatory, comprehensive oral health training for representative of all state nursing homes and for all state surveyors. Including nursing homes as public health settings for the preventive practice of dental hygienists will continue the leadership of Iowa that is of value at both the state and national levels.

While my supportive position of this effort is independent of the College of Dentistry or the Department of Preventive and Community Dentistry, my experience in teaching in the nationally recognized Special Care Program provides daily evidence of the need of this ruling. The oral health referral of our state's most frail elders who have the highest prevalence of oral disease currently depends on the assessment skills of nursing staff and physicians who have very limited training in this area. (The University of Iowa College of Medicine removed the oral health didactic class from their curriculum over eight years ago.) I believe that improving access to dental care means improving the access to the dentist. I believe that dental hygienists are well trained to provide preventive, education, and referral services desperately needed and federally required in nursing facilities. Such a ruling will bring the oral care of nursing home residents into the realm of the dental profession where it belongs. Thank you, and I welcome the opportunity to discuss this topic further.

Sincerely,

Catherine Watkins

Catherine Watkins DDS, MS, PhD
Assistant Professor
Department of Preventive and Community Dentistry

THE UNIVERSITY OF IOWA

September 23, 2002

Jennifer Hart, Executive Officer
Dental Hygiene Committee of the Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

Dear Members of the Dental Hygiene Committee:

I have had an opportunity to review the request that has been forwarded to you by the Iowa Dental Hygiene Association related to adopting a rule allowing public health supervision of dental hygienists in Iowa. It is my understanding that this would allow dental hygienists working in public health settings to provide preventive dental services to underserved and at-risk populations. It is also my understanding that the hygienists providing theses services would be following protocols adopted by the State's Department of Public Health, under the direction of the State of Iowa's Dental Director.

I am in favor of this ruling as I believe it will increase access to valuable preventive services for children in Iowa who either don't have access to dental care, or whose parents do not take them to the dentist until it is too late. I am hopeful that the Iowa Dental Association, the Iowa Dental Hygiene Association, and the Iowa Board of Dental Examiners can work together on this issue, and can come to an agreement that will help improve the oral health of all children in Iowa.

My position in support of this ruling is independent, and does not necessarily represent the position of either the College of Dentistry or of the Department of Pediatric Dentistry. Thank you, and please feel free to contact me if you have questions.

Sincerely,

Michael Kanellis

Michael Kanellis, DDS, MS
Associate Professor and Head
Department of Pediatric Dentistry

College of Dentistry | Department of Pediatric Dentistry | 201 Dental Science S, Iowa City, Iowa 52242-1001 | 319/335-7479, Fax 319-353-5508

September 17, 2002

Jennifer Hart, Executive Officer
Dental Hygiene Committee of the Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

Dear Members of the Dental Hygiene Committee:

As the lead health specialist for Region VII Head Start, I can attest to the critical need of Early Head Start and Head Start children for quality dental care. Our performance standards mandate the all children receive thorough screening within 45 days of enrollment. This screening includes oral health status. Within 90 days, children need an examination by a dental professional.

Research in states such as Maryland show that when a trained dental professional conducts the initial Head Start screening, the number of early childhood caries identified almost doubles. Our Head Start programs have a very high level of respect for the competence and commitment of dental hygienists.

Therefore, we support the petition of the Iowa Dental Hygienists' Association to the Iowa Board of Dental Examiners to adopt a rule allowing public health supervision of a dental hygienist. This type of supervision would allow a dental hygienist to provide dental hygiene services following protocols approved by the dental bureau of the department of public health in settings which provide care for dentally underserved and at risk populations, other than in the private dental office.

In Early Head Start and Head Start, our teachers and home visitors see the negative impact of undetected oral health problems. Children suffering from caries lack the enthusiasm, energy, and concentration to learn, interact positively with others, and play. We are committed to doing our part in prevention, onsite oral hygiene and family education. Please support changes in regulations that increase the population of dental professionals who can provide the professional support we desperately need.

Sincerely,

Marcia A. Manter
Region VII Head Start Health Specialist

Mid-Iowa Community Action, Inc.

126 S. Kellogg, Suite 1
Ames, IA 50010-7031

Phone: (515) 956-3312
Fax: (515) 956-3310

October 7, 2002

Dear IBOBE and IDHA Members:

I would like to give my strong support of the IDHA's proposal for the use of the dental hygienists under public health supervision

I am involved with the EPSDT program and the Dental Task Force for Story County. Many children, adults and the elderly are uninsured or underinsured. No dentists in our area are taking Title XIX clients. Most of our Story County dentists are on a full payment on the day of service. It is difficult for many of my clients to pay $100-300 even if they will be reimbursed in 4-6weeks. We are having a dental crisis and professional dental care is becoming a luxury rather than a routine care. It is very sad when a parent tells me that they can't afford dental care and they are barely making enough to pay their rent and buy food.

Ideally, everyone should have a dental home, have routine exams and cleanings. With the current tight budgetary dilemma that we are facing requires more creative approaches to make our dental funding meet the maximum need. Approval of public health supervision for the educated and experienced dental hygienists is one way to increase access and actually save time and money compared with direct and general supervision. Dental screening and education by dental hygienist will be very cost effective as well as having a big impact on oral health. Please consider these factors as you make your decision. Thank you for your time and effort.

Sincerely,

Cecelia Nassif, A.R.N.P.

October 7, 2002

Dear IBODE and IDHA members:

On behalf of Mid-Iowa Community Action (MICA), I would like to state strong support of the IDHA's proposal for the use of dental hygienists under public health supervision.

Story County has a full third of its population under 200 percent of federal poverty guidelines; this translates to nearly 27,000 individuals in Story County alone. Many of these are children, elderly and the "working poor," who are either uninsured or receiving Title XIX benefits. Because no Story County dentists are seeing new Title XIX patients, and the uninsured cannot afford to pay out-of-pocket expenses, these persons' dental needs largely go untreated.

To help meet these needs of the underserved, MICA was recently awarded a generous grant from the Robert Woods Johnson Foundation with dollar-for-dollar matching funds from local donors to open a three-operatory fixed dental clinic and elderly outreach program in nursing homes. We anticipate opening in mid-December. Local dentists will volunteer their services one night per week, with a hygienist staffing the clinic two days per week to start.

Allowing the hygienist to perform preventive services under public health supervision would greatly increase the number of individuals we could see, versus limiting the number of new patients to only those that could be seen by the dentist one evening per week. Referrals for those patients seen by the hygienist at the initial visit would be made to the dentist serving the clinic that week or the next.

Increasing dental care access to those Iowans who need it most requires creative approaches in these tight budgetary times. Approval of public health supervision for educated and experienced dental hygienists is one way to increase access and actually save time and money compared with direct and general supervision requirements. I urge you to consider these factors carefully. Thank you for your efforts.

Sincerely,

VaLinda Parsons, R.D.H., B.S.

VaLinda Parsons, R.D.H., B.S.
Project Director, Story County Community Dental Clinic

Sheila Temple

From: "Jan Brown" <JBrown2521@compuserve.com>
To: "Sheila Temple" <classcutedo@hotmail.com>
Sent: Tuesday, October 08, 2002 6:22 PM
Subject: Suport Letters modification

October 7, 2002
Jennifer Hart, Executive Officer
Dental Hygiene Committee of the Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

Dear Members of the Dental Hygiene Committee:

As director of the Des Moines Health Center, we are constantly challenged to meet the many needs of our patients. By improving access to preventive services such as sealants and fluoride varnish, we are beginning to meet those needs. If dental hygienists could add preventive services such as prophys under this purposed public health supervision rule, access to care would again be improved. Preventive services would reduce the amount of treatment needed, treatment plans would reduce and the available dentists would see more patients. At the Des Moines Health Center we currently have a pediatric dentist who spends one day a week at the hospital providing dental care to children with decay so extensive they can not be seen in the clinic. If these children would have had earlier preventive dental care, that a dental hygienist could provide, much of their decay could have been prevented. We lose valuable treatment time in the clinic when the dentist has to go to the hospital.

Therefore, I support the petition of the Iowa Dental Hygienists' Association to the Iowa Board of Dental Examiners to adopt a rule allowing public health supervision of a dental hygienist. This type of supervision would allow a dental hygienist to provide dental hygiene services following protocols approved by the dental bureau of the department of public health in settings which provide care for dentally underserved and at risk populations, other than in the private dental office. All dental hygienists who have passed regional and national boards and have a valid license should, by virtue of their education be able to perform dental hygiene services with minimal supervision.

Increasing the access to dental care that public health supervision would provide is a win-win situation. As dental treatment needs are reduced by preventive services, dental providers will be able to see more patients. Please support changes in regulations that increase the population of dental professionals who can provide the professional support we desperately need.

Sincerely,

Mike DeAnda
Executive Director
Des Moines Health Center
1111 9th Street
Des Moines, IA 50314

DesMoines
PUBLIC SCHOOLS

Department of Health Services

August 13, 2002

To whom it may concern:

I am writing in enthusiastic support of proposed language changes in the Iowa Code that would allow dental hygienists to provide preventative dental health services to under-served populations and high risk individuals without the Dentist having to be in the proximate area of the service being provided.

There are many barriers to accessing preventative dental health care services in Iowa. Every year, through the fine efforts of the Des Moines Health Center, children attending Des Moines Schools are identified with dental needs that require follow-up. Reasons cited by parents as to why they do not obtain regular preventative dental services for their children are that they do not have the money to pay for the services, they do not have dental health insurance or there are not enough dentists in the community who can take new patients. There is a shortage of area dentists that accept patients who do not have dental insurance. As a result, parents oftentimes forgo preventative dentistry with the hope that their child will be lucky and not need corrective or restorative dental care down the line.

We have been fortunate through our collaborations with the Des Moines Health Center to be able to offer dental education, dental screening and sealant placement services to many under-served, high-risk student populations. Due to the successes we have enjoyed through this collaboration, I would support changes in current law that would expand programs of this nature to other high need groups or expand the ability of dental hygienists to offer further preventative health services without the dentist being in the proximate area.

If you have any questions or would like to visit with me, please call me at (515) 242-7618. Thank you.

Jean Phillips

Jean Phillips
Health Services Facilitator

1801 16th Street Des Moines, Iowa 50314-1992
515-242-7831 Fax: 515-242-8267 Web site: www.des-moines.k12.ia.us

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

IOWA BOARD OF DENTAL EXAMINERS
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

Agenda

Meeting November 13, 2002
400 SW 8th St., Suite D
Des Moines, Iowa

Noon — Call Meeting to Order

Consideration of Rules

Petition for Rulemaking submitted by Iowa Dental Hygienists' Association
Request to amend 650 Chapter 1.1(153) by adding a new definition of "public health supervision of a dental hygienist"

Iowa Administrative Code 650
Chapter 27, Standards of Practice and Principles of Professional Ethics
Consideration of sub rule 27.7(8)

4:00 p.m. — * Consideration of Complaints

5:00 p.m. — Adjourn

If you require the assistance of auxiliary aids or services to participate in or attend the meeting because of a disability, please call the office of the Board at 515/281-5157.

The times given for discussion of agenda items are approximate times and are intended to serve only as a general guide. The actual time of the discussion of each agenda item may occur earlier or later than the stated time.

*This portion of the meeting may be conducted in closed session to discuss confidential matters that may concern patient records and reports on the condition, diagnosis, care or treatment of a patient or investigation reports and other investigative information which is privileged and confidential under the provisions of Section 22.7(2) and 272C.6(4) of the 2001 Code of Iowa.

400 SW 8th STREET, SUITE D, DES MOINES, IA 50309-4687
PHONE:515-281-5157 FAX:515-281-7969 http://www.state.ia.us/dentalboard

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schmudlach@ialawyers.com

November 13, 2002

Dr. LeRoy Strohman
Chairperson
Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687

Re: Iowa Dental Association Response to IDHA Petition For Rulemaking to Allow Public Health Supervision of Dental Hygienists

Dear Dr. Strohman:

This firm represents the Iowa Dental Association ("Association") regarding regulatory matters. The purpose of this letter is to inform the Iowa Board of Dental Examiners ("Board") of a variety of procedural and regulatory concerns regarding the petition for rulemaking submitted by the Iowa Dental Hygienists Association ("IDHA") to allow public health supervision of dental hygienists. For the reasons described below, the Association respectfully requests that the Board either deny the IDHC's petition for rulemaking or delay action on the request until these issues are resolved.

Summary of Relevant Statutory and Regulatory Provisions

Iowa Code Chapter 153 contains the statutory requirements which must be followed in the practice of dentistry. The "practice of dentistry" is defined in Section 153.13 as follows:

> For the purpose of this subtitle the following classes of persons shall be deemed to be engaged in the practice of dentistry:
>
> 1. Persons publicly professing to be dentists, dental surgeons, or skilled in the science of dentistry, or publicly professing to assume the duties incident to the practice of dentistry.
>
> 2. Persons who perform examination, diagnosis, treatment, and attempted correction by any medicine, appliance, surgery, or other appropriate

> method of any disease, condition, disorder, lesion, injury, deformity, or defect of the oral cavity and maxillofacial area, including teeth, gums, jaws, and associated structures and tissue, which methods by education, background experience, and expertise are common to the practice of dentistry.

In contrast, Section 153.15 defines the scope of term of dental hygienists in Iowa. This section states the following:

> A licensed dental hygienist may perform those services which are educational, therapeutic, and preventive in nature which attain or maintain optimal oral health as determined by the board of dentistry and may include but are not necessarily limited to complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, obtaining and preparing nonsurgical, clinical and oral diagnostic tests for interpretation by the dentist, preparation of preliminary written records of oral conditions for interpretation by the dentist. *Such services shall be performed under supervision of a licensed dentist* and in a dental office, a public or private school, public health agencies, hospitals, and the armed forces, *but nothing herein shall be construed to authorize a dental hygienist to practice dentistry.*

(Emphasis added).

The Iowa Board of Dental Examiners rules governing the practice of dentistry are contained at Iowa Administrative Code Part 650. Section 650-1.1 contains definitions which are relevant to these regulations. The "practice of dental hygiene" is defined as follows:

> *'Practice of dental hygiene'* as defined in Iowa Code section 153.15 means the performance of the following educational, therapeutic, preventive and diagnostic dental hygiene procedures *which are delegated by and under the supervision of a dentist* licensed pursuant to Iowa Code chapter 153.
>
> 1. Educational: Assessing the need for, planning, implementing, and evaluation oral health education programs for individual patients and community groups; conducting workshops and in-service training sessions on dental health for nurses, school personnel, institutional staff, community groups and other agencies providing consultation and technical assistance for promotional, preventive and educational services.
>
> 2. Therapeutic: Identifying and evaluation factors which indicate the need for and performing (a) oral prophylaxis, which includes supragingival and subgingival debridement of plaque, and detection and removal of calculus with instruments or any other devices; (b) periodontal scaling and root planning; (c) removing and polishing hardened excess restorative material; (d) administering

> local anesthesia with the proper permit; (d) administering nitrous oxide inhalation analgesia in accordance with 650-subrules 29.6(4) and 29.6(5); (f) applying or administering medicaments prescribed by a dentist, including chemotherapeutic agents and medicaments or therapies for the treatment of periodontal disease and caries.
>
> 3. Preventive: Applying put and fissure sealants and other medications or methods for caries and periodontal disease control; organizing and administering fluoride rinse or sealant programs.
>
> 4. Diagnostic: Reviewing medical and dental health histories; performing oral inspection; indexing dental and periodontal disease; making occlusal registrations for mounting study casts; testing pulp vitality; analyzing dietary surveys.
>
> The following services may only be delegated by a dentist to a dental hygienist: administration of local anesthesia, placement of sealants, and the removal of any plaque, stain, calculus, or hard natural or synthetic material except by toothbrush, floss, or rubber cup coronal polish.

(Emphasis added).

I.A.C. 650-Chapter 10 deals with the licensure of dentists and dental hygienists. Section 10.3 requires that dental hygienist services must be provided under the supervision of a licensed dentist. This section states the following:

> 10.3(1) The administration of local anesthesia or nitrous oxide inhalation analgesia shall only be provided under the direct supervision of a dentist. Direct supervision of the dental hygienist requires that the supervising dentist be present in the treatment facility, but it is not required that the dentist be physically present in the treatment room.
>
> 10.3(2) *All other authorized services provided by a dental hygienist shall be performed under the general supervision of a dentist currently licensed in the state of Iowa.* General supervision shall mean that a dentist has examined the patient and has prescribed authorized services to be provided by a dental hygienist. The dentist need not be present in the facility while these services are being provided. If a dentist will not be present, the following requirements shall be met:
>
> . . . [sections deleted]
>
> *Subsequent examination and monitoring of the patient, including definitive diagnosis and treatment planning, is the responsibility of the dentist and shall be carried out in a reasonable period of time in accordance with the professional*

judgment of the dentist based upon the individual needs of the patient.

. . .

10.3(3) *A dental hygienist shall not practice independent from the supervision of a dentist nor shall a dental hygienist establish or maintain an office or other workplace separate or independent from the office or other workplace in which the supervision of a dentist is provided.*

(Emphasis added).

Section 650-10.4 deals with the unauthorized practice of dentistry, and states that "[a] dental hygienist who . . . renders dental service(s) directly or indirectly on or for members of the public other than as an employee or independent contractor supervised by a licensed dentist shall be deemed to be practicing illegally . . . The unauthorized practice of dental hygiene also means the performance of services by a dental hygienist which exceeds the scope of practice granted in Iowa Code section 153.15.

These statutory and regulatory provisions make clear distinctions between the responsibilities of Iowa licensed dentists and dental hygienists.

Summary of Proposed Rulemaking By Iowa Dental Hygienists' Association

On September 13, 2002, the IDHA submitted a petition for rulemaking to the Iowa Board of Dental Examiners and the Board, proposing to amend I.A.C. 650-1.1 by adopting the following new definition:

> "Public health supervision of a dental hygienist" means that the dental hygienist is following protocols approved by the bureau of oral health at the department of public health when providing care in settings for dentally underserved and at risk populations, other than in the private dental office. The dental hygienist must have a minimum of 2,500 hours of clinical practice within three of the last five years and possess a baccalaureate degree, or be currently employed in a public health setting prior to January 2003. The dental hygienist may provide services within the scope of dental hygiene practice as established in 650-10.3 (153), except for the administration of local anesthesia or nitrous oxide inhalation analgesia, and must inform the individual, parent, or authorized gent that referral to a dentist is necessary for dental planning and treatment.

The proposed rule contains no other provisions, nor does it propose to revise any other portions of the Board's regulations.

Iowa Dental Association Comments and Concerns Regarding Proposed Rulemaking

The Association has concerns regarding the rule proposed by the IDHA. Following is an

explanation of these concerns.

Concern #1: The proposed rule is inconsistent with other rules promulgated by the Iowa Board of Dental Examiners.

The rule change proposed by the IDHA will allow dental hygienists to provide services within the scope of dental hygiene practice, but without the supervision of a dentist. However, the existing Board rules contain numerous references to the requirement that dental hygienist services be provided only under the supervision of a dentist. Therefore, the proposed rule is inconsistent with existing Board rules.

For example, the definition of "practice of dental hygiene" contained at I.A.C. Section 650-1.1 specifically requires that the listed dental hygienist services must be " . . . delegated by and under the supervision of a dentist licensed pursuant to Iowa Code chapter 153." If the proposed rule is adopted, an inconsistency would result between these provisions.

The licensure requirements contained at I.A.C. 650-Chapter 10 also state that dental hygienist services must be provided under the supervision of a licensed dentist. Sections 10.3(1) and (2) currently require that all dental hygienist services must be performed under the general or direct supervision of an Iowa licensed dentist. If the proposed rule is adopted, inconsistency would result between these provisions as well.

Furthermore, the proposed regulation is inconsistent with existing rules governing the unauthorized practice of dental hygiene. As explained above, Section 650-10.4 states that "[a] dental hygienist who . . . renders dental service(s) directly or indirectly on or for members of the public other than as an employee or independent contractor supervised by a licensed dentist shall be deemed to be practicing illegally . . . The unauthorized practice of dental hygiene also means the performance of services by a dental hygienist which exceeds the scope of practice granted in Iowa Code section 153.15." If the proposed rule is adopted, then inconsistency would result between these provisions.

Concern #2: For a variety of reasons, the practical implications of the proposed rule are unclear.

Many of these concerns have already been raised by the Board in its correspondence with the IDHA, but have not been resolved. These concerns include the following:

* What are the protocols of the Bureau of Oral Health of the Iowa Department of Public Health which deal with the supervision of hygienists in the public health arena or other underserved areas? How are the Bureau's protocols adopted and approved? What is the role of the Bureau in regulating the proposed provisions?

* Will the Board retain authority to regulate/oversee/discipline dental hygienists, or will these powers be delegated to the DPH Bureau of Oral Health?

* How will patients requiring further care be referred to a dentist?

* Will hygienists performing services without supervision carry their own liability insurance?

* What types of emergency or backup protocols will be used to ensure patient safety?

* What type of screening will be performed on patients to ensure that the initial screening is appropriate for a hygienist rather than an Iowa licensed dentist? (e.g., underlying health concerns which present a greater risk of complications).

* How will the proposed hygienist services be reimbursed?

For these reasons, the Association respectfully requests that the Board either deny the IDHC's petition for rulemaking or delay action on the request until these issues are resolved. Thank-you for your consideration of the Association's input regarding this issue.

Sincerely,

Deborah J. Schmudlach

RECEIVED
DEC 10 2002
IOWA BOARD OF
DENTAL EXAMINERS

December 8, 2002

Jennifer Hart, Executive Officer
Dental Hygiene Committee of the Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

Dear Members of the Dental Hygiene Committee and the Iowa Board of Dental Examiners:

During the last month, the Iowa Dental Hygienists' Association has carefully considered concerns expressed by the Iowa Board of Dental Examiners in regards to our petition for rulemaking. In an attempt to address those concerns and still allow access to preventive services for the dentally underserved and at risk populations, we respectively submit the following petition for rulemaking.

We propose the following be added to the definition of general supervision in 650-1.1 (153) Definitions:
In settings other than the private dental office, the dental hygienist, with the proper qualifications, may perform preventive services without the patient first being examined by a licensed dentist, if the dental hygienist has entered into a collaborative agreement with one or more "consulting" dentists.

Add a new definition to 650-1.1(153) Definitions:
"Collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The agreement will contain protocols or standing orders for the dental hygienist to follow when providing services.

Add a new section or sections to 650-10.3(153) to include the following:
In settings other than the private dental office, the dental hygienist, with the proper qualifications, may perform preventive services without the patient first being examined by a licensed dentist, if the dental hygienist has entered into a collaborative agreement with one or more "consulting" dentists. A collaborative agreement means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The agreement will contain protocols or standing orders for the dental hygienist to follow when providing services within the scope of dental hygiene as established in 650-10.3(1) except for the administration of local anesthesia or nitrous oxide inhalation analgesia. The dental hygienist must be licensed in the state of Iowa and have a minimum of 2500 hours of clinical practice during the previous five years of employment or be currently employed as a public health hygienist prior to (effective date or rule). The dental hygienist must refer the patient to the dentist for a yearly dental examination.

This will allow the dental hygienist to provide services prior to a dental exam by expanding the general supervision definition rather than creating a new form of supervision. Also, a specific dentist will be developing the protocols and be responsible

for the services performed by the dental hygienist rather than the Oral Health Bureau of the Department of Health. The patient must be referred to the dentist for a dental examination each year. Of course, this does not preclude the immediate referral of the patient. It does assure that maintenance care may not be provided without continual dental examinations. Since this change is not that different than what is presently allowed under general supervision, we have eliminated the necessity of a baccalaureate degree. Although new dental hygiene graduates currently have education and clinical experience in public health settings, to assure the safety of the public, we have included the experience criteria for all dental hygienists except those who are currently working in public health settings.

We hope these changes reflect the wishes of the Iowa Board of Dental Examiners. We respectively request your consideration of our petition for rulemaking.

We understand that Constance Price is setting up a meeting in January with interested parties and feel that this petition will help to facilitate that meeting. Input from all parties at this meeting will help to shape the future of access to care in the state of Iowa. Thank you again for your time and consideration.

Sincerely,

Sheila Temple

Sheila Temple, RDH
President, Iowa Dental Hygienists' Association
2565 Buckeye Avenue
Keota, IA 52248-9487

MEMORANDUM

TO : Members, Dental Hygiene Committee

FROM: Nancy LePeau

DATE: April 17, 2000

SUBJECT: Draft of Rule Regarding Supervision of Dental Hygienists in Public Health Settings

To date, dental hygienists in public health settings in Iowa have followed protocols and standing orders developed by the Dental Bureau of the Iowa Department of Public Health relative to dental hygiene care such as dispensing fluoride supplements. Currently there are no rules of the Board of Dental Examiners regarding this type of supervision. Following is a draft of a rule which addresses this issue:

650--10.3(153) Supervision of Dental Hygienists

10.3(2) Add the following statement at the end of this section:

Dental hygienists who provide dental hygiene care while employed in local or state public health settings must follow the protocols and standing orders for that care developed by the Dental Bureau of the Iowa Department of Public Health.

MEMORANDUM

TO : Members, Dental Hygiene Committee

FROM: Nancy LePeau

DATE: April 17, 2000

SUBJECT: Draft of Rule Regarding Supervision of Dental Hygienists in Public Health Settings

To date, dental hygienists in public health settings in Iowa have followed protocols and standing orders developed by the Dental Bureau of the Iowa Department of Public Health relative to dental hygiene care such as dispensing fluoride supplements. Currently there are no rules of the Board of Dental Examiners regarding this type of supervision. Following is a draft of a rule which addresses this issue:

650--10.3(153) Supervision of Dental Hygienists

10.3(2) Add the following statement at the end of this section:

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August 21, 2002

Iowa Board of Dental Examiners.
Executive Hills West
1209 E. Court Ave
Des Moines, IA 50319

Dear Iowa Board of Dental Examiners:

The Iowa Department of Public Health Dental Advisory Council (DAC) has been considering ways to improve access to dental care for underserved populations. On behalf of the DAC, I would appreciate your thoughts about the practice act implications, if any, of one of the models for delivering care to nursing home residents and Head Start participants that we are interested in pursuing.

In this care delivery model, each nursing home or Head Start classroom would have a dentist of record who could provide oral examinations and evaluations of the health status of the nursing home residents or children. The dentist would then write a note in the patient's chart (or pre-school record) indicating that an examination had been completed with the consent of the resident, parent or legal guardian. The dentist would then prescribe the appropriate preventive therapies in the chart (e.g., prophylaxis and fluoride varnish treatment). A hygienist, most likely from either the dentist's practice or the local health department, could then go into the facility and provide the preventive care at a future date.

We believe this is similar to a dental hygienist providing a prophylaxis under general supervision in private practice but would appreciate your thoughts on this.

If you believe this is acceptable under the practice acts as currently written, we are will pursue ways to educate interested dentists on the care for these populations, purchasing portable equipment and linking interested providers with interested nursing homes and Head Start Centers.

We are hopeful that developing more efficient methods for providing dental care to nursing home residents or Head Start participants will increase the interest of private practitioners the care of these populations.

Thank you for your consideration on such short notice. If you would like further information, please let contact either Dr Hayley Harvey or myself.

Sincerely

Peter C. Damiano, DDS, MPH
Chair, IDPH Dental Advisory Council and
Professor, University of Iowa
(319) 335-6813

C.G. EGELAND, DDS

MEDICAL ARTS BUILDING • 1015 DUFF AVENUE • AMES, IOWA 50010 • (515) 232-4236

Date 10/22/02

RECEIVED

OCT 23 2002

IOWA BOARD OF
DENTAL EXAMINERS

Iowa Board of Dental Examiners
Constance Price, Exec. Director
400 SW 8th St., Suite D
Des Moines, IA 50309

Dear Members of the Iowa Board of Dental Examiners.

I am in support of the Iowa Dental Hygiene Association's proposal allowing dental hygienists in public health settings to perform specific services for dentally underserved clients prior to a dentist's exam.

I understand this new level of public health supervision would allow only those hygienists meeting certain education and experience requirements to perform such duties in public health settings. The duties included in the proposal are all services currently allowed in hygienists' scope of practice EXCEPT administration of local anesthesia and nitrous oxide.

Passage of this proposal would greatly expand the numbers of clients which we hope to serve in the Story County Community Dental Clinic when it opens later this year. The clinic is expected to be staffed one night per week by a volunteer dentist and two days per week by a public health hygienist. This ruling would allow the volunteer dentists to focus solely on restorative procedures during their scheduled hours, and allow the hygienist to focus solely on preventive procedures during the "hygienist-only" days. Exams and referrals for restorative treatment (identified by the hygienist during her screening) would be done by a dentist at a later date.

This proposal is a creative and cost-efficient measure to help alleviate the dental care access problem for those Iowans who need our services the most. I strongly urge your passage of this proposal. Thank you.

Sincerely,

C.G.Egeland,D.D.S.
1015 Duff Ave.
Ames, IA 50010

Ames
Pediatric
Dental

319 Lincoln Way • Ames, Iowa • (515) 956-3423

RECEIVED
OCT 24 2002
IOWA BOARD OF
DENTAL EXAMINERS

October 22, 2002

Iowa Board of Dental Examiners
Constance Price, Exec. Director
400 SW 8th St., Suite D
Des Moines, IA 50309

Dear Members of the Iowa Board of Dental Examiners:

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This proposal is a creative and cost-efficient measure to help alleviate the dental care access problem for those Iowans who need our services the most. I strongly urge your passage of this proposal. Thank you.

Sincerely,

Debbie Grandgenett

Dr. Debbie Grandgenett, DDS

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OCT 2 5 2002

IOWA BOARD OF
DENTAL EXAMINERS

October 24, 2002

Iowa Board of Dental Examiners
Constance Price, Exec. Director
400 SW 8th St., Suite D
Des Moines, IA 50309

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Sincerely,

Tom Stark

Tom Stark, D.D.S., M.S.D.

TMS/ck

1212 Duff Avenue, Ames, Iowa 50010 • (515) 232-2255 (888) 402-2255
703 8th Street, Boone, Iowa 50036 • (515) 432-6244

Member American Association of Orthodontists

DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

RECEIVED

OCT 2 9 2002

BOARD OF
DENTAL EXAMINERS

October 28, 2002

Iowa Board of Dental Examiners
Constance Price, Exec. Director
400 SW 8th St., Suite D
Des Moines, IA 50309

Dear Members of the Iowa Board of Dental Examiners:

I am in support of the Iowa Dental Hygiene Association's proposal allowing dental hygienists in public health settings to perform specific services for dentally underserved clients prior to a dentist's exam.

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This proposal is a creative and cost-efficient measure to help alleviate the dental care access problem for those Iowans who need our services the most. I strongly urge your passage of this proposal. Thank you.

Sincerely,

Sheila Riggs

Sheila Riggs, DDS, DMSc
405 South Wilmoth Ave
Ames, IA 50014

AMES ORAL SURGEONS, P.C.

Fellows
American Association of
Oral and Maxillofacial Surgeons

CHARLES D. FARRELL, D.D.S.
ROBERT A. RUDMAN, D.D.S.
JOHN B. KAZWELL, D.D.S

RECEIVED
OCT 30 2002
IOWA BOARD OF
DENTAL EXAMINERS

October 28, 2002

Iowa Board of Dental Examiners
Constance Price, Exec. Director
400 SW 8th Street, Suite D
Des Moines, IA 50309

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This proposal is a creative and cost-efficient measure to help alleviate the dental care access problem for those Iowans who need our services the most. I strongly urge your passage of this proposal. Thank you.

Sincerely,

John Kazwell, DDS

1212 DUFF AVENUE AMES, IOWA 50010 TELEPHONE 515-232-6830

AMES ORAL SURGEONS, P.C.

Fellows
American Association of
Oral and Maxillofacial Surgeons

CHARLES D. FARRELL, D.D.S.
ROBERT A. RUDMAN, D.D.S.
JOHN B. KAZWELL, D.D.S

October 28, 2002

Iowa Board of Dental Examiners
Constance Price, Exec. Director
400 SW 8th Street, Suite D
Des Moines, IA 50309

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Sincerely,

Robert Rudman, DDS

1212 DUFF AVENUE AMES, IOWA 50010 TELEPHONE 515-232-6830

Fellows
American Association of
Oral and Maxillofacial Surgeons

AMES ORAL SURGEONS, P.C.

CHARLES D. FARRELL, D.D.S.
ROBERT A. RUDMAN, D.D.S.
JOHN B. KAZWELL, D.D.S

October 28, 2002

Iowa Board of Dental Examiners
Constance Price, Exec. Director
400 SW 8th Street, Suite D
Des Moines, IA 50309

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Sincerely,

Charles Farrell

Charles Farrell, DDS

1212 DUFF AVENUE AMES, IOWA 50010 TELEPHONE 515-232-6830

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OCT 2 8 2002
IOWA BOARD OF
DENTAL EXAMINERS

Paul Readhead, D.D.S.

2720 Stange Road, Ames, Iowa 50010
515-268-0516 • Toll Free: 877-232-4994
Fax: 515-268-9161

October 24, 2002

Iowa Board of Dental Examiners
Constance Price, Exec. Director
400 SW 8th St., Suite D
Des Moines, IA 50309

Dear Members of the Iowa Board of Dental Examiners:

I am in support of the Iowa Dental Hygiene Association's proposal allowing dental hygienists in public health settings to perform specific services for dentally underserved clients prior to a dentist's exam.

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This proposal is a creative and cost-efficient measure to help alleviate the dental care access problem for those Iowans who need our services the most. I strongly urge your passage of this proposal. Thank you.

Additionally, I would ask the Board to consider allowing dental hygienists to provide services to residents of care facilities who are bed-bound or otherwise unable to physically get to a dental office, without a prior examination by a dentist. I suggest that in this case the facility certify that no dentist were available to do an examination.

Sincerely,

Paul Readhead

Paul Readhead, DDS, FAGD

Jennifer Hart

From: Linda Pickering [lpicker@mail.bon.state.ia.us]
Sent: Wednesday, October 30, 2002 10:17 AM
To: Jennifer Hart
Subject: FW: Public Health Supervision

-----Original Message-----
From: Al Kruger [mailto:kruger5050@yahoo.com]
Sent: Tuesday, October 29, 2002 8:09 PM
To: ibde@bon.state.ia.us
Subject: Public Health Supervision

Dear Members of the Iowa Board of Dental Examiners,

I am writing to request that you enable Iowa's public health hygienists to assist in the access to care problem by allowing them public health supervision. Your change in the rules will allow those hygienists to give care to the underserved in our state by providing preventive oral health care they so badly need. Despite our efforts, we in the private sector are unable to provide adequate treatment to the underserved population. As the average age of the dentists in Iowa increases, I believe you will find that the enthusiasm for treating these patients will decrease even further. Hence, this is the time to make an effort to begin to address the problem. Please consider allowing public health supervision to become a reality in our state.

Respectfully,

Alan Kruger, D.D.S. Oelwein, Iowa

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Jennifer Hart

From: Linda Pickering [lpicker@mail.bon.state.ia.us]
Sent: Wednesday, October 30, 2002 10:17 AM
To: Jennifer Hart
Subject: FW: Supervision for Public Health Hygienists

-----Original Message-----
From: Mary Hartman [mailto:mary4040@yahoo.com]
Sent: Tuesday, October 29, 2002 7:32 PM
To: ibde@bon.state.ia.us
Subject: Supervision for Public Health Hygienists

To the Iowa Board of Dental Examiners,

I am writing to request that the board approve the change in rules applying to the supervision of public health hygienists. With so many of Iowa's population suffering from a lack of access to dental care, our public health hygienists fill a very important niche. The success of school based sealant programs reflects continued need to provide care for the underserved school-age population. The public health hygienist is also valuable to the oral health care of our geriatric population by providing education and preventive care. Dental hygienists are well equipped to help solve the access to care problem plaguing our state. Please enable our public health hygienists by allowing them "public health supervision".

Respectfully,

Mary Hartman, RDH President, Waterloo District Dental Hygiene Association.

Embrace Change!
Mary Hartman
email: mary4040@yahoo.com

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Jennifer Hart

From: Linda Pickering [lpicker@mail.bon.state.ia.us]
Sent: Wednesday, October 30, 2002 4:37 PM
To: Jennifer Hart
Subject: FW: Statement of Support

dntl1030.doc

-----Original Message-----
From: fguild@co.black-hawk.ia.us [mailto:fguild@co.black-hawk.ia.us]
Sent: Wednesday, October 30, 2002 2:49 PM
To: ibde@bon.state.ia.us
Subject: Statement of Support

Attached please find a statement of support from Tom O'Rourke, Director, Black Hawk County Health Department.

(See attached file: dntl1030.doc)

October 30, 2002

Sheila Temple, RDH
2565 Buckeye Avenue
Keota, IA 52248-9487

Dear Ms. Temple:

Please add this statement of support to the IDH efforts to expand their practice in the public health domain. The Black Hawk County Health Department is acutely interested in your efforts for a variety of reasons:

- Public health screenings of immigrant children as far back as 1996 showed large number of Latino and Bosnian immigrants to be afflicted with multiple oral health problems. This issue has continued to the present day.

- The Black Hawk County Health Department has conducted a dental sealant program for over three years which has clearly demonstrated the presence of an epidemic proportion of dental caries within the Waterloo schools. These statistics are believed to be the highest methodically assessed numbers within the state of Iowa.

- The Black Hawk County Health Department formed the Cedar Valley Oral Health Initiative Study/Research Group in conjunction with the local Federally Qualified Health Center and the dental hygiene program from Hawkeye Community College. This effort is continuing to gather data and move forth towards creating dental services within our community.

- A request has been made to the Iowa Department of Public Health to evaluate the area as a Health Professional Shortage Area as it relates to dentistry.

As the above items would indicate, the necessity for a public health intervention for this oral health epidemic is both necessary and critical. Even without the HPSA designation, it is apparent to us that the number of dentists who accept Medicaid or no pay clients is simply inadequate to meet the needs of our county. The proposal by the Iowa Dental Hygienists Association for a new level of supervision for public health hygienists is precisely the action needed at this point in time.

I would hope these comments can be considered in the decision making process currently underway. Thank you for this opportunity to express the public health perspective on this critical issue.

Sincerely,

Thomas A. O'Rourke, Director
Black Hawk County Health Department

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NOV 01 2002

IOWA BOARD OF
DENTAL EXAMINERS

THE UNIVERSITY OF IOWA

October 29, 2002

Jennifer Hart, Executive Officer
Dental Hygiene Committee of the Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Ms. Hart:

I would like to comment on the letter of September 23, 2002 from Dr. Mike Kanellis to you. While the views expressed have been clearly stated as the views of Dr. Kanellis, the letter appears on University of Iowa College of Dentistry stationary; the views expressed do not necessarily represent policy statements or recommendations by the College of Dentistry.

Thank you.

Sincerely,

David C. Johnsen, D.D.S.
Dean

College of Dentistry
Office of the Dean
300 Dental Science N
Iowa City, Iowa 52242-1010
319/335-9650
FAX 319/335-7155

RECEIVED

NOV 01 2002

IOWA BOARD OF
DENTAL EXAMINERS

STANIFORTH-CALHOUN-HAWTHORNE
DENTAL OFFICE
616 5th St. Box 848
Ames, IA 50010

Iowa Board of Dental Examiners
Constance Price, Exec. Director
400 SW 8th St., Suite D
Des Moines, IA 50309

Dear Members of the Iowa Board of Dental Examiners:

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This proposal is a creative and cost-efficient measure to help alleviate the dental care access problem for those Iowans who need our services the most. I strongly urge your passage of this proposal. Thank you.

Sincerely,

10-25-02

Neil Calhoun DDS

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF EDUCATION
TED STILWILL, DIRECTOR

January 23, 2004

RECEIVED

FEB 04 2004

IOWA BOARD OF
DENTAL EXAMINERS

Jennifer Hart, Executive Officer
Iowa Board of Dental Examiners
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Ms. Hart:

The Iowa Department of Education joins with the Iowa Department of Public Health, in supporting the amendment to Chapter 10, "General Requirements", Iowa Administrative Code, to allow public health supervision for a dental hygienist within a public health setting. We do this because we believe good oral health is a necessary prerequisite to school-readiness and success in school. The proposed amendment would increase services to young children and students, especially for populations where access is a problem, and ensure that every student has a dental home.

The issue of decreased access to oral health care in the United States is well documented, the most comprehensive discussion within "Oral Health in America: A Report of the Surgeon General", published in 2000. Disparities exist in access to oral heal care, particularly for low-income families and elderly.

National problems of decreased access to oral health care are mirrored in Iowa. Iowa is seeing a decrease in the number of dentists practicing in the state. Seventy-two of Iowa's 99 counties are designated as Dental Health Professional Shortage Areas, based on federal guidelines and approval by the Health Resources and Services Administration. The 1999 Oral Health Survey, conducted by the Iowa Department of Public Health and the University of Iowa College of Dentistry, showed the twice as many children from low-income families had untreated decay as children from high-income families. Twenty-four percent of low-income children had a preventive sealant, versus 37 percent of high-income children. In FFY02, 60 percent of children enrolled in Medicaid in Iowa did not receive any dental care. The currently proposed rule, incorporating a definition of public health supervision for dental hygienists, is one way to increase access to oral health services for at-risk populations in the state.

Because we know that oral health affects learning, this traditionally health-related concern is also an educational one. Children with poor oral health have more frequent absences and suffer academically. Early tooth loss caused by dental decay can result in

failure to thrive, impaired speech development, absence from and inability to concentrate in school, and reduced self-esteem.

Conversely, the most successful early childhood programs in our state, including Shared Visions and Head Start, emphasize dental screening, connecting children and their families to dental services, and the establishment of dental homes for all enrolled students. Preschool programs that do this are demonstrating a commitment to quality that is consistent with the expectations of the governor's leadership plan.

Iowa Department of Education supports efforts to ensure that all families have a dental home, defined as a primary dental office where comprehensive care is accessible. We are aware of Iowa Department of Public Health's programs that target at-risk populations and provide enabling and preventive services and see them as vital to our educational mission because these same populations are often at-risk academically. For many low-income families, these programs are their introduction to dental care and the importance of oral health.

Some public health programs in Iowa already use dental hygienists to provide screening and fluoride varnish services for children and pregnant women. The hygienists also educate families about the need for regular dental care and assist families with referrals to a dental office. Counties in Iowa that use dental hygienists in this way have higher percentages of Medicaid-enrolled children that receive any dental care (Dubuque 56%, Fayette 49%, Floyd 46%, Mahaska 43%, Mitchell 52%, Wapello 42%, Washington 42%). This is a documented improvement in access to oral health care.

The proposed rule change would allow additional services (prophylaxis and sealants) to be provided to children or individuals through public health programs, further increasing their access to oral health care.

Oral health is integral to overall health and the Iowa Department of Education strives to promote and protect the health of all Iowans. In an effort to improve access to oral health for low-income families and other at-risk populations, we support and ask that you approve this amendment to add the definition of public health supervision of a dental hygienist to your rules.

Sincerely,

Ted Stilwill, Director
Department of Education

Jennifer Hart

From: Kathy Kell [rudkell@msn.com]
Sent: Tuesday, December 02, 2003 8:45 AM
To: The Halburs; Jennifer Hart; Allen Carrell; Larry Carl; Martin Averill; P T Grimes
Subject: Re: IBDE Report

Marty,
Good analysis. The report does another good job of describing the problem, but still does not come up with conclusions that will work.
KK

----- Original Message -----
From: The Halburs
To: Jennifer Hart ; Allen Carrell ; Kathy Kell ; Larry Carl ; Martin Averill ; P T Grimes
Sent: Tuesday, December 02, 2003 12:10 AM
Subject: IBDE Report

Dear All,

I must say that the report is well written and contains alot of data but does not answer the question of cost or the question of what is the best solution. The report comes close in especially two places to the real answer. Those places are in the last section of page 2 and last section of page 28. These state that, "The board's rules cannot address the real needs of patients - to provide dental providers who are willing to accept new Medicaid patients and attend to their restorative treatment needs. Combating this problem will require action and commitment from the Iowa legislature." ie: better Medicaid reimbursement Why should we pass something that is not a solution to the problem, has not worked where it has been used in other states and is not a good business solution. Passing this will use up alot of our already inadeguate Medicaid dollars and thus reduce the number of procedures that can be delivered in the dentist offices. Remember we alocated over $100,000 at the ADA HOD to study this problem and report back next year. Let us wait for this report before we get into something that just won't work. As a last resort if something needs to be passed immediately then put a sunset clause on it to end in one or two years unless it has the statistics to justify renewal.

Jennifer Hart put alot of sincere effort into this report and we should build from it but the new rule related to public health supervision is not the answer. Please enlighten me if I am wrong.

Sincerely,
Marty Halbur DDS

Jennifer Hart

From: The Halburs [dmmkea@win-4-u.net]
Sent: Tuesday, December 02, 2003 12:10 AM
To: Jennifer Hart; Allen Carrell; Kathy Kell; Larry Carl; Martin Averill; P T Grimes
Subject: IBDE Report

)ear All,

must say that the report is well written and contains alot of data but does not answer the question of cost or the question of what is he best solution. The report comes close in especially two places to the real answer. Those places are in the last section of page ! and last section of page 28. These state that, "The board's rules cannot address the real needs of patients - to provide dental ıroviders who are willing to accept new Medicaid patients and attend to their restorative treatment needs. Combating this problem vill require action and commitment from the Iowa legislature." ie: better Medicaid reimbursement Why should we pass something hat is not a solution to the problem, has not worked where it has been used in other states and is not a good business solution. ?assing this will use up alot of our already inadeguate Medicaid dollars and thus reduce the number of procedures that can be lelivered in the dentist offices. Remember we alocated over $100,000 at the ADA HOD to study this problem and report back next 'ear. Let us wait for this report before we get into something that just won't work. As a last resort if something needs to be passed ımmediately then put a sunset clause on it to end in one or two years unless it has the statistics to justify renewal.

lennifer Hart put alot of sincere effort into this report and we should build from it but the new rule related to public health supervisior ; not the answer. Please enlighten me if I am wrong.

;incerely;
/larty Halbur DDS

RECEIVED

OCT 1 0 2003

IOWA BOARD OF
DENTAL EXAMINERS

4001 Meadowknolls Road
Marion, Iowa 52302-9405
October 5, 2003

Iowa Board of Dental Examiners
400 SW 8th Street
Des Moines, IA 50309-4687
Jennifer Hardt, Executive Officer

Dear Ms. Hardt,

I am writing to you to ask that my you bring before the Iowa Board of Dental Examiners that I am strongly in favor of keeping dental sealants in the scope of services that dental hygienists can provide in the proposed rule change of Chapter 10 of the General Requirements of the Iowa Administrative Code.

I am currently a licensed practicing dental hygienist in Iowa. I have been in practice for 34 years. I have seen what a tremendous tooth saving measure that dental sealants provide. I worked in the same practice in Vermont for 20 years (we started doing sealants in 1976) and I was personally able to follow the effective benefits of sealants.

The concern that sealants can be unknowingly places over carious lesions due to lack of evaluation by a dentist should not preclude this service from the neediest part of the population. We observed that if this was done in our practice the sealant would simply lose its retention and not cause any further damage to the tooth. In contrast unsealed teeth have a great risk of deep caries at a very young age leading to tooth loss. I know, because I lost three first permanent molars, due to occlusal caries by 9 years of age. That is when my family moved from a very rural area to a small city where we had access to dental care.

Please let the board members know how important it is for sealants to be done to the underserved under this new level of supervision. We know the board members and Governor Vilsack have a kind heart for the needy children of Iowa and this measure would provide a great tooth saving benefit for them.

Sincerely yours,
Carol Hennessy R.D.H.

Carol Hennessy

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OCT 1 0 2003

IOWA BOARD OF
DENTAL EXAMINERS

Barbara J Fiori, RDH
314 East Walnut St.
Ogden, IA 50212

September 22, 2003

Jennifer Hart, Executive Officer
Board of Dental Examiners
400 SW 8th St
Des Moines, IA 50309-4687

TO: The Iowa Board of Dental Examiners:

I am contracted as a public health dental hygienist by Mid-Iowa Community Action to serve Boone and Story counties. I witness the need, first hand to expand the scope of practice of Public Health Dental Hygienist to provide preventive services for the numerous under-served areas of rural Iowa. A majority of dentists, in Iowa do not accept Medicaid in their private offices. Therefore a large number of people are going without dental care. This proposal will not change treatment needs for these people. It will simply allow dental hygienists to provide fluoride, sealants, cleanings and oral health education to people who would otherwise be unserved. Restorative needs remain with the dentist. However maybe we can reduce the urgency for such services.

Sincerely,

Barbara J. Fiori, RDH

Barbara J Fiori, RDH

Monticello Family Dentistry & Stone Creek Dental

630 S. Main St. * Monticello
319-465-3533

613 16th Avenue* Dyersville
319-875-9180

Brian L. James, D.D.S.
Craig Puffer, D.D.S.

RECEIVED
OCT 1 0 2003
IOWA BOARD OF
DENTAL EXAMINERS

Dear Board of Examiners,

I am writing you in regard to your proposed ruling regarding dental hygienists' public health supervision. I am very much in favor of allowing dental hygienists to practice their professional duties outside the traditional dental office setting. There currently is a tremendous population of patients not having their dental health care needs met. You have identified many of these groups. I would urge you to go one step further and allow dentists to employ hygienists who can directly provide hygiene services to <u>any</u> nursing home or assisted care facility, not just those with a public health program. Allow a dentist to provide on site care for this population by utilizing assisted hygienists.

Please strongly consider allowing an assistant to aid in the delivery of such care. By allowing the hygienist an auxiliary you will provide a much higher standard of care. Assistants can record the perio pocket depths; they can assist in suctioning during scaling and root planning and in keeping a dry field during placement of sealants. With an assistant dentists and hygienists can better serve more patients effectively and efficiently. Currently, when a dentist is out of the office and the hygienist is caring for patients of record, the hygienist is not allowed to have an assistant to aid them in the delivery of care. I believe this is not in the patient's best interest. Perhaps it is an oversight in our practice act. As dentists, we all realize how much more effective we are with auxiliaries. Let's afford the hygienist the same luxury.

As a practicing dentist in this state for 16 years, I have witnessed an adversarial relationship between dentists and hygienists. This has been to the detriment of the respective professions and to our patients. I truly believe that when evaluating proposals; significant enhancement to our dental practice act can be accomplished in a win, win manner. As a dental board I applaud that you are addressing many of the issues that make our state dental practice act less than progressive.

I am in favor of expanding our care to the many underserved populations by expanding the function and scope of practice for hygienists and assistants. Let's do it in a way that makes economic sense for the dentist, hygienist, assistant and public without adding costly bureaucratic restraints and regulations. Dentists should be given the latitude to train their staff (hygienists and assistants) to provide for the expanded function capacity, which will enhance our effectiveness as a profession.

I would urge you to move swiftly and enact rules that allow dentists to employ hygienists in non traditional settings such as nursing homes, mobile dental clinics, schools, etc. Allow them to work without direct supervision and let them utilize assistants to aid them in their delivery of care. Establish criteria that make the dentist responsible for this training. It is time to move forward with a progressive dental practice act.

Thank you for your consideration!

Sincerely,

Brian L. James, D.D.S.

BLJ/arh

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

October 3, 2003

RECEIVED

OCT 0 6 2003

IOWA BOARD OF
DENTAL EXAMINERS

Jennifer Hart, Executive Officer
Iowa Board of Dental Examiners
400 SW 8th St, Suite D
Des Moines, IA 50309-4687

RE: Proposed Rule Changes – IAC 650-10.5 – Public Health Supervision

Dear Ms. Hart:

The Department of Human Services supports the rule changes proposed by the Board of Dental Examiners that permit the provision of dental hygiene services in public health settings with contracted supervision of a dentist. Although the screening, prophylaxis, sealants and fluoride varnish applications to be provided by the hygienists in such settings will have a calculated fiscal impact on the Medicaid budget, these services are preventative services. It is cost effective to provide preventative dental services rather than more costly restorative services. Thus, the immediate fiscal impact must be evaluated in terms of the offset in savings from restorative dental services.

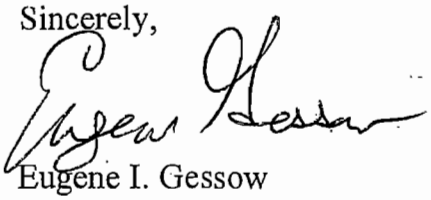
Total estimated savings are impossible to predict. Research results reported by the National Center for Disease Control however enable calculation of a savings from providing dental sealants to children. Sealants are applied to the pit and fissures in molars where 90% of decay in children has been determined to occur. Sealants are nearly 100% effective in preventing decay. In fiscal year 2003, Medicaid paid a total of $2,077,577 for restorations provided to 13,894 unique Medicaid recipients under 21 years of age. Assuming 90% of this expenditure was for restorations on molars, a total $1,869,819 could have been saved had these children received sealants. The potential savings from sealants alone exceeds the estimated minimum $1,237,790 fiscal impact to Medicaid for dental hygiene services provided to both children and adults.

Untreated dental decay only worsens over time to such that more costly repair is required. In fiscal year 2003, Medicaid paid a total of $656,273 for to place crowns on the teeth of children that could not be restored with conventional fillings. A total of $911,456 was spent to extract teeth in children under 21 years of age. The savings from services that could have prevented some of this need further offsets the impact to the Medicaid budget.

Iowa has a critical dental access problem for Medicaid recipients. The reasons are complex and not unique to Iowa. The result however is that less that one third (32.5%) of

Medicaid recipients saw a dentist in fiscal year 2003. Currently, 72 counties and one urban area have been designated as Federal Dental Health Professional Shortage Areas (HPSAs). As Iowa's currently practicing dentists age toward retirement and dental colleges graduate fewer new dentists to replace them, the access problem can be expected to worsen. Utilizing dental hygienists in public health settings will help fill the void.

Sincerely,



Eugene I. Gessow
Medicaid Director

Sept 19, 03

Dear Members of the IBODE,

I am writing in support of the proposed rule change involving Public health. I have read through the rules and it is clear to me that the client receiving the service will have to be referred to a dentist, but the dentist is not required to provide future dental treatment. It seems that we will be working together. We need each others talents and expertise. I am so impressed with the handful of Public health hygienists that I come in contact with. (I work in a Private Practice setting). They want to use our Dental Hygiene Scope of Practice to HELP People especially the underserved.

Thank You,

Crystal Hartel, RDH

1634
~~1602~~ 43rd St NW
Altoona, IA 50009

RECEIVED
SEP 22 2003
IOWA BOARD OF
DENTAL EXAMINERS

August 20, 2003

TO: Iowa Board of Dental Examiners

FROM: John E. Clary, D.D.S.

RE: Expanded functions for dental assistants – follow-up thoughts

Dear Board,

I recently sent a letter to you via e-mail outlining my thoughts and strong support for expanded function dental assisting in Iowa. In the letter I expressed my thoughts regarding why I feel that expanded function dental assisting is vitally necessary to the growth and progression of dentistry in our State. In addition, I discussed why I firmly believe that expanded function is also of definite benefit to the public by helping provide more dental care at reasonable cost. Since the attending dentist is ultimately responsible for the actions of the expanded function assistant, I feel that the public is also well protected.

While our profession appears solid in it's support for expanded dental assisting, the main question seems to be format – a "list" approach or a "non-list" approach. In my initial letter to the Board I outlined why I ultimately preferred the "non-list" approach. I still feel that this is the best approach long-term. However, I also understand that we have to begin somewhere. I have faith that the Board of Dental Examiners has done an excellent job in thoroughly researching and evaluating all of the aspects of this question. I have had lengthy discussions with past and current members of the Board on this topic. I am confident that the Board has the best understanding of the proper course to take to finally accomplish expanded function dental assisting in Iowa. Many dentists in our state, myself included, have worked long and hard to make expanded function a reality in Iowa. It is time it finally happens. As a result, I support the Board in their proposed "list" approach. While not perfect, I feel that this approach is an excellent step for the future of dentistry in Iowa.

Respectfully submitted,

John E. Clary, D.D.S.

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

IOWA BOARD OF DENTAL EXAMINERS
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

AGENDA

DENTAL HYGIENE COMMITTEE MEETING
JANUARY 8, 2003

Teleconference Meeting Originating From:
Conference Room
400 S.W. 8th Street, Suite D
Des Moines, Iowa

12:15 p.m. Call meeting to order

Agenda

Petition for Rulemaking submitted by Iowa Dental Hygienists' Association
Request to amend 650—1.1(153) by amending the definition of "general supervision of a dental hygienist," adopting a new definition of collaborative agreement, and amending 650—10.3(153)

If you require the assistance of auxiliary aids or services to participate in or attend the meeting because of a disability, please call the office of the Board at 515-281-5157 prior to the date of the meeting.

400 SW 8th STREET, SUITE D, DES MOINES, IA 50309-4687
PHONE:515-281-5157 FAX:515-281-7969 http://www.state.ia.us/dentalboard

IOWA DENTAL NEWS

A newsletter for Iowa dentists

Member Publication
American Association of Dental Editors

Volume XXIV, Number 1
February, 2003

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- **District Meetings**

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- **PFA Academy Foundation**

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Iowa Board of Dental Examiner Actions

At the January 23 meeting of the Iowa Board of Dental Examiners (IBDE), action was taken on proposed rules implementing expanded functions for dental assistants. See Executive Director's Message for further details.

In other action at the meeting, board members voted to approve the Petition for Rulemaking submitted by the Iowa Dental Hygienists' Association. This petition seeks to add the following definition of general supervision to 650-1.1(153): "In settings other than the private dental office, the dental hygienist, with the proper qualifications, may perform preventive services without the patient first being examined by a licensed dentist, if the dental hygienist has entered into a collaborative agreement with one or more 'consulting' dentists." The petition defines collaborative agreement as "...a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The agreement will contain protocols or standing orders for the dental hygienist to follow when providing services". The IBDE's will now officially notice a revised rule and gather public comment.

HIPAA Update

We have been notified by the ADA that VHS and DVD versions of the popular HIPAA Seminar are now available for purchase. The three-hour seminar breaks down HIPAA privacy requirements into manageable tasks to ease compliance. The seminar also gives tips on real world implications of HIPAA, including individuals' rights to control access and disclosure of protected health information; responsibilities of information holders to safeguard against inappropriate use of disclosure; how to train dental staff on privacy practice, consent and authorization; required business associate agreements; and sanctions for violations. This is the same seminar that was offered December 4 in Iowa. The seminar is available on VHS tape or DVD and can be purchased through the ADA catalog for $99.95. To order, call 1-800-947-4746 or log on to adacatalog.org.

The deadline for implementation of privacy rules is April 14, 2003.

THE DENTAL PRACTICE, P.C.

Steven G. Rabedeaux, DDS, FAGD

104 N. 2nd Ave. E., Newton, IA. 50208 641-792-2780 / drrab@pcpartner.net www.thedentalpractice.net

Iowa Board of Dental Examiners
400 S.W. 8th St.
Suite D
Des Moines, IA. 50309-4687

RECEIVED
FEB 21 2003
BOARD OF
DENTAL EXAMINERS

RE: General concern

I recently attended the Academy of General Dentistry meeting 2-7-03. The end of the meeting was informational about what challenges the board is facing. Iowa dentists were encouraged to provide any meaningful input. I have several thoughts.

1. Concerning fees for dentists, hygienists, and assistants. I have just learned that the fees for dentistry don't all go to dentistry. With the additional work load the legislature has put upon you, of registering dental assistants and administering training exams, the job you have done this far is amazing. I can't imagine having my work load double, lose part of my staff, and have to do it with less money. I don't think most dentists realize the position the board has been put in. They only see the additional hassle factors involved with practice administration and they blame the board.

I will encourage all the dentists I know to make it clear to our legislature that we feel all fees from dental related license and administrative fees go 100% back to dentistry. It is unbelievable that our fees go to the general fund and then we only get a portion of it returned.

2. There was discussion about an unknown change regarding dental radiography training. Several dentists stated that they were told there would no longer be student status or in office training after Jan. 2003. This was unknown by two board member dentists present at the meeting. Hopefully this is not the case and is some type of horrible misunderstanding. If it is the case, hopefully, this action can be amended.

This will seriously handicap dentists statewide, including myself, from having adequate staff. Currently there is no other training available anywhere and there is not any on the immediate horizon to my knowledge. The inability to have adequate staff creates barriers to care for Iowans. It becomes an access to care issue in rural areas and a handicap to the profession.

I don't believe that dental radiography has caused a patient harm since I have been in

practice. I do believe that our impending shortage of dental personnel does have consequences. We need to be able to train dental assistants in dental radiography in our offices with our equipment (which is state inspected on a regular basis). The current system has served both dentists and the public very well for many years with very few problems.

I have not been very impressed with the radiographic skills of assistants who were trained in a formal program. Without fail they have required retraining on the job to take diagnostic quality films. In fact the radiology course has far too much theory that has little to do with the practical reality of dental radiography

A change at a time when training has become more complex in all other areas, and with additional regulation, does not make sense. If this is a ruling from the state radiology agency, we need to work together to correct this damaging situation.

3. There is an issue before you that deals with the supervision of hygienists. I have responded previously to the board my feelings concerning independent hygiene practice and will provide that reference if requested. If I understand correctly, this deals with hygienists serving in nursing homes, care facilities and public health settings where the dentist is not present. The issues are the same: proper diagnosis of disease and the public receiving timely proper care.

I have seen the oral hygiene care given at some care facilities. It can be deplorable, non existent and an embarrassment for Iowa. One might be tempted to follow the logic that some care is better than none. Is this good public policy? Is this a foot in the door toward independent practice? I, for one, am not certain I would put my license and credentials at risk to enter into such an arrangement. This requires careful thought and consideration, both for me and for the board.

In the school and public health arena, the issues are far more serious. I have restored way too many poorly placed sealants with rampant caries under them, some requiring endodontic therapy. Those patients were lead to feel safe, yet they suffered a form of harm.

I place sealants in my office with magnification, and with air abrasion to be certain they are done properly and not placed over existing caries and in a well controlled field. This is a serious procedure with the very real possibility of harm to the patient if not done properly. I do not delegate this task and question whether it should ever be delegated. The actual placement is simple, it is the proper diagnosis and preparation that makes or breaks a sealant. According to the dental practice act, I am responsible, and I take that seriously.

School screening and instruction on oral hygiene can no doubt be of benefit. The

danger lies in the parent whose child is seen and told "I don't see any decay" or "everything looks OK" and there is an undiagnosed problem. The parent may not have easy access or perhaps is financially unable to follow up with a dentist. They may feel a false sense of security and dental health may not even come to mind for several more years, or when there is a problem.

Most hygienists I have worked with are very skilled and have excellent clinical skills. They often bring diagnostic concerns to my attention. They do not however, all have equal diagnostic skills. How well a concern is communicated to a care facility, school staff member or parent may be critical for timely patient care.

4. You have on record my thoughts about expanded function for dental assistants. I believe you are on a reasonable course by having multiple training avenues for approved training and not totally tied to institutional training. We will never agree on a list of duties. That is OK, it is more important to get started and realize this will be an ongoing and evolutionary process. It is fun to get it right the first time, but in this case it might not be possible or realistic.

You as the governing body for dentistry again are faced with finding the balance between protecting and serving the public dental health and the profession. I take the time to share my thoughts with you because I love my profession. God willing, I hope to practice for many more years and I seek the proper balance as well. Thank you for considering my input.

Sincerely,

S.G. Rabedeaux, DDS

Jane Greimann
STATE REPRESENTATIVE
Forty-Fifth District
Statehouse: (515) 281-7742
e-mail – jane.greimann@legis.state.ia.us

HOME ADDRESS
1518 13th Street
Ames, Iowa 50010
Home: (515) 232-5238

House of Representatives
State of Iowa
Eighteenth General Assembly
STATEHOUSE
Des Moines, Iowa 50319

COMMITTEES
Environmental Protection,
Ranking Member
Human Resources
Judiciary

APPROPRIATIONS SUBCOMMITTEE
Education

RECEIVED
MAR 06 2003
IOWA BOARD OF
DENTAL EXAMINERS

March 4, 2003

Jennifer Hart
400 SW 8th St , Ste D
Des Moines, IA 50309

Dear Jennifer,

I support the Iowa Dental Hygienists' Association (IDHA) in attempting to modify the rules to change the sequence by which dental hygienists provide care. This allows clients to receive screenings, data gathering and education, in addition to preventative services such as cleanings and sealants while they are awaiting referral to a dentist. The modified rules would require referral to a licensed dentist for a follow-up examination and additional dental care that may only be provided by a dentist.

In Story Country we want to utilize dental hygienists for data gathering, triage, and preventative services while awaiting referral at our two public clinics. Less time will be spent on an initial exam as data gathering and preventative work would already have been done. This increases the dentists' ability to be able to see and treat patients in a more efficient manner.

This proposal would allow a dentist to assume professional responsibility for a hygienist working beyond the confines of a private dental office. It does not expand a dental hygienist's scope of practice nor change the professional oversight by a dentist in any meaningful way.

Sincerely,

Jane Greimann

Representative Jane Greimann

IOWA BOARD OF DENTAL EXAMINERS
PUBLIC HEARING

APRIL 1, 2003

DES MOINES, IOWA

Pursuant to the Notice of Intended Action published in the March 5, 2003, as **ARC 2327B**, a public hearing on proposed amendments to 650- Chapter 1, "Administration," and Chapter 10, "General Requirements," was held in the Conference Room, 400 S.W. 8th St, Suite D, Des Moines, Iowa, on April 1, 2003, beginning at 10 a.m.

Staff present:
Constance L. Price, Executive Director
Jennifer Hart, Executive Officer

Also present:
Sheila Temple, RDH, President, Iowa Dental Hygienists' Association
Larry Carl, Executive Director, Iowa Dental Association
Sandra Leggett, RDH, Des Moines Area Community College Dental Hygiene Program
Mike DeAnda, Des Moines Health Center

Larry Carl provided written comments on behalf of the Iowa Dental Association.

Sandra Leggett read a copy of the written comments she submitted. In addition, Ms. Leggett noted that Iowa was one of the first states to have hygienists in public health roles. Around the 1920s, hygienists played a role in school settings working under the supervision of a dentist. The model has been in place for a long time. Ms. Leggett suggested considering additional facilities to meet these basic needs. Ms. Leggett also suggested that there should be greater collaboration between medicine and dentistry to provide greater access to care. Ms. Leggett stated that dentists and hygienists need to cooperate in this effort.

Sheila Temple read a copy of the written comments submitted on behalf of the Iowa Dental Hygienists' Association.

Mike DeAnda stated that he did not have formal comments prepared, but indicated that he is supportive of ways to improve access to care. Mr. DeAnda is the administrator for the Des Moines Health Center. The center utilizes hygienists in their programs and operates mobile dental clinics. The center also operates in school settings and is one of the few organizations that accepts Medicaid. Mr. DeAnda suggested that the Board look closely at ways to work this out to make it acceptable for hygienists to play an increased role. He indicated that he would like to see the locations specified where care under collaborative agreements could be provided so that it is not subject to

interpretation. For example, limited to public health organizations or federally funded community health centers. The board should keep this narrow in scope to prevent possible abuse.

Additional written comments have been received concerning the proposed amendments. All comments will be submitted to the Board for consideration.

Respectfully submitted,

CONSTANCE L. PRICE
Executive Director

CLP/jh

Patricia G Larson
716 Peosta St.
Peosta, Iowa 52068

attn
J. Hart

April 6, 2003

Iowa Board of Dental Examiners
400 SW 8th Street, Suite D
Des Moines, Iowa 50309-4687

Dear Board Members,

I am writing to you with several concerns regarding the issue of the expanded function rules proposal that has recently come to my attention.

As I understand it, under the expanded function rules proposal Certified or Registered Dental assistants would have the capability of extending their skills into some of the work that only dentists do now. Such as root canal drying, crown preparation and packing retraction cord etc.

As the proposal now reads you have no standards set for the protection of the public. The dentist is set up as the educator and there are no statewide uniform standards for certification or testing. How will I, as a patient, know what the assistants have been trained in especially if I were to change dental offices? Will all assistants in the same office have the same training? Will assistants be training other assistants at some point? Also, how is the public to know what training an assistant has when they are not required to wear a name badge listing their credentials? Frankly, at this point, the public has little or no idea who does what in their dental office. I was totally in the dark about the fact that until recently dental assistants could just be hired off the street and begin to work in my mouth with whatever training the dentist deemed relevant. That fortunately, is no longer true. I am appalled at the idea that you, the people that we the public depend upon to protect us, would allow the expanded functions proposal to go through as it now reads with no statewide standard for testing and certification.

It is my sincere hope that you will take into consideration all the information that you have before you and make a decision that protects the rights of the public that you serve.

Thank you for your time and consideration.

Patricia G Larson

Patricia G. Larson

14395 Christoph Rd.
Dyersville, IA 52040
April 5, 2003

Iowa Board of Dental Examiners
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Board Members,

The letter will, in part, address the issue of extended care rules; who will decide upon them, how they are decided on and what impact will they have on not only the Dental Profession but on the public as well.

On Friday, April 4, 2003, I spoke via telephone with Jennifer Hart. During this conversation Jennifer informed me that a large number of letters had been received by the board from dentists expressing their opinion concerning the expanded rules issue but very few had been received by dental assistants. Five dentists sit on The Iowa Board of Dental Examiners. However, there is **no** representation on the board for dental assistants although it is required that we are apprised regarding all issues, nor does the board ever *request* a statewide survey of our opinions or ideas. With no representation how do you propose we stay up-to-date on the latest issues? Thus, we are consistently uninformed about issues, which pertain to and directly affect us.

It is my understanding that because of the deluge of letters written by dentists, there is now a third proposal for the expanded function rules. This proposal sets no statewide standards, the patient has no way of knowing what procedure the dental assistant can perform and could lead to one dental assistant training another. How is any investigator or member of the public supposed to know if that assistant was properly trained? Is this safeguarding the public? I would hope that the members of The IBDE have the **public's** best interests in mind when you make these life altering decisions, not the dentist's.

What happened to the expanded function group with dental assistants on it? For our voice to be heard, this group was very substantial. This group put in many long hours to come up with some resolution for expanded functions. The proposal that came from them was tabled. I can say I was much more comfortable with those two proposals than this third one. The board disregarded what time and effort that expanded function group put forth. I am dissatisfied in the way the board is managing this proposition. This group looked at what other states had accomplished and learned that with expanded function, assistants have some type of registration process and statewide uniform training. Thank you for your attention to this matter.

Sincerely,

Karen Nurre

Karen Nurre, CDA, RDA

Additional Comments submitted by IDHA

VISUALIZING THE COLLABORATIVE AGREEMENT

The collaborative agreement is a creative way of making dental services available to those who are in dire need of care, but because of their situation, are unable to be treated in the same sequence as occurs in the private practice. The dental hygienist will become the case manager who will attempt to distribute patients to a variety of dental providers who will share the responsibility for these population groups.

In discussions with board members, it became obvious that it was difficult for them to visualize what the elements of a collaborative agreement would be. I conferred with the dentists in my areas as to what data they would like included in such an agreement. We agreed that the following information should be included: medical considerations that would prohibit care, methods of assessment, preventive services to be provided, referral protocols, and requirements for ongoing review of the agreement. We would support adding these stipulations to the definition of collaborative agreement, if the change would not be substantial enough to necessitate starting the rulemaking process over. If these changes would necessitate starting the process over, we would recommend instead that the Dental Hygiene Committee and the Board of Examiners have the authority to make these changes and any others that may be needed as time goes on. We would hope that this rule could be implemented without further delay because the need is so great.

Jennifer Hart

From: Punkingeesh@aol.com

Sent: Sunday, April 06, 2003 9:22 PM

To: jhart@bon.state.ia.us

Subject: general supervision of dental hygienist

Hello, my name is Brian Ancell, DDS. I am a member of the Iowa dental association, and I am writing to say that I oppose the revision of General Supervision of A Dental hygienist. I do not feel that dental hygienists are properly trained to deal with medical emergencies, and should not be practicing without a dentist present to perform examinations. I currently practice in a public health facility, and have not noticed any problems with patients getting proper access to care.

I agree with the statements written in the March 13th letter sent from Larry Carl outlining the limitations of dental assistants. I feel that this proposal is not in the best interest of the patients,and I am opposed to it.

I understand that I am past the April 1st deadline for submitting a letter, but feel strongly that I should make my opinion known. Please contact me if any other information is needed.

Sincerely,

Brian Ancell, DDS

JERSEY RIDGE DENTAL ASSOCIATES

DAVID L. SAMUELSON, D.D.S. H. DOUGLAS ROBERTSON, D.D.S.

Comprehensive Family, Cosmetic, and Implant Dentistry

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RECEIVED

APR 07 2003

IOWA BOARD OF
DENTAL EXAMINERS

April 2, 2003

Ms. Jennifer Hart
Executive Officer
Board of Dental Examiners
400 S.W. 8th St.
Suite D
Des Moines, Iowa 50309

Dear Ms. Hart,

I am writing in regard to the potential rule changes allowing expanded functions for Dental Assistants. I have opposed the registration of Dental Assistants in the past. I have found it very difficult to hire, train, and have assisting staff pass both the registration and radiology examinations. Requiring these examinations have turned potential staff away from dentistry into other professions where they can earn the same or higher pay with no study time or examinations. Many of the applicants we have had for dental assistants are young mother's some married and some single mom's. These young people simply do not have the time to study to pass the registration examination and keep up with their homes and children. In visiting with other Dentists, this is a problem in cities and a greater problem in rural communities.

Now I understand the Board of Dental Examiners are considering developing a laundry list of expanded functions for Assistants. I feel developing specifics and putting specific procedures into the practice act is a bad idea. This is best left to the Dentist. Every practioner is different, each one must determine his comfort level allow assistants to do various expanded functions. Each one of us have different abilities to train staff for various duties. Most expanded functions require the Dentist to work harder, utilizing more chairs, giving us less time with each patient, while taking more time for training and supervision. This is simply heading dentistry in the wrong direction. It is turning us into technicians and office managers. Most patients do not want to be treated in assembly lines and like the personal attention they have received by Dentists.

I strongly recommend before implementing any rule changes in Dental Assisting or Dental Hygiene, a study of manpower needs in regards to both professions be completed. This study has to include both city and rural communities. We as a profession need to look at what changes are needed to allow us to provide optimal dental care for the public while protecting them at the same time. Changes are forever, lets think this through so whatever changes are made have the best interest of the public in mind.

As always, I would be happy to discuss this matter with any Board member at any time. Thank you for you work on behalf of the profession.

Sincerely,

David L. Samuelson, D.D.S.

Summary of Comments on ARC 2327B

117 written comments received.

31 expressed support for the amendments

9 Nurses
6 Hygienists (including IDHA)
5 Dentists
11 Other (IDPH, social worker, MD, administrators, Pres of Iowa Caregivers Assoc)

79 expressed serious concern regarding the amendments

76 Dentists (including IAGD)
2 Hygienists
1 Other (Iowa Dental Association)

7 were undecided, or supportive if changes were made

7 Dentists

SUMMARY OF COMMENTS IN SUPPORT:

- This will potentially have a large impact on dental health, especially for the rural poor
- If hygienists could provide cleanings and sealants, could decrease dental caries
- There is a huge problem with lack of access to dental health care, especially for children and low income groups
- This will allow the hygienist to do data gathering, triage, and preventive services while awaiting referral; means less time spent at initial exam thereby increasing efficiency; enables more families to access services if efficiency is increased
- Affordable, accessible preventive care can impact the need for more expensive dental care later on; Problems are more expensive to fix than prevention
- Local dentists who work with public health are already supportive of preventive services under their consultation
- Will help to meet Healthy Iowans 2010 oral health goals
- Missing opportunity to provide sealants because dentists are unwilling to do initial screenings in schools
- Can increase the number of patients seen by increasing settings
- Same type of system with nurse practitioners and medical directors – nurses practice following protocols/standing orders and refers to doctor; nurse practitioners also do physical exams for physicians
- This does not expand the scope of practice of hygiene or need for professional oversight by a dentist, it just changes the sequence of services .
- Lack of hygiene creates problems and suffering that could have been prevented
- Oral health in nursing facilities and other institutional care settings often go unmet due to staff shortage, lack of training, etc
- Partnerships with hygienists will increase referrals and timely screenings, increase school readiness and success

- Protocols help to protect the hygienist, dentist, and patients
- Public health clinics now are impeded because can't provide care unless dentist has seen patient first
- These highly trained and educated professionals are capable of providing treatment in these settings
- These expanded services would personally aid this dentist in providing care for residents of care facilities
- Need flexibility when it comes to public health concerns
- Screening and basic care will prevent backlog in basic services for underserved
- Because many dentists won't accept Medicaid there is a huge access problem
- Pleased with success of current public health hygiene programs and would be beneficial if they could do more
- So far only hygienists have put their intentions in writing and taken steps to solve the access problem
- Don't need to limit the number of agreements
- Need to work together to provide care because the problem is not getting smaller
- Contractual collaboration does not expand scope it just makes it less cumbersome to identify and provide prevention and referral
- Research demonstrates that education can have a significant impact on oral health
- Some kids may only have two levels of care: no care or prevention
- Hygienists have passed a national board exam and regional practice exam to demonstrate qualification to provide these services without direct supervision
- Also need to add dental assistants to help hygienist in providing care, especially with sealants, isolation, radiographic developing
- 72 of Iowa's 99 counties are dentally underserved
- Counties in Iowa that use hygienists for screening, education, & fluoride show higher percentages of Medicaid-enrolled kids that receive any dental care; this is documented improvement in access to oral health care
- Sealants can reduce incidence of tooth decay. Allowing hygienists to provide prior to seeing a dentist would allow more children to be served and decrease costs
- Providing prophys is esp. beneficial for low income pregnant women based on research linking periodontal disease to incidence of pre-term, low birth-weight deliveries and preeclampsia
- Hygienists are educationally prepared to provide this care based on accreditation guidelines, national and regional board exams that assess this preparation. Exams cover special needs and medically compromised patients. Additional experience required further ensures higher standard
- Has board dealt with complaints of unsafe practice by hygienists in public health – public health hygiene has been in place since the 1930s and has been successful due to the knowledge and skill of these practitioners
- Need to ensure changes do not adversely impact existing public health programs to ensure that educational services, assessment, fluoride, and screening programs can continue to operate as they now do, by changing wording to state the hygienist must ensure the patient has been examined prior to providing an additional prophylaxis or series of sealants

- Research on sealants shows placing them on incipient caries and a frank cavitated lesion can arrest development of caries
- Rule change does not mean hygienists will no longer be supervised, this rule expands the definition of supervision and changes the sequence of treatment
- Requirement for collaborative agreement strengthens the referral process
- Hygienists cannot now prescribe - dentist in collaborative agreement will be responsible for this just like in private practice
- IDHA agreeable to specifying agreement must be with Iowa licensed dentist
- Cannot force patients to see a dentist – this concern is addressed by limiting services that can be provided until the patient is examined
- May need to collaborate with more than one dentist to spread responsibility for treatment of these patients
- IDHA agreeable to eliminating "such as" clause to specify settings
- In states that allow collaborative agreements, has not increased liability coverage
- IDHA supports adding additional specifics in definition of collaborative agreement

SUMMARY OF CONCERNS:

- Concerned about proposal as written – the access to dentists required in the proposal is just not possible; need to be able to provide existing public health services even if patient has not been examined
- Liability questions are not adequately addressed
- Hygienists do not have enough education in pharmacology, anatomy, oral pathology, physiology, and biochemistry to provide care without a patient first being examined by a dentist; Hygienists need additional education and training to be able to do this; Two year hygiene education is too limited in scope
- Concern about having multiple agreements with multiple hygienists to the extent that actual supervision would not take place – suggest limit to single agreement per dentist and specify Iowa licensed dentist
- Need to specify the time period for a dental exam under a collaborative agreement and ensure exam takes place within reasonable amount of time
- Schools have not indicated they want this – not the school's role, questions about where will they provide the care and keep track of records in schools
- This will not solve the problem of the dentally underserved patients; not a good answer to helping the underserved
- Some care is not always better than no care
- Problem with placing sealants on teeth with caries; results in more expensive dental care later on and the real possibility of patient harm if not done right; Placement of sealants is relatively simple but proper diagnosis and preparation is the key
- If sealants are placed prior to exam, dentist cannot then probe with explorer or us Diagnodent to diagnose occlusal caries
- Problem for patients if they are told everything looks OK and there is an undiagnosed problem that is not addressed
- Gives patients a false sense of security that dental care has been provided
- This allows care without an exam and supervision. Concern that patients leave after being seen by a hygienist without proper diagnosis and tx planning

- Need to specify the settings; Too vague as to where hygienist can provide care outside of private office; too open to interpretation
- The training of a hygienist is predicated on supervision of a dentist
- Concern about lack of training in pharmacology and how to ensure patients that need appropriate pre-meds are prescribed this medication
- Concern about providing treatment to medically compromised patients – in these patients due to potential complications it is especially important that dental exam take place first; especially in nursing facilities these patients require additional diagnostic, evaluation and management
- Should first try to put pressure on Iowa dentists to find a way to treat these underserved groups
- Need to tighten up language to be more specific
- Concern if patients had a life-threatening reaction and no dentist was present to manage or prescribe for these potential complications
- What happens if a restoration fractures or is removed during hygiene services – who is responsible and how will the patient afford that
- This is a stepping stone for independent practice
- Hygienists are trained to work in a team with a dentist and need to provide tx together
- Need to increase dental participation
- Answer to access problem is not to provide substandard care
- This could impact the cost of hygiene without providing needed services to targeted groups
- Need to fully study consequences before taking action
- Difficult to imagine a scenario where tx by a hygienist without diagnosis and treatment planning would be beneficial
- State financial programs are to blame for part of the access problem – this does not change that problem; Title XIX reimbursement is too low
- There may just be an administrative problem in reaching people rather than an access problem; to totally change the way care is delivered is not the answer
- Need to decide if these groups deserve a lower standard of care than other citizens
- Total dental care requires an exam by a dentist; Dental hygiene services cannot be separated from total patient care ; There's no reason to leave dentists out of the sequence just because these settings are different; general supervision already addresses most of these issues
- Public does not understand distinction between hygiene assessment and dental exam by a dentist
- Problem with care in these settings is often more limited by lack of appropriate facilities and equipment rather than time
- This creates inefficiency for the patient and requires an increased time commitment by the patient to get complete care
- Increases health risks because patients are receiving fractured care
- If any subgingival scaling is done, it is periodontal treatment, requiring more knowledge, skill and judgment
- Very few nursing residents have a healthy mouth only needing prophylaxis
- Who is responsible if patient is misdiagnosed or a problem is not discovered

- Allowing hygienists to practice without a dental exam or treatment plan is not giving equal protection to all citizens; Treatment of an untreated population by providing substandard care is simply swapping one problem for another.
- Could alter malpractice coverage for all licensees, resulting in increased dental fees
- Hygienists lack equipment and supplies to adequately provide care in these settings; for example, may need radiography to determine bone loss or tell depth of calculus prior to giving services
- The real problem is a shortage of general dentists and also a shortage of hygienists, esp. in rural areas
- Need same standard of experience for all – a hygienist who is currently employed as public health hygienist may not have same experience level
- An exam has to be done to prescribe sealants and root planning because these are invasive treatments
- Facilitate licensure by credentials to help access problem
- Why separate health of gums from rest of oral cavity; Prophylaxis has no benefit if there are other disease processes in the mouth
- Part of problem is lack of education in routine care like brushing rather than a lack of professional cleaning
- Inferior out of office practice decreases quality and patients are the ones who are least likely to detect the change
- Need to be more specific rather than saying ensure patient has been examined – need to specify that written and prescribed treatment is directed for additional care; who will verify patient has been examined unless there is written prescribed treatment for additional services
- How will authority for treatment be provided for students and nursing home patients
- What about patient records – who maintains them, how will treatment be entered, where are they kept, how is insurance of other costs billed
- How can you tell who is the collaborating dentist and responsible for each patient if there is more than one agreement
- Does this require dentist to make these patients of record?
- Need to look at long range implications before rushing forward
- Given the direction the board is taking to regulate dental assistants it seems inappropriate to change hygiene requirements
- There is a potential for economic abuse; this could provide fertile ground for shady practitioners driven by financial interests
- Medicaid problems such as funding, valuing care and keeping appointments won't be resolved by this
- Consider delaying action on this proposal to enable Dental Access Committee proposal to collaborate with nursing facilities in matching them with dental provider can develop and move forward; may significantly improve chances of success for this unprecedented collaboration

IOWA ORAL & MAXILLOFACIAL SURGEONS, P.C.

Dr. John A. Maletta • Dr. Steven T. Reynolds • Dr. Neil T. Dunbar • Dr. Darren R. Jirsa

April 10, 2003

LeRoy I. Strohman, DDS, Chairperson
Iowa Board of Dental Examiners
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Dr. Strohman:

By way of this correspondence, I wish to inform you of an exciting activity being undertaken by the Iowa Department of Public Health's Dental Advisory Committee (DAC). This may well represent one of the most important opportunities for addressing many of the "access to dental care" issues being grappled with by the various health care leaders in Iowa including the Iowa Board of Dental Examiners.

As you know, the Iowa Department of Public Health initiated an oral health professional forum made up of dentists, dental hygienists, dental assistants, representatives from U of I College of Dentistry and the Iowa Board of Dental Examiners which is responsible for advising the Director of Public Health regarding issues related to improving access to dental health. More specifically, one of the group's more significant responsibilities is to develop plans to address the barriers to oral health care for our most vulnerable populations.

At our April 9, 2003 meeting, our DAC chairperson, Peter C. Damiano, DDS, MPH from the University of Iowa Health Policy Research Program introduced a proposal designed to match oral health care practitioners with one of our most vulnerable populations…nursing home residents. Dr. Damiano's proposed plan incorporates resources from the University of Iowa College of Dentistry, the Iowa Department of Inspections and Appeals, the Iowa Department of Public Heath, the Iowa Dental Association and the Iowa Dental Hygienists Association. The nursing homes themselves would naturally play a significant role in any final plan of action adopted by the DAC. I know myself, as a current officer of the Iowa Dental Association that the IDA welcomes the leadership being demonstrated by Dr. Damiano and the Dental Advisory Council.

As a founding member of the Dental Advisory Council, I wish to bring this action to the attention of the Iowa Board of Dental Examiners in hopes that your Board will consider taking no action related to access to oral health care. By eliminating or delaying any planned regulatory action, the Board of Dental Examiners may significantly improve the chances of this unprecedented collaboration of oral health care practitioners and related organizations to succeed.

My expectation is that the successes realized in this endeavor will translate success to many other Iowa vulnerable populations.

Sincerely,

Dr John A. Maletta

John A. Maletta, DDS, MS
Member
Dental Advisory Council
Iowa Department of Public Health

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Iowa Board of Dental Examiners

Memo

To: George North, DDS, Rick Reay, DDS, Deb Yossi, RDH, & Elizabeth Brennan

From: Jennifer Hart

Date: 05/06/2003

Re: Committee Meeting – May 16, 2003

Just a reminder that the Board committee concerning the proposed amendments to 650—Chapters 1 and 10 (dental hygiene collaborative practice) will meet on Friday, May 16, 2003, beginning at 10 a.m. at the Board office.

Representatives from the Iowa Dental Association and Iowa Dental Hygienists' Association have been invited to this meeting.

Dr. North asked that the following additional information be copied for your review:

- Copy of the original Notice of Intended Action
- Article submitted by Dr. Reay for committee review;
- Copy of law/rules from other states with collaborative practice/public health supervision;
- Administrative Rules Digest article concerning proposed amendments & article from ARRC meeting minutes on this rule;
- Copy of nursing home access proposal from IDHP Dental Advisory Meeting on April 9,2003.

If you would like any additional information copied for committee review, please let me know.

ARC 2327B

DENTAL EXAMINERS BOARD[650]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 147.76, the Board of Dental Examiners hereby gives Notice of Intended Action to amend Chapter 1, "Administration," and Chapter 10, "General Requirements," Iowa Administrative Code.

These amendments change the definition of "general supervision of a dental hygienist" and add a new definition of "collaborative agreement." These amendments would allow a dental hygienist who has 2,500 hours of clinical practice or who is employed as a public health hygienist as of June 1, 2003, to perform preventive services in settings other than a private dental office without the patient's first being examined by a dentist. The hygienist must have entered into a collaborative agreement with a dentist who authorizes and accepts responsibility for the services provided by the hygienist. The collaborative agreement must contain protocols or standing orders for the hygienist to follow.

At their January 23, 2003, regular meeting, the Board approved a petition for rule making submitted by the Iowa Dental Hygienists' Association to amend the rules as proposed in this Notice.

These amendments are subject to waiver at the sole discretion of the Board in accordance with 650—Chapter 7.

Any interested person may make written comments or suggestions on the proposed amendments on or before April 1, 2003. Such written comments should be directed to Jennifer Hart, Executive Officer, Board of Dental Examiners, 400 SW 8th Street, Suite D, Des Moines, Iowa 50309-4687. E-mail may be sent to jhart@bon.state.ia.us.

Also, there will be a public hearing on April 1, 2003, beginning at 10 a.m. in the Conference Room, 400 SW 8th Street, Suite D, Des Moines, Iowa. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendments. Any person who plans to attend the public hearing and who may have special requirements, such as hearing or mobility impairments, should contact the Board and advise of specific needs.

These amendments were approved at the February 4, 2003, teleconference meeting of the Board of Dental Examiners.

These amendments are intended to implement Iowa Code chapters 17A, 147, 153, and 272C.

The following amendments are proposed.

ITEM 1. Amend rule **650—1.1(153)** as follows:

Adopt the following **new** definition:

"Collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for services performed by the dental hygienist. The agreement shall contain protocols or standing orders for the dental hygienist to follow when providing services within the scope of dental hygiene as established in 650—10.3(153). The dental hygienist must ensure that the patient has been examined by a dentist prior to providing additional hygiene services.

Amend the definition of "general supervision of a dental hygienist" as follows:

"General supervision of a dental hygienist" means that a dentist has examined the patient and has prescribed authorized services to be provided by a dental hygienist. The dentist need not be present in the facility while these services are being provided. If a dentist will not be present, the following requirements shall be met:

1. Patients or their legal guardians must be informed prior to the appointment that no dentist will be present and therefore no examination will be conducted at that appointment.
2. The hygienist must consent to the arrangement.
3. Basic emergency procedures must be established and in place and the hygienist must be capable of implementing these procedures.
4. The treatment to be provided must be prior prescribed by a licensed dentist and must be entered in writing in the patient record. *In settings other than a private dental office, such as schools, public health agencies, and health care facilities, a dental hygienist who has a minimum of 2,500 hours of clinical practice during the previous five years of employment or who is employed as a public health hygienist as of June 1, 2003, may perform preventive services without the patient's first being examined by a licensed dentist, if the dental hygienist has entered into a collaborative agreement with one or more dentists.*

ITEM 2. Amend subrule 10.3(3) as follows:

10.3(3) All other authorized services provided by a dental hygienist shall be performed under the general supervision of a dentist currently licensed in the state of Iowa in accordance with 650—1.1(153). *In settings other than a private dental office, such as schools, public health agencies, and health care facilities, a dental hygienist who has a minimum of 2,500 hours of clinical practice during the previous five years of employment or who is employed as a public health hygienist as of June 1, 2003, may perform preventive services without the patient's first being examined by a licensed dentist, if the dental hygienist has entered into a collaborative agreement with one or more dentists. The dental hygienist must ensure that the patient has been examined by a dentist prior to providing additional hygiene services.*

ARC 2325B

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"*b*."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 68B.32A, the Iowa Ethics and Campaign Disclosure Board hereby gives Notice of Intended Action to rescind Chapter 4, "Campaign Disclosure Procedures," Iowa Administrative Code, and adopt a new Chapter 4 with the same title.

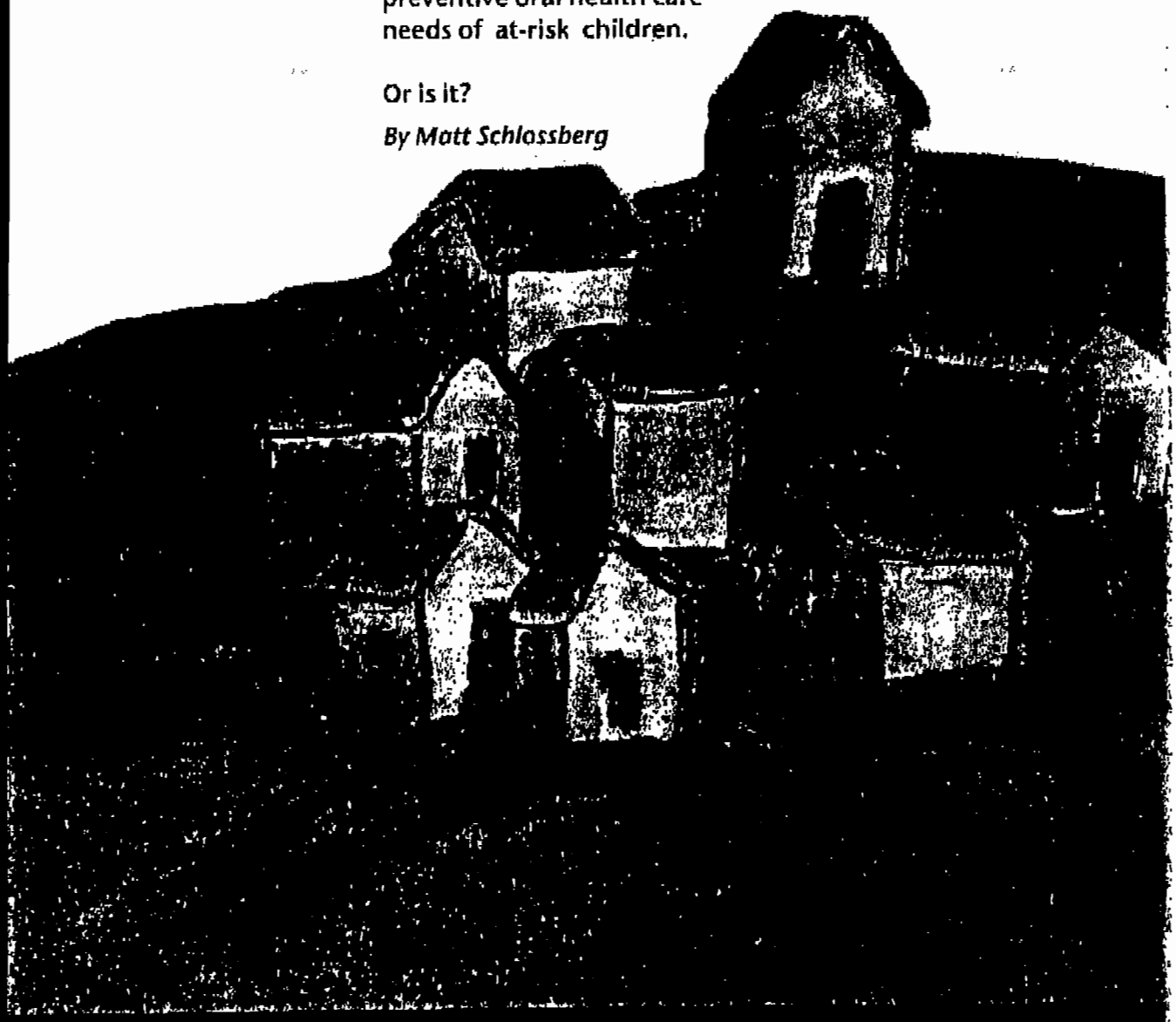
This proposed amendment renumbers the current rules on campaign disclosure procedures to eliminate rules that have been previously rescinded and reserved. Two rules are left reserved to reflect anticipated future rule makings. No

Does it take a village to treat a child?

It's hard to argue with programs aimed at addressing the preventive oral health care needs of at-risk children.

Or is it?

By Matt Schlossberg



Does it take a village to treat a child?

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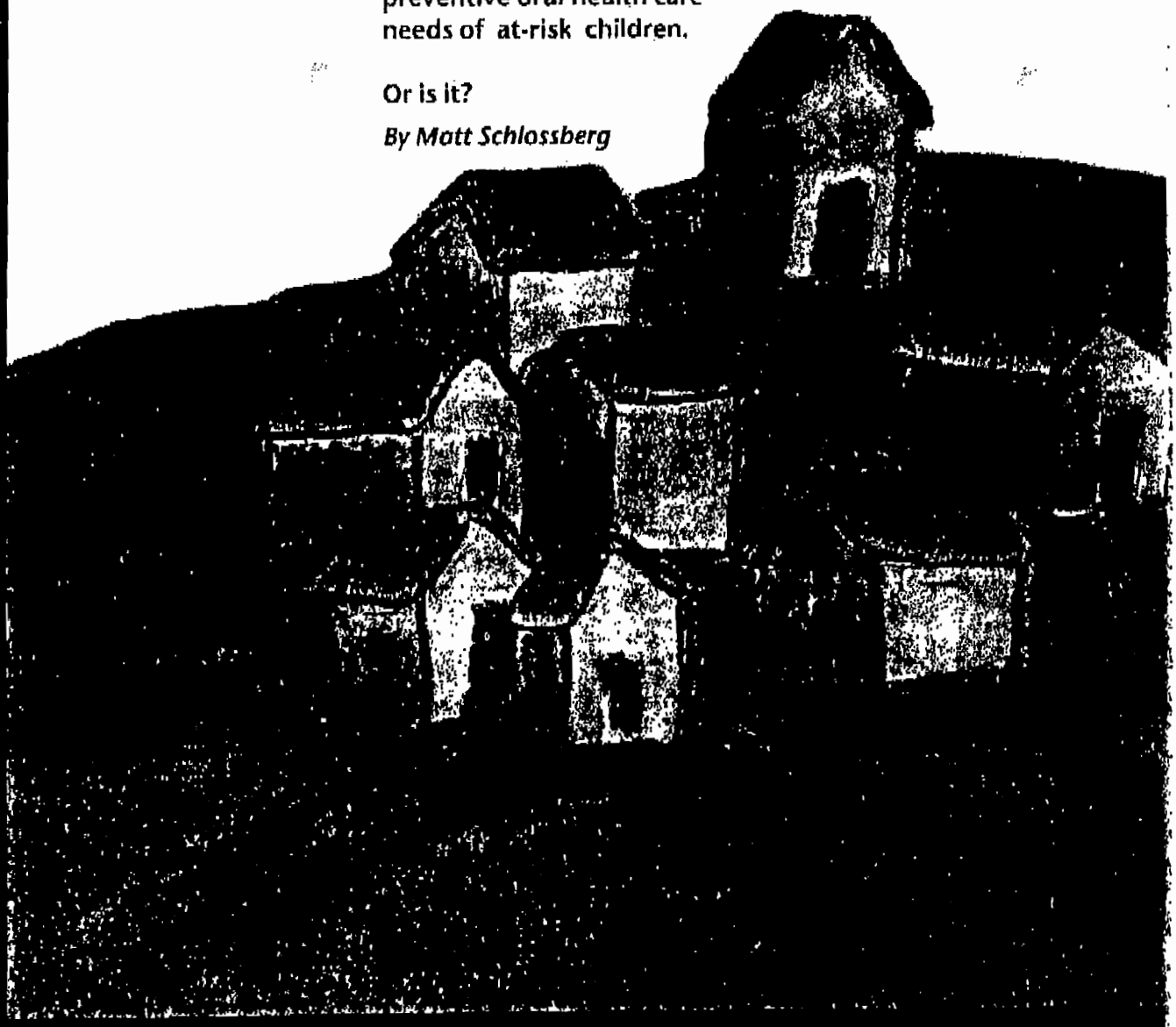

Access to dental care continues to be the "silent epidemic" described in the Surgeon General's 2000 report "Oral Health in America."

Dentistry has responded to the multifaceted problem in several ways, including licensure reform, oral health literacy initiatives, loan forgiveness, volunteerism, and lobbying for increased Medicaid reimbursement.

But some health care professions, legislators, and the public believe this is not enough. Most states—through regulatory agencies or legislators—are reaching out to the underserved through the use of alternative models of oral care delivery through the collaboration of various health care professions, including dentists, dental auxiliaries, physicians, pediatricians and registered nurses.

"I work directly with nurse practitioners, pharmacists and dieticians. We're just beginning to put dental care on the map for these other professions," says Judy Boothby, RDHAP, consultant, Alta California Regional Center, Sacramento.

Ms. Boothby is a Registered Dental Hygienist in Alternative Practice (RDHAP), a special designation for qualified dental hygienists who treat patients at private residences, daycare programs, and public institutions.

The idea behind many of the programs is akin to a "health care village" to meet the oral health needs of indigent and low-income residents. The alternative model is one more weapon in the battle for greater access. Collaborations vary in scope and partnerships, but most are statewide and commonly depend on one of two professions: physicians and dental hygienists.

Many of these collaborators say dentists are instrumental in shaping the programs. They also are one of they key factors in the success or failure of a given program. Alternative models exist in nearly every state and involve many health care professions, but dentists remain at the center of oral health care.

The existence of an alternative delivery model doesn't hinge simply on the thumbs up/thumbs down judgment of local dentists—other crucial factors, such as funding, are necessary to its success (see sidebar, page 11). But a recent study suggests that support from organized dentistry, as well as individual dentists, is "perhaps the most important factor."

The 266-page report, "The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children," examined alternative models in all 50 states, and the factors that decided the programs' success or failure. The alternative model study was published in January by the Center for Health Services, Research and Policy at The George Washington University Medical Center, Washington D.C.

"I don't think dentists can handle access alone. We all have to be involved, the whole system—

dentists,

lab techs,

hygienists,

assistants.

It's everybody's responsibility to look toward a solution."

Ann Battrell,
American Dental Hygienists' Association

"Without dentists' support, [alternative models] just aren't going to happen," says Walt Wolford, DDS, former dental director of New Mexico. The state's alternative model has met enormous barriers in large part because organized dentistry was unhappy with it.

The 500-pound gorilla

Within dentistry there is friction over the need for—and the safety of—alternative programs. Some dentists believe all dental care should begin and end in the dental office.

"I have a healthy level of discomfort when it comes to dental procedures being performed outside the dental office," says Myron Bromberg, DDS, chair, Academy of General Dentistry (AGD) Council on Dental Care. "I personally believe this opens the door for the potential of allowing other dental procedures outside dental offices."

Other dentists give their blessings to alternative models, though there are divisions over which models are acceptable.

Take two states, for example, with similar access problems approached with different solutions.

The physician-based fluoride varnish program launched in North Carolina has met with considerable success. According to Kelly Haupt, RDH, MHA, she has trained more than 1,000 private-practice physicians in fluoride varnish application. It's estimated that more than 5,000 children have received initial applications in about 200 private medical offices. She adds that more than 22 states have inquired about the program.

This alternative model is not unusual. Thirty-two states allow, either through legislation or state board regulation, physicians to provide preventive oral health treatments such as fluoride varnish.

"Into the Mouths of Babes," a North Carolina dental screening and varnish program, launched as a pilot project in several counties in 1999, went statewide in April 2001. The project's goal was to train private-practice physicians, pediatricians, and registered nurses to apply fluoride varnish to the teeth of Medicaid-dependent children from birth to age three.

About the same time, New Mexico was laying the groundwork for an alternative program, this one focusing on dental hygienists.

New Mexico, like North Carolina, has one of the worst access problems in the country. The dearth of general practitioners in rural areas has been compounded by the lack of a dental school to produce more dentists. Poor Medicaid participation, due in part to low reimbursement, also is a major access barrier.

In New Mexico, the state legislature passed a bill allowing qualified dental hygienists to practice in rural and underserved areas without the supervision of a dentist.

Supervision

There are at least five basic levels of supervision for dental hygienists to perform basic prophylaxis.

Independent practice. Dental hygienists can provide scope-of-practice dental services without dental supervision in independently owned practices. Dentists must consult. Colorado is the only state that allows dental hygienists to practice unrestricted and unsupervised by a dentist.

Unsupervised practice. Dental hygienists can provide scope-of-practice dental services without dental supervision. At least 10 states permit this type of practice.

General supervision. Forty-two states allow for general supervision in institutional settings. Though a dentist's presence is not required to perform scope-of-practice hygiene services, the supervising dentist usually sees the patient first, maps a treatment plan, and/or issues a work order. Thirty-six states allow general supervision in the dental office.

Indirect supervision. Dentist is required to be on premises when treatment is delivered. He or she must authorize the procedures.

Direct supervision. Dentist is required to be on premises when treatment is delivered. He or she must authorize the procedures and approve all services provided by the dental hygienist.

Called collaborative practice, the law allows dental hygienists to own and manage a practice while consulting with one or more dentists who provide treatment recommendations, prescriptions and diagnostic services for certain procedures.

Collaborative practice has struggled. Estimates of dental hygienists participating in the program range from 15 to 30 out of more than 600 practicing in the state. But while North Carolina had the advantage of being one of a majority of states with physician-based models, New Mexico is one of only seven states that allow the unsupervised practice of dental hygienists.

The telltale signs that North Carolina and New Mexico are burdened with a significant access problem are as clear as day. Both turned to non-dentists to provide preventive treatment. Why are the results strikingly different?

Dentists' support—or lack of it—is the primary reason given in both instances.

"[Into the Mouths of Babes] is endorsed by many members of the dental community. Dental input in terms of intervention has been extensive," says Gary Rozier, DDS, who's been with the project since its inception.

The program is the result of collaboration among the University of North Carolina (UNC) School of Dentistry, the state Medicaid agency, the state division of public health, the UNC School of Public Health, the North Carolina Academy of Family Physicians and the North Carolina Pediatric Society. Dr. Rozier, a professor of health policy and administration at the UNC School of Public Health, evaluates the efficacy of the statewide program, and says that the collaborative efforts of the health care community, among other things, points to the success of the program.

"One of the model characteristics that I see is screening and referral. You're not going to get 200,000 Medicaid kids from ages zero to three into a dental office, but [through physician screenings] you can get high-risk kids in the dental office," Dr. Rozier says.

New Mexico, initially, didn't fare as well. Dentists were dissatisfied with the legislation that created collaborative practice, even though local dental organizations helped shape the law. The controversy surrounding the law focused on dental hygienists practicing without the supervision of a dentist.

Today, more than four years since the bill's passage, less than 30 out of more than 600 dental hygienists are participating in the program. And according to the study, many can't find a dentist to collaborate with. Until recently, dental hygienists in collaborative practice couldn't bill Medicaid directly; they had to go through a dentist.

"Organized dentistry just felt it was one more step to independent practice. They perceived that it was the ultimate goal of collaborative practice," Dr. Wolford says.

Supervision

American Dental Association (ADA) policy recognizes that many state medical boards define limited preventive oral health care as being within a physician's scope of practice. The ADA, however, frowns on dental hygienist-based projects because that requires hygienists to provide services without the general or direct supervision of a licensed dentist.

ADA policy on dental auxiliaries states: "Supervision and coordination of treatment by a dentist are essential to comprehensive oral care. Unsupervised practice by dental auxiliaries reduces the quality of oral health care, fails to protect the dental health of the public and is opposed by the American Dental Association."

Because the profession of dental hygiene is not completely autonomous (except in Colorado), the success of a dental hygiene-based program depends very much on how local dentists feel about it. The degree of supervision dentists have over dental hygienists was a key concern of dentists in New Mexico.

"The more restrictive the supervisory requirements are, the less flexibility states will have in designing alternate models of preventive oral health delivery by dental hygienists. The efforts to control dental auxiliaries by procedure and varying degrees of supervision lead to confusion in what can be done, where, with what level of supervision, and approval. This confusion, in itself, is a deterrent to designing alternate delivery models," states the alternative model report.

There are several different degrees of supervision (see sidebar, left). New Mexico is one of seven states that permit the unsupervised practice of dental hygienists. Forty-four states allow general supervision of dental hygienists, meaning the supervising dentist is not required to be on premises (be it a private office or

public institution) when a dental hygienist delivers preventive treatment. Other states have stricter regulations and require dentists to on the premises before a dental hygienist can go to work; this is known as direct supervision.

The AGD and the ADA oppose unsupervised practice of dental auxiliaries. The organizations argue that general or direct supervision is necessary to ensure patients receive the highest quality comprehensive dental care safely and effectively.

"Traditionally, the team approach has been the most efficient and beneficial to the patient," says Jon Holtzee, director of state government affairs at the ADA.

For years, the American Dental Hygienists' Association (ADHA) and its components have fought for relaxing restrictions on dentists' supervision. "If dentists and dental hygienists work in a collaborative team role, [the number of] patients seeing dentists actually increases," says Ann Barrell, director of education at the ADHA. "I don't think dentists can handle access alone. We all have to be involved, the whole system—dentists, lab techs, hygienists, assistants. It's everybody's responsibility to look toward a solution."

The ADA argues unsupervised practice has not made a dent in access to care.

"It's specious to make this claim that [unsupervised practice] increases access to care," Mr. Holtzee says. "And even if a large number of hygienists worked unsupervised, the most they could do is provide hygiene services. There's still no comprehensive dental care."

Hot topic

Supervision is the hot-button issue that may be the greatest schism between organized dentistry and organized dental hygiene.

Testifying before the Public Health Subcommittee of the U.S. Senate Committee of Health, Education, Labor and Pensions, in June 2002, the ADHA stated, "restrictive dental hygiene supervision laws constitute one of the most significant barriers to oral health services."

ADHA executive director Stanley Peck also testified that "increased utilization of dental hygienists in non-traditional settings such as schools, medical clinics, after-school programs, and nursing homes would promote increased use of dental services among low-income persons. These dental hygienists can serve as a pipeline that can refer patients to dentists. Increased utilization of dental hygiene services is critical to addressing the nation's crisis in access to oral health care for vulnerable populations."

Although a dental hygienist trains all physicians participating in the Into the Mouths of Babes program, the North Carolina State Board of Dental Examiners does not allow the state's 3,600 dental hygienists to perform any dental procedure without the direct supervision of a dentist unless a public institution employs the auxiliary.

"[Fluoride varnish is] a tremendous benefit for low-income children, but the only way it can get done by dental professional is if a dentist does it himself, or a dental hygienist is under the direct supervision of a dentist," Deana Billings, executive director of the Wilkes County Health Department in North Carolina, says.

Other factors play role in alternative models' success

According to a recent report, dentists play a crucial role in the success or failure of alternative models. But the report, "The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children," published by the Center for Health Services, Research and Policy at The George Washington University Medical Center, Washington, D.C., concludes that at least seven other factors also play important roles in their success.

The report notes success is often dependent on:

Medicaid support. North Carolina's Medicaid agency promises reimbursement, special billing codes and training to the state's physician-based fluoride varnish program, "Into the Mouths of Babes."

Develop reimbursement plan. Until recently, New Mexico dental hygienists who wanted to participate in the state's collaborative practice program had to route all Medicaid bills through a dentist's office. This hurt interest in the program, says Christine Nathe, RDH, M.S., associate professor, University of New Mexico Division of Dental Hygiene, Albuquerque. After Medicaid began allowing hygienists to bill directly, interest grew.

Develop referral mechanisms. Like most alternative models, both programs in New Mexico and North Carolina are designed to deliver preventive treatment only. Patients still need to see a dentist in order to receive comprehensive care.

Type of alternative practice. Because [illegible] organized dentistry may oppose [illegible] involved unsupervised dental hygienists, [illegible] these, the report states, would make the programs difficult to implement.

Outreach and training. Dentists and auxiliaries are vital to training other professionals to deliver limited preventive services and provide health education.

Incremental approaches. The report states that alternative models should be designed to meet a great need. North Carolina took this approach by restricting its fluoride varnish program to Medicaid-dependent children ages zero to three because there are fewer than 50 pediatric dentists in the state.

Professional recognition. This factor says that local dentists and dental organizations realize that the alternative model is addressing a need. In Iowa, for example, the report states that an alternative program was not fully embraced by dentistry because the access need isn't as severe as in other states.

Read the report

Go online and read the report "The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children." The study is available in a PDF format at www.gwhealthpolicy.org/downloads/Oral_Health.pdf.

"I had special permission from the state health director to work outside the direct supervision," says Ms. Haupt, who trains physicians to apply fluoride varnish. "I've had physicians who'd love to hire a dental hygienist, but it's not possible, not right now."

Though relaxing supervision requirements of hygienists would probably be viewed as an opportunity for Wilkes County, Ms. Billings says the health department has not made any overtures to the state dental board, and probably won't in the future. "In North Carolina the best way to get something like that approved is for it to come out of UNC [School of Dentistry] or a dental society. It tends to be a more accepted thing," Ms. Billings said.

The ADA plans to examine the effect unsupervised practice purports to have on access to care. In October 2002, at the ADA's Annual Session in New Orleans, the House of Delegates adopted a resolution to examine the feasibility of conducting a study to determine the impact independent practice settings for dental hygienists had on access to care for the underserved.

"I think the House wanted to examine the argument that unsupervised practice somehow increases access to care. In the states where this is allowed, very few hygienists avail themselves of this," Mr. Holtzee says.

Under pressure

Organized dentistry is under increased pressure to better address oral health disparities.

In a way, alternative models have put enormous pressure on dentistry, in some cases forcing dentists to adopt access programs they may not believe serve patients best interests.

"While I trust the judgment of good legislators, decisions can be made in an environment of hostility," says Carl Ebert, DDS, director of community dentistry, Apple Tree Dental, Minneapolis, and advocate of unsupervised dental hygiene. "[Solutions to access] will be imposed on us."

According to Dr. Wolford and a report by the ADA, the New Mexico Dental Association was under a lot of pressure from legislators to reach a compromise

AGD access initiatives

Working with other professions in the health care community as well as associations, organizations and government offices, the Academy of General Dentistry (AGD) has put forth a variety of initiatives to address the access to care problem affecting much of the country.

"The Academy's been proactive in responding to the United States' crisis involving access to dental care for the poor," says Cynthia Sherwood, DDS, chair, AGD Council on Legislative and Governmental Affairs (LGA). "The dental profession did not cause the lack of access to care for the poor, but we must be willing to join in the crusade to promote preventive, educational, legislative and regulatory changes that will make a difference to the disadvantaged."

Below are a few of the Academy's most recent access initiatives. Information about these initiatives can be found on the AGD Web site, www.agd.org.

Memorandum of Understanding (MOU). This five-year agreement was signed by the AGD and the U.S. Department of Health and Human Services (HHS) in June 2002 to encourage the two organizations to work together to meet Healthy People 2010 goals. The Academy will work with other medical and public health groups to address the oral health component of Healthy People 2010. Where applicable, the AGD will tailor programs to Healthy People 2010 goals; in return the AGD will be able to leverage HHS resources in spreading the message that good oral health is a crucial component of good overall health. The AGD is the first dental organization involved in the project and the only dental organization with a written commitment and outline to incorporate the Healthy People 2010 objectives into existing or new programs. The MOU was the springboard [illegible] the Academy's access initiatives.

Oral Health Literacy. In 2002, the CDC created a task force to investigate ways to develop an oral health curriculum from kindergarten through high school. The surgeon general's 2000 report, "Oral Health in America," cited a major gap in the nation's oral health literacy. At the task force's February meeting, it set a course for the AGD to convince teachers, school boards, legislators and parents that a widespread public education program can work to vastly improve a nation's oral health and provide measurable results. A pilot program was established to begin in the fall. When implemented, the public school program would add to the Academy's repertoire of public information and [illegible] campaigns, which includes SmileLine, [illegible] 1-877-2X-A-YEAR consumer referral number, and public service announcements.

Age 1 dental visit. "Oral Health in America" highlights children's access issues and the danger of early childhood caries. The AGD, as well as the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD), are actively encouraging members to see children within six months of the first eruption of the child's first tooth, on around age 1. Academy is working with the AAPD and the American Association of Pediatricians to build member awareness and develop continuing education programs on how to provide this valuable service.

with dental hygienists on collaborative practice.

Just prior to the passage of the Collaborative Practice Act, New Mexico lawmakers flirted with a bill that would have required dentists to treat a certain percentage of Medicaid patients in order to renew their licenses. Dentists balked and agreed to the alternative model, though many did not embrace it.

The access problem in North Carolina provides an adequate snapshot of the myriad access barriers facing many areas of the nation.

Approximately 79 percent of North Carolina's counties are federally designated dental professional shortage areas. Of the state's 3,000 dentists, only 16 percent accept Medicaid, which covers 665,000 children.

But even in counties where participation is high, access to dental offices has proved to be a significant barrier. The outlook is even darker for the youngest patients. The entire state has fewer than 50 pediatric dentists. Although the AGD, American Academy of Pediatric Dentists, and ADA encourage the age-1 dental visit, few general practitioners have opened their practices to children that young.

Access doesn't stop at Medicaid or even perceived shortages or mal-distributions of dental professionals. Geographic and cultural barriers are equally formidable. "There are a lot of children who just don't have access to transportation," says Ms. Billings.

Though 80 percent of Wilkes County dentists are Medicaid providers, the dentist/population ratio stands at a grim 1-to-5631, according to Ms. Billings in a 1999 fluoride varnish proposal she co-authored. State and national dentist/population ratios average 1-to-2631 and 1-to-1667, respectively.

The patients themselves can act as an access barrier. "I know that among parents and children there's a lot of apathy. Compliance is the problem," said Christophe Roberts, DDS, president, Blue Ridge Dental Society, North Carolina.

The alternative model study concludes that although many of these programs have been in operation for years, it may be too soon to gauge their impact on increasing access to oral health services. "We're not implying that we've come close to solving the problem," Dr. Rozier says. "The reason we are doing this program is because we don't have enough dentists to meet the demand in the [North Carolina]."

In the case of dental hygienists, the lack of dentists' support and their ability to bill Medicaid directly has certainly hindered efforts. And because many physicians lack an adequate referral system, the ideal of comprehensive care is still far on the horizon for underserved populations. **AGD**

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Access to dental care continues to be the "silent epidemic" described in the Surgeon General's 2000 report "Oral Health in America."

Dentistry has responded to the multifaceted problem in several ways, including licensure reform, oral health literacy initiatives, loan forgiveness, volunteerism, and lobbying for increased Medicaid reimbursement.

But some health care professions, legislators, and the public believe this is not enough. Most states—through regulatory agencies or legislators—are reaching out to the underserved through the use of alternative models of oral care delivery through the collaboration of various health care professions, including dentists, dental auxiliaries, physicians, pediatricians and registered nurses.

"I work directly with nurse practitioners, pharmacists and dieticians. We're just beginning to put dental care on the map for these other professions," says Judy Boothby, RDHAP, consultant, Alta California Regional Center, Sacramento.

Ms. Boothby is a Registered Dental Hygienist in Alternative Practice (RDHAP), a special designation for qualified dental hygienists who treat patients at private residences, daycare programs, and public institutions.

The idea behind many of the programs is akin to a "health care village" to meet the oral health needs of indigent and low-income residents. The alternative model is one more weapon in the battle for greater access. Collaborations vary in scope and partnerships, but most are statewide and commonly depend on one of two professions: physicians and dental hygienists.

Many of these collaborators say dentists are instrumental in shaping the programs. They also are one of they key factors in the success or failure of a given program. Alternative models exist in nearly every state and involve many health care professions, but dentists remain at the center of oral health care.

The existence of an alternative delivery model doesn't hinge simply on the thumbs up/thumbs down judgment of local dentists—other crucial factors, such as funding, are necessary to its success (see sidebar, page 11). But a recent study suggests that support from organized dentistry, as well as individual dentists, is "perhaps the most important factor."

The 266-page report, "The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children," examined alternative models in all 50 states, and the factors that decided the programs' success or failure. The alternative model study was published in January by the Center for Health Services, Research and Policy at The George Washington University Medical Center, Washington D.C.

"I don't think dentists can handle access alone. We all have to be involved, the whole system—

dentists,

lab techs,

hygienists,

assistants.

It's everybody's responsibility to look toward a solution."

Ann Battrell,
American Dental Hygienists' Association

"Without dentists' support, [alternative models] just aren't going to happen," says Walt Wolford, DDS, former dental director of New Mexico. The state's alternative model has met enormous barriers in large part because organized dentistry was unhappy with it.

The 500-pound gorilla

Within dentistry there is friction over the need for—and the safety of—alternative programs. Some dentists believe all dental care should begin and end in the dental office.

"I have a healthy level of discomfort when it comes to dental procedures being performed outside the dental office," says Myron Bromberg, DDS, chair, Academy of General Dentistry (AGD) Council on Dental Care. "I personally believe this opens the door for the potential of allowing other dental procedures outside dental offices."

Other dentists give their blessings to alternative models, though there are divisions over which models are acceptable.

Take two states, for example, with similar access problems approached with different solutions.

The physician-based fluoride varnish program launched in North Carolina has met with considerable success. According to Kelly Haupt, RDH, MHA, she has trained more than 1,000 private-practice physicians in fluoride varnish application. It's estimated that more than 5,000 children have received initial applications in about 200 private medical offices. She adds that more than 22 states have inquired about the program.

This alternative model is not unusual. Thirty-two states allow, either through legislation or state board regulation, physicians to provide preventive oral health treatments such as fluoride varnish.

"Into the Mouths of Babes," a North Carolina dental screening and varnish program, launched as a pilot project in several counties in 1999, went statewide in April 2001. The project's goal was to train private-practice physicians, pediatricians, and registered nurses to apply fluoride varnish to the teeth of Medicaid-dependent children from birth to age three.

About the same time, New Mexico was laying the groundwork for an alternative program, this one focusing on dental hygienists.

New Mexico, like North Carolina, has one of the worst access problems in the country. The dearth of general practitioners in rural areas has been compounded by the lack of a dental school to produce more dentists. Poor Medicaid participation, due in part to low reimbursement, also is a major access barrier.

In New Mexico, the state legislature passed a bill allowing qualified dental hygienists to practice in rural and underserved areas without the supervision of a dentist.

COLLABORATIVE PRACTICE/PUBLIC HEALTH SUPERVISION – RULES FROM OTHER STATES

California

Some limits on what these hygienists can do, can't do expanded duties, like local, nitrous, soft tissue curettage. Need to have a prescription for each patient authorizing general hygiene services. Barriers getting prescription and coursework. To be eligible, need to have additional education program of 150 hours. Only had one program come forward to offer the hours and courses.
21 people have permit, out of 13,300 hygienists. These 21 were grandfathered into the program.

Colorado

I. DENTAL PRACTICE LAW (Updated July 1, 1996)
12-35-122.5. What constitutes practicing unsupervised dental hygiene.
(1) Unless licensed to practice dentistry, any person shall be deemed to be practicing unsupervised dental hygiene who:
(a) Removes deposits, accretions, and stains by scaling with hand, ultrasonic, or other devices from all surfaces of the tooth and smoothes and polishes natural and restored tooth surfaces;
(b) Removes granulation and degenerated tissue from the gingival wall of the periodontal pocket through the process of gingival curettage;
(c) Provides preventive measures including the application of fluorides and other recognized topical agents for the prevention of oral disease;
(d) Gathers and assembles information including, but not limited to, fact-finding and patient history, oral inspection, and dental and periodontal charting;
(e) Administers a topical anesthetic to a patient in the course of providing dental care.
(2) Unsupervised dental hygiene may be performed by licensed dentists and licensed dental hygienists without the supervision of a licensed dentist.
(3) Notwithstanding the provisions of section 12-35-103 (5) or 12-35-110 (1) (b), a dental hygienist may be the proprietor of a place where supervised or unsupervised dental hygiene is performed and may purchase, own, or lease equipment necessary to perform supervised or unsupervised dental hygiene.

12-35-122.6. What constitutes practicing supervised dental hygiene. (1) Unless licensed to practice dentistry, any person shall be deemed to be practicing supervised dental hygiene who:
(a) Removes deposits, accretions, and stains by scaling with hand, ultrasonic, or other devices from all surfaces of the tooth and smoothes and polishes natural and restored tooth surfaces, including root planing;
(b) Removes granulation and degenerated tissue from the gingival wall of the periodontal pocket through the process of gingival curettage. Such curettage may include the incidental removal of live epithelial tissue and is to be performed under the general supervision of a licensed dentist.
(c) Provides preventive measures including, but not limited to, the application of fluorides and other recognized topical agents for the prevention of oral disease;
(d) Gathers and assembles information including, but not limited to, fact-finding and patient history, radiographic and x-ray survey, preparation of study casts, oral inspection, and dental and periodontal charting;
(e) Administers a topical anesthetic to a patient in the course of providing dental care;

(f) Administers local anesthetic under the direct supervision of a licensed dentist pursuant to rules and regulations of the Board, which rules shall include minimum education requirements and procedures for such administration.

(2) Supervised dental hygiene may be performed by licensed dentists and, except for the administration of local anesthetic performed under paragraph (f) of subsection (1) of this section, by licensed dental hygienists under the general supervision of a licensed dentist in accordance with rules and regulations adopted by the Board.

Connecticut

Public health facility defined as an institution, community health center, group home or school, preschool operated by local/regional board of health, or Head Start Program. Can practice without supervision if done in public health setting and (1) refer for treatment patients with needs outside scope of practice of hygienist and (2) coordinate referral to licensed dentist. Rules allow hygienist to be reimbursed directly. Need 2 years of practice as a hygienist.

Dental Hygiene Regs at **http://www.dph.state.ct.us/Licensure/apps/denhy.pdf**

Sec. 20-126l. Definitions. Scope of practice. Limitations. Continuing education.

(a) As used in this section:

(1) "General supervision of a licensed dentist" means supervision that authorizes dental hygiene procedures to be performed with the knowledge of said licensed dentist, whether or not the dentist is on the premises when such procedures are being performed;

(2) "Public health facility" means an institution, as defined in section 19a-490, a community health Center, a group home or a school, a school, a preschool operated by a local or regional board of education or a head start program; and

(3) The "practice of dental hygiene" means the performance of educational, preventive and therapeutic services including: Complete prophylaxis; the removal of calcerous deposits, accretions and stains from the supragingival and subgingival surfaces of the teeth by scaling, root planing and polishing; the application of pit and fissure sealants and topical solutions to exposed portions of the teeth; dental hygiene examinations and the charting of oral conditions; dental hygiene assessment, treatment planning and evaluation; and collaboration in the implementation of the oral health care regimen.

(b) No person shall engage in the practice of dental hygiene unless such person (1) has a dental hygiene license issued by the Department of Public Health and (A) is practicing under the general supervision of a licensed dentist, or (B) has been practicing as licensed dental hygienist for at least two years, is practicing in a public health facility and complies with the requirements of subsection (e) of this section, or (2) has a dental license.

(c) A dental hygienist licensed under sections 20-126h to 20-126w, inclusive, shall be known as a "dental hygienist" and no other person shall assume such title or use the abbreviation "R.D.H." or any other words, letters or figures which indicate that the person using such words, letters or figures is a licensed dental hygienist. Any person who employs or permits any other person except a licensed dental hygienist to practice dental hygiene shall be subject to the penalties provided in section 20-126t. Licensed dental hygienists may provide dental hygiene services in any office of a licensed dentist or in any public or private institution or in any convalescent home under the general supervision of a licensed dentist.

(d) A licensed dental hygienist shall in no event perform the following dental services: (1) Diagnosis for dental procedures or dental treatment; (2) the cutting or removal of any hard or soft tissue or suturing; (3) the prescribing of drugs or medication which require the written or oral order of a licensed dentist or physician; (4) the administration of local, parenteral, inhalation or general

anesthetic agents in connection with any dental operative procedure; (5) the taking of any impression of the teeth or jaws or the relationship of the teeth or jaws for the purpose of fabricating any appliance or prosthesis; (6) the placing, finishing and adjustment of temporary or final restorations, capping materials and cement bases.

(e) Each dental hygienist practicing in a public health facility shall (1) refer for treatment any patient with needs outside the dental hygienist's scope of practice, and (2) coordinate such referral for treatment to dentists licensed pursuant to chapter 379.

Sec. 20-126s. Payment for dental hygiene care of patients in chronic and convalescent hospitals and convalescent homes. Payment for dental hygiene care rendered to patients in chronic and convalescent hospitals or convalescent homes shall be made directly to the dental hygienist rendering such care. The commissioner of social services shall not be required to recognize the cost of employing or contracting with a dental hygienist in the rates established for convalescent homes pursuant to section 17b-340.

Delaware

TITLE 24 - Professions and Occupations, CHAPTER 11. DENTISTRY AND DENTAL HYGIENE, Subchapter III. Dental Hygiene

§ 1157. Employment and duties of dental hygienists.

(a) Any licensed dentist, public institution or school authority may employ dental hygienists registered under this subchapter.

(b) The registered dental hygienist may remove calculus deposits, plaque, accretions and stains from all surfaces of the teeth and make instrumental examinations of the teeth for cavities and assemble all necessary information for use by the dentist in diagnosis and treatment planning and may perform such prophylactic or preventive measures in the case of teeth, including the application of chemicals to the teeth, designed and approved for the prevention of dental caries, as the Board may from time to time authorize, but shall not perform any other operation on the teeth or tissues of the mouth.

(c) A registered dental hygienist may operate only under the general direction or supervision of a licensed dentist, in the dentist's office or in any public school or other institution.

(d) A dental hygienist may practice under the general supervision of the Delaware State Dental Director in state institutions, federally qualified health centers, non-profit organizations or other locations as designated by the Delaware Health Care Commission in consultation with DIDER.

(e) The Board may suspend or revoke, with power to reinstate, the license of any dentist who permits any dental hygienist, operating under the dentist's supervision, to perform any operation other than that permitted under this section.

(f) The Board may also suspend or revoke, with power to reinstate, the certificate of registration of any dental hygienist violating this subchapter. The procedure to be followed in the case of such suspension, revocation or reinstatement shall be the same as that prescribed by law in the case of suspension, revocation or reinstatement of a licensed dentist. (Code 1915, § 892-I; 38 Del. Laws, c. 48, § 2; Code 1935, § 982; 24 Del. C. 1953, § 1157; 49 Del. Laws, c. 409; 65 Del. Laws, c. 210, §§ 11, 12; 70 Del. Laws, c. 186, § 1; 72 Del. Laws, c. 481, §§ 4, 5.)

1.0 Supervision: Definitions - There are 3 recognized levels of supervision:

1.1 Direct Supervision - The dentist is present in the office, personally examines the patient and specifically authorized the work to be performed. The dentist checks the work before the patient leaves the office.

1.2 Indirect Supervision - A dentist is present in the office and generally authorizes the work to be performed. The dentist may examine the patient, either before or after work is performed. The dentist is available for consultation during the patient visit.
1.3 General Supervision - A dentist may or may not be present in the office while the work is performed. The dentist authorizes the work to be performed. Emergency care and consultant services are provided by an "on-call" dentist not present in the treatment facility, if the primary dentist is not present.
1.4 Dental Technician - Any person not licensed to practice dentistry in this State, engaged in the business of constructing, altering, repairing or duplicating full dentures ("plates"), partial dentures, splints, orthodontic appliances, fixed bridges or any other prosthetic appliances.

5.0 Supervision
5.1 Conditions Applicable to General Supervision - A licensed dental hygienist, by virtue of having passed a licensure examination and being duly licensed by the State, is capable of performing those services allowed by law under supervision, the following conditions shall exist:
5.2 Advance Notice to Patient - The patient is notified, as soon as it is known, that the dentist will not be present, and is given the option to reschedule to a time when the dentist will be present in the office.
5.3 Dentist Review of Records - The dentist shall review the treatment records of each patient prior to and following the patient treatment.
5.4 Patient Contraindications - Patients for whom it is medically or dentally contraindicated,will not be scheduled when the dentist is not present.
5.5 Office Requirements - A second office employee shall be present in the treatment facility at all times when patient care is performed. This is both for safety and security reasons.
5.6 Practice in a Public Health Institution - A licensed dental hygienist, per 24 Del.C. §1157(c), may operate under the general direction of a dentist in an institution, provided that all of the conditions of general supervision are met.

Georgia

150-7-.01 Public Health License. Amended.

(1) In order to provide urgent and necessary dental care for the patients and inmates at state-operated eleemosynary or correctional institutions, the Board may, in its discretion, issue a temporary public health license to a graduate of an accredited dental school who holds a dental license in good standing in another state, and shall be valid only for the period set forth below, and for the particular institution(s) named in the temporary public health license.

(2) A temporary public health license issued pursuant to this Rule shall expire automatically in the event that the applicant fails to register for or successfully complete, the next scheduled examination given after the granting of the temporary public health license. Provided, however, the Board may, in its discretion, renew a temporary public health license issued pursuant to this Rule one time, to permit a dentist who has failed the first scheduled board examination to take and receive the results of the next regularly scheduled board examination.

New Rule of same title adopted. F. Oct. 25, 1989; eff. Nov. 14, 1989. Amended: F. Oct. 29, 1996; eff Nov. 18, 1996.

Indiana

IC 25-13. ARTICLE 13. DENTAL HYGIENISTS

IC 25-13-1-10 Locations; practice of dental hygiene; instruction and in-service training

Sec. 10. (a) A licensed dental hygienist may be employed to practice dental hygiene in Indiana in the following:

(1) The office of a legally practicing proprietor dentist.

(2) A dental school or dental hygiene school to teach and demonstrate the practice of dental hygiene.

(3) The dental clinic of any public, parochial, or private school or other institution supported by public or private funds in which the licensee is employed by the state department of health or any county or city board of health or board of education or school trustee or parochial authority or the governing body of any private school. However, institutional practice, other than dental hygiene instruction and dental prophylaxis for children up to and including grade 12 pupils at all times must be under the supervision of a licensed dentist.

(4) The dental clinic of a bona fide hospital, sanitarium, or eleemosynary institution duly established and being operated under the laws of Indiana in which the licensee is employed by the directors or governing board of such hospital, sanitarium, or institution. However, such practice must be under the supervision at all times of a licensed dentist who is a staff member of the hospital or sanitarium or a member of the governing board of the institution.

(5) The dental clinic of an industrial or a commercial establishment in which the licensee's services are under the supervision of a licensed dentist.

(b) A licensed dental hygienist may provide without supervision the following:

(1) Dental hygiene instruction and in-service training without restriction on location.

(2) Dental prophylaxis for children up to and including grade 12 if the dental hygienist is employed by any of the following:

(A) The state department of health.

(B) The department of education.

(C) The elementary or secondary school where the services are provided.

(3) Screening and referrals for any person in a public health setting.

(Formerly: Acts 1945, c.90, s.10.) As amended by Acts 1981, P.L.222, SEC.116; P.L.169-1985, SEC.42; P.L.155-1988, SEC.4; P.L.185-1991, SEC.4; P.L.2-1992, SEC.766.

Kansas

65-1456. Dental hygienists; suspension or revocation of licenses, when; notice and hearing; practice of dental hygiene defined; rules and regulations; supervision defined; issuance of permits for dental screening; authorized activities, requirements. (a) The board may suspend or revoke the license of any dentist who shall permit any dental hygienist operating under such dentist's supervision to perform any operation other than that permitted under the provisions of article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof, and may suspend or revoke the license of any hygienist found guilty of performing any operation other than those permitted under article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof. No license of any dentist or dental hygienist shall be suspended or revoked in any administrative proceedings without first complying with the notice and hearing requirements of the Kansas administrative procedure act.

(b) The practice of dental hygiene shall include those educational, preventive, and therapeutic procedures which result in the removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci. Included among those educational, preventive and therapeutic procedures are the instruction of the patient as to daily personal

care, protecting the teeth from dental caries, the scaling and polishing of the crown surfaces and the planing of the root surfaces, in addition to the curettage of those soft tissues lining the free gingiva to the depth of the gingival sulcus and such additional educational, preventive and therapeutic procedures as the board may establish by rules and regulations.

(c) Subject to such prohibitions, limitations and conditions as the board may prescribe by rules and regulations, any licensed dental hygienist may practice dental hygiene and may also perform such dental service as may be performed by a dental assistant under the provisions of K.S.A. 65-1423 and amendments thereto.

(d) Except as otherwise provided in this section, the practice of dental hygiene shall be performed under the direct or general supervision of a licensed dentist at the office of such licensed dentist. The board shall designate by rules and regulations the procedures which may be performed by a dental hygienist under direct supervision and the procedures which may be performed under general supervision of a licensed dentist. As used in this section: (1) "Direct supervision" means that the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and before dismissal of the patient evaluates the performance; and (2) "general supervision" means a Kansas licensed dentist may delegate verbally or by written authorization the performance of a service, task or procedure to a licensed dental hygienist under the supervision and responsibility of the dentist, if the dental hygienist is licensed to perform the function, and the supervising dentist examines the patient at the time the dental hygiene procedure is performed, or during the 12 calendar months preceding the performance of the procedure, except that the licensed hygienist shall not be permitted to diagnose a dental disease or ailment, prescribe any treatment or a regimen thereof, prescribe, order or dispense medication or perform any procedure which is irreversible or which involves the intentional cutting of the soft or hard tissue by any means. A dentist is not required to be on the premises at the time a hygienist performs a function delegated under part (2) of this subsection.

(e) The practice of dental hygiene may be performed at an adult care home, hospital long-term care unit, state institution, local health department or indigent health care clinic on a resident of a facility, client or patient thereof so long as:

(1) A licensed dentist has delegated the performance of the service, task or procedure;

(2) the dental hygienist is under the supervision and responsibility of the dentist;

(3) either the supervising dentist is personally present or the services, tasks and procedures are limited to the cleaning of teeth, education and preventive care;

(4) the supervising dentist examines the patient at the time the dental hygiene procedure is performed or has examined the patient during the 12 calendar months preceding performance of the procedure; and

(5) nothing in this subsection (e) shall be construed to prevent a dental hygienist from providing dental education in a school setting.

(f) The board may issue a permit to a licensed dental hygienist to provide dental screening under such terms and conditions as the board may reasonably establish in such permit. Such permit shall be for a period of one year and shall be subject to renewal at the time the license for dental hygiene is renewed.

(g) In addition to the duties specifically mentioned in subsection (b) of K.S.A. 65-1456, and amendments thereto, any duly licensed dental hygienist may:

(1) Give fluoride treatments as a prophylactic measure, as defined by the United States public health service and as recommended for use in dentistry;

(2) remove overhanging restoration margins and periodontal surgery materials by hand scaling instruments; and

(3) administer local block and infiltration anesthesia and nitrous oxide. (A) The administration of local anesthesia shall be performed under the direct supervision of a licensed dentist. (B) Each dental hygienist who administers local anesthesia shall have completed courses of instruction in local anesthesia and nitrous oxide which have been approved by the board.

(h) (1) The courses of instruction required in subsection (g)(3)(B) of K.S.A. 65-1456, and amendments thereto, shall provide a minimum of 12 hours of instruction at a teaching institution accredited by the American dental association.

(2) The courses of instruction shall include courses which provide both didactic and clinical instruction in: (A) Theory of pain control; (B) anatomy; (C) medical history; (D) pharmacology; and (E) emergencies and complications.

(3) Certification in cardiac pulmonary resuscitation shall be required in all cases.

History: L. 1943, ch. 221, § 40; L. 1976, ch. 269, § 1; L. 1984, ch. 313, § 103; L. 1996, ch. 210, § 4; L. 1997, ch. 30, § 3; L. 1998, ch. 141, § 2; L. 2000, ch. 169, § 13; July 1.

Source or prior law: 65-1414.

Attorney General's Opinions: Act inapplicable to certain practices, acts and operations; exceptions. 89-70.

Attorney General's Opinions: Dental hygienists; dental hygiene practice defined; rules and regulations; supervision; permits for dental screening. 93-151.

Dental act not applicable to certain practices, acts and operations. 95-29.

Dentists providing anesthesia services operate independently and with same qualifications to supervise as anesthesiologist M.D. and D.O. 1998-57.

Maine

Program been in place since 98/99. Requires very formal detailed process run through the board office. Staff report practitioners are hard to keep track of. They are supposed to file reports with the board office that detail the number of patients seen, # screened, # sealants done, # cleanings and referrals, etc. Reports not always filed. Big access problem in the state and shortage of dentists.

130 practitioners have been authorized.

MAINE: RULES 02-313, chapter 1,

Section 1. DEFINITIONS.

A. General Supervision: "General supervision" shall mean that the dentist is not required to be in the dental office at the time the procedures are being performed on a patient of record.

B. Direct Supervision: "Direct supervision" shall mean that the dentist must be in the dental office at the time the duties under his/her supervision are being performed. In order to provide direct supervision of patient treatment, the dentist must at least diagnose the condition to be treated, authorize the treatment procedure prior to implementation, and examine the condition after treatment and prior to the patient's discharge.

C. Public Health Supervision: "Public Health Supervision" means that:

(1) The dentist provides general supervision to a dental hygienist who is practicing in a Public Health Supervision status that has been approved by the Board under Section 4 of this Chapter, with the exception that the patient being treated shall not be deemed to be a patient of record of the dentist providing Public Health Supervision; and

(2) The dental hygienist has an active Maine license and practices in settings other than a traditional dental practice, provided that the service is rendered under the supervision of a dentist with an active Maine license. These settings may include but are not necessarily limited to public and private schools, medical facilities, nursing homes, residential care facilities, dental vans, and any other setting where adequate parameters of care, infection control, and public health guidelines can and will be followed.

(Under list of services RDH may perform:

K. Apply sealants, provided that a licensed dentist first makes the determination and diagnosis as to the surfaces on which the sealants shall be applied; In Public health or school sealant programs only, determination and diagnosis of the sealant site by a dentist need not occur.

Section 4. PUBLIC HEALTH SUPERVISION STATUS

A. Public Health Supervision Status Allowed. The Board may grant "Public Health Supervision" status, as defined in Section 1(C), to a dental hygienist in situations the Board deems appropriate in its discretion, giving due consideration to the protection of the public.

B. Roles and Responsibilities. When working together in a Public Health Supervision relationship, dentists and dental hygienists shall enter into a Public Health Supervision Agreement based on the following roles and responsibilities:

(1) The dentist providing Public Health Supervision must:

☐ Be available to provide an appropriate level of contact, communication, collaboration, and consultation with the dental hygienist;

☐ Have specific standing orders or policy guidelines for procedures which are to be carried out for each location or program, although the dentist need not be present when the procedures are being performed;

☐ Help provide for the patient's additional needed care in collaboration with the dental hygienist, although the dentist has no responsibility for providing treatment.

(2) A dental hygienist providing services under Public Health Supervision may perform only those duties within the accepted scope of practice of dental hygiene, as specified in Section 2 (General Supervision of Dental Hygienists), and must:

☐ Provide to the patient, parent or guardian a written plan for referral or an agreement for follow-up recording all conditions that should be called to the attention of a dentist;

☐ Have each patient sign a permission slip or consent form that informs them that the service to be received does not take the place of regular dental checkups at a dental office and is meant for people who otherwise would not have access to the service;

☐ Inform each patient who may require further dental services of that need;

☐ Inform the Board in writing of any changes in or termination of the Public Health Supervision Agreement; and

☐ Maintain an appropriate level of contact and communication with the dentist providing Public Health Supervision.

C. Criteria. In deciding whether to grant Public Health Supervision status to a dental hygienist, the Board shall consider the following criteria:

(1) The proposal fills a need not currently being met;

(2) The particular proposed practice setting(s), including the proposed supervisor, will be adequate to accomplish the goal;

(3) Appropriate public health guidelines can be followed in the proposed setting(s);

(4) Adequate parameters of care can be maintained in the proposed practice setting(s);

(5) A dentist is available to provide Public Health Supervision to the dental hygienist and specific standing orders are submitted to and approved by the Board; and

(6) If criteria (1) – (4) are met, but a dentist is not readily available under (5), the Board shall assist the dental hygienist in finding a dentist to provide Public Health Supervision.

D. Application and Approval Process. A dental hygienist wishing to practice under Public Health Supervision must apply to the Board for approval, on an application form specified by the Board, providing such information as the Board may deem necessary. The dental hygienist shall list all known locations at which he or she expects to practice. Upon approval by the Board, the dental hygienist may practice under Public Health Supervision for a specified period determined by the board not to exceed three years. If, during the specified period, the dental hygienist finds that he or she will be providing services at additional locations than those described in the application form, he or she shall notify the Board about each of these locations, in the manner specified by the Board. Any application approved for a specified period may be amended, upon submission by the dental hygienist and approval by the Board. The Board may revoke its approval if a program does not continue to meet the criteria specified in 4(C).

E. Reporting Requirements. Each dental hygienist who has rendered services under Public Health Supervision must complete a summary report at the completion of a program, or, in the case of an ongoing program, at least annually. The report must be completed in the manner specified by the Board, including information about each location where the dental hygienist has rendered these services. The dental hygienist must submit the form to the dentist providing Public Health Supervision for his or her signature, before sending it to the Board.

no dentist tribe

F. Reimbursement. Dental hygienists providing services under Public Health Supervision may be compensated for their work by salary, honoraria, and other mechanisms by the employing or sponsoring entity. Nothing in this rule shall preclude the entity that employs or sponsors a dental hygienist from seeking payment, reimbursement, or other source of funding for the services provided.

Michigan

Program run through the public health department (recently renamed to something else). Board not involved in determining qualifications. Board is an umbrella agency, not specific authority.

Michigan: PUBLIC HEALTH CODE (EXCERPT) - Act 368 of 1978 (statute)

333.16625 Rules as to dental hygienist or dental assistant; dental hygiene services performed under supervision of dentist as part of program for dentally underserved program; designation of grantee health agency; advisory committee; "supervision" defined.

Sec. 16625.

(1) The board may promulgate rules to prohibit or otherwise restrict the assignment of procedures to a dental hygienist or a dental assistant if the board determines that the assignment constitutes or may constitute a danger to the health, safety, or welfare of the patient or the public.

(2) Notwithstanding section 16601(1)(f) or the rules promulgated under subsection (1), a dental hygienist may perform dental hygiene services under the supervision of a dentist as part of a program for dentally underserved populations in this state conducted by a local, state, or federal grantee health agency for patients who are not assigned by a dentist. The director of public health shall designate a person as a grantee health agency for a 2-year period if the person applies to the department of public health on a form provided by the department of public health and meets all of the following requirements:

(a) Is a public or nonprofit agency administering a program of dental care to a dentally underserved population.

(b) Obtains more than 50% of its total revenue from public or nonprofit organization sources.

(c) Employs or contracts with at least 1 dentist and 1 dental hygienist.

(d) Is not associated with a private dental practice or an incorporated dental service provider whose only source of state or federal funding is reimbursement under the program for medical assistance administered by the department of social services under the social welfare act, Act No. 280 of the Public Acts of 1939, being sections 400.1 to 400.121 of the Michigan Compiled Laws.

(e) Submits a program overview indicating the approximate population to be served, the method by which the service is to be provided, and the procedures for program oversight and direction.

(3) The director of public health may appoint an advisory committee to assist the director of public health in designating grantee health agencies under subsection (2). If the director of public health does appoint an advisory committee under this subsection, the director of public health shall include on the advisory committee, at a minimum, a representative from the Michigan dental hygienist association or its successor organization and a representative from the Michigan dental association or its successor organization.

(4) As used in this section, "supervision" means the overseeing of or participation in the work of any other individual by a health professional licensed under this article in circumstances in which 1 or more of the following exist:

(a) The continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and a licensed health professional.

(b) The availability of a licensed health professional on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation to the supervised individual, to review

records, and to further educate the supervised individual in the performance of the individual's functions.

(c) The provision by the licensed supervising health professional of predetermined procedures and drug protocol.

History: 1978, Act 368, Eff. Sept. 30, 1978 ;--Am. 1991, Act 58, Imd. Eff. June 27, 1991 .

Popular Name: Act 368

Minnesota

150A.10 Allied dental personnel.

Subdivision 1. Dental hygienists. Any licensed dentist, public institution, or school authority may obtain services from a licensed dental hygienist. Such licensed dental hygienist may provide those services defined in section 150A.05, subdivision 1a. Such services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Such services shall be provided under supervision of a licensed dentist. Any licensed dentist who shall permit any dental service by a dental hygienist other than those authorized by the board of dentistry, shall be deemed to be violating the provisions of sections 150A.01 to 150A.12, and any such unauthorized dental service by a dental hygienist shall constitute a violation of sections 150A.01 to 150A.12.

Subd. 1a. Limited authorization for dental hygienists.

(a) Notwithstanding subdivision 1, a dental hygienist licensed under this chapter may be employed or retained by a health care facility to perform dental hygiene services described under paragraph (b) without the patient first being examined by a licensed dentist if the dental hygienist:

(1) has two years practical clinical experience with a licensed dentist within the preceding five years; and

(2) has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

(b) The dental hygiene services authorized to be performed by a dental hygienist under this subdivision are limited to removal of deposits and stains from the surfaces of the teeth, application of topical preventive or prophylactic agents, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking of radiographs, and performance of root planing and soft-tissue curettage. The dental hygienist shall not place pit and fissure sealants, unless the patient has been recently examined and the treatment planned by a licensed dentist. The dental hygienist shall not perform injections of anesthetic agents or the administration of nitrous oxide unless under the indirect supervision of a licensed dentist. The performance of dental hygiene services in a health care facility is limited to patients, students, and residents of the facility.

(c) A collaborating dentist must be licensed under this chapter and may enter into a collaborative agreement with no more than four dental hygienists. The collaborative agreement must include:

(1) consideration for medically compromised patients and medical conditions for which a dental evaluation and treatment plan must occur prior to the provision of dental hygiene services; and

(2) a period of time in which an examination by a dentist should occur.

The collaborative agreement must be maintained by the dentist and the dental hygienist and must be made available to the board upon request.

(d) For the purposes of this subdivision, a "health care facility" is limited to a hospital; nursing home; home health agency; group home serving the elderly, disabled, or juveniles; state-operated

facility licensed by the commissioner of human services or the commissioner of corrections; and federal, state, or local public health facility, community clinic, or tribal clinic.

(e) For purposes of this subdivision, a "collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services authorized under this subdivision and the collaborative agreement may be performed without the presence of a licensed dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

Missouri

Section 332.311 Dental Hygienists allowed to practice without supervision in Public Health settings - conditions apply. A currently licensed dental hygienist who has been in practice at least three years and who is practicing in a public health setting may provide fluoride
treatments, teeth cleaning and sealants, if appropriate, to children who are eligible for medical assistance, pursuant to chapter 208, RSMo, without the supervision of a dentist. Public health settings will be defined jointly by the Department of Health and the Missouri Dental Board by rule. This provision expires on August 28, 2006.

4 CSR 110-2.131 Definition of a Public Health Setting
PURPOSE: The purpose of this rule is to implement section 332.311, RSMo as amended by HB567 of the 91st General Assembly and defines the public health settings in which a dental hygienist may practice without the supervision of a dentist.

(1) For the purposes of section 332.311, RSMo only, the term "public health setting" shall be defined as a location where dental services authorized by section 332.311, RSMo are performed so long as the delivery of services are sponsored by a governmental health entity which includes:

(A) Department of Health and Senior Services;

(B) A county health department;

(C) A city health department operating under a city charter;

(D) A combined city/county health department; or

(E) A nonprofit community health center qualified as exempt from federal taxation under section 501(c)(3) of the *Internal Revenue Code* including a community health center that receives funding authorized by sections 329, 330, and 340 of the United States Public Health Services Act.

Nevada

Law went into effect in 2000. Can practice in health facility, school, or other place designated by board without supervision. Most go out into clinics run by the state where there is a dentist, so not very many people interested in program.

1 person has applied to board

New Hampshire

http://gencourt.state.nh.us/rules/den100-500.html
Den 101.13 "Public health supervision" means a dentist with an active license authorizes procedures to be carried out by a dental hygienist with an active license practicing in a school, hospital, or institution without the dentist having to be present but the dentist will review the records once in a 12 month period.
Den 402.01 Hygienists' Duties. A dental hygienist shall perform the following duties:

(c) Under public health supervision as defined in Den 101.12 and arranged by degree of supervision in Den 302.02:

(1) Collect and assess medical and dental histories, including preliminary inspection of the oral cavity, surrounding structures and periodontal probing and charting;

(2) Perform complete oral prophylaxis as appropriate, including the removal of calciferous deposits and the removal of subgingival accretions and stains by scaling and root planing;

(3) Apply topical fluoride; and

(4) Instruct in oral hygiene techniques.

New Mexico

16.5.29.10 PRACTICE SETTINGS: New Mexico licensed dental hygienists may practice in the following settings:

A. the office of a licensed dentist;

B. a clinic or clinics operated or approved by an executive agency of the State of New Mexico;

C. a hospital with written authorization;

D. a state licensed nursing home or long term care facility with written authorization; or

E. a school regulated by the New Mexico Department of Education.

[5-31-95, A, 12-15-97; Recompiled 12/31/01]

16.5.17.2 SCOPE: The provisions of 16.5.17 NMAC apply to all dentists, dental hygienists and dental assistants who work in a collaborative practice arrangement.

16.5.17.3 STATUTORY AUTHORITY: 16.5.17 NMAC is promulgated pursuant to the Dental Health Care Act, NMSA 1978 Section 61-5A-4 (1999 Repl. Pamp.).

16.5.17.4 DURATION: Permanent

16.5.17.5 EFFECTIVE DATE: February 14, 2000, unless a different date is cited at the end of a Section or Paragraph.

16.5.17.6 OBJECTIVE: To regulate the collaborative practice of dental hygiene in New Mexico.

16.5.17.7 DEFINITIONS:

A. "Acting Consulting Dentist" means a dentist who meets the qualifications of a consulting dentist who is named by a consulting dentist to act in his place when that dentist will be away from his practice for more than two weeks.

B. "Collaborative Practice Agreement" means a written agreement between a dentist who meets the qualifications of 16.5.17.9 NMAC to be a consulting dentist as defined in 16.5.17 NMAC of these rules, and a collaborative practice dental hygienist. This agreement shall follow the format as determined by the Board.

C. "Collaborative Practice of Dental Hygiene" means the science of the prevention and treatment of oral disease through the provision of educational, assessment, preventive, clinical and other therapeutic services as specified in Section 61-5A-4(B) in a cooperative working relationship with a consulting dentist but without general supervision, as set forth by the rules jointly established by the board and committee.

D. "Consulting (Collaborative) Dentist" means a dentist who meets the qualifications specified in Section 16.5.17.9 NMAC of this rule and who agrees to serve or continues to serve as a patient's dentist of record in collaboration and consultation with the practice dental hygienist as specified in the rules.

E. "Non-participating Dentist" is a dentist who does not wish to collaborate with a collaborative practice dental hygienist.
F. "Standard collaborative practice protocols" is the protocol to be used by the collaborative practice dental hygienist to treat a patient, as specified in Section 16.5.17.13 NMAC of this part.
G. "Written prescription orders" means instructions from the consulting dentist to the collaborative hygienist to perform those allowable treatments requiring a diagnosis and treatment plan, subject to the limitations of Section 16.5.17.12 NMAC of these rules, or directions written to modify the standard collaborative practice protocols, or the collaborative practice agreement.
H. "Verbal prescription or orders" means instructions not communicated in written form, which must be recorded in the patient's record or the protocol agreement by both the collaborative hygienist and the consulting dentist when given.
[2-14-00; 16.5.17.7 NMAC - Rn & A, 16 NMAC 5.17.7, 12-14-00]

16.5.17.8 Certification for the Collaborative Practice of Dental Hygiene: The Board, based on the recommendation of the Dental Hygienists Committee, will certify qualified dental hygienists for collaborative practice.
A. Prerequisite Requirements for Certification. Each applicant for certification as a collaborative practice dental hygienist must possess the following qualifications:
(1) Possess a current New Mexico dental hygiene license in good standing.
(2) Have been engaged in the active practice of dental hygiene as defined in 61-5A-4(B) of the Act for not less than:
(a) 2400 hours of active practice for the past eighteen months; or
(b) a total of 3,000 hours of active practice and has been engaged in active practice for two of the past three years.
(3) Meet the educational criteria for licensure in Section 61-5A-13 (A) of the Act.
(4) Have 15 hours of continuing education in clinical dental hygiene in the twelve (12) months prior to certification, which includes courses in infection control and medical emergencies.
B. Documentation Requirements: Each applicant for certification as a collaborative practice dental hygiene must submit a completed application, the required fees and following documentation:
(1) Verification of a current active license;
(2) Proof of the active practice of dental hygiene as defined in paragraph (2) Subsection A of 16.5.17.8 NMAC of this Part. This proof may be in the form of notarized letters from employers, supervisors of dental clinics of one of the Uniformed Services of the United States, or faculty administrators of accredited schools. If this documentation cannot be obtained, the applicant may request to provide other proof of the required hours to the Committee for consideration;
(3) Copy of proof of current basic life support;
(4) Proof of 15 hours of continuing education related to the clinical practice of dental hygiene; and
(5) A copy of a signed collaborative practice agreement between a dental hygienist and a consulting dentist.
C. Renewal Requirements: Each dental hygienist certified for collaborative practice shall:
(1) Submit a completed renewal application for certification for collaborative practice, along with the triennial renewal application for their license, accompanied by the required fees as defined in 16.5.18 NMAC.
(2) Complete 60 hours of continuing education every triennial renewal period. If the initial certification period is less than three years, the required continuing education will be prorated at 20 hours per full year of certification.
(3) Submit a current list of all consulting dentists to the Board with each renewal application.
[2-14-00; 16.5.17.8 NMAC - Rn, 16 NMAC 5.17.8, 12-14-00]

16.5.17.9 Qualifications for Consulting Dentists: A consulting dentist must meet the following qualifications:

A. Possess a current New Mexico dental license in good standing;

B. Maintains an active clinical general dentistry or public health practice within the State and within a reasonable referral distance from the collaborative dental hygiene practice as determined by the Board upon recommendation of the Dental Hygienists Committee.

[2-14-00; 16.5.17.9 NMAC - Rn & A, 16 NMAC 5.17.9, 12-14-00]

16.5.17.10 Responsibilities of a Consulting Dentist: The consulting dentist shall:

A. In collaboration with the dental hygienist, provide for the patient's additional needed dental care;

B. Be available to provide consultation to the collaborative practice dental hygienist;

C. Make provisions for a qualified acting consulting dentist to act in his/her place should he/she be away from his practice for more than two weeks;

D. Maintain an appropriate level of contact and communication with the collaborative practice dental hygienist;

E. In conjunction with the collaborative practice dental hygienist, be responsible and liable for acts and omissions in the collaborative dental hygiene practice; and

F. Assure that each collaborative practice dental hygienist is duly licensed and certified for collaborative practice by the Board of Dental Health Care.

G. Maintain a separate and distinct collaborative practice agreement with each collaborative practice dental hygienist for whom he/she serves as a consulting dentist.

H. Provide verbal and/or written prescriptions to the collaborative practice dental hygienist for those procedures requiring a diagnosis.

I. Provide verbal and/or written prescriptions to the collaborative practice dental hygienist when the consulting dentist deems it appropriate to provide exception to the standardized protocols.

J. Provide a written prescription within (7) business days following a verbal prescription or order.

K. Maintain in the patients record a duplicate of the written prescriptions and/or orders as described in Subsection H of 16.5.17.10 NMAC through Subsection J of 16.5.17.10 NMAC

L. Provide a written diagnosis and treatment recommendations from the records provided by the collaborative practice dental hygienist to the patient and the hygienist with in thirty days of receipt of such records.

N. Each collaborative agreement will be kept on file by the collaborative practice dental hygienist and the consulting dentist, the basic format of the agreement will be provided with the application by the Board.

[2-14-00; 16.5.17.10 NMAC - Rn & A, 16 NMAC 5.17.10, 12-14-00]

16.5.17.11 Responsibilities of a Collaborative Practice Dental Hygienist: The collaborative practice dental hygienist shall:

A. Refer each patient for a dental examination every twelve (12) months, as well as anyone who may require further dental services, to the patient's consulting dentist or to a dental specialist in the case of an emergency.

B. In conjunction with the consulting dentist, be responsible and liable for acts and omissions in the collaborative dental hygiene practice;

C. Assure that each consulting dentist is duly licensed by the Board of Dental Health Care; by verification with the Board Office.

D. Maintain a collaborative practice agreement with each consulting dentist; and

E. Maintain an appropriate level of contact and communication with the consulting dentist.

F. Shall contact the patient's dentist of record, if not a consulting dentist, prior to treating the patient to give the dentist the option of becoming a consulting dentist.

G. Shall offer the patient a choice of the collaborative practice dental hygienist's consulting dentists if the patient's dentist of record chooses to be a non-participating dentist.

H. Not to perform any treatment if the patient does not have an active consulting dentist on record with the collaborative practice dental hygienist.

I. Follow the standardized protocol unless modified by the consulting dentist by prescription or order.

J. Follow the verbal and written prescriptions and orders of the consulting dentist for those treatments requiring a diagnosis.

K. Forward all records and x-rays, or duplicates, to the consulting dentist within 14 days.

L. Assure that each consulting dentist meets the requirements of a consulting dentist as stated in 16.5.17.9 NMAC.

[2-14-00; 16.5.17.11 NMAC - Rn & A, 16 NMAC 5.17.11, 12-14-00]

16.5.17.12 Collaborative Dental Hygiene Practice and Limitations:

A. A collaborative practice dental hygienist may have more than one consulting dentist.

B. A dentist shall have a consulting agreement with no more than three collaborative practice dental hygienists. The board may grant exception to this limitation for public health settings on a case-by-case basis.

C. The collaborative practice dental hygienist may own and/or manage a dental hygiene practice, or enter into a contractual arrangement, in any location or setting in New Mexico.

E. The Committee, through the Board, may take any disciplinary action allowed by the Uniform Licensing Act, against a dental hygienist certified in collaborative practice.

F. A collaborative practice dental hygienist shall not:

(1) Administer local anesthesia except under the indirect supervision of a dentist; and only if certified to do so by the Board.

(2) Administer a drug or medication, except those directly indicated as Dental topical therapeutic or preventive agents. Other therapeutic agents may only be dispensed if the collaborative practice dental hygienist holds a Class C clinic license. Any drugs dispensed as a Class C clinic must be on the specific individual authorization of a dentist.

(a) All non-controlled substance medications requiring a prescription or order from the dentist may only be dispensed for immediate use in the collaborative practice dental hygienist office, and only on the specific order or protocol from the consulting dentist. A log of these dispensing shall be kept and a copy of this log shall be sent to the corresponding consulting dentist every 6 months. Collaborative practice dental hygienists may not dispense or administer any controlled substance.

(b) Prescription drugs, which are kept in bulk at the collaborative practice dental hygienist's office, to be dispensed or used by the collaborative practice dental hygienist as in paragraph (2) of Subsection F 16.5.17.12 NMAC, must be purchased on an order or prescription by a consulting dentist.

(3) Diagnose dental disease, but may advise the patient of suspected pathology and periodontal status;

(4) Perform oral hygiene procedures on any patient identified as having a significant health risk from the procedures; unless the patients' current health history has been reviewed by the patient's dentist of record or the consulting dentist; or for patients who reside in residential or long term care facilities, the patient's dentist or physician.

(5) Perform treatments requiring the diagnosis of a dentist without a prescription/order from the consulting dentist. Such treatments include but are not limited to, root planning, sealant application, administration of therapeutic agents and other services defined in Section 61-5A-4(B) as within the scope of dental hygiene practice but which require a dentists diagnosis.

(6) Modify the standard collaborative practice protocol without a prescription or order from the consulting dentist.

(7) Take impressions for bleaching trays, deliver bleaching materials or provide systems of home bleaching, or provide instructions to patients on using bleaching materials unless it is authorized on a case by case basis by prescription from a consulting dentist.

(8) Provide in office bleaching systems unless under indirect supervision of a Consulting Dentist.

[2-14-00; 16.5.17.12 NMAC - Rn & A, 16 NMAC 5.17.12,12-14-00; A, 06-14-01]

16.5.17.13 Standard Collaborative Practice Protocols: All protocols will include but are not limited to; Review of health history charting of existing teeth and restorations, periodontal charting as necessary, and notations of potential pathology. Protocols may be amended upon written order of the consulting dentist. Time intervals for these protocols must be established in the Collaborative Practice Agreement as provided in Subsection G of 16.5.17.13 NMAC.

A. Protocols for children 12 and under:

(1) Appropriate panoramic or occlusal x-rays
(2) Two bitewing x-rays
(3) Prophylaxis/scaling
(4) Topical fluoride treatment
(5) Other radiographs as indicated by consultation with the dentist.

B. Protocols for teenagers:

(1) Appropriate panoramic or full mouth radiographs
(2) Two or four bitewing x-rays
(3) Prophylaxis/scaling
(4) Topical fluoride treatment
(5) Other radiographs as indicated by consultation with the dentist.

C. Protocols for adults:

(1) Full mouth or panoramic radiograph
(2) Bitewing radiographs annually
(3) Complete periodontal charting
(4) Prophylaxis/scaling or gross debridement and consultation with the consulting dentist if periodontal assessment suggests periodontal involvement.

D. All other procedures not listed in the protocols shall require a prescription from the consulting dentist as stated in Subsection H of 16.5.17.10 NMAC and Subsection N of 16.5.17.10 NMAC.

E. Guidelines for patient release forms, to include a disclaimer signed by the patient or legal guardian that the dental hygiene services rendered do not preclude the need for routine examinations by a dentist.

F. Both the consulting dentist and the collaborative practice dental hygienist shall sign a copy of this or amended protocol and keep on file.

G. Changes to practice protocol and/or agreements must be in prescribed in writing by the consulting dentist and recorded by both the consulting dentist and the collaborative practice dental hygienist.

[2-14-00; 16.5.17.13 NMAC - Rn, & A, 16 NMAC 5.17.13, 12-14-00]

16.5.17.14 Dental Assistants in Collaborative Dental Hygiene Practice: Collaborative practice dental hygienists may work with and supervise dental assistants, including dental assistants certified to perform functions as defined in 16.5.39 NMAC of these rules.
[2-14-00; 16.5.17.14 NMAC - Rn, 16 NMAC 5.17.14, 12-14-00]

North Carolina:

SUBCHAPTER 16W - PUBLIC HEALTH HYGIENISTS
SECTION .0100 - PUBLIC HEALTH HYGIENISTS

.0101 DIRECTION DEFINED
Pursuant to G.S. 90-233(a), a public health hygienist may perform clinical procedures under the direction of a licensed dentist who is employed by a State government dental public health program or a local health department as a public health dentist. The specific clinical procedures delegated to the hygienist must be completed, in accordance with a written order from the dentist, within 60 days of the dentist's in-person evaluation of the patient. The dentist's evaluation of the patient shall include a complete oral examination, thorough health history and diagnosis of the patient's condition.
History Note: Authority G.S. 90-223; 90-233(a); Temporary Adoption Eff. October 1, 1999.

.0102 TRAINING FOR PUBLIC HEALTH HYGIENISTS
(a) Prior to performing clinical procedures pursuant to G.S. 90-233(a) under the direction of a duly licensed dentist, a public health hygienist must have:
(1) five years of experience in clinical dental hygiene;
(2) CPR certification, updated annually;
(3) six hours of continuing education in medical emergencies each year; and
(4) such other training as may be required by the Dental Health Section of the Department of Health and Human Services.
(b) For purposes of this Rule, a minimum of 4000 hours performing primarily prophylaxis or periodontal debridement unde r the supervision of a duly licensed dentist shall be equivalent to five years experience in clinical dental hygiene.
History Note: Authority G.S. 90-223; 90-233(a); Temporary Adoption Eff. October 1, 1999.

.0103 TRAINING FOR PUBLIC HEALTH HYGIENISTS PERFORMING PREVENTIVE PROCEDURES
(a) Public health hygienists who provide only educational and preventive procedures such as application of fluorides, fluoride varnishes, and oral screenings, and not clinical procedures, shall be subject to the training provisions set out in Paragraph (b) of this Rule instead of the training provisions required by 21 NCAC 16W .0102.
(b) A public health hygienist may perform preventive procedures as set out in Paragraph (a) of this Rule under the direction of a duly licensed public health dentist if the hygienist:
(1) maintains CPR certification; and
(2) completes such other training as may be required by the Oral Health Section of the Department of Health and Human Services.
History Note: Authority G.S. 90-223; 90-233(a); Temporary Adoption Eff. February 8, 2000; Eff. April 1, 20

Oregon

1997 legislation, effective late October, rules in 1998. Requires Limited Access Permit, issued by the Board, in order to practice. Executive Director reports no problems with the program, however, not enough people are applying. There were some problems getting the extended coursework that is required. Law was expanded in 2001 to allow additional facilities where people with permit can practice to include schools. Hygienists cannot already provide assessments or screenings because the board has interpreted Oregon law to say that they are diagnosing. In 2003, the hygiene group will be trying to change the statute to make it clear hygienists can provide these assessments and screenings. The definition of supervision is in statute. Reimbursement not too much of issue, about 25% of the hygienists have needed the Executive Director to write a letter saying they are authorized to provide the services and be reimbursed directly.
24 people received permit so far

(Limited Access Permits)

680.200 Issuing permit. (1) Upon application accompanied by the fee established by the Oregon Board of Dentistry, the board shall grant a permit to practice as a limited access permit dental hygienist to any applicant who:

(a) Holds a valid, unrestricted Oregon dental hygiene license;

(b) Presents evidence satisfactory to the board of at least 5,000 hours of supervised dental hygiene clinical practice within the previous five years;

(c) Presents proof of current professional liability insurance coverage; and

(d) Presents documentation satisfactory to the board of successful completion of a total of 40 classroom hours of courses from a formal, post-secondary educational institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency and approved by the board, including but not limited to:

(A) General medicine and physical diagnosis;

(B) Pharmacology;

(C) Medical emergencies and cardiopulmonary resuscitation;

(D) Oral pathology;

(E) Management and psychology of geriatric and disabled patients; and

(F) Jurisprudence relating to unsupervised practice with limited access patients.

(2) All permits issued pursuant to subsection (1) of this section expire two years following the date of issuance unless renewed on or before that date by:

(a) Payment of the renewal fee as set by the board;

(b) Submission to the board of satisfactory evidence of completion of at least 36 hours of continuing education, 12 hours of which shall be in the coursework areas required in subsection (1) of this section; and

(c) Presentation to the board of proof of professional liability insurance coverage.

(3) The board may refuse to issue or renew a limited access permit or may suspend or revoke the permit of a limited access permit dental hygienist who has been convicted of an offense or been disciplined by a dental licensing body in a manner that bears, in the judgment of the board, a demonstrable relationship to the ability of the applicant to practice limited access permit dental hygiene in accordance with the provisions of this chapter or ORS chapter 679, or who has falsified an application for permit, or any person for any cause described under ORS 679.140 or 679.170. [1997 c.251 §2]

680.205 Services rendered under permit. (1) A dental hygienist issued a permit to act as a limited access permit dental hygienist under ORS 680.200 shall be authorized to render all services within the scope of practice of dental hygiene as defined in ORS 679.010 and as authorized by the limited access permit to:

(a) Patients or residents of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:

(A) Nursing homes as defined in ORS 678.710;

(B) Adult foster homes as defined in ORS 443.705;

(C) Residential care facilities as defined in ORS 443.400;

(D) Adult congregate living facilities as defined in ORS 441.525;

(E) Mental health residential programs administered by the Department of Human Services;

(F) Facilities for mentally ill persons, as defined in ORS 426.005;

(G) Facilities for persons with mental retardation, as defined in ORS 427.005; or

(H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth correction facilities as

defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005.

(b) Students or enrollees of nursery schools and day care programs, Job Corps and other similar employment training facilities and primary and secondary schools, including private schools and public charter schools.

(2) At least once each calendar year, a dental hygienist issued a permit to act as a limited access permit dental hygienist shall refer each patient or resident to a dentist who is available to treat the patient or resident.

(3) Nothing in this section shall be construed to authorize a limited access permit dental hygienist to administer local anesthesia, to provide sealants, denture soft lines, temporary restorations and radiographs except under the general supervision of a dentist licensed under ORS chapter 679, or to administer nitrous oxide except under the indirect supervision of a dentist licensed under ORS chapter 679.

(4) The Oregon Board of Dentistry may not expand the scope of unsupervised practice of a limited access dental hygienist by rule.

(5) A person granted a limited access permit under ORS 680.200 shall also procure all other permits or certificates required by the board under ORS 679.250. [1997 c.251 §3; 2001 c.592 §1]

Texas

Sec. 262.1515. DELEGATION OF DUTIES TO DENTAL HYGIENIST PRACTICING IN CERTAIN LONG-TERM CARE FACILITIES AND SCHOOL-BASED HEALTH CENTERS.

(a) A licensed dentist may delegate a service, task, or procedure, pursuant to this section, to a dental hygienist, without complying with Section 262.151(a)(2) if:

(1) the dental hygienist has at least two years' experience in the practice of dental hygiene; and

(2) the service, task, or procedure is performed in one of the following locations:

(A) a nursing facility as defined in Section 242.301, Health and Safety Code; or

(B) a school-based health center established under Section 38.011, Education Code, as added by Chapter 1418, Acts of the 76th Legislature, Regular Session, 1999.

(b) The patient must be referred to a licensed dentist after the completion of a service, task, or procedure performed under Subsection (a).

(c) A dental hygienist may not perform a second set of delegated tasks or procedures until the patient has been examined by a dentist in compliance with Section 262.151(a)(2).

(d) A dental hygienist may not perform any service, task, or procedure under this section without the express authorization of a dentist.

(e) The nursing facility or school-based health center shall note each delegated service, task, or procedure performed by the dental hygienist under this section in the patient's medical records.

Washington

RCW 18.29.220

Community-based sealant programs in schools.

(1) For low-income, rural, and other at-risk populations and in coordination with local public health jurisdictions and local oral health coalitions, a dental hygienist licensed in this state as of April 19, 2001, may assess for and apply sealants and apply fluoride varnishes in community-based sealant programs carried out in schools without attending the department's school sealant endorsement program.

(2) For low-income, rural, and other at-risk populations and in coordination with local public health jurisdictions and local oral health coalitions, dental hygienists who are school sealant endorsed under RCW 43.70.650 may assess for and apply sealants and fluoride varnishes in community-based sealant programs carried out in schools.
[2001 c 93 § 3.]NOTES: Findings -- Intent -- Effective date -- 2001 c 93:

RCW 18.29.180 Exemptions from chapter.
The following practices, acts, and operations are excepted from the operation of this chapter:
(1) The practice of dental hygiene in the discharge of official duties by dental hygienists in the United States armed services, coast guard, public health services, veterans' bureau, or bureau of Indian affairs;
(2) Dental hygiene programs approved by the secretary and the practice of dental hygiene by students in dental hygiene programs approved by the secretary, when acting under the direction and supervision of persons licensed under chapter 18.29 or 18.32 RCW acting as instructors.

RCW 18.29.056 Employment by health care facilities authorized -- Limitations.
(1) Dental hygienists licensed under this chapter with two years' practical clinical experience with a licensed dentist within the preceding five years may be employed or retained by health care facilities to perform authorized dental hygiene operations and services without dental supervision, limited to removal of deposits and stains from the surfaces of the teeth, application of topical preventive or prophylactic agents, polishing and smoothing restorations, and performance of root planing and soft-tissue curettage, but shall not perform injections of anesthetic agents, administration of nitrous oxide, or diagnosis for dental treatment. The performance of dental hygiene operations and services in health care facilities shall be limited to patients, students, and residents of the facilities. For dental planning and dental treatment, dental hygienists shall refer patients to licensed dentists.
(2) For the purposes of this section, "health care facilities" are limited to hospitals; nursing homes; home health agencies; group homes serving the elderly, handicapped, and juveniles; state-operated institutions under the jurisdiction of the department of social and health services or the department of corrections; and federal, state, and local public health facilities, state or federally funded community and migrant health centers, and tribal clinics.
[1997 c 37 § 2; 1984 c 279 § 63.] NOTES:Severability -- 1984 c 279: See RCW 18.130.901.

WAC 246-815-170 General provisions. (1) "Unprofessional conduct" as used in this chapter shall mean the conduct described in RCW 18.130.180.
(2) "Hospital" means any health care institution licensed pursuant to chapter 70.41 RCW.
(3) "Nursing home" means any health care institution which comes under chapter 18.51 RCW.
(4) "Department" means the department of health.
(5) "Dental hygienist" means a person licensed pursuant to chapter 18.29 RCW.
(6) "Mentally or physically disabled dental hygienist" means a dental hygienist who is currently mentally incompetent or mentally ill as determined by a court, or who is unable to practice dental hygiene with reasonable skill and safety to patients by reason of any mental or physical condition and who continues to practice while so impaired.

WAC 246-815-190 Health care institutions. The chief administrator or executive officer or their designee of any hospital or nursing home shall report to the department when any dental hygienist's services are terminated or are restricted based on a determination that the dental hygienist has either committed an act or acts which may constitute unprofessional conduct or that the dental hygienist may be unable to practice with reasonable skill or safety to the client by reason of a mental or physical condition.

IOWA GENERAL ASSEMBLY

ARRC

Administrative Rules Review Committee

STATEHOUSE * ROOM 116 * DES MOINES, IOWA 50319 * (515) 281-3084/3355
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THE RULES DIGEST

April, 2003

Scheduled for committee review
Monday, April 14th, 2003
Statehouse Room #116

Reference
XXV IAB No. 18 (03/05/03)
XXV IAB No. 19 (03/19/03)
XXV IAB No. 20 (04/02/03)

HIGHLIGHTS IN THIS ISSUE:

DRAM SHOP REQUIREMENTS, Alcoholic Beverages Commission 1
DENTAL HYGIENISTS: COLLABORATIVE AGREEMENTS, Dental Board of Examiners 2
TEACHER EVALUATIONS, Department of Education 3
CLOSING ATTENDANCE CENTERS, Department of Education 3
CAMPAIGN FINANCE PROCEDURES, Ethics & Campaign Finance 5
MEDICAID DRUG REIMBURSEMENT, Department of Human Services 6
UNFAIR TRADE PRACTICES, Insurance Division 8
CHILD PROTECTION GRANTS, Public Health Department 10
ALTERNATE ENERGY PRODUCTION, Utilities Division 10

ALCOHOLIC BEVERAGES DIVISION

9:15

Dram shop requirements, IAB Vol. IAB Vol. XXV, No. 20, ADOPTED.

In August 2001 the division proposed the first increase in dram shop insurance requirement in three decades. The current level is $35,000--$10,000 for bodily injury, with a $20,000 maximum for multiple injuries and $5,000 for property damage. The August, 2001 proposal would raise these amounts to $50,000, $100,000 and $20,000 respectively. A new category is added--$50,000 or loss of support, for a total of $220,000. Department representatives stated this level was well within the range of limits for those states requiring dram shop insurance, although it was noted many states had no such requirement at all. Committee members were generally supportive of some dram shop reform, but felt more information was needed on the cost impact of these revisions. For that reason the committee requested a regulatory analysis to estimate the financial impact this increase would have an licensees. This request delayed the final adoption of the rule until this study was completed.

The study was reviewed by the ARRC in September, 2002. It stated that the current requirements were was adopted in 1973 and in the following years, according to the consumer price index, the cost of living has increased nearly 400%. Of Iowa's 5,000 licensees 25% would experience an increase from 18% to 158% in their rates while 60% would have no increase because they already had more coverage than the amount required by the proposed amendments. The analysis estimates that the total costs of alcohol-related accidents was $1.2 billion in 2001.

The study did set out a number of alternatives to dram shop insurance; these include surety bonds, risk pools, and deposits with the State Treasurer and even additional training for servers. However,

all of these alternatives will require legislative action.

The division has now completed action on this rule-making. The support provisions have been reduced from $50,000 to $25,000 for an individual and reduced from $100,000 to $50,000 for two or more persons. Provisions for $25,000 property damage coverage have been eliminated entirely. Newly added coverage for assault and battery injury has been retained.

AGRICULTURAL DEVELOPMENT AUTHORITY
10:10

Loan participation program, IAB Vol. XXV, No. 19, ARC 2359B, NOTICE.

The IADA loan participation program assists lenders and qualified farmers by providing government participation in a loan for the purchase of agricultural improvements, machinery, breeding livestock or property. To be eligible, an individual farmer may have a net worth no greater than $200,000, a partnership, no greater than $400,000. Debt is limited to $400,000 for an individual and $800,000 for a partnership. Those amounts are now being raised to $300,000 and $600,000 respectively. The aggregate amount of the participated loan can be no more than two times the net worth of the borrower, however, the amount of the loan is being raised from $50,000 to $100,000.

DENTAL EXAMINERS BOARD
9:30

Dental hygienist: collaborative agreements, IAB Vol. XXV, No. 18, ARC 2327B, NOTICE.

Under Iowa Code §153.15 the Board of Dental Examiners may define the *"educational, therapeutic, and preventive"* services performed by a licensed hygienist. These services are set out in great detail in rule 650 IAC 10.3. The statute also requires these services to be performed under *"supervision"* of a licensed dentist in a dental office, a school, public health agencies, hospitals, or the armed forces. Supervision is clearly defined in rule 650 IAC 1.1. Under this definition a dentist does not need to be in the facility while hygienist services are being provided, with four conditions:

- ⌘ Informed consent by the patient;
- ⌘ Consent by the hygienist;
- ⌘ Basic emergency procedures must be established;
- ⌘ The treatment to be provided must be prior prescribed by a licensed dentist and entered in writing in the patient record.

Based on the existing statutory and regulatory framework this proposed rule administratively creates a function roughly similar to that of physician assistants. This rulemaking would allow a dental hygienist who has 2,500 hours of clinical practice or who is employed as a public health hygienist to perform *preventive* services in a variety of settings such as schools, public health agencies, and health care facilities without the patient's first being examined by a dentist. The hygienist must have a collaborative agreement with a dentist who authorizes and accepts responsibility for the services provided by the hygienist. The collaborative agreement must contain protocols or standing orders for the hygienist to follow. The agreement and protocols would need to meet the four conditions required for general supervision.

ECONOMIC DEVELOPMENT
9:40

Entrepreneurial ventures assistance program, IAB Vol. XXV, No. 19, ARC 2360B, NOTICE.

The entrepreneurial ventures assistance (EVA) program is in part a training program. It encourages the development of entrepreneurial venture planning and managerial skills in conjunction with the delivery of a financial assistance program for business start-ups and expansions. Eligible businesses include start–up or early–stage companies, or existing companies developing a new product or technology. The owners must provide evidence that they are currently participating in, or have completed an "entrepreneurial venture development curriculum." This course of study covers such things as entrepreneurial training, management team development, intellectual property management, market research and analysis, sales and distribution

March 2003 ARRC Meeting

Summary of Issues

The May meeting of the Administrative Rules Review Committee will be on Tuesday, May 13th, 2003 in Statehouse Room #116. For more information contact Joe Royce at 281-3084; email: joe.royce@legis.state.ia.us.

ALCOHOLIC BEVERAGES, Dram shop insurance, 04/02/03 IAB, ARC 2385B, ADOPTED.

BACKGROUND: After a two year rulemaking, the division completion action on the first increase in dram shop requirements in 30 years. The Iowa Dram Shop Law, Iowa Code § 123.92 imposes liability on any licensee or permittee for any personal or property injury resulting from the intoxication of a person. Licensees and permitees are required by law to maintain liability insurance in an amount determined by the division.

COMMENTARY: The previous level was $35,000 maximum: $10,000 for bodily injury, $20,000 maximum for multiple injuries and $5,000 for property damage. The new levels are $50,000, $100,000 and $20,000 respectively. A new category is added-- $25,000 or loss of support. Assault and battery is also now included as a compensable loss. A regulatory analysis of these changes was completed in August, 2002; it revealed that of Iowa's 5,000 licensees 25% would experience an increase from 18% to 158% in their rates while 60% would have no increase because they already had more coverage than the amount required by the proposed amendments. Implementation of the new coverage will occur as policies are renewed-- beginning September 1, 2003, and ending August 31, 2004. It was felt that a long lead time was needed to allow the insurance industry an opportunity to properly rate these changes. Division representatives noted these levels were reasonable when compared to other states.

The committee generally agreed the changes were within the authority of the division, but some members felt that setting these requirements should be accomplished in statute. More specifically members expressed concern over subrule 5.8(5) which made dramshop liability insurance subject to *"ordinary or customary exclusions usually found in a policy..."* Members found this language vague and they also felt this phrase implied the division might review and approve individual policies. Division representatives responded this language was added at the request of the industry. Committee members were still uneasy with the idea that dramshop insurance was detailed in rule, not statute; for that reason, the committee voted to refer these rules to the General Assembly for additional review.

ACTION: GENERAL REFERRAL. Final discussion at May meeting.

DENTAL BOARD OF EXAMINERS, Dental hygienist: collaborative agreements, 3/5/03 IAB, ARC 2327B, NOTICE.

BACKGROUND: Under a limited set of circumstances a dental hygienist may provide certain educational, therapeutic, and preventive services when the dentist is not present. The board proposes to expand this privilege by allowing a hygienist to perform *preventive* services in a variety of settings such as schools, public health agencies, and health care facilities without the patient's first being examined by a dentist.

COMMENTARY: This change is the result of a petition for rulemaking; it would allow the hygienist to provide preventative services to a patient who has never seen the

dentist. It was noted this was a significant expansion in the current practice of a dental hygienist.

ACTION: NO ACTION. Additional review when the rule is adopted in final form.

EDUCATION DEPARTMENT, Closing attendance centers, 4/2/03 IAB, NOTICE.

BACKGROUND: Over 25 years, on a case-by-case basis the department has evolved a policy on the closing of "attendance centers" by local boards; it now proposes to codify that policy, called the "Barker guidelines", in rule—thus formally giving the policy the force and effect of law.

COMMENTARY: Under Iowa law the state board hears appeals from persons who are aggrieved by local board actions; school closings are a common source of these appeals. Over the years these decisions have formulated a process for public notice that a district must follow before it can close a school. This process is not judicial---there is no right to present evidence and have the final decision based on that evidence. It sets out seven requirement that provide for public notice and a right to be heard prior to the final board decision.

ACTION: NO ACTION.

ENVIRONMENTAL PROTECTION COMMISSION, Postclosure accounts, 567 IAC Ch. 111, SELECTIVE.

BACKGROUND: Iowa Code §455B.306(8) requires that landfill operators maintain postclosure accounts. The amounts placed in these accounts is to be based on the amount of solid waste received by the facility. In 2002 the EPC adopted rules which essentially required current reveneues should finance the costs of postclosure.

COMMENTARY: The EPC maintains that a variety of mechanisms exist to provided the required financial assurance, and that over half of the public landfills have chosen to fund a separate account in advance of closure. The EPC representatives stated that the intent of the statute is to require those who generate the waste to pay for the post closure costs. They noted that four landfills are having problems funding postclosure and stated that the EPC was working with those facilities. Opponents of this requirement contended that municipalities should have discretion to fund post closure work as they see fit; they felt the Divisions role was to ensure the work was done, not specify the method of finance. They noted that municipalities remain liable for the cost of post closure and, unlike private corporations, cannot simply file for bankruptcy and walk away from the site. Opponents also stated that in some cases the timeframe for funding the account was short and would result in greatly increased tipping fees to fully fund the account.

ACTION: NO ACTION

HUMAN SERVICES DEPARTMENT, Electronic foodstamps, 4/2/03 IAB, ARC 2333B, ADOPTED.

BACKGROUND: The department will replace the current food stamp books with ATM-like cards that can used at the client's grocery store. The changeover is mandated by the federal government and Iowa is one of the last states to implement this measure. Once the client receives the card the client will then contact the department to obtain a personal identification number.

COMMENTARY: Department representatives noted that most larger stores would simply use their current devices to process the cards. In those locations where the

Proposal for a systematic approach to providing assessment and triage of dental care for nursing home residents in Iowa DRAFT

Proposal: To match oral health providers with Iowa nursing homes in an effort to enhance the oral health of residents while meeting the cost considerations of dental providers and nursing homes.

Need

1. Nursing home residents are one of the most dentally underserved populations in Iowa.
2. Many nursing homes in Iowa are in need of oral health professionals who can provide oral health assessments, triage emergency and definitive care as well as staff training to meet regulatory mandates.

Purpose

1. To provide nursing home residents in Iowa with appropriate dental assessments, oral health care plans and access to needed dental services.
2. To provide nursing homes with the oral health-related services and training needed to provide residents with appropriate oral health care and meet regulatory mandates.

Possible roles

The Iowa Department of Public Health Dental Advisory Council, in coordination with the University of Iowa College of Dentistry, the Iowa Dental Association, the Iowa Dental Hygiene Association, the dental practices in Iowa and the Iowa Department of Inspections and Appeals could collaborate to develop a coordinated system of oral health care-related services to nursing homes throughout Iowa.

1. The University of Iowa, College of Dentistry could be responsible for developing practical models for oral health care in Iowa nursing homes. These models would include options for assessing the nursing home residents' oral health needs, developing daily oral health care plans, prescribing/referring residents to appropriate oral health professionals when needs are identified and providing annual in-service training for nursing home staff members. Models for the financing of such care would also be included.

   Annual certificate-level continuing education programs could be provided by College of Dentistry faculty and staff. Financial support for these programs could be solicited to reduce or eliminate the cost for dentists/hygienists/assistants willing to participate in this certificate-level training program.

2. The Iowa Department of Inspections and Appeals **(This needs to be confirmed with the Department)** could be responsible for helping to locate Nursing homes in need of a dentist of record (DOR). The Iowa Department of Inspections and Appeals is currently responsible for evaluating the compliance of nursing homes with regulations regarding the adequacy of oral health-related services in long term care facilities including:
   a. Oral health assessments for the Minimum Data Set upon entry into the facility
   b. Annual training of staff regarding oral health care of residents
   c. Care for treatment needs found during assessments
   d. Access to emergency and palliative care

3. The Iowa Dental Association could be responsible for identifying dentists willing to participate as the dentist of record for nursing homes (as identified by the Dept of Inspections and Appeals). The Iowa Dental Hygiene Association could provide similar support in locating hygienists in areas where the hygienist from a private practice is not interested/available to provide these services.

4. The dentist of record (DOR) could be responsible for (but not necessarily perform themselves) oral health assessments, daily oral care plans, triage and referral and possibly emergency care for either an entire nursing home or, where feasible, for a portion of a home. The DOR is not automatically responsible for providing all definitive treatment but is responsible for appropriate referral of problems identified in assessments. The DOR for a facility could also be a rotating position among a number of dentists in a community.

   The goal would be to have as much emergency and routine care as possible provided by dentists in their own practice with transportation provided by the nursing home. Many dentists in a community already provide services for residents in nursing homes who were patients in their practice prior to moving to the facility. An effort would be made to keep these relationships when possible for both emergency and routine care.

5. Financing the care would be the responsibility of both the nursing home and the nursing home resident/responsible party. The nursing home could pay the dentist a fee of $X/bed per month. For this fee, the dentist would be responsible for providing services such as the following (these need to be refined):
   a. Oral health assessments for the Minimum Data Set upon entry into the facility
   b. Annual training of staff regarding oral health care of residents
   c. Assessment of emergencies or problems that arise
   d. Notification of identified problems to an staff member of the nursing home to receive approval from responsible party
   e. Referral of residents to appropriate care provider
   f. Additional treatment could be provided by the DOR/hygienist as recommended by DOR with the responsible party charged on a fee for service basis. This could include
      1. Preventive therapies including prophylaxis, fluoride varnish, etc at the nursing home
      2. Emergency and routine care if the patient does not have a personal dentist of record.

Many of the services provided under this contract could be provided under existing practice act authority by the DOR, a hygienist (could be from the dentist's practice), or a public health hygienist is available in the area and the DOR prefers not to provide these directly. Many of these concepts could also be relevant for other underserved sites such as head start centers.

Iowa Board of Dental Examiners
Rulemaking Analysis

Proposed Rule(s):

This rulemaking analysis is intended to ensure that rules are in compliance with the criteria for regulatory review contained in Executive Order Number 8 and the regulatory principles of Executive Order Number 9, signed by Governor Vilsack in September 1999.

The basic principles of these executive orders state that rules must be authorized by state law and (1) aid in interpreting the law or (2) serve an important public need.

NEED:

1. **Is there a need for the proposed rule?**

2. **What is the problem or important public need the proposed rule attempts to correct?**

3. **Is the problem or public need significant?**

4. **What is the degree and nature of the risk?**

5. **Have any existing rules or laws contributed to the problem?**

6. **Should these existing laws or rules be modified or eliminated in order to correct the problem?**

7. **Can the provision of economic incentives correct the problem?**

8. **Can the provision of more information correct the problem?**

9. **Is there a scientific, technical, or economic basis for the proposed rule?**

10. Does any other information establish the need for the proposed rule?

INTENT & STATUTORY AUTHORITY:

11. Is the proposed rule authorized by statute(s)?

Cite authority: _____

12. Is the statutory authority sufficient?

13. Is the proposed rule necessary to comply with the statute that authorizes it?

14. Is the proposed rule consistent with the legislative intent of the authorizing statute(s)?

15. Is there a need to develop additional legislative authorization in order to protect the health, safety, and welfare of the people of Iowa?

CLARITY:

16. Is the proposed rule simple and easy to understand?

17. Is the proposed rule concise and narrowly-tailored?

18. Is the proposed rule duplicative or does it conflict with other Board rules or rules of other state agencies?

19. Has the proposed rule been harmonized with related local regulations and have the views of affected local officials been sought prior to adopting the rule?

20. Does the proposed rule minimize the potential for uncertainty and litigation?

COST:

21. What are the qualitative benefits of the proposed rule (including economic, environmental, public health and safety, and other benefits)?

22. What are the quantitative benefits of the rule (including economic, environmental, public health and safety, and other benefits)?

23. What are the qualitative costs of the proposed rule (including economic, environmental, public health and safety, and other costs)?

24. What are the quantitative costs of the rule (including economic, environmental, public health and safety, and other benefits)?

25. Do the qualitative and quantitative benefits of the proposed rule exceed the costs of the rule?

26. What are the qualitative and quantitative benefits of not adopting the proposed rule?

27. What are the qualitative and quantitative costs of not adopting the proposed rule?

28. Is there an alternative regulatory approach other than rulemaking?

29. Does the proposed rule or alternative regulatory approach maximize net benefits?

30. Is the proposed rule cost-effective?

Considerations:
-Cost of cumulative regulations
-Incentives
-Innovation
-Consistency
-Predictability
-Flexibility
-Equity
-Enforcement & Compliance Costs
-to government
-to regulated entities
-to the public

31. Do the benefits of the proposed rule justify its costs?

FAIRNESS:

32. Is the proposed rule fair?

33. Does the proposed rule apply equally to all those affected by it?

34. Is the proposed rule or an alternative regulatory approach most equitable?

35. Is the proposed rule the best available method of achieving the desired outcome?

36. Does the proposed rule impose the least possible burden on society, including individuals, businesses, and other entities?

37. Has the public participated in the development of this proposed rule prior to filing notice of intended action?

38. Have interested parties participated in the development of this proposed rule prior to filing notice of intended action?

39. Date of completion of analysis:

RECOMMENDATION:

DATE OF ACTION:

H:\Rules\Analysis.doc

THE GEORGE WASHINGTON UNIVERSITY
MEDICAL CENTER
WASHINGTON DC

Center for Health Services Research and Policy
School of Public Health and Health Services

Report

THE EFFECTS OF STATE DENTAL PRACTICE LAWS ALLOWING ALTERNATIVE MODELS OF PREVENTIVE ORAL HEALTH CARE DELIVERY TO LOW-INCOME CHILDREN

EXECUTIVE SUMMARY

January 17, 2003

Lea Nolan, MA[*], Brian Kamoie, JD, MPH[*], Jennel Harvey, MHSA[±], Lissette Vaquerano[*], Sarah Blake, MA[¥], Satvinder Chawla[£], Jeffrey Levi, PhD[*], Sara Rosenbaum, JD[*]

The Center for Health Services Research and Policy (CHSRP) was funded by the Centers for Disease Control and Prevention's (CDC) Public Health Practice Program Office to examine state dental practice laws that permit alternative models of delivering preventive oral health care to low-income children[1].

BACKGROUND

Although the incidence of tooth decay has decreased considerably over the past two decades, the prevalence of caries among children and adolescents remains high. Minorities and low-income populations experience more dental decay than those with higher incomes, and they are also more likely to have a higher proportion of untreated decayed teeth.[2] Low oral health care utilization is the primary reason for higher tooth decay among low-income and minority populations. Low use of

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[*] Center for Health Services Research and Policy, School of Public Health and Health Services, The George Washington University; [±] Doctoral student, School of Public Administration and Policy, Eller College of Business and Public Administration, University of Arizona; [¥]Department of Health Policy and Management, Rollins School of Public Health, Emory University; [£]JD/MPH Candidate, The George Washington University Law School/School of Public Health and Health Services, The George Washington University.

[1] This project was funded under the grant "Research on the Impact of Laws and Policies on Public Health" (grant number R06/CCR318771) from the CDC Public Health Law Program. The contents of this report are solely the responsibility of the authors and do not necessarily represent the official views of CDC, or the Public Health Law Program. The George Washington University Institutional Review Board (non-Medical) approved this study and provisions regarding informed consent in approval number 100026ER."

[2] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, page 63.

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dental services among low-income and minority children is related to several factors that reduce their access to such services, which include low dentist Medicaid participation, shortage of dentists, mal-distribution of dentists, restrictive state laws, patients' lack of health insurance, and families' lack of understanding and awareness of the need for preventive oral health care.

PROJECT OVERVIEW

Project Purpose

The purpose of this project was to examine state dental practice laws and the extent to which they encourage alternative models of delivering preventive oral health care. This project encompassed two distinct study components: 1) an analysis of existing state dental statutes and regulations; and 2) case studies to examine the enactment of public health-oriented provisions encouraging alternative models of delivering preventive oral health care to low-income children; and the development and implementation of such alternative models.

METHODS

Review State Dental and Medical Practice Laws

We reviewed state dental practice acts for the 50 states and the District of Columbia to determine how they address the delivery of preventive oral health care services by dentists and dental hygienists.[3] We also examined any applicable exemptions for physicians and nurses to deliver oral health care. In addition, we reviewed the statutes for supervision requirements for dental hygienists, consultation between dentists and hygienists when delivery of oral health services is unsupervised or independent, and the educational and competency requirements for dental hygienists.

Case Studies

We opted to study six states that had: 1) enacted a statute that permitted/encouraged an alternative model; and/or 2) had or had not yet implemented the alternative model. We chose to examine two types of

[3] We reviewed state dental and medical practice laws during 2000-2001. The full report contains a full description of the scope of our review.

alternative models: 1) a model that uses dental hygienists working under either general supervision or without a dentist's supervision (but not independent practice) to provide preventive services; and 2) a model that uses physicians to provide screening, education, and in some cases, topical fluoride application to very young children. Our study states included Connecticut, Iowa, New Mexico, North Carolina, South Carolina, and Washington.

FINDINGS

Analysis of State Health Professions Laws

The licensing of dentists, as with other health professionals, is governed by state law. Health professions licensing statutes are implemented by boards dominated by the relevant professionals themselves.[4] In the case of dental practice, definitions and scope of practice provisions become important when considering the role of dental hygienists. Generally, dental hygienists are subject to governance by boards of dentistry, which define and in many jurisdictions limit the scope of permissible practice.

The licensing system and self-regulation by the dental and medical professions have profound implications for low-income children. In many jurisdictions, state laws restrict the delivery of preventive oral health care to dentists. In other jurisdictions, restrictive licensing laws restrict the scope of practice of dental hygienists. These legal restrictions operate as a barrier to the provision of preventive oral health services to low-income children by limiting the number of individuals who can provide such services.

Although some states have begun to loosen their practice acts to allow dental auxiliaries to perform more preventive oral health services, these focus primarily on hygienists. Many jurisdictions require a dentist to be on-site and sign-off on preventive oral health services provided by dental auxiliaries. Although many state dental licensing laws provide exemptions for the delivery of preventive oral health care by physicians, other obstacles limit such delivery (e.g., training and equipment).

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[4] *See* Furrow et al., Health Law. 2000. St. Paul, Minnesota: West Group Publishing, at 59. *See also* Orentlicher D, "The Role of Professional Self Regulation" in *Regulation of the Healthcare Professions* at 129 (Timothy S. Jost, ed. 1997).

State Options

Our analysis revealed that states have elected to use one of three options in changing existing laws to allow for alternative models of oral health care delivery: 1) a state legislature can pass a new statute that explicitly permits an alternative model; 2) a state agency or dental/medical board can establish new regulations or rules (based on existing law) allowing an alternative model; and 3) a state agency, dental/medical board, or group of providers can reinterpreting an old law or set of regulations/rules, usually with a broader interpretation, and implement an alternative model.

Supervision Requirements for Dental Hygienists

Two key issues stand out in the design of alternative delivery models for the delivery of preventive health services to low-income children: 1) whether a dentist has to be on the premises when services are provided; or 2) whether a dentist has to sign-off on the work performed prior to patient discharge.

The review of the dental practice laws demonstrates that for the four identified preventive oral health services, most state dental practice laws require supervision of a dentist at some level (direct, indirect, general) for the delivery of preventive oral health services by dental hygienists. Colorado has an independent practice law that allows dental hygienists to provide oral health services without the supervision of a dentist, and Washington state allows independent practice under certain conditions. The more restrictive the supervisory requirements are, the less flexibility states will have in designing alternate models of preventive oral health delivery by dental hygienists. The efforts to control dental auxiliaries by procedure and varying degrees of supervision lead to confusion in what can be done, where, with what level of supervision and approval. This confusion, in itself, is a deterrent to designing alternate delivery models.

Case Studies

Our findings reveal that making a change in the law does not result in an *immediate* change to the oral health care delivery system. In fact, in three of the cases (IA, NC, and WA) the alternative model could be developed *without* the creation of a new public health-oriented law. In

these states, existing dental and medical practice laws, accompanied by changes to rules, regulations, or administrative policies, were sufficient to permit a new model. In the remaining cases the alternative model could not be pursued unless the law was changed. Where laws are changed, it may take a substantial amount of time for the dental profession and the market to respond to such changes. However, in all cases we learned that the success of the alternative oral health care models lay not merely in the laws themselves, but in certain factors essential to their implementation.

Our findings suggest that a combination of essential factors is required for the implementation of an alternative oral health care delivery model, whether or not a new public health-oriented law has been enacted. The factors that facilitated the implementation of alternative models for delivering preventive oral health care are summarized below:

- Gaining the **support of dentists**, either through their organizational representatives or through the leadership of individual dentists is perhaps the most important factor in the success of an alternative model.

- Creating a **reimbursement mechanisms** for providers in the alternative model.

- Gaining **state Medicaid agency support** is essential.

- The **lack of a formal referral mechanism** severely hindered the successful implementation of most of the alternative models.

- The **type of alternative model** may predetermine how easily it is implemented in a state.

- Alternative models that utilize an **incremental approach** seem to have more success.

- **Outreach and training** are necessary.

- **Professional recognition and acceptance of the need** for the alternative model.

CONCLUSION

The alternative models we studied have had little impact on the preventive oral health care delivery systems in our study states. In states with dental hygienist alternative models (CT, NM, and SC), the law and models have not yet significantly changed the way that dental hygienists work. In all three states, dental hygienists provide the same services they did before the law or model was enacted or implemented (e.g., treatment planning, prophylaxis, and care coordination). Prior to the law, dental hygienists worked under some degree of supervision by a dentist, and they continue to do so currently. Until a reimbursement mechanism can be instituted, thus creating a provider number to allow for direct billing, dental hygienists will be forced to maintain their ties to a dentist of record. As we have seen, this can encourage the old models of general supervision (or indirect supervision), and discourage increased access since dental hygienists interested in the alternative model will have to rely on a dentist to bill for their services.

Given the arduous task of implementing an alternative oral health care model, and the slow progress that accompanies such an endeavor, we conclude that states planning to undertake such an effort should be mindful of several factors: 1) it is difficult to make changes in the scope of practice of one class of professionals who are overseen by a different group of professionals; 2) action should be taken at deliberate speed, and incremental steps should be made; 3) preventive oral health care providers operating within the model must have the ability to self-regulate; 4) viable funding mechanisms must be set up prior to implementing the program; and 5) careful consideration should be given to the type of model the state seeks to implement, the types of providers it will include, and the political viability of such a model.

RECOMMENDATIONS

This study did not focus on dentist workforce training and supply issues, and, therefore, our recommendations do not address these factors. Instead we focus on those elements that facilitate the development and implementation of alternative models of delivering preventive oral health care services.

- Public health leadership is needed to create a greater awareness of the need for oral health among poor children.

- Public health and dental professional leadership is needed to destigmatize the services provided by non-dentists. Disseminating the results of recent studies indicating that dental hygienists provide safe care may facilitate these efforts.

- Federal and state Medicaid officials can be effective leaders in implementation and reimbursement issues. In particular, officials can follow the example of the North Carolina Medicaid agency and its leadership in promoting the alternative oral health care model.

- Federal government and professional societies should address outreach and training issues associated with implementation of these models.

- Even without legal changes, Medicaid and public health officials can encourage the role of pediatricians regarding applying fluoride varnish. In most states physicians are already permitted to provide such services.

- Further study is needed on successfully implemented preventive oral health care models. Study should be undertaken at the individual provider level to learn exactly what elements are necessary to make a particular model successful.

Administrative
Rules
Review
Committee

INTEROFFICE MEMORANDUM

TO: JENNIFER HART
IOWA DENTAL BOARD

FROM: JOE ROYCE, STAFF-ADMINISTRATIVE RULES REVIEW COMMITTEE

SUBJECT: INFORMAL REGULATORY ANALYSIS: ARC 2783B, RELATING TO PUBLIC HEALTH SUPERVISION OF DENTAL HYGIENISTS

DATE: 10/15/2003

At its October 13th 2003 meeting the Administrative Rules Review Committee voted to request an informal regulatory analysis concerning ARC 2783B, which establishes rules relating to the "public health supervision" of hygienists under collaborative agreements with a supervising dentist. This filing appears as a notice of intended action, published in IAB Vol. XXVI, No. 06 (09/17/03).. ARRC members have determined that more information is needed relative to the regulatory impact of the proposal and more generally to the workings and goals of the proposal. However, the members did not wish to delay the adoption of this filing, so an "informal" regulatory analysis has been requested to obtain this additional information, but without the publication and adoption delays imposed by the formal process detailed in Iowa Code §17A.4A.

This analysis should address the bulleted items contained in the October 13th, 2003 memorandum provided to the committee by the Iowa Dental Association; a copy of that memorandum is included for your convenience. Please include whatever additional information you feel appropriate.

IOWA BOARD OF DENTAL EXAMINERS
PUBLIC HEARING
OCTOBER 16, 2003

DES MOINES, IOWA

Pursuant to the Notice of Intended Action published in the Iowa Administrative Bulletin on September 17, 2003, as **ARC 2783B**, a public hearing on proposed amendments to 650—Chapter 10, "General Requirements," was held in the Conference Room, 400 S.W. 8th St, Suite D, Des Moines, Iowa, on October 16, 2003, beginning at 10 a.m.

Board members present:

George North, DDS, Chairperson
Debra Yossi, RDH, Secretary
Elizabeth Brennan, Public Member
Richard M. Reay, DDS
Gary D. Roth, DDS
Suzan Stewart, Public Member

Staff present:

Jennifer Hart, Executive Officer
Theresa Weeg, Assistant Attorney General

Also present:

Frank Severino, Iowa Dental Association
Larry Carl, Executive Director, Iowa Dental Association
Mary Mariani, DDS, Iowa Dental Association
Kathy Kell, DDS, Iowa Dental Association
Brice Oakley, Iowa Dental Hygienists' Association
Joe Royce, Legal Counsel, Administrative Rules Review Committee
Barb Blough, Iowa Dental Association
Tracy Rodgers, Oral Health Bureau, Iowa Department of Public Health
Heather Miller, Oral Health Bureau, Iowa Department of Public Health
Jane Slach, RDA, Iowa Dental Assistants Association
Maureen T. Mosse, CDA, RDA, Iowa Dental Assistants Association
Sandra Leggett, RDH, Des Moines Area Community College
Mary Kelly, RDH
Daniel Venker, DDS
Nancy Adrianse, RDH, Iowa Dental Hygienists' Association
Peggy Funk, RDH, Iowa Dental Hygienists' Association
Sheila Temple, RDH, Iowa Dental Hygienists' Association
Sue Hyland, RDH, Iowa Dental Hygienists' Association
Tom Cope, Iowa Dental Hygienists' Association

ARC 2783B relates to public health supervision of a dental hygienist. The proposed amendment allows a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting. The amendment defines public health settings and details the responsibilities of each licensee operating under public health supervision.

Kathryn Kell, DDS, President of the Iowa Dental Association (IDA) read written comments on behalf of the IDA. The IDA has serious concerns about the proposed amendments and suggested several changes.

Mary Mariani, DDS, read written comments expressing opposition to the proposed amendments.

Sandra Leggett, RDH, from Des Moines Area Community College, read written testimony previously submitted in support of the proposed amendments.

Dr. Daniel Venker, DDS, read written comments in support of the proposed amendments.

Mary Kelly, RDH, offered oral testimony in support of the proposed amendments. Ms. Kelly currently works in a school-based sealant programs in Des Moines. The program provided 1,300 sealants last year, with a 99 percent retention rate. With respect to testimony previously provided about patients with problems caused by sealants, those cases apply to situations where a dentist examined the patient, showing that a dental exam alone does not prevent problems.

Tracy Rodgers, RDH, from the Oral Health Bureau of the Iowa Department of Public Health indicated that the department is very supportive of the board's proposed amendments.

Sheila Temple, RDH, Immediate Past President of the Iowa Dental Hygienists' Association, read written comments in support of the proposed amendments. Ms. Temple provided a copy of a caries risk assessment tool that can be used by dental hygienists in conducting risk assessments.

Peggy Funk, President of the Iowa Dental Hygienists' Association read written comments in support of the proposed amendments.

Additional written comments have been received concerning the proposed amendments. All comments will be submitted to the Board for consideration.

Respectfully submitted,

CONSTANCE L. PRICE
Executive Director

CLP/jh

IOWA BOARD OF DENTAL EXAMINERS - PUBLIC HEARING SIGN-IN SHEET
400 S.W. 8th St, Suite D, Des Moines
October 16, 2003 - 10 a.m.

Hearing For:
Public Health Supervision; ARC 2783B

NAME	ADDRESS	ORGANIZATION
Frank Severino	4401 75th. D.M. 50322	IDA
LARRY CARL	505 5TH AVE SUITE 333	IDA
Mary Mariani DDS	500 W River Dr. Davenport 52801	IDA
Kathryn Ku DDS	5359 Eastern Davenport	IDA
Brice Oakley	418-38 PL. DSM	IDHA
Joe Royce	STATE Capitol	Legis
Barb Blough	505th Ave, DM	IDA
Tracy Rodgers	Lucas Bldg. 321 E. 12th DSM	IDPH
Heather K. Miller	" "	IDPH
Jane Slack	231 Edgewater Ave Cedar Rapids 52241	IDAH
Maureen Mosse	2608 Valley Dr DA	IDHA

Hearing Info

IOWA BOARD OF DENTAL EXAMINERS - PUBLIC HEARING SIGN-IN SHEET
400 S.W. 8th St, Suite D, Des Moines
October 16, 2003 - 10 a.m.

Hearing For:
Public Health Supervision; ARC 2783B

NAME	ADDRESS	ORGANIZATION
Brenda Lynott	4900 Pleasant St #3 W. Des Moines	DMACC
Mary Kelly	5707 Walnut Hill	self
Daniel Venker	4613 SW 6th St. Des Moines	self
Nancy Adriansse	3210 SW 33rd St. DM IA	IDHA
Peggy Funk	2228 385th St Osage IA	IDHA
Sheila Temple	2565 Brockway Ave Keota, IA	IDHA
Sue Hyland	1111 9th Street Suite 109 DM IA	IDHA
Tom Cope	8073 Cobblestone Rd Urbandale IA	IDHA

Ladies and gentlemen my name is Mary Mariani and for the past 14 years I have practiced dentistry in a federally qualified health center in Davenport. I am currently and for the last five years the dental director of Community Health Care.
I am here to express my deep opposition to the purposed rule change that would allow a hygienist in public health settings to perform preventive services without the patients first being examined by a dentist. This is particularly disturbing because it puts at risk those patients of low socioeconomic circumstance, the patients that I treat every day.

I do not understand why anyone would want to provide care to patients who are already at risk for oral disease without benefit of an exam with radiographs. The current standard of care, as I understand it, is that all patients receive an exam by a dentist before treatment. This is what is taught in every dental school in the country. This proposed rule change would mean that dental patients receiving treatment in free clinics, FQHC's, nonprofit health centers and public schools could receive hygiene care **including sealants** without the benefit of an exam. Why would anyone advocate for substandard care for children and poor people.

Failure to diagnose caries before the placement of sealants can have devastating consequences and without adequate isolation, sealants can and do fail. Many a time in our office I have consoled a mother of a child who thought she was doing the right thing by having her child's teeth sealed at school. Who was led to believe that sealants would prevent her child from getting cavities only to discover that now her child has such a big cavity that the tooth needs a root canal or an extraction. These at risk children do not have the economic means to afford root canal, buildup and crown and in most cases unless the child has Medicaid, the permanent tooth is extracted. It breaks my heart to see 8, 9, and 10 year children losing their permanent first molars because someone in a school setting place a sealant over caries. What's more, if the law does not require an exam prior to treatment then there is no liability for failure. If a hygienist places a sealant over caries and subsequently, the tooth develops irreversible pulpitis, under the proposed rule, there is no recourse for the patient to recover damages, as there was no requirement that a dentist would examine or diagnose caries prior to the sealant being placed.

While we do place sealants in our office, it is only after and exam by a dentist including radiographs. These sealants are checked at 6-month recall and radiographed once per year. The hygienists in our office place only those

sealants, where the tooth is newly erupted, where there is no dark staining or incipient caries. They use a dental assistant and high-speed evacuation to insure adequate isolation. These teeth are examined by a dentist and radiographed at regular intervals. The parents are informed that sealants only prevent decay on the chewing surfaces of the teeth and that the sealants need to be regularly examined for signs of failure such as chipping or leaking.
I do not understand the logic that says that if you are a patient in private practice, a dentist will examine your teeth before any treatment is rendered including cleaning. However if you are a patient receiving care in a free clinic or a federally qualified health center or if you are a public school child receiving dental care at school irregardless of your socioeconomic status sealants can be placed without an exam or radiographs by a hygienist. And I might add without parental consent.

I am very concerned about patient safety. Without at dentist supervising, what happens if a patient has a sudden allergic reaction to latex or prophy paste? Theses reactions can be fatal if not treated immediately and are becoming more and more common. While 911 can be called, it takes only 7 minutes of depriving the human body of oxygen before the brain starts to die. In rural Iowa emergency response times can be 15 minutes or more. If a dentist is present he or she can administer the necessary medicine to keep the patient alive. Under current law the hygienist cannot and doesn't have the necessary training to administer any drugs other than local anesthetic, if certified. In their two-year training programs, hygienists receive only minimal training in pharmacology. They are certified in CPR but CPR will not help if a patient's airway is swollen shut. While anaphylaxis is the most devastating emergency, smaller emergencies also occur with the practice of dental hygiene. Many a time in the last 14 years I have been called over to hygiene operatory because while scaling and root planing, a restoration has been fractured or removed. I have placed many temporaries over the years for hygiene patients. I have also removed stuck floss and tips of broken curettes and other foreign bodies from the oral cavity. Without a dentist supervising who is going to help these patients? Under the proposed "public health supervision" (10.5(2) b.) the dentist in the agreement **is not** required to provide future dental treatment. Then, I ask who will provide even emergency follow-up care? This purposed rule change seems irresponsible and not well thought out.

Please don't think that for one minute this is not about money. The federal government is pouring thousands of dollars into sealant programs and other oral health care programs. The federally qualified health centers that apply for

these grants use this as a means of improving their bottom lines. They do not have to pay a hygienist as much as they would have to pay a dentist and therefore actually can make money on these programs.
I am also aware that the National Dental Hygiene Association and well as the Iowa Dental Hygiene Associations ultimate goal is the independent practice of dental hygiene and an independent state dental hygiene board. This purposed rule change is a stepping-stone to further these goals.

I have the utmost respect for dental hygienists. The three hygienists in our office do wonderful work. They are well trained in the cleaning of teeth, prevention of oral disease and dental patient education. They are specifically trained to work with a dentist. **We are a team**. We provide a very high quality of care for our underserved patients. These patients need it and deserve it. To provide less care could lead to dangerous consequences and I believe is morally and ethically wrong. There are those that say that some care is better than no care. I disagree. Some care can lead the patient to a false sense of security. Some care can result in pain, infection, tooth loss and in rare instances loss of life.

Having dental hygienists provide substandard care is not a solution to dental access problems. You need to look at encouraging dentists to treat the underserved by providing tax incentives, increasing Medicaid reimbursement, loan repayment programs and federal and state grant programs. You need to make it easier for dentists to stay in Iowa to practice by not over regulating them to the point where they retire early or move to a state with fewer regulations.
There is an oral health care access problem in the state of Iowa but let's not add to it by providing substandard care. I respectfully ask that you abandon this purposed rule change and I urge you to look at other options for providing access to oral health care for the citizens of Iowa.

I am honored to have been chosen to speak to you today and I thank you for your attention to this matter.

Iowa

Department of Public Health

321 E. 12th Street • Des Moines, IA 50319-0075
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The Iowa Department of Public Health supports the petition before the board regarding public health supervision of dental hygienists.

The issue of decreased access to oral health care in the United States is well documented, the most comprehensive discussion within "Oral Health in America: A Report of the Surgeon General", published in 2000. Disparities exist in access to oral health care, particularly for low-income families.

National problems of decreased access to oral health care are mirrored in Iowa. Oral health is integral to overall health and the Iowa Department of Public Health strives to promote and protect the health of all Iowans. In an effort to improve access to oral health care for low-income families and other at-risk populations, we support and ask that you approve this amendment to add the definition of public health supervision of a dental hygienist to your rules.

Iowa Dental Hygienists' Association

Speaking on behalf of the Iowa Dental Hygienists' Association (IDHA) as the Immediate Past President, I would like to start my testimony with a short quote sent to me by a fellow public health hygienist.

"For those who believe, no explanation is necessary.
For those who do not believe, none will suffice."-Unknown

Where do we turn to substantiate or make decisions about the issues that we believe in? Common sense tells us that we should look toward evidence to establish our beliefs and our own individual code of ethics. So what does evidence show us at this time?

- Almost 52 million school hours are missed annually by children because of oral problems.
- Extensive tooth decay can lead to developmental as well as emotional problems in children.
- Vulnerable populations (i.e.-low income children, pregnant women, and elderly) have more oral problems and less access to adequate dental care.
- Periodontal health is directly linked to overall health and plays a significant role in healthy children being born and quality of life issues for the elderly.
- In the United States, 25% of children and adolescents experience 80% of dental decay in permanent teeth.
- Prevention is the best and most cost effective form of treatment for all populations, not just those who can afford it.
- Dental sealants are one of the most effective means of preventing decay or arresting incipient lesions, but is the most under utilized because it is not cost effective in private practice.
- We are graduating fewer dentists and of those we are graduating, a very low percentage stay in Iowa to replace older retiring dentists, especially in rural areas of the state.
- Approximately 80 hygienists are graduating every year in Iowa and most stay in Iowa to practice.
- Dental hygienists, on basis of their education, are well-trained to educate others about oral health and to provide oral disease assessments and prevention services.

Concerns have been raised about the effect this petition will have on private practice dentistry. There are many dentists in Iowa who are Medicare/Medicaid or Title XIX providers, but there is a huge disparity between those who are "providers" and those who accept "NEW" Medicare/Medicaid patients. This petition will actually help those offices providing the most care to these underserved populations. Their loss margin would be reduced dramatically by having the patients screened and data gathering information plus preventative services done before they even set foot in their offices. This type of time management can only help improve the private practices' ability to meet overhead costs.

As far as hygienists leaving private practice to do public health service, thus causing a

shortage of allied personnel in offices, I would emphatically say, "NONSENSE". Many will volunteer for a day or two a year but Public Health hygienists go into public health because they wish to serve and feel a calling to this type of service. We can make much more in private practice and work in much more esthetically beautiful facilities. Instead we work in institutions, on stages and in closets at schools, and out of our cars. We carry heavy equipment up multiple levels of stairs and set up and tear down sometimes multiple times in a day. Paperwork and follow up are a never ending process to name just a few glamours of our jobs. We write plans and grants, lead and implement programs, supervise employees and volunteers. We network, partner, promote and advocate for oral health, plus we provide care to high risk/high need patients others are "too busy" for. Our patients have AIDS, head lice, diabetes, mental illness, and physical disabilities. They are 12 and up single, low income pregnant women. They are teenagers who are current or former drug users. They are veterans of war and on the other extreme they are prisoners. They are migrant or seasonal farm workers and refugees who have never been to a dentist. They are infants and toddlers who sleep with bottles and drink soda all day, and finally our patients are everyone's child when they learn about oral health at school, get a sealant, or participate in fluoride programs through school. We see patients and do what is in the best interest of that patient regardless of their ability to pay for those services. Public Health hygienists practice autonomously and are mid-level oral health care providers. We don't do this for the money. We do it out of love. We do it because we make a difference and improve the lives of those we touch.

The last point I would like to address in my testimony today is information on the tools that Public Health hygienists utilize everyday in our programs. The caries-risk assessment tool (CAT) was developed, using evidence based research by the American Academy of Pediatric Dentists, as a framework for classifying caries risk in infant, children and adolescents based on a set of physical, environmental and general health factors. CAT is intended to be used when clinical guidelines call for caries-risk assessment. It does NOT render a diagnosis, however clinicians using CAT must be familiar with the clinical presentation of dental caries and factors related to caries initiation and progression. It is within the scope of practice for hygienists, medical doctors and nurses to use this tool. Unfortunately the oral health component is severely lacking for medical doctors and nurses during their education, so it stands to reason that the hygienists are the most qualified to use this assessment tool to help determine the need for prevention and treatment services. I have included a copy of this tool with my testimony today for your further perusal. I would like to thank you all again on behalf of the Iowa Dental Hygienists' Association and the underserved populations in Iowa, for your dedication and commitment in helping to develop workable solutions to lesson the dental access to care crisis in our state.

Respectfully submitted,

Sheila Temple, RDH

Sheila Temple, RDH
Immediate Past President-Iowa Dental Hygienists' Association

AAPD Caries-risk Assessment Tool (CAT)

Caries-risk indicators	Low risk	Moderate risk	High risk
Clinical conditions			
	• No carious teeth in past 24 months	• Carious teeth in the past 24 months	• Carious teeth in the past 12 months
	• No enamel demineralization (enamel caries "white-spot lesions")	• 1 area of enamel demineralization (enamel caries "white-spot lesions")	• More than 1 area of enamel demineralization (enamel caries "white-spot lesions")
	• No visible plaque; no gingivitis	• Gingivitis*	• Visible plaque on anterior (front) teeth
			• Radiographic enamel caries
			• High counts of mutans streptococci
			• Wearing dental or orthodontic appliances†
			• Enamel hypoplasia‡
Environmental characteristics			
	• Optimal systemic and topical fluoride exposure§	• Suboptimal systemic fluoride exposure with optimal topical exposure§	• Suboptimal topical fluoride exposure§
	• Consumption of simple sugars or foods strongly associated with caries initiation‖ primarily at mealtimes	• Occasional (ie, 1-2) between-meal exposures to simple sugars or foods strongly associated with caries	• Frequent (ie, 3 or more) between-meal exposures to simple sugars or foods strongly associated with caries
	• High caregiver socioeconomic status¶	• Midlevel caregiver socioeconomic status (ie, eligible for school lunch program or SCHIP)	• Low-level caregiver socioeconomic status (ie, eligible for Medicaid)
	• Regular use of dental care in an established dental home	• Irregular use of dental services	• No usual source of dental care
			• Active caries present in the mother
General health conditions			
			• Children with special health care needs#
			• Conditions impairing saliva composition/flow**

*Although microbial organisms responsible for gingivitis may be different than those primarily implicated in dental caries, the presence of gingivitis is an indicator of poor or infrequenr oral hygiene practices and has been associated with caries progression

†Orthodontic appliances include both fixed and removable appliances, space maintainers and other devices that remain in the mouth continuously or for prolonged time intervals and which may trap food and plaque, prevent oral hygiene, compromise access of tooth surfaces to fluoride or otherwise create an environment supporting dental caries initiation

‡Tooth anatomy and hypoplastic defects such as poorly formed enamel, developmental pits and deep pits may predispose a child to develop dental caries

§Optimal systemic and topical fluoride exposure is based on the American Dental Association/American Academy of Pediatrics guidelines for exposure from fluoride drinking water and/or supplementation[4] and use of a fluoride dentifrice

‖Examples of sources of simple sugars include carbonated beverages, cookies, cake, candy, cereal, potato chips, french fries, corn chips, pretzels, breads, juices and fruits. Clinicians using caries-risk assessment should investigate individual exposures to sugars known to be involved in caries initiation.

¶National surveys have demonstrated that children in low-income and moderate-income households are more likely to have dental caries and more decayed or filled primary teeth than children from more affluent households. Also, within income levels, minority children are more likely to have caries. Thus, sociodemographic status should be viewed as an initial indicator of risk that may be offset by the absence of other risk indicators.

#Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally[9]

**Alteration in salivary flow can be the result of congenital or acquired conditions, surgery, radiation, medication or age-related changes in salivary function. Any condition, treatment or process known or reported to alter saliva flow should be considered an indication of risk unless proven otherwise.

TOP 15 REASONS SEALANTS ARE A PUBLIC HEALTH MEASURE

1. Sealants are one of the best preventive measures for tooth decay that we can offer the public.

2. Sealants are esthetic, non-invasive, performed with no anesthetic and are a cost-effective method of prevention.

3. Sealants have been in use for almost 40 years.

4. Pit and fissure (where sealants are placed on the top of the tooth) tooth decay accounts for 88 percent of total tooth decay in children.

5. Sealants are 100 percent effective in preventing pit and fissure tooth decay if they are completely retained.

6. With proper placement techniques, sealant retention rates for the first year are as high as 98 percent.

7. Sealants remaining in place for up to 15 years is common.

8. Over the course of 20 years, studies have shown 65 percent of sealants are fully retained and 22 percent are partially retained and the teeth are free of tooth decay.

9. Only 2% to 4% of all sealants need some form of repair over the lifetime of the tooth.

10. Sealants have proven to be effective in more than 15 years of study.

11. The fee for a sealant is one-third the cost of a permanent filling.

12. Sealants should be placed on molars as soon after eruption as possible because decay susceptibility in molars remains the highest.

13. Studies have shown that sealing in beginning decay will block off the nutrient source from the decay which stops the decay process.

14. According to the Centers for Disease Control Oral Health 2000 Facts & Figures, tooth decay remains one of the most common childhood diseases.

15. The goal is to prevent tooth decay and maintain health throughout life.

References from the American Dental Association Library

My name is Peggy Funk. I grew up on a farm and still am a farmer's wife as well as a dental hygienist. Farming can be a dangerous profession and often in the busy season of fall or spring, someone is hurt and neighbors will take a day and work together to help each other out. I thought that was the American way. I am also the President of the Iowa Dental Hygienists' Association. I'm new to the legislative arena and have really had my eyes opened in the last year.

Having been a dental hygienist for the past 28 years, and having worked in both private offices and public health settings, I have worked closely with the people this proposal will affect.

I would like to quote from a recent article in the October issue of the IDA journal. Some of you on the board ~~are~~ may be familiar with this since you were listed as contributors to this article. "Current estimates show there will be a substantial decline in the number of dentists in Iowa within the next 10-20 years due to the disproportionate attrition of Iowa dentists primarily from retirement." This article goes on to state "The 3rd issue is the gradual erosion in the number of dentists in rural areas of the state. Generally, there are larger percentages of older dentists practicing in rural counties. This problem will become more acute when many of these practitioners retire and there is no replacement with a younger dentist. While there has always been a maldistribution of dentists with a much higher percentage concentrated in suburban and the outer core of urban centers, attracting dentists to rural environs has been increasingly more difficult. States-and in some instances counties are now, only starting to realize the issue of an aging dentist workforce. End of quote. I could go on in other research and give you numbers like only around 2-3 graduating dentists stay in the state where around 80 graduating hygienists stay in the

state. I realize there are always facts and figures a person can give to substantiate a claim so instead I will tell you about the people I've met.

I worked in private practice for 25 years. Throughout this career, I worked in 5 offices and was told more than once that we need to be careful how many Title XIX patients we see, as those people tell everyone they know and pretty soon our practice will be full of only Title XIX patients. In the last office I worked in, we saw a few nursing home people and a few comprehensive patients. Many of these people were physically compromised due to their age. They needed help getting in and out of the chair. Oftentimes, they were unable to hold a toothbrush so that they could really clean their teeth and flossing was out of the question. The difficulty in getting these people to the office ~~often~~ caused them to only come for visits to fix the pain of a tooth allowing their gums to go untreated. We all know how serious this can be, especially with so many of the elderly having heart, diabetes and other health problems. Many times, the dentist would ask me to clean their teeth before he could see them well enough to do a proper examination. A nursing home once sent an elderly patient to us claiming she had a bony growth protruding from her gums. This actually turned out to be a ledge of calculus. You can imagine the inflammation in the tissue surrounding these teeth.

When giving an in-service to aides working in nursing homes, I was told by the aides, they don't have the time or the inclination to put their hands in someone else's mouth to help them brush. One day in visiting my own Grandma in a care facility in Rochester, Minnesota, I was stunned to find out she had someone else's denture in her mouth. No one at the facility knew this had happened. I worked in a nursing home in both high school and college. I learned the elderly still have their pride and it can be

very difficult for them to ask for help for their own daily care. They would rather go without or endure pain, than admit they need help. As these people age, they can't even feed themselves let alone care for their teeth properly. Have you ever seen a complete meal that is totally pureed because someone can't chew due to tooth loss? This was 30 years ago. The fastest growing demographic is the oldest old, those over 85. Today's elders are also better educated, more politically aware and have higher health care expectations than any generation of seniors, previously. How will Iowa meet the needs and health concerns of these elderly?

I've heard the argument that this proposal will take more hygienists away from private practice. This is hard for me to believe. Let me tell you about my public health job. It is not a glamorous position nor is the pay as good as private practice. I took this job because I thought I could make a difference. I work with WIC clinics in 9 counties. Usually we set up in churches. In the hot Iowa summer there is no air conditioning. You can become quite warm carrying your equipment up stairs in the heat and humidity of July and August. In the winter, churches will turn down their heat right after Sunday services, to save money. They are reluctant to turn them up very high for only one day and do you know how long it takes to heat a church up? I drive by myself and carry my equipment in my car. I often drive over an hour to reach the clinic and the mileage compensation does not make up for the wear and tear on my car.

At least once a week, I see at least one child whose parent tells me they can't get them in to see a dentist. The mother tells me of the numerous long distance phone calls she has made, how she'll take off work if she has to but no one will see her child. What do ~~you~~ I tell a mother who has tears in her eyes, when she asks me why these dentists can

refuse to see her child just because she is on Title XIX. As a professional, I must simply help her find a dentist. I've also had mothers practically talk with their mouths closed because they are ashamed of their own teeth but are willing to live with pain and embarrassing smiles as long as we can help their children. Just imagine what prevention could have done for these families.

More attention has now been given to the studies showing how a pregnant woman's oral health can affect the unborn child. We have a maternal health clinic with our WIC clinics. We have 6 people who work with care coordination trying to get children and pregnant women in to see a dentist. They tell me getting a pregnant woman in to a dentist is extremely difficult. With all of the children I see, it's very difficult for me to have the time to work with the pregnant women showing them how to properly brush and floss and explain the importance of both. Even though the importance of this continues to emerge, it is difficult to find dentists willing to take these clients.

One can't even pick up a magazine anymore without seeing the word prevention in it. We are told we can prevent many ailments or at least help lessen some of the worst symptoms of diseases with prevention such as good periodontal maintanence, sealants and fluorides. Studies also show prevention is less expensive then fixing something after the fact. How many lives in Iowa can we improve by preventing oral diseases? How much money in the long run will this save the state for reimbursement for multiple expensive restorative work?

There are several states in the United States, who are helping to solve their access issue by using the trained professionals already available to them.This proposal is one of the many ways we can help the less fortunate and elderly maintain and improve both their

oral and total health. Let's make sure in our effort to protect Iowa's citizens we aren't depriving them instead.

Thank you for allowing me to speak to you today. - and thanks so much for the time, effort, and dedication you give to serve the people of Iowa.

Peggy A. Frank RDH, BS
President IDHA

DMACC
DES MOINES AREA COMMUNITY COLLEGE

Jennifer Hart, Executive Officer
Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687

October 16, 2003

Dear Board Members:

I appreciate the opportunity to provide testimony in support of the proposal to amend Chapter 10, "General Requirements," Iowa Administrative Code, to allow a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting.

In April 2003, I provided a brief overview of dental hygiene education including the American Dental Association, standards for program accreditation, the National Board Dental Hygiene Examination, and the Central Regional Dental Testing Service Examination all of which are required for dental hygiene licensure in Iowa. Today I will focus on curricula that support the education and skills necessary for the practice of dental hygiene in public health settings.

Community Dental/Oral Health is a required course for dental hygiene accreditation. According to Accreditation Standard 2-14, "Dental hygiene science must include oral health education and preventive counseling, health promotion, patient management, clinical dental hygiene, provision of services for and management of patients with special needs, community dental/oral health, medical and dental emergencies including basic life support, legal and ethical aspects of dental hygiene practice, infection and hazard control management, and the provision of oral health care services to patients with bloodborne infectious diseases.

The American Dental Education Association (ADEA), Section on Dental Hygiene Education Competency Development Committee, developed dental hygiene competencies to assist dental hygiene schools in meeting the accreditation standards. The ADEA Community Dental/Oral Health Competencies are as follows:

- Assess the oral health needs of the community and the quality of resources and services.
- Provide screening, referral, and educational services that allow clients to access the resources of the health care system.
- Provide community oral health services in a variety of settings.
- Facilitate client access to oral health services by influencing individuals and organizations for the provision of oral health care.
- Evaluate reimbursement mechanisms and their impact on the patient's or client's access to oral health care.
- Evaluate the outcomes of community-based programs and plan for future activities.

In order to implement these competencies, students are enrolled in courses such as Dental Health Education, and Community Health. These courses provide activities in a variety of community settings that introduce them to excellent programs addressing dental health needs on a community (public health) level. There are many similarities between community oral health practice and private practice. Community oral health practice extends the role of the dental hygienist in private practice to include the people of the community as a whole. Students are involved in providing education and treatment in many public health settings such as the hospital, community clinic, school or agency, in addition to their on campus clinical experience.

Dental hygienists learn to appreciate their role as health professionals at the local, state and national levels. This role requires the graduate dental hygienist to assess, plan and implement programs and activities to benefit the general population. In this role, the dental hygienist is prepared to promote the values of oral and general health and wellness to the public and organizations within and outside the profession.

Oral health, as an integral component of the overall health and well-being of individuals, must be available and attainable by all populations. Throughout my many years of working in dental hygiene, I have observed the dedication and commitment of dental health professionals working toward this goal. They need to be commended and thanked and told to keep up their efforts. Many worthwhile programs and services have been provided, but there is still much to be done.

I want to assure you that dental hygiene education is preparing dental hygiene graduates to address community oral health needs. I appreciate the Board of Dental Examiners willingness to advocate for cooperation among the communities of education, regulation, dental and dental hygiene practice, and other health professionals. Much will be gained by the coming together of public and private policymakers to establish partnerships to reduce oral health disparities in vulnerable populations in Iowa.

Sincerely,

Sandra Leggett

Sandra Leggett, D.H., M.A.
Dental Hygiene Program Chair

October 15, 2003

Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, IA. 50309

Dear Board Members,

I'd like to introduce myself, Dr. Daniel J. Venker. I graduated from the University of Iowa College of Dentistry in Iowa City, Iowa in 1983. In my 20 years of dental practice, I have practiced about 10 years in the public health setting and 10 years in solo private practice in family dentistry. In August 2003, I received my Master of Science degree in dental public health from the University of Iowa College of Dentistry. My thesis research was in the area of dental sealants. I have submitted a manuscript for publication of my school-based dental sealant program research to the Journal of Public Health in Dentistry. I also have a Bachelor of Science degree in microbiology and chemistry from the University of Iowa. I have worked closely and interactively on a clinical basis with the Des Moines school-based dental sealant program over five of its six-year history. I teach part-time at the Des Moines Area Community College, both in the classroom and clinically, with dental assisting and hygiene students. I still practice clinical family dentistry on a limited basis in West Des Moines, Iowa.

I want to personally thank you for your time and energy you have put into considering the matter of public health supervision of the dental hygienist in the State of Iowa. I know this issue is of concern to all licensed dental professionals in our state. I also know that many dentists are concerned and some are not supporting the amendment to Chapter 10 "General Requirements", Iowa Administrative Code. As a licensed dentist in the state of Iowa the past 20 years, I want to let you know I do support the amendment regarding the matter of public health supervision of the dental hygienist in our state. I have several reasons why I am supporting the proposed amendment.

First, definitions in the amendment must be clearly stated and understood. There is a difference between "screening" and an "examination". The term "screening" must not imply to anyone, including the patient, that a complete examination is being performed. If the patient understands and consents to screening through a signed consent form, then the patient knowingly and positively understands what is being provided in

the public health setting. Right now, in our school-based dental sealant program for the Des Moines school district, we use such a consent form. The screening does not replace a complete examination by a licensed dentist. The patient's parent or guardian has agreed to have an examination by a dentist after the hygienist has performed the screening, which may include education, prophylaxis and fluoride application. If the patient does not have an examination, no further treatment will be provided other than education, assessments, screenings and fluoride. The amendment criteria in which the public health hygienist can work are limited until the collaborating dentist does a complete exam, which includes medically compromised patients or medical conditions for which a dentist needs to be consulted prior to any treatment being delivered.

In the amendment to Chapter 10 the hygienist is under general supervision. In order for the hygienist to qualify for designation as a public health hygienist, they have to have several years of clinical experience. Therefore, a recent graduate of an accredited hygiene program cannot qualify for a clinical public health position. I do not see this as an avenue for dental hygienist to proceed toward independent practice. The public health setting is obviously different from private practice. Some may be uncomfortable in the beginning since this is new to many in the profession. The patient is not physically brought to the private dental office, however, the services being rendered by the hygienist are the same. Quality of care is assured by the contract the hygienist signs with the dentist. The patient cannot continue to receive preventive services in the public health setting without routine examination by a licensed dentist. A similar model has been done with nurses and physicians in the medical field for many years and can work for us in dentistry. Patient protection is essential and guaranteed even if the patient does not follow through with their part of the agreement to see a dentist for a complete examination.

Second, I am in my sixth year of participating in the school-based dental sealant program for the Des Moines Independent School District. Our "School Smiles" program is administered through the Des Moines Health Center, a federally qualified health center, in Des Moines, Iowa. I have volunteered with the same hygienists and assistants since Fall 1998. It may seem unreasonable for the hygienists to be evaluating second and third graders for the placement of sealants, however it really is not in this public health setting. In the sealant program, radiographs are not exposed to detect the presence of caries not clinically detectable or apparent. Neither the dentist or the hygienist both do not have the added benefit of radiographs. Dental research has shown through more than one research study that caries

that are sealed into the tooth will not progress. Since the parents and guardians of the children give a positive or negative consent, they understand that the sealant "screening" does not replace the regular (and more complete) dental examinations they receive from their regular dentist (which might include radiographs). The reality of the situation is that some of these students are probably having incipient caries sealed in their teeth. Many public health dentists in the area of dental sealants have acknowledged this and this fact is published in guidelines pertaining to sealant placement. This can possibly happen if radiographs are not exposed. Is that of concern to me as a professional in the field? No, not if the parents or guardians are taking their children for regular dental examinations. If the sealed tooth should happen to need to be restored, then the student's regular dentist can provide those services. In our Smiles Program, if students do not have an established dentist of record ("a dental home"), we do our best through our program and the aid of the school nurse, to help those students needing referrals to establish a dental home. When a dentist identifies caries around their crowns they have provided for patients, this does not mean they stop doing crowns. The same rationale needs to be applied to dental sealants.

Licensed dental hygienists are able to do caries risk assessments and caries detection. Caries detection is part of their education and board examination experiences. Currently, in the sealant program, the dentist performs only a clinical assessment of the tooth structure. A hygienist performing the same clinical assessment, including caries risk assessment, can detect if there is active caries that necessitates the student seeing their regular dentist for definitive diagnosis. In the case of suspicious caries, a sealant is not to be placed and referred for definitive diagnosis. I am comfortable with the public health hygienists in the Des Moines sealant program being able to know whether a tooth needs to be sealed or not be sealed since the child will eventually be seeing a dentist. Even if enamel caries are sealed into the tooth and the child does not see their dentist for an examination, research supports that there is no harm done. In fact, research supports that caries sealed into a tooth will be arrested and will remain arrested as long as the sealant remains fully intact in the pit and fissured surface. When the public hygienist is able to perform these assessments and seal the teeth, the time the dentist spends doing the sealant assessments can be better spent providing restorative care. Research even supports that if a tooth is sealed that has dentinal caries present, the caries process will be arrested as long as the sealant remains fully intact.

As a recent graduate of the master's program in dental public health at the University of Iowa College of Dentistry, I feel comfortable with public

health hygienists performing these needed preventive services under public health supervision. My thesis for my master's degree was in the area of dental sealants. The thesis examined sealant retention in the area of school-based sealant programs. I am confident of the sealant treatment that the public health hygienists are providing in the school-based program in Des Moines, which is comparable to (if not slightly better) than published research on other school-based programs in the United States. Their expertise in this sealant program, along with their clinical experience in a public health setting and prior hygiene education, put them in excellent clinical practice to assess students for active caries and making appropriate, timely referrals to the dentist for definitive diagnosis and treatment.

Third, the geriatric populations of the nursing care facilities have access problems to routine preventive dental services. As the Baby Boomers approach retirement, this population is expecting and wanting maintenance of their natural dentitions. Many of them have expended time, money and energy into complex restorative care, including fixed prostheses and implants. There is an expectation that dental care will still be provided at a professional level they had as young and middle-aged adults. Fifty percent of the nursing care facilities in Polk County have a dentist and hygienist that routinely come to their facility to provide preventive and restorative dental care. That number is may seem large, however those services are provided by only one dental office. That percentage is significantly less in the rural areas of Iowa. By allowing dental hygienists to work collaboratively with public health supervision, many more nursing care residents will have access to routine preventive dental services. Again, the patient or their guardian will give consent for at least an annual dental examination to be performed by a licensed dentist. If routine dental examinations are not performed, then the hygienist cannot perform any services other than educational services, assessments, screenings, and fluoride.

Over my 20-year dental career I have seen the benefits sealants have given to many children, both in the public health and private practice settings. This also includes the benefits of the school-based program sealant program I have seen the last six years. Low-income children receive a necessary preventive service to help prevent the high percentage of caries that occurs in this population of children in the most susceptible sites for caries; the pit and fissured surfaces of the molar teeth. The education that hygienists receive in accredited dental hygiene programs provide an excellent foundation for the public health setting. After several years of clinical experience, this experience can help in providing needed services to an underserved population. Preventive services they provide can also be

translated to another underserved population; the geriatric population in the nursing care facilities. Though my experience in the nursing care facilities is limited, as a volunteer on a dental pilot program for nursing care facilities in Polk County, some interesting information from the nursing staff has been gathered. Many of the staff are uncomfortable entering the oral cavity to do assessments and screenings. Their training is minimal and limited regarding the health of teeth, gingiva and oral mucosa. Generally, I have observed that the nursing staff is unable to do an adequate oral assessment due to lack of education and familiarity with oral soft and hard tissues. Public health hygienists provide not only a source of preventive services but provide a resource to the nursing care facility to educate and assist the staff members. Nursing care facilities will be able to better identify potential dental and other oral problems earlier with the help of hygienists, so to better help the residents avoid pain and maintain a healthy oral environment.

With the current issues regarding access to dental care, this proposed amendment change is a good one as long as:

1. Terms and definitions are well defined in the proposed amendment change.
2. Written consent forms are well defined and understood by patient and dental professionals, including the necessity of an annual dental examination by a licensed dentist (at a minimum).
3. Further treatment is terminated by the hygienist if the patient does not adhere to the request of an annual dental examination by a licensed dentist. Then, the hygienist can *only* provide education, assessment, screening and fluoride until a complete examination is performed by a licensed dentist.

This proposed amendment change is a good step towards helping underserved-populations to receive much needed preventive dental care and show that our profession is keeping pace with changing times and situations. The Surgeon General's Oral Health Report in Year 2000 stated "oral health is integral to general health". Recently published research in the Journal of the American Dental Association shows the association between the impact of poor oral health on nutrition. All of us know the importance of good nutrition in the elderly. The proposed amendment change is needed to help alleviate the disparities in dental care we are see between certain populations, mainly the poor and the affluent. This disparity is also addressed and recognized in the Surgeon General's Oral Health Report in Year 2000.

Thank you for your time in considering my thoughts and expertise on this matter regarding the proposed amendment change in Chapter 10. If you have any further questions regarding what I have written about in this letter, please feel free to contact me at the address below.

Sincerely,

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Iowa Board of Dental Examiners
Regulatory Analysis – ARC 2783B
Public Health Supervision of a Dental Hygienist

Prepared by Jennifer Hart, Agency Rules Administrator,
Iowa Board of Dental Examiners
Approved December 2, 2003

Introduction

On August 21, 2003, the Board of Dental Examiners voted unanimously to file a Notice of Intended Action to amend 650—Chapter 10 by adopting a new rule related to public health supervision. Notice of Intended Action was published in the *Iowa Administrative Bulletin* on September 17, 2003, as **ARC 2783B.** The proposed amendment would allow a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting. The amendment defines public health settings and details the responsibilities of each licensee operating under public health supervision. The proposed rule differs significantly in one important aspect from existing dental hygiene supervision rules: under public health supervision, a dental hygienist may render services prior to a dentist examining the patient.

On October 13, 2003, the Administrative Rules Review Committee (ARRC) discussed the Noticed rules and requested an informal regulatory analysis from the Board of Dental Examiners related to the proposed amendments. The request for an informal analysis asked the Board to address specific concerns raised by the Iowa Dental Association in their memo to the ARRC, dated October 13, 2003. The informal regulatory analysis provided here will address the IDA's concerns within the framework of the requirements for an analysis as specified in Iowa Code section 17A.4A. However, because this was an informal request for an analysis, the Board was advised by the committee that it is not under an obligation to publish the findings of this analysis in the Iowa Administrative Bulletin or to hold additional public hearings. The information provided in this analysis is informational in nature to address questions raised by members of the ARRC, concerns of the IDA, and to guide the board in its decision making while considering adoption of the proposed amendments.

Executive Summary

- There is clear agreement that a dental access problem exists in the state of Iowa, just as in other parts of the U.S. Seventy-two of Iowa's 99 counties, and one urban area, have been designated as dental health profession shortage areas.
- Less than one-third of Iowa Medicaid recipients received any dental services in FY 2003.
- Dental caries is the single most common chronic childhood disease. Twenty-five percent of children suffer 80 percent of tooth decay. Poor children suffer twice as much tooth decay as their more affluent peers. [1]
- A number of factors are responsible for the access problem, including: low reimbursement rate for Medicaid claims; administrative burden of filing Medicaid claims; high failure rate of appointments for Medicaid patients; a lack of understanding of the

importance of oral health; a general shortage/maldistribution of dentists in Iowa; and a lack of dentist providers in Medicaid.

- The Iowa Board of Dental Examiners became involved in the dental access debate for the first time in September 2002 in response to a petition for rulemaking. The Board studied and debated this issue for over a year. The Board believes its current rulemaking action strikes a compromise between the competing views of the IDA and IDHA and the Board's obligation to protect the public.
- The Board's proposed amendment will allow a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting. The Board's proposal addresses previously identified concerns of maintaining board authority over licensees, ensuring practice protocols are written by a dentist, ensuring that protocols address medically compromised patients, ensuring that patients are advised in writing that the hygiene services do not substitute for a dental exam, that a written plan for referral to a dentist is made for all patients, that hygiene services are limited if a dental exam does not take place, and that procedures for maintaining dental records are established.
- The Board's proposed amendment is voluntary. Both a dentist and a dental hygienist must agree to practice under public health supervision.
- The Board's proposed amendments address the regulatory barriers involving the high failure rate of Medicaid patients, the lack of understanding of the importance of oral health needs, and access to preventive services and treatment.
- Dental sealants are a comparatively inexpensive, easy way to prevent tooth decay, especially in high-risk populations. Research supports the safety of sealant placement, even in cases of incipient tooth decay.
- The cost of implementing the proposed amendments is minimal compared to other alternatives. Providing preventive care is cheaper than paying for more costly treatment needs. Long-term savings can be realized by increasing access to preventive care. The Iowa Department of Human Services supports the rule change proposed by the Board.
- The dental access problem has been debated and studied in Iowa and across the nation for many years, with little or no progress in the state of Iowa. Financial barriers seem to be a major limitation – most attempts to resolve the problem will require a substantial on-going commitment of public funds. With the difficult financial situation faced by the state legislature, there is only limited opportunity to fight the dental access problem using approaches that do not require a major commitment of public funds. Many states are seeking innovative approaches to combat dental access, like expanding the role of dental hygienists through public health supervision.
- The Board's proposed rules have a limited ability to address the dental access problem, but do address important barriers to access. By focusing on providing preventive services, access issues will be tackled by trying to reduce the need for more costly restorative dental treatment. The board's rules cannot address the real needs of patients—to find dental providers who are willing to accept new Medicaid patients and attend to their restorative treatment needs. Combating this problem will require action and commitment from the Iowa legislature. Given current budget realities, the Board's approach is a relatively low-cost method of removing some regulatory barriers to positively impact the ability of patients who do not otherwise have access to care to receive preventive oral health services.

Oral Health in Iowa

According to the report *Oral Health in America: A Report of the Surgeon General*,[2] the following facts summarize the oral health problem in America:

- Tooth decay is the single most common chronic childhood disease; it is five times more common than asthma and seven times more common than hay fever.
- Over 50 percent of 5-9 year old children have at least one cavity or filling.
- Poor children suffer twice as much decay as their more affluent peers, and their disease is more likely to be untreated.
- Over 108 million children and adults lack dental insurance, which is over 2.5 times the number that lack medical insurance.
- Children from families without dental insurance are 3 times more likely to have dental needs than children with dental insurance.
- More than 51 million school hours are lost each year to dental-related illness.

Specific surveys by the Iowa Department of Public Health (IDPH) further illustrate the oral health problem for Iowa children.[3] An oral health survey of grades 2-4 conducted by department in 1999 found that:

- 57% of children had a history of decay;
- 68% of low-income children had a history of decay;
- 33% had untreated decay;
- 47% of low-income children had untreated decay; and
- 30% of low-income children had more than one decayed tooth.

Data from the 2002-03 School-based Sealant Program[4] (grades 2-7) also found that:

- 58% of children had a history of decay;
- 64% of Medicaid-enrolled children had a history of decay;
- 33% of children had untreated decay; and
- 39% of Medicaid-enrolled children had untreated decay.

Claims data provided by the Department of Human Services show that less than one-third (32.5 percent) of Iowa Medicaid-enrollees saw a dentist during fiscal year 2003.[5] This figure compares to statistics from the Centers for Disease Control and Prevention National Center for Health Care Statistics that nationally approximately 73.3 percent of persons ages 2-17 had a dental visit in the last year and 64.6 percent of persons ages 18-64 were able to see a dentist in the last year.[6] Even when poverty status is factored into these statistics, nationally 61.0 percent of poor children (family with income less than 100 percent of federal poverty level) and 63.2 percent of "near poor" children (family with income between 100 and 200 percent of the poverty threshold) were able to see a dentist in the last year. For adults ages 18-64, these rates drop to 45.8 percent of poor and 46.9 percent of near poor. [7]

The Iowa Department of Public Health Bureau of Health Care Access is responsible for designating health professional shortage areas (HPSAs) in the state of Iowa. A designation of a dental health shortage area is based on either a geographic area or a special population group designation. A geographic shortage designation is based on a population to provider ratio of 5,000 to 1. A special population group shortage designation is measured by using the income

rates of population below 200 percent of poverty and the physicians that participate in the Medicaid program. The ratio must be 4,000 to 1. In Iowa, there are 72 counties with dental health care shortage designations. Seventy-two counties are whole county designations. In addition, one county (a portion of Polk County) is designated as a census tract Low-Income Population designation.[8] See Attachment A for specific information on counties in Iowa that have been designated as dental shortage areas.

Iowa's 99 counties are scheduled to be reviewed later this year for updates. According to the Bureau of Health Care Access, it is expected that more counties will qualify as shortage designation areas. Bureau representatives also noted that if dental access were judged based on the ability of the uninsured to access care using a sliding fee scale, then virtually every county would qualify as the only dentists that are using a sliding fee scale are the community health centers, a United Way sponsored dental clinic in Polk County, and a solo practitioner in Lyon County.

Results from these surveys and other findings clearly illustrate that, like the rest of the nation, Iowa is faced with a severe dental access problem. Multiple barriers contribute to the dental access problem in Iowa and across the nation; these barriers are numerous, multi-dimensional, and complex. The next section of this report will attempt to briefly describe the major barriers to dental access.

Barriers to Access to Dental Care

Numerous studies and groups have convened over the years to discuss the dental access problem and identify the barriers that contribute to the problem. Nationally, many different government organizations and dental-related groups have identified barriers to greater oral health care access. Similar groups in Iowa have also identified these same barriers. These barriers will be listed in brief and then addressed in more detail. Barriers include the following:

- Low reimbursement rate for Medicaid claims;
- Administrative burden of filing Medicaid claims;
- High failure rate of appointments for Medicaid patients, which increases the financial burden on providers;
- Lack of understanding of the importance of oral health;
- General shortage/maldistribution of dentists in Iowa; and
- Lack of dentist providers in Medicaid that will take new patients.

Reimbursement

A low reimbursement rate for dental services provided to Medicaid patients is one of the most significant barriers affecting access to care for low-income patients. Until July 2000, reimbursement to dentists treating Medicaid patients was based on a fee schedule that was last updated in 1987. Previous increases allocated by the General Assembly were less than one-fourth the rate of inflation for the dental component of the Consumer Price Index.[9] In July 2000, reimbursement rates were increased using tobacco settlement funds to permit reimbursement at 75 percent of the usual and customary fees. However, budget shortfalls for the state general fund resulted in a 3% reduction in dental reimbursement beginning in July 2001. When added to the

Consumer Price Index for medical inflation in the years 2000, 2001, and 2002, rates have returned dental reimbursement almost to the pre-2000 level.[10]

The American Dental Association recently published a report that compares Medicaid reimbursement rates for 15 common pediatric dental services against prevailing fees charged for the same procedures by general practitioner dentists located in a given region. In Iowa, the ADA report shows that Medicaid reimbursement rates for 12 of the 15 procedures are in the 9th percentile or below in relation to regional fees. This means that 9 percent or fewer dentists charged the Medicaid fee or a lower fee for a specific procedure, while 91 percent charged a higher fee than the Medicaid reimbursement level. The remaining 3 procedure reimbursement rates for Iowa are in the 10th to 24th percentile compared to regional fees.[11]

Administrative Burden

The administrative burden of filing Medicaid claims has historically been cited as a contributing barrier to access to care for Medicaid patients. The perception that filing Medicaid claims is an overly complex process with multiple rejected claims and heavy paperwork prohibits some dental providers from participating in the program. Even when the reality of the administrative requirements for Medicaid does not differ significantly from similar claims issues with other insurance companies, perceptions of a high administrative burden persist.

According to discussions of the Dental Advisory Council (DAC) of the Department of Public Health, complaints about the process from providers include the following: a high rate of rejected claims, sometimes for little mistakes; delayed payment based on rejected claims; requirements for multiple claims re-submissions; additional paperwork burdens for prior authorizations, claims, and resubmissions; a lengthy and cumbersome application process; difficulty accessing a "live person" for customer service; and problems with the claims agency not recognizing standard ADA code procedures.[12] Another common administrative complaint cited is the need for prior authorizations for certain dental work. Prior authorizations are required for some periodontics work, crowns, dentures, and orthodontia dental work. According to a representative from the Iowa Department of Human Services (DHS), however, there have not been complaints about the prior authorization requirements for several years.[13]

Furthermore, DHS reports that other improvements have been made in an attempt to reduce administrative requirements. According to the DAC, however, the overall feeling was that although the system for claims submission was deemed "doable" it was very labor intensive, thereby resulting in doing more work for less money. Coupled with negative provider perceptions about the process, administrative issues with Medicaid continue to contribute to the dental access problem.

High Failure Rate of Appointments

The 1997 IDA Medicaid Dental Task Force identified a high failure rate of appointments as a major reason that dentists did not participate in the Medicaid program.[14] Broken appointments and a high "no-show" rate increase the financial burden on providers. A recent study that assessed the appointment-keeping behavior of Medicaid-enrolled pediatric dental patients in Eastern Iowa found that 35 percent of Medicaid dental appointments cancelled, failed, or were late, compared to 15% of non-Medicaid appointments at these same practices.[15]

Various reasons contribute to the high failure rate of appointments for Medicaid beneficiaries. Getting time off from work to visit the dentist, arranging transportation to the dentist, and finding or affording child care for dental appointments, while minor inconveniences for higher-income patients, can be significant barriers for low-income patients.[16] Although there are programs like Medicaid's Early & Periodic Screening, Diagnosis & Treatment (EPSDT) care coordination that can assist children on Medicaid with these barriers, more must be done to educate beneficiaries and providers on the availability of these programs.

Lack of understanding of the importance of oral health

A lack of understanding of the importance of oral health prevention and treatment needs is another barrier to achieving greater access to dental care. All patients, regardless of income, must understand the importance of regular and ongoing oral health care. Policymakers must also understand the impact of inadequate oral health to the overall health of their constituents and communities. Education should stress the cost savings to individuals and to state budgets on accessing preventive services to avoid more costly dental treatment services.

Both patients and policymakers must understand that poor oral health can lead to more significant and costly health problems. For example, research has established a link between periodontal disease and low-birthweight babies in mothers with higher levels of periodontal disease. In addition, several studies have found that people with periodontal disease are more likely to have cardiovascular disease and are more likely to have difficulty controlling blood sugar with diabetes. Another study found that mother's with untreated decay were more likely to pass decay-causing bacteria from their mouths to the mouth of their infants.

For families with limited incomes or families that have other barriers to care like a lack of transportation, dental services are often considered deferrable until dental problems become painful. As a result, oral health needs often receive low priority and patients may not practice good oral hygiene or follow dentists' instructions. Adult patients and parents of children need to be educated about the importance of oral health, the need for early care to prevent common dental problems, and how to access services, such as the EPSDT program, that will facilitate referral to dentists, appointment reminders, and transportation to care. Until oral health is valued as equally important as other health services, disparities in access to care will continue to exist.

General shortage of dentists in Iowa

Further exacerbating the dental access problem is a general shortage of dentists in certain areas of the state. Rural areas of the state are especially vulnerable due to an aging dentist population and the challenges of recruiting new dental practitioners. As discussed earlier, 72 of Iowa's 99 counties are designated as dental health profession shortage areas. The simple fact is that for many of Iowa's counties, there simply are not enough dentists.

Statistics from the Office of Statewide Clinical Education Programs, UI Carver College of Medicine, show that Iowa had 1,302 private practice dentists in 2001; 173 of these dentists were age 60 or older. This figure also represents a consistent decline in Iowa's overall private practice dentist population between 1997 and 2001. In 1998 there was a net loss of 18 private practice dentists in Iowa; in 1999, there was a net loss of 1 dentist, followed by a net loss of 13 dentists in

2000, and a net loss of 11 dentists in 2001. Retirement is responsible for just over half of the attrition rate. Relocation was responsible for about 30 percent of the attrition, while death and other reasons accounted for about 15 percent of the attrition.[17]

While 2002 brought the first net gain (+19) in Iowa's private practice dentist workforce in several years, critical shortages still remain in many areas of the state.[18] The age distribution of Iowa's dentists also shows some cause for concern. Only about 22 percent of Iowa's dentist workforce is under 40 years of age. About 32 percent of all Iowa dentists are between 40 to 49 years of age, while 31 percent are between 50 and 59 years of age, and 14.5 percent are age 60 or older. Cumulatively, 45.5 percent of Iowa's dentists are age 50 or older.[19]

Iowa's dental workforce shortage is not unique. While a 2001 Report on Dental Workforce by the American Dental Association argued that the national dental workforce seems to be adequate, the report acknowledged that regional workforce issues do exist and may become more pronounced in the future.[20]

Nationally, the number of dental school graduates is decreasing. Last year there were 344 vacant faculty positions at 54 dental schools nationwide.[21] Shortages in dental school faculty affect the ability of schools to educate and train more graduates and dental specialists. Coupled with a rising U.S. population and the large number of dentists who are eligible for retirement in the near future, these shortages are particularly troubling. Even in states where the number of practicing dentists is deemed adequate for the state's population, a maldistribution of dentists in the state can severely hamper access to care, particularly in rural areas. In a state that is predominately rural like Iowa, these problems are more apparent.

The dental workforce issue is also complicated by the lack of an adequate number of practitioners who are trained to treat children. There is a severe shortage of pediatric dentists in Iowa and around the nation. Nationwide, only about 2.5 percent of dentists specialize in pediatric dentistry.[22] In Iowa, there were only 30 pediatric dental specialists in private practice in 2002.[23] For children with special health needs who require the services of a pediatric specialist, this creates unique access difficulties.

A particular access problem for children under age 3 also exists because a large number of general dental practitioners will not treat children this young. Both the American Academy of Pediatrics and the American Association of Pediatric Dentistry recommend that all children be seen by a dentist within 6 months of the first eruption of teeth or by age one. EPSDT guidelines recommend dental visits at least yearly thereafter until the age of 3 and twice yearly after that. Despite these recommendations, the vast majority of dentists will not treat children under age 3. Only 200 dental providers statewide are listed on the EPSDT Registry as being willing to treat children under age 3.[24] In fact, a 1996 survey of dentists conducted by Dr. Michael Kannelis through the Public Policy Center at the University of Iowa, found that only 11 percent of dentists surveyed thought that children should be seen by age 1.

For low-income children who are especially vulnerable to dental disease, this situation is especially troubling. Significant dental disease can occur in young children. Of particular concern is a condition called early childhood carries or ECC. Early childhood caries, sometimes

called baby bottle tooth decay, is rampant caries in the primary teeth of infants and toddlers, typically the result of a child going to bed with a bottle of sugared drinks or pop or drinking at will from a bottle during the day. Most cases of ECC are preventable, but early detection is necessary to prevent or stop the progression of the disease.[25] Studies show that up to twenty percent of children from families with low incomes have ECC.

Because of the risk of ECC for children from low-income families, it is especially important that early access to dental care take place. When treatment for rampant decay is delayed, costs can increase dramatically. In some cases, hospital care is required to treat rampant decay by providing restorative care to young children under general anesthesia. In a study of expenditures for restorative dental care delivered under general anesthesia to Iowa Medicaid children, costs were $2,009 per case.[26] According to the study, "less than 2 percent of Medicaid-enrolled children under 6 years of age who received any dental service accounted for 25 percent of all dollars spent on dental services for this age group, including hospital and anesthesia care." The minimal costs of educating parents of young children, providing early preventive services like fluoride varnish, and ensuring routine early access to care pales in comparison.

Lack of dentist providers in Medicaid

Faced with an overall shortage of dentists for the entire population, the problem of finding dentists to treat Medicaid and other low-income patients is exacerbated. Even where there is an adequate supply of dentists, few treat a significant number of Medicaid patients. According to the United States General Accounting Office (GAO), "While several factors influence the access low-income groups have to dental care, the primary one is limited dentist participation in Medicaid."[27] This national problem is mirrored in the state of Iowa.

During fiscal year 2003, there were 1,118 dentists in Iowa who billed Medicaid, including 58 staff and residents at the University of Iowa College of Dentistry. However, 160 of these dentists, *about 14 percent*, saw 10 or fewer Medicaid patients. Only 394 dentists saw 100 or more Medicaid patients. The median number of patients seen was 55: half of all the dentists saw more than 55 patients, while half saw fewer than 55 patients.[28]

Of more significant concern is the number of dental providers who are willing to treat new Medicaid patients. According to a statewide survey of dentists conducted in March of 2002 by the University of Iowa Department of Pediatric Dentistry, only 168 providers in the state of Iowa were willing to have their name listed on the EPSDT Registry as accepting new Medicaid patients. Only 200 providers statewide would see children under the age of 3, regardless of payment source.[29]

The problem of finding dentists willing to treat new Medicaid patients is particularly difficult in rural areas of the state where there is already a limited number of dentists for all patients. However the problem is not uniquely rural. For example, in Polk County there are only 9 providers on the registry that accept new Medicaid patients out of a total of 223 providers.

Although there are a few more dentists who accept patients in all three categories, but who did not want to have their names listed on the registry, the number does not significantly affect access for new Medicaid patients (in 2000, the discrepancy was about 7% of dentists who saw

patients in any of the three categories but who did not want their name published on the registry).[30] Indeed, the fact that many dentists are fearful of advertising their willingness to treat new Medicaid patients is indicative of the severe problems faced by the program. Because the need is so great, some dentists are unwilling to have their name published on the registry for fear of being overwhelmed by new patients seeking care. While there was some increase in the number of providers published in the EPSDT Registry between 2000 and 2002, there is still a severe shortage of providers willing to treat new Medicaid patients and children under age three.

According to the GAO, the primary reason cited for not treating Medicaid patients are that payment rates are too low. Coupled with the perceived administrative burden in treating Medicaid patients, patient issues like appointment-keeping, and dentists' attitudes toward low-income patients, provider participation will continue to be a problem. In a study of states that took various steps to improve access to care among Medicaid recipients, including raising payment rates, streamlining administrative processes, and conducting outreach activities to both dentists and beneficiaries, the GAO found that low utilization remained a problem.[31]

In the conclusion of its study, the GAO stated

> *Despite the availability of dental coverage through public programs such as Medicaid, SCHIP, and other HHS programs, access to dental services remains low for low-income populations. Structural issues that affect service use across all income levels – including the availability of dentists and the priority that individuals assign to preventive dental care – are often more pronounced for low-income populations. Despite federal and state programs to improve access to dental care for low-income or otherwise disadvantaged populations, difficulties remain. The experience of states working to attract more dentists to Medicaid by paying higher fees, streamlining administrative requirements, and providing patient education has resulted typically in some incremental improvements in access…this is a public health issue that requires the concerted attention of many, especially the public and private sectors at the federal, state, and local levels.*[32]

The Board's Proposed Amendment

This section of the regulatory analysis will provide a brief history of the Board of Dental Examiners proposed amendment and specific information about what the amendment requires.

History of the Amendment

The Iowa Board of Dental Examiners became involved in the dental access problem for the first time in September 2002 in response to a petition for rulemaking filed by the Iowa Dental Hygienists' Association. Prior to this petition, the Board had not been involved in any previous efforts to study or address the dental access issue. The petition for rulemaking was the first time that the Board was asked to address the access issue from a regulatory perspective.

The petition proposed to amend 650—1.1(153) by adopting a new definition of "public health supervision" to allow dental hygienists with a specified level of education and experience to provide services to dentally underserved and at-risk populations as long as the hygienist follows protocols approved by the Bureau of Oral Health of the Department of Public Health. Following

review of the petition and related information, the Board voted in November 2002 to deny that petition. In its written denial, the Board identified several flaws with the petition:

- The original petition placed responsibility for writing practice protocols with the Bureau of Oral Health, with no mechanism for Board oversight. No protocols currently existed and the Board lacked legal authority to determine if supervision and practice protocols were appropriate.
- The Board was concerned that the Bureau of Oral Health would soon be without a dental director, meaning that a person without dental training could potentially be responsible for writing dental protocols. Since only a dentist can supervise a dental hygienist, it would have seriously undermined the program.
- The petition lacked a clear and specified plan to ensure dental diagnosis takes place. The Board was concerned that patients may mistakenly believe that no further treatment was needed and that a hygienist could diagnose dental problems.
- The petition did not fully define the settings where public health supervision could take place.
- The Board was concerned that the petition lacked a substantive plan to ensure that patients requiring care beyond the scope of dental hygiene services would be referred to a dentist for other treatment needs. The Board noted that of the 16 states reviewed that allowed alternative public health practice, almost all required some type of formal involvement by a dentist.
- The Board was concerned that the petition would be a step backwards from existing programs by placing responsibility for supervision in an entity and not a dentist.

While the Board noted that the petition was flawed in several respects, the Board expressed its desire to formally explore the access to care issue, to explore other alternatives, and its pledge to work with all interested parties on this issue. Following denial of the petition, the Board worked to put together an Access to Care Committee with representation from all interested parties. However, after considering that the Board's committee was duplicative to a Dental Advisory Committee (DAC) of the Iowa Department of Public Health, the Board decided to instead seek representation on the DAC. In the interim, while the Board was in the process of forming a committee, it was asked to consider another petition for rulemaking.

In December 2002, the Iowa Dental Hygienists' Association filed a second petition for rulemaking with the Board of Dental Examiners. The second petition sought to amend the Board's rules by changing the definition of "general supervision of a dental hygienist" and adding a new definition of "collaborative agreement." The amendments would have allowed a dental hygienist who has 2,500 hours of clinical practice or who is employed as a public health hygienist as of June 1, 2003, to perform preventive services in settings other than a private dental office without the patient's first being examined by a dentist. The hygienist must have entered into a collaborative agreement with a dentist who authorizes and accepts responsibility for the services provided by the hygienist. The collaborative agreement must contain protocols or standing orders for the hygienist to follow.

In a split vote in January 2003, the Board voted to accept the petition and file Notice of Intended Action on the amendments proposed in the petition. Notice of Intended Action was published in the Iowa Administrative Bulletin as ARC 2327B on March 5, 2003. A public hearing on the

noticed rules was held in April 2003. Approximately 120 written and oral comments on the proposed rules are received: about one-third of the comments expressed support, while the vast majority expressed opposition and others were undecided or supportive only if changes were made. Most of the comments received in opposition to the proposed amendments reiterated the concerns of the Iowa Dental Association (IDA). Concerns expressed by the IDA in their written comments were as follows:

- The IDA felt the proposed amendments were contrary to Iowa law because they failed to ensure that a dentist would look over, inspect, or oversee the work of a dental hygienist.
- The IDA was concerned that ongoing hygiene services could potentially be provided without assurance that a dentist would see the patient. The IDA expressed concern that there was not a mechanism to ensure that a dental exam takes place.
- The IDA expressed concern about the potential liability of a dentist under a collaborative agreement.
- The IDA expressed concern about services being provided to medically compromised patients.
- The IDA expressed concern about lack of training in diagnosing dental conditions and disease by dental hygienists, which could lead to delayed or missed diagnosis. Concern was also expressed that hygienists lack education to formulate comprehensive dental treatment plans.
- The IDA expressed concern about lack of training in pharmacology by hygienists and the inability of hygienists to prescribe medications. According to the IDA, this could create concerns for medically compromised patients or in the event of an allergic reaction.
- The IDA expressed the concern that without the presence of a dentist, patients might believe critical diagnosis and treatment planning services were rendered.

Other comments in opposition to the proposal identified the following issues:

- Many comments expressed concerns about a dentist possibly having multiple agreements with multiple hygienists;
- Numerous comments suggested that the time period for a dental exam be specified under a collaborative agreement to ensure an exam takes place within a reasonable amount of time;
- Many expressed the belief that some care is not always better than no care – because it could give a false sense of security to patients or could lead to problems diagnosing decay if a sealant was placed;
- Many comments suggested specifying the settings where care could be rendered;
- Multiple dentists commented on their belief that the proposal will not help the access problem because of lack of adequate reimbursement in Title XIX, lack of appropriate facilities and equipment to provide care to underserved, administrative burden in reaching target populations, the problems of keeping appointments; and a lack of adequate dental and dental hygiene providers;
- There was concern about dental record issues including where records would be maintained and stored; and
- Many expressed their belief that the proposal creates substandard care for underserved populations.

In April 2003, the Board of Dental Examiners met to review the Notice and the comments received. Due to the number of concerns, the Board voted unanimously to refer consideration of the pending rules to a Board committee, with committee recommendations due back at the August Board meeting.

The Board committee met with representatives from the Iowa Dental Association and Iowa Dental Hygienists' Association in May 2003 to discuss the proposed rules further. At the May meeting, the Board committee identified the following concerns with the proposed amendments:

- The committee and legal counsel for the Board expressed significant concern about whether the placement of sealants without a dental exam met the standard of care. Sealants were a major component of the proposal. However, at the time the committee felt that whether a tooth is appropriate to be sealed requires a dental diagnosis and that the standard of care for this diagnosis should not be different in two different settings.
- The committee discussed the question of liability, which had also been raised a number of times. The Board is not involved in typical questions of liability – that is a determination between an insurance company and the policy holder. However, the Board needs to be able to address responsibility from an enforcement perspective. If a complaint about one of these cases would come in, the Board must be able to answer questions related to who is the dentist of record, where to find dental records, etc.
- The committee expressed concern regarding if a hygienist was working under multiple agreements, each with different protocols, then how do you determine for any given patient who the dentist of record is and what protocols the hygienist is supposed to be working under? If records had to be subpoenaed, who do you issue the subpoena to?
- The committee discussed some concern that the current wording was ambiguous and did not make it clear whether this created a new level of supervision under the collaborative agreement. The wording needed to be modified for clarity.
- The proposal also referred to a public health hygienist. However, there is no definition of a public health hygienist anywhere in the rules. It is not clear if it meant someone with specific public health education or just anyone with experience in public health.
- The amendments also referred to preventive services. However, the term "preventive services" has a very narrow meaning under board rules. Preventive services only refer to sealant and fluoride rinse programs. Therapeutic services deal with prophylaxis, scaling and root planing. Under the proposal, a hygienist could continually perform scaling and root planing without a dentist ever examining a patient.
- Questions concerning record keeping and who is responsible also need to be addressed.
- The committee also discussed that the meaning of health care facility was also unclear, overly broad, and needed to be more clearly defined.

Committee members felt that it should not be the Board's responsibility to work out a solution to the many unanswered questions with the proposal. Committee members felt that the associations needed to work out a solution together. In the meantime, the committee suggested the waiver process as a mechanism to work out problems on a case-by-case basis. The committee recommended that the Board not move forward with the Notice of Intended Action. The committee also unanimously suggested that the dental and dental hygiene association work together to discuss their concerns and attempt to resolve this issue.

Following the May committee meeting, the associations failed to meet and attempt to resolve differences related to the proposed amendments. The Director of the Iowa Department of Public Health, in consultation with the Governor's office, also attempted to facilitate meetings between the groups to resolve concerns. These attempts were also unsuccessful. Following unsuccessful attempts to mediate a resolution and with the support of the Governor's office, the Board's committee worked to develop a compromise proposal that would address many of the concerns previously identified, ensure sufficient patient protections were established, and facilitate access to services in public health settings.

Committee members developed the current proposal based on a review of programs in other states, feedback from the earlier petitions and rulemaking actions, and comments received. The full Board met in August and unanimously voted to support the committee's proposal. The Board voted to terminate the rule making commenced in ARC 2327B and file Notice of Intended Action to amend Iowa Administrative Code 650—Chapter 10, "General Requirements," by adopting a new amendment related to public health supervision, as proposed in ARC 2783B.

The Board's Public Health Supervision Amendment

The proposed amendment in ARC 2783B would allow a dentist to provide public health supervision to a dental hygienist providing services within the scope of practice of dental hygiene in a public health setting. The amendment defines public health settings and details the responsibilities of each licensee operating under public health supervision. The proposed rule differs significantly in one important aspect from existing dental hygiene supervision rules: under public health supervision, a dental hygienist may render services prior to a dental exam of the patient based upon written protocols

Both the dentist and the dental hygienist working under public health supervision are responsible for maintaining contact and communication with each other. The dentist and the dental hygienist must also have a written supervision agreement that provides age and procedure specific standing orders for the performance of dental hygiene services. The standing orders must include consideration for medically compromised patients and medical conditions for which no services can be provided prior to a dental exam. The specific location where services will be provided must be specified. The agreement must also limit the length of time in which further hygiene services can be provided to a patient unless a dental exam has taken place.

The application of initial pit and fissure sealants by a dental hygienist under public health supervision prior to a dental exam shall also follow the supervising dentist's age and procedure specific protocols and be based on a dental hygiene assessment.

The dental hygienist must provide each patient, parent, or guardian a written plan for referral to a dentist. Patients must also sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups and are meant for people who otherwise would not have access to services. The supervision agreement must also specify a procedure for creating and maintaining dental records for patients, including where these records are to be located.

The dentist and dental hygienist must maintain the supervision agreement and review the agreement at least biennially. A copy of the agreement must be available to the board upon request. To facilitate public health programs, a copy of the agreement must also be filed with the Oral Health Bureau of the Iowa Department of Public Health. The hygienist is also responsible for providing summary reports to the Department of Public Health to enable the department to assess the impact of public health supervision to public health programs.

In creating its current proposal, the Board carefully considered the concerns previously identified with the first two petitions for rulemaking, the many written comments received, and similar programs and supervision rules from other states. The Board sought to balance competing views on this complex issue, with the need to provide more services to the underserved and the overwhelming need to ensure that public health, safety, and welfare is protected under the rules. After considering the issue at length, the Board believes that there may be regulatory barriers that could be removed that may impact access to care for some underserved people. The Board's believes its current rulemaking action strikes a compromise between the competing views of the IDA and IDHA and the Board's obligation to protect the public.

Barriers Addressed by the Proposed Amendments

While the Board acknowledges that it cannot begin to address all of the barriers contributing to Iowa's overwhelming dental access problem, the Board believes it can remove certain regulatory obstacles. Any action that the Board takes will be innovative from the perspective that the Board has not previously been involved in the dental access issue in Iowa. However, as with any innovative approach, it is impossible for the Board to accurately predict the true impact the change will have on addressing the many complex barriers to oral health care. With that in mind, there are three main areas that the Board's proposed amendments can impact:

- *Lack of understanding of the importance of oral health needs;*
- *High failure rate of appointments; and*
- *Access to preventive services.*

Dental hygienists are licensed oral health professionals who focus on preventing and treating oral diseases by providing clinical and therapeutic services as well as oral health education. In the state of Iowa, all dental hygienists are required to graduate from an accredited dental hygiene program that is at least two years in length. Hygienists must also successful complete the written National Board Dental Hygiene Examination as well as a regional examination that includes both written and clinical components. According to education standards for dental hygiene education, students are prepared to assume responsibility for individual oral health counseling, community health programs, assessment, planning, and implementation of preventive and therapeutic services.[33]

Dental hygienists are front-line providers in educating the public and patients in the importance of oral health and preventive care. In fact, Board rules at Iowa Administrative Code 650—10.3(153) specify four categories of dental hygiene services: educational, therapeutic, preventive, and diagnostic. Education on the importance of oral health is a large component of dental hygiene and one of their primary responsibilities.

Dental hygienists can play an important role in educating patients and policymakers about the importance of oral health so that this barrier can be reduced or eliminated. Dental hygienists can help to educate and counsel patients about oral hygiene techniques to maintain healthy teeth and gums, teach strategies for plaque control, stress the importance of good nutrition to maintain optimal oral health, provide prevention strategies for parents to eliminate or reduce the risk of early childhood caries/ baby bottle syndrome, and communicate the importance of regular and on-going preventive dental care. Hygienists can also educate parents on the importance of keeping appointments and how early preventive care can help prevent more costly and time-consuming restorative dental care. With better education, treatment needs can be reduced because much of the disease experience by children and adults could be prevented with better personal care.

As discussed previously, a high failure rate of patient appointments is another contributing barrier to greater access to dental care. A lack of transportation, inability to get time off from work, inability to find child care, and a lack of understanding of the importance of oral health needs all contribute to the problem that low-income patients have keeping appointments. If more services can be provided in fewer appointments, this barrier becomes less of an obstacle for low-income patients.

Under existing programs, it may require the coordination and time commitment of at least three different appointments to have an oral prophylaxis: the initial screening at a public health clinic and referral to a dentist; the appointment and initial exam by the dentist following the lengthy wait for the appointment (or inability to find a provider accepting new Medicaid patients); followed by the appointment for the prophylaxis/cleaning and any additional appointments for further treatment needs. If a hygienist is working under public health supervision, the hygienist could provide the cleaning at the initial screening visit, thereby reducing the number of appointments needed. If fewer appointments are necessary, there is less of an opportunity to miss appointments and it may be easier to keep future ones.

Under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) component of Medicaid, dental hygienists can also help by facilitating care coordination for families with children from birth to 21 years of age. The Iowa Department of Public Health administers informing and care coordination services for the Department of Human Services. IDPH contracts with 26 Title V agencies in the state to provide 'informing' and care coordination services in all 99 Iowa counties. Care coordination services help by educating families about the importance of preventive dental care for children; assisting families in locating dentists who are Title V or Title XIX providers and by scheduling appointments; reminding families that exams are due; reminding individuals and families about appointments, counseling families on the importance of keeping appointments and providing follow-up if appointments are missed; assisting families with finding child care for the day of an appointment; providing transportation; and providing follow-up education and monitoring of the dental plan.[34, 35]

While nurses and other health professionals can serve as care coordinators, Title V agencies that utilize dental hygienists in this capacity tend to be the most successful at reducing the high failure rate for appointments and in facilitating oral health care. Rates of Medicaid-enrolled children receiving dental services in counties that have Title V agencies using dental hygienists

have increased at a higher rate than agencies where hygienists are not involved in this capacity.[36] The opportunity to expand the success of EPSDT care coordination can only be enhanced by increasing the ability of dental hygienists, operating within their scope of practice, to do more in fewer appointments.

Studies also support the belief that missed appointments are less of an issue in public health settings. The same study of the appointment-keeping behavior of pediatric patients in Eastern Iowa also found that appointment rates for Medicaid patients were better at the public health clinic and University-based pediatric dentistry clinic than in the private practice setting.[37] The report by the U.S. General Accounting Office also confirmed this phenomenon, noting, "The effect of missed appointments by Medicaid and other low-income patients appears to be less of a problem at public health clinics and community health centers, where officials report that walk-in patients and emergency cases generally fill any appointment times."[38]

Increasing access to preventive dental hygiene services will also address several barriers to oral health care. If dental treatment is not available due to a lack of providers or lack of willing providers, more must be done to reduce treatment needs through prevention. For example, fluoride varnish can reduce tooth decay in children. According to the Iowa Department of Public Health most studies have shown 25 to 45 percent reductions in the decay rate with the use of fluoride varnish. Of special note is the reduction of decay in pits and fissures, as well as on smooth surfaces of teeth. A two-year study by Holm using 225 three year-olds resulted in a 44 percent caries reduction rate following semi-annual varnish applications.[39]

Under the Board's proposed amendment hygienists would also be able to provide preventive services like an oral prophylaxis prior to a dental exam. An oral prophylaxis consists of removal of plaque, calculus, and stain from the exposed and unexposed (below the gumline) surfaces of the teeth. An oral prophylaxis helps to maintain oral health and prevent the initiation of dental diseases, like periodontitis. Preventing periodontitis is especially important because bacteria from the disease can enter the blood stream and travel to major organs to begin new infections. According to the American Academy of Periodontology, research suggests that this may increase a patient's risk of stroke, increase a woman's risk of having a pre-term baby, contribute to the development of heart disease, and pose a serious threat to people whose health is compromised from diabetes, respiratory diseases, or osteoporosis.[40]

Other preventive services that hygienists can provide can also significantly reduce the need for more expensive restorative dental treatment. Dental sealants are thin plastic coatings that are applied to the chewing surfaces of the back teeth to prevent tooth decay by creating a physical barrier against plaque and food.[41] Dental hygienists are educated and trained to apply dental sealants and are also authorized under Board rules to do so. According to the National Institutes of Health, dental sealants are almost 100 percent effective in preventing decay.

Dental hygienists currently work in school-based dental sealant programs to apply dental sealants after a dentist has first examined each child. According to the Oral Health Bureau at the Department of Public Health, at the present time sealant programs are limited due to both a lack of grant funds and in certain areas of the state, the inability to find a dentist willing to conduct dental exams prior to sealant placement. Under the Board's proposed amendment, this barrier

could be eliminated by authorizing a hygienist to place sealants according to written protocols as specified by a dentist. In making this change, Iowa would be joining the ranks of an increasing number of states that recognize the value of sealants in preventing decay to help combat the dental access problem. These states include, but are not limited to: California, Connecticut, Idaho, Maine, Minnesota, Missouri, Montana, New Mexico, Oregon, South Carolina, and Texas.

If decay can be prevented in the first place, treatment needs will be reduced, helping the access problem. In addition, substantial savings can be realized because the cost of sealants is less than half the cost of filing a tooth. Because sealants have been an issue of particular concern with respect to the proposed amendments, the next section of this report will discuss this issue in more detail.

Sealants

Dental sealants were first developed and used beginning in the 1960s. The application of sealants is a relatively simple and painless procedure. In simple terms, sealants are placed by painting on a liquid material that quickly hardens to form a shield over the tooth. This shield protects the teeth from decay by keeping out the germs and food that cause decay. Sealants are applied to the chewing surfaces of molar teeth where small pits and fissures can harbor bacteria that lead to decay. According to the Centers for Disease Control and Prevention, among children, 90 percent of decay is in pits and fissures.[42]

Once applied, sealants can last up to 10 years. However, following sealant placement, it is important to have regular dental check-ups to make sure the sealants do not chip or wear away. Chipped or worn sealants are not as effective in preventing tooth decay, but can be repaired by adding more sealant material. All of the research cited below heavily emphasizes the need for regular checks for sealant retention and maintenance where indicated. Research indicates that without regular check and maintenance, sealants can fail, leading to tooth decay.

In December 1983, the NIH hosted a consensus development conference on dental sealants in the prevention of tooth decay, which concluded that sealants were 100 percent effective in pits and fissures that remain completely sealed, though sealant retention declined over time. Since then, additional research has confirmed the effectiveness of sealants.[43] Despite their effectiveness at preventing decay, their prevalence remains low. Baseline data from *Healthy Iowans 2010* show that in 1994 only 30 percent of third graders in Iowa had sealants.[44] An Oral Health Survey conducted in 1999 by IDPH also found a large discrepancy (12.5 percent) in sealant placement rates between children of higher socioeconomic status and those of lower socioeconomic status: 36.5 percent of children with a higher socioeconomic status had at least one sealant compared to 24 percent of children with low socioeconomic status.[45] This discrepancy is particularly troubling when considering the fact that poor children suffer twice as much tooth decay as their more affluent peers. In fact, eighty percent of tooth decay is concentrated in only 25 percent of children.[46]

One of the oral health goals in *Healthy Iowans 2010* is to increase to at least 70 percent by 2010 the proportion of third grade children who have received protective sealants in permanent molar teeth. With a baseline of less than 40 percent of third grade children currently receiving sealants,

dramatic action is needed to accomplish this goal. Allowing dental hygienists to apply sealants in schools and public health settings, by following protocols written by a dentist, is one way to increase the sealant placement rate to help prevent tooth decay in high-risk children.

Sealants are extremely cost-effective compared to the cost of filling a tooth. In Iowa, the Medicaid reimbursement rate for a dental sealant is $19.40. The reimbursement rate for a single surface amalgam restoration is $43.65, up to $75.66 for a four surface restoration.[47] Once established, dental caries requires treatment. The longer a cavity remains untreated, the larger and more expensive it becomes to treat.[48] If decay progresses, it may be necessary to perform more costly dental work such as crowns, bridges, root canals, or extractions. The best approach is to use proven and cost-effective prevention methods, like fluoride and dental sealants to prevent decay.

Although much anecdotal testimony has been presented to the Board related to possible harm from sealant placement, all of the research presented on this issue supports the safety of dental sealants, even in cases where sealants are placed on teeth with incipient decay. The U.S. Department of Health and Human Services advocates using sealants on incipient lesions stating, "If incipient lesions are sealed instead of restored, the total cost of treatment is lower."[49] In fact, a retrospective study by Heller et al found that sealants were much more effective in preventing further caries on surfaces that had incipient lesions than initially sound surfaces.[50] The study by Heller compared a group of patients who received sealants with a group of patients who did not receive sealants. After 5 years in the study, molars that were initially found to be incipient became carious at a rate of 11 percent in sealed cases compared to a rate of 52 percent in nonsealed cases.

JA Weintraub reviewed multiple studies concerning the use of sealants in high-risk individuals. In her review of a 1991 study by Handelman that looked at the therapeutic use of sealants in cases of dental caries she found, "caries is inhibited and may in fact regress under intact sealants."[51] Weintraub goes on to state that a Diagnodent laser can be used to detect caries beneath an unfilled sealed surface to alleviate concerns regarding hidden caries. She also notes that in 1994 a federally funded workshop recommended, "based on the available evidence and consensus of workshop participants, that teeth with questionable caries or enamel caries be sealed in addition to caries-free teeth determined to be at-risk, and dentin caries be restored."[52]

As explained by Trost and Kaiser:

> *Bacteria can be trapped beneath a sealant, and inadvertent sealing of incipient primary decay can also occur. The ability of bacteria to survive beneath a dental sealant is substantially low because the ingested carbohydrates cannot penetrate the chewing surfaces of an intact sealant. Additionally, trapped bacteria can diminish over time. Even incipient decay that was intentionally left before sealant placement was shown radiographically not to progress. Sealants can then become a significant barrier—not only for the initial presentation of caries, but also for preventing further decay progression.*[53]

The FAQs section on dental sealants by the National Institutes of Dental and Craniofacial Research simplifies this best with the following question and answer: What if a small cavity is

accidentally covered by a sealant? The decay will not spread because it is sealed off from its food and germ supply."[54]

Additional research by Mertz-Fairhurst et al (1998),[55] Hassall et al (2001),[56] Adair (2003),[57] and others further supports these theories that placing a sealant over incipient decay reduces the number of microorganisms present and has no deleterious effect. [58]

The Board recognizes that isolated cases of poor tooth selection for sealant placement and improper sealant placement may happen. Board rules provide appropriate remedies to address cases of incompetent care. In fact, anecdotal testimony about problems seen in Iowa patients due to inappropriate sealants apply to situations in which teeth were first examined by a dentist, as required by current board rules. This illustrates the fact that even in the best of circumstances isolated problems will happen.

While some testimony provided to the Board argued that sealants should only be placed following radiographs of the teeth, school based sealant programs currently operate without the use of dental x-rays. Again, research presented to the Board supports the safety of sealant programs operating in this manner. Research shows that caries that is not clinically detectable or apparent will not progress even if it is inadvertently sealed in teeth.

Dental hygienists, operating under written protocols established by a dentist, can utilize their background and education in oral health to safely assess the appropriateness of sealants for patients in public health settings. They do so in at least 10 other states. Assessment tools are also available to further guide dental hygienists and dentists in developing written protocols for sealant selection and placement. The caries-risk assessment tool (CAT), utilized by dental hygienists working in public health settings and developed using research by the American Academy of Pediatric Dentistry, is one example of an assessment tool that can be incorporated into practice protocols to further guide decision-making.

Dental hygienists are authorized under Board rules to make oral health assessments. The Board's amendment simply extends their ability to apply dental sealants based on the results of the assessment and as further authorized by a dentist according to established written protocols. The Board acknowledges the need for patients to be fully informed that the services being provided by a dental hygienist do not constitute a dental exam nor do they substitute for a dental exam. The proposed amendment requires all patients to be notified of this fact in writing. The Board expects that consent forms for sealants will clearly communicate the need for a dental exam and regular check-ups. As added security, the proposed amendment limits the ability of the dental hygienist to provide certain services to patients who do not follow through by having a dental examination.

Oral and written testimony by Dr. Daniel Venker provides some of the most persuading arguments for allowing dental hygienists to provide sealants prior to a dental exam in public health settings. Dr. Venker is a 1983 graduate from the University of Iowa College of Dentistry who recently completed his Masters degree in dental public health and who completed his thesis research on the area of dental sealants. For the last six years he has also worked in the school-based dental sealant program for Des Moines schools.

According to Dr. Venker's testimony, "Licensed dental hygienists are able to do caries risk assessments and caries detection. Caries detection is part of their education and board examination experiences. Currently, in the sealant program, the dentist performs only a clinical assessment of the tooth structure. A hygienist performing the same clinical assessment, including caries risk assessment, can detect if there is active caries that necessitates the student seeing their regular dentist for definitive diagnosis. Even if enamel caries are sealed into the tooth and the child does not see their dentist for an examination, research supports that there is no harm done…When the public health hygienist is able to perform these assessments and seal the teeth, the time the dentist spends doing the sealants assessments can be better spent providing restorative care."[59]

Dr. Venker further stated that in the Des Moines sealant program the expertise of the dental hygienists, along with their prior education, "…put them in excellent clinical practice to assess students for active caries and making appropriate, timely referrals to the dentist for definitive diagnosis and treatment." [60]

Costs of the Amendments

The next section of this informal regulatory analysis will address costs associated with the Board's proposed amendment. A formal regulatory analysis requires a great deal of focus on the impact of proposed amendments on small business. In this case, such a focus is not appropriate because the Board's proposed amendment does not adversely impact small business and instead focuses on helping a particular class of persons access additional services.

Because the goal of the amendment is to help patients who currently lack access to care achieve greater access, it is also difficult to predict the cost of the amendment. In an ideal situation, all patients who currently lack access to oral health care would achieve greater access. In this respect, the goal of the amendment is to increase expenditures for preventive oral health services. However, the ability to achieve this ultimate goal is obviously hampered by the limitation that the proposed amendment only addresses barriers related to services that can be provided by a dental hygienist and does not directly increase access to restorative dental treatment, which can only be provided by a dentist.

It should also be noted that the proposed amendment will only work if there is consent on the part of both a dentist and a dental hygienist. Public health supervision is a voluntary arrangement: both the dentist and the dental hygienist must agree and comply with the specific requirements of the amendment. There are no specific mandated costs of compliance with the amendment because it is permissive arrangement, rather than an obligatory one.

In addition, the amendments do not change the fundamental concept that dental hygienists cannot work independently, nor can they establish their own business. They must work under the supervision of a licensed dentist. The proposal specifically requires that a dentist be involved in what they are doing, that they communicate and consult regularly, and work off detailed protocols. The amendments do not change the reimbursement structure for Medicaid or

hawk-i dental services. Dental hygienists are not eligible for provider numbers. Reimbursement for services provided by dental hygienists working in public health settings is done through their dental office or employing agencies, most likely Title V clinics.

Finally, it is extremely difficult to predict costs associated with an innovative approach. The Board has no baseline data to utilize or compare to estimate the impact of the proposed amendment. The Board has no way of predicting how widely public health supervision arrangements will be used. The lack of general support for the amendments by the Iowa Dental Association suggests that public health supervision agreements will not be widely utilized. At a minimum, the Board hopes that the 30 dental hygienists who now work in public health settings will be able to take advantage of the opportunities offered by the amendment. In addition, the Board hopes that at least some community health clinics that do not already have an oral health component will be able to add these services.

With these limitations in mind, the following cost data is provided:
There is no overall fiscal impact on dentists or dental hygienists. There may be some minimal costs incurred by certain licensees who agree to work under public health supervision. These costs are related to photocopying the supervision agreement, maintaining regular communication between the supervising dentist and hygienist, and filing a report with the Oral Health Bureau.

The proposed amendment may have some impact on expenditures by the Department of Human Services Medicaid program. Again, it is extremely difficult to predict costs related to the amendment without knowing how widespread use of the amendment will be. Attachment B is a copy of the fiscal impact statement prepared and filed at the time of the Notice of Intended Action. Again, it is difficult to know how accurate these estimates are. Given that there are only 30 dental hygienists working in public health settings, it is likely that a smaller range of estimates may actually be more realistic.

The true fiscal impact of the proposed amendments must be measured in long-term costs and benefits. It is more cost-effective to provide preventive dental services rather than more costly restorative services. As indicated by Eugene Gessow, Iowa's Medicaid Director, "[] the immediate fiscal impact must be evaluated in terms of the offset in savings from restorative dental services. Total estimated savings are impossible to predict."[61] Attachment C is a copy of the letter of support for the Board's amendment from the Department of Human Services.

For example, as discussed earlier, sealants are nearly 100 percent effective in preventing decay in the pit and fissures of molars where 90 percent of decay in children has been found to occur. Data provided by the Medicaid program shows that in fiscal year 2003, Medicaid paid just over $2 million dollars for restorations provided to 13,894 unique Medicaid recipients under 21 years of age. "Assuming that 90% of this expenditure was for restorations on molars, a total $1,869,819 could have been saved had these children received sealants."[62] In addition, it was noted that Medicaid paid over $650,000 to place crowns on the teeth of children that could not be restored with conventional fillings and over $900,000 to extract teeth in children 21 years of age. (ibid) Some of these costs may be saved if dental decay could be prevented in these children.

Exceptional savings can also be realized by preventing cases of early childhood caries. This disease can be prevented through early education and a change in feeding habits. Early intervention by a dental hygienist can help to decrease the rate of early childhood caries. One study found that to treat a single case of early childhood caries with hospital care resulted in an average expenditure of over $2,000.

More importantly, costs must also be assessed against the benefit patients who lack access to oral health care will receive. Poor oral health care contributes to lost school and work hours, patient pain and discomfort, early childhood caries, periodontal disease, which can lead to pre-term labor in pregnant women as well as heart disease and stroke, and other infections. Currently less than one-third of Medicaid recipients in Iowa are seen by a dentist.

States that have embraced a similar strategy of utilizing dental hygienists in a greater capacity in public health settings have shown positive results. For example, a change in the practice act in South Carolina allowed dental hygienists to begin providing cleanings, fluoride treatments, and sealants in South Carolina schools. In the six months that followed, licensed hygienists had screened over 19,000 children and provided cleanings, fluoride treatments, and other services to more than 4,000 children, including nearly 3,000 Medicaid-eligible children.[63]

Finally, cost estimates in the fiscal note have only considered the impact on Medicaid. Estimates have not been provided for how this proposal could affect *hawk-i* participants or other low-income recipients. Without baseline data for comparison, there is simply no way of knowing or predicting the impact of the Board's amendment on these programs. Again, as with the Medicaid program, the goal for all of these patients is to increase access to preventive services, which can result in a long-term savings on restorative dental needs.

Iowa Dental Association Comments

The next section of this regulatory analysis will briefly address each of the concerns and bullets raised by the Iowa Dental Association (IDA) in their memo to the Administrative Rules Review Committee requesting the regulatory analysis.

- *We are concerned that the shortage of dental allied staff, including dental hygienists could be exacerbated due to this proposal.*

There are currently 1,283 licensed dental hygienists working in Iowa. There are four community colleges that offer an Associate's Degree in Dental Hygiene: Des Moines Area Community College in Ankeny, Kirkwood Community College in Cedar Rapids, Hawkeye Community College in Waterloo and Iowa Western Community College in Council Bluffs. According to the Iowa Dental Hygienists' Association, these four schools graduate approximately 80 dental hygienists every year in Iowa and most of these graduates stay in Iowa to practice. The American Dental Hygienists Association also notes that there are more than 120,000 licensed dental hygienists in the U.S. compared to approximately 130,000 dentists. While the number of dental graduates declined by 23 percent from 1985-86 to 1995-96, the number of dental hygiene graduates increased 20 percent.[64]

Distribution data prepared by the Office of Statewide Clinical Education Programs at the University of Iowa on the location of Iowa's licensed dental hygienists shows that like dentists, dental hygienists are more concentrated in Iowa's urban areas. There are currently 10 counties in Iowa that lack dental hygienists: Adams (1 dentist), Audubon (2 dentists), Fremont (1 dentist), Ida (3 dentists), Lyon (4 dentists), Monroe (2 dentists), Palo Alto (2 dentists), Ringgold (1 dentist), Sac (3 dentists), and Worth County (1 dentist).[65] These counties correspond to geographic areas where there is also a low number of dentists.

At the present time, there are currently about 30 dental hygienists working under the general supervision of a dentist in public health settings. Only about 3 of these practitioners work full-time; the vast majority of dental hygienists in public health settings work part-time with the remainder of their work-week spent also working part-time in a private dental office. Dental hygienists are not eligible for provider numbers under the Board's proposed amendment. It is highly unlikely that without a significant change in the reimbursement structure for hygiene services that there would be an adverse affect on the distribution of dental hygienists. The most likely scenario is a slight increase in the number of dental hygienists performing some part-time public health work.

- *We wish to have the Board of Dental Examiners establish a baseline of information including the number of additional Iowans who will be served by this proposal.*

As discussed in the cost section of this analysis, because this is an innovative approach in Iowa, there is no way to establish a baseline of information regarding the number of additional Iowans who could be served by the proposal. A baseline of information cannot be established until the program has operated for at least one year. At that point, the only existing baseline of data that can be used to determine the impact of the proposed amendments is the number of Medicaid recipients who receive any dental services (currently 32.5 percent). Any increase in this percentage can be viewed as a positive development in the dental access crisis.

- *We are hopeful that the Board of Dental Examiners will clearly delineate more detailed information regarding the workings of this proposal.*

The proposed amendment in ARC 2783B provides detailed information regarding the specific requirements to operate under public health supervision. The location where services can be provided is specified and limited to public health settings. Dental hygienists are limited to providing services within their current scope of practice. The responsibilities of each licensee are clearly detailed in proposed rule 650—10.5(153). To achieve a baseline of data and assess the impact of the amendments, each dental hygienist operating under public health supervision must complete a summary report regarding the number of patients seen and services provided. The Board of Dental Examiners will be provided with summary reports on an annual basis.

To help ensure compliance with the rule requirements, the Board will also put a sample public health supervision agreement on its website. The sample agreement will be intended to serve as a general guide for licensees who want to ensure compliance with the rule. Specific practice protocols will not be provided in order to maintain flexibility for each licensee to determine the appropriateness of services based on their unique practice situation.

In fact one of the recurring themes in previous rulemaking comments received by the Iowa Dental Association is the desire of their membership to have flexibility in complying with the rules. The request by the IDA for additional details with respect to how and in what manner dentists would provide public health supervision is puzzling given their previous rulemaking comments which highlighted the need for flexibility.

For example, when commenting on previous rules related to expanded functions for dental assistants, the IDA stated, "Within the statutory limits adopted by the legislature, a dentist should be allowed to train and delegate activities to his/her allied personnel. The dentist is fully responsible and must be allowed to function as the professional that he/she has been educated and trained to be. Over time, without the capability to freely delegate within legislative limitations, the ability of Iowa dentists to continue to provide affordable oral health care will be significantly challenged."[66] In IDA's comments concerning temporary permits, the IDA suggested the Board eliminate a certain provision limiting the number of permits that could be issued, commenting, "The rational for limiting the flexibility of the Iowa Board of Dental Examiners is unclear and the IDA recommends deletion of this proposed limitation."[67] In other comments related to proposed amendments specifying training requirements for dental hygienists monitoring nitrous oxide inhalation analgesia, the IDA commented that they were supportive of the intent to "provide additional flexibility to the licensed dentists to care for their patients through use of allied personnel."[68]

The Board believes that this need for flexibility should extend to public health supervision. It would be inappropriate to mandate specific details that all dentists should follow regarding communication issues and practice protocols. Recognizing that all practitioners operate a little differently, licensees need to have some flexibility within the limits of the rules to adapt requirements to their particular practice situation. For example, concerning the requirement that the dentist and dental hygienist maintain regular communication with each other, it would be inappropriate to mandate a specific number of phone calls or visits because all licensees are different depending on their particular office situation – some may actually visit with the hygienist at a satellite office. In some public health clinics, dentists are on site at specific times. Some licensees may want frequent telephone contact.

Likewise, the Board should not mandate specific protocols for services because dentists need to have flexibility depending on their practice situation. Some dentists, for example, may not want to authorize the placement of sealants by a dental hygienist prior to a dental exam. Other dentists will have different philosophies on caries placement over incipient decay or based on the results of a caries-risk assessment. Recognizing that there is not a single standard that will be appropriate for all public health situations, the Board has placed responsibility for writing protocols with each licensed dentist so that they can respond to the needs of the patients, the education, background, and training of the dental hygienist involved, and their own practice protocols regarding certain services.

- *We expect that the Board of Dental Examiners will clearly establish that the public health is being protected without a dentist exam as contemplated by this proposal.*

The proposed amendments require a number of protections that will help to ensure the public health is being protected under public health supervision:

- A dentist must write detailed protocols for a dental hygienist to follow when providing services.
- Protocols must be age and procedure specific.
- Protocols must address medically compromised patients and dental conditions for which no care can be provided prior to a dental evaluation.
- The dentist and dental hygienist must maintain contact and communication with each other.
- Protocols mandate that if a patient has not been examined by a dentist within 12 months, no additional services beyond education, assessment, and screening can be provided.
- In addition to the education, training, and examinations required for licensure in Iowa, dental hygienists working under public health supervision must have at least three years of clinical practice experience.
- Each patient will be informed that the hygiene services provided do not take the place of a dental exam and must sign a consent form.
- Each patient is provided with a written plan for referral to dentist and assessment of further dental treatment needs.
- Procedures for creating and maintaining dental records must be indicated in the supervision agreement.

- *We wish to know the Board of Dental Examiners' expectation regarding success indicators such as the projected number of dental hygienists and dentists involved in this program after one year, 3 years, and 5 years.*

Without a baseline of data for comparison, it is difficult to predict success indicators for the program. Even a program with limited participation by dentists and dental hygienists will be beneficial to the patients who are able to access oral health services. An increase of one new school-based sealant program would be a success in terms of the number of potential caries prevented in those children. At a minimum, the Board would like to see the following participation rates:

- 1 year success indicators: 10 hygienists working under public health supervision
- 3 year success indicators: 30 hygienists working under public health supervision
- 5 year success indicators: 40 hygienists working under public health supervision

These numbers are intentionally low because there is no way to predict the impact of the proposed amendment. Even if only a small population base is served – *some* prevention to *some* patients who do not otherwise have access to care will help with the overall dental access problem in Iowa.

- *We hope to establish on what basis dental hygienists would apply sealants without the advantage of a dentist's exam, diagnosis, and treatment plan.*

See pages 17 to 20 for a detailed discussion of the sealant issue. To summarize these findings:

- Research provided to the Board supports the safety of sealants, even in cases of incipient decay.
- Sealants will be applied on the basis of a dental hygiene assessment, following age specific protocols written by a dentist to further guide the decision making process.

Alternatives

In their denial of the first petition for rulemaking filed on this issue, the Board stated, "..The main access problem in the state right now appears to be getting dentists involved in providing diagnostic, restorative, and other treatment needs in these underserved areas. Finding a dental home for patients is another significant problem…Overall, the Board believes that the main access problem in Iowa and in other states is how to get more dentists involved in providing care in shortage areas and to underserved populations."[69] The Board still believes these statements accurately reflect the problems faced in Iowa. While the Board now believes, however, that an appropriate alternative may be to allow dental hygienists to provide preventive services, the Board acknowledges there are other alternatives that would do a better job of combating the lack of access to oral health services. However, the vast majority of these alternatives will require on-going and substantial commitments of public funds to achieve success.

The first alternative is to simply do nothing. Inaction will continue to perpetuate the oral health crisis, particularly for Iowa's most vulnerable population group: people of lower socioeconomic status. In this regard, there will continue to be a high unmet need for dental services and a need to perform more costly restorative treatment because prevention needs were not met.

The problem of dental access has been studied and debated in Iowa for a number of years. The most recent efforts in Iowa include a 1996 study, supported in part by the Department of Human Services, which assessed utilization of Medicaid dental services, dentists' attitudes about participation, and provided program recommendations. In 1997, the Iowa Dental Association also issued a report identifying reasons for nonparticipation by dentists in Iowa's Medicaid program. From 1997 to 2000, a Special Committee on Access to Dental Care, formed by the Iowa Department of Public Health (IDPH), met to discuss barriers to access to care and develop specific recommendations to improve access. From 2001 to April 2003, the Director's Dental Advisory Committee of IDPH performed this function. In January 2000 and April 2002, statewide dental summits were held. The departments of Public Health and Human Services have also worked collaboratively for several years in attempts to remedy the access problem.

Although efforts to identify and eliminate barriers to dental access have been on-going for many years, little progress has been made. A brief summary of the various recommendations to improve dental access that have been suggested by these various committees is presented below.

Medicaid reimbursement rates for dental care need to be increased. According to the General Accounting Office, low reimbursement is the number one factor contributing to a low provider participation rate in the Medicaid program. Although attempts to increase the rate in Iowa were made in July 2000, subsequent budget cuts and inflation have returned reimbursement levels to previous low levels. Increasing the reimbursement rates will require a substantial investment of budget funds by the state legislature.

With respect to the barrier concerning the perceived administrative burden in filing Medicaid claims, more can be done to communicate with providers regarding improvements in the process and further improvements could be studied. DHS reports that improvements have been made in the last few years in an attempt to reduce administrative requirements. Medicaid provider enrollment forms for dentists have been simplified to one double-sided page. Electronic billing and claims submission were adopted in 1997. Staff members of Medicaid's fiscal agent, ACS, are available by telephone to assist dental offices with policy, claims, and beneficiary eligibility information during the work week. An automated patient eligibility verification system is available 24 hours a day by toll-free telephone and field representatives are available to make on-site visits to dental offices to provide assistance on claim filing and other problems. The ADA's CDT dental codes and claim forms were adopted in 1998, updated to CDT-3 in 2000 and CDT-4 in 2003. In addition, the dental provider manual fee schedules may be viewed on the Internet.[70]

A large part of this problem may simply be provider perceptions. Data provided by the DHS actually shows that compared to other health providers, dentists have one of the lowest percentages of denied claims submitted to Medicaid. During fiscal year 2003, the Medicaid claims adjudication data shows that 12.69 percent of dental claims were denied. This rate compares to the total denied claims for all health professions of 19 percent.[71]

Although the processing time for dental claims is high compared to the other health professions, overall the rate is still relatively low – about 12 days. Data from other insurance companies was not available to compare processing rates between Medicaid and other insurance companies. However, 12 days does not seem excessive. It is also worth noting that dentists have the lowest rate of electronic billing compared to the other Medicaid providers. Only about 31 percent of dental claims were filed electronically. The rate of electronic dental claims is at least one-third lower than other health providers. The data provided showed that with only one exception, higher rates of electronic claims submission reduced the processing time of submitted claims.[72]

Alternatives that should be considered include further exploring ways to streamline the administrative process of filing claims, exploring ways to increase electronic submission of claims by dentists, and simply communicating program improvements to dentists. Perceptions of administrative requirements seem to have an important influence on the willingness of dentists to participate in Medicaid. More can be done to educate providers about improvements and try to change these negative perceptions.

Other alternatives to improve dental access that have been suggested by various groups, committees, and reports include the following:

- Expand the loan repayment program for dentists and dental hygienists. The Iowa Department of Public Health operates the Primary Care Recruitment and Retention Endeavor (PRIMECARRE) that currently supports the Iowa Loan Repayment Program, with matching federal and state funds. The Loan Repayment Program provides up to $20,000 per year for dentists and $15,000 per year for hygienists who agree to a two-year commitment to practice in a public or non-profit clinic in a dental shortage area.[73] The National Health Service Corps operates a similar federal program. However, both

programs have been hampered by a lack of available funds and a lack of dental applicants.[74]

- Consider "carving out" the dental insurance component of Medicaid and *hawk-i* to an established insurance company in Iowa. This would provide instant access to a very broad network of dentists for all Medicaid enrollees. According to the Dental Advisory Committee, this model is being successfully demonstrated in Michigan and appears to be one of the few successful models for improving access to care for Medicaid enrollees.
- Support legislation to give tax relief to dentists who provide services to Medicaid patients.
- Increase funding to further expand the school-based sealant programs.

Conclusion

The dental access problem has been debated and studied in Iowa and across the nation for many years, with little or no progress in the state of Iowa. Financial barriers seem to be a major limitation – most attempts to resolve the problem will require a substantial on-going commitment of public funds. With the difficult financial situation faced by the state legislature, there is only limited opportunity to fight the dental access problem using approaches that do not require a major commitment of public funds. Many states are seeking innovative approaches to combat dental access, like expanding the role of dental hygienists through public health supervision.

The Board's proposed amendment in ARC 2783B would allow a dentist to provide public health supervision to a dental hygienist who is operating within the scope of practice of dental hygiene in specified public health settings. This Board's proposed amendment was the result of one year of study and debate on this issue. The current amendment represents a compromise of previous rulemaking attempts. The Board's current proposal addresses many of the major concerns previously expressed by the Iowa Dental Association and their members. The Board tried, without success, to have the Iowa Dental Association and Iowa Dental Hygienist's Association resolve more specific concerns to their mutual satisfaction. When those attempts failed, the Board worked to develop a compromise proposal that ensured sufficient patient protections were established while facilitating access to preventive dental services in public health settings.

The Board acknowledges that its proposed amendment has a limited ability to address the dental access problem. However, the Board feels that its proposed amendment does address important barriers to access. By focusing on providing preventive services, access issues will be tackled by trying to reduce the need for more costly restorative dental treatment. The board's rules cannot address the real needs of patients—to find dental providers who are willing to accept new Medicaid patients and attend to their restorative treatment needs. Combating this problem will require action and commitment from the Iowa legislature. Given current budget realities, the Board's approach is a relatively low-cost method of removing some regulatory barriers to positively impact the ability of patients who do not otherwise have access to care to receive preventive oral health services.

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Attachment A: Iowa Dental Health Shortage Designations

Dental Health Care

1) Geographic Area - HPSA with a population to provider ratio of 5,000:1;
2) Special Population Group - HPSA measured by using the income rates of population below 200 percent of poverty and the physicians that participate in the Medicaid program. The ratio must be 4,000:1.

NOTE: Other qualifiers that may be used for eligibility for National Health Service Corps assignment are 50 percent non-fluoridated public water, population below 100 percent of poverty, and distance to the nearest source of care outside the designated area.

Dental Health Care Designations:
There are 73 counties with Dental Health Care designations. 72 are whole county; *1 is a census tract Low-Income Population designation.

01 - Adair	26 - Davis	53 - Jones	78 - Pottawattamie
02 - Adams	27 - Decatur	54 - Keokuk	79 - Poweshiek
03 - Allamakee	28 - Delaware	55 - Kossuth	80 - Ringgold
04 - Appanoose	29 - Des Moines	56 - Lee	81 - Sac
06 - Benton	32 - Emmet	58 - Louisa	82 - Scott
08 - Boone	33 - Fayette	60 - Lyon	83 - Shelby
10 - Buchanan	35 - Franklin	61 - Madison	84 - Sioux
11 - Buena Vista	37 - Greene	62 - Mahaska	86 - Tama
12 - Butler	39 - Guthrie	65 - Mills	87 - Taylor
13 - Calhoun	40 - Hamilton	67 - Monona	88 - Union
15 - Cass	42 - Hardin	69 - Montgomery	89 - Van Buren
16 - Cedar	43 - Harrison	71 - O'Brien	90 - Wapello
18 - Cherokee	44 - Henry	72 - Osceola	92 - Washington
20 - Clarke	45 - Howard	73 - Page	94 - Webster
21 - Clay	46 - Humboldt	74 - Palo Alto	95 - Winnebago
22 - Clayton	47 - Ida	75 - Plymouth	96 - Winneshiek
23 - Clinton	49 - Jackson	76 - Pocahontas	97 - Woodbury
24 - Crawford	51 - Jefferson	*77 - Polk	98 - Worth
			99 - Wright

Source: Iowa Department of Public Health, available at:
http://www.idph.state.ia.us/ch/health_care_access_content/rhpc/dental.htm

Attachment B: Administrative Rule Fiscal Impact Statement

Date: 08/29/2003

Agency: Board of Dental Examiners
IAC Citation: 650—10.5(153) – proposed new rule
Agency Contact: Jennifer Hart 1-0997

Summary of the Rule: Adopts new definition of public health supervision and allows performance of dental hygiene services prior to a dental exam in certain public health settings.

Fill in this box if the impact meets these criteria:

___ No Fiscal Impact to the State.
___ Fiscal Impact of less than $100,000 annually or $500,000 over 5 years.
___ Fiscal Impact cannot be determined.

Brief Explanation:

Fill in the form below if the impact does not fit the criteria above:

_x__ Fiscal Impact of $100,000 annually or $500,000 over 5 years.

* Fill in the rest of the Fiscal Impact Statement form.

Assumptions:

1. There is no way to estimate the impact to local public health programs and to clients who are not Medicaid-eligible, but do not have dental insurance or cannot otherwise access dental services in a private office. The number of these low income clients is unknown. Fiscal impact is provided only for Medicaid clients.
2. Preventive services are cheaper than restorative services, however, it is impossible to estimate the savings realized by preventing future restorative dental needs. For example, sealants may result in caries reduction. It costs Medicaid 19.40 per tooth for a sealant. A one-surface amalgam restoration is reimbursed at $43.65, up to $63.05 for four surfaces.
3. Only about 35% of Medicaid patients currently see a dentist. There were 120,717 Medicaid recipients for which a claim for dental services was paid during FY2003, out of 339,343 total Medicaid eligibles. Of these 172,958 were children and 71,019 were adults (excluding aged and disabled).
4. The proposed rules will not impact the aged Medicaid eligibles (36,872), as there are not currently public health programs operating in nursing homes, or the disabled group (58,494).
5. The rules will only impact hygiene services. It is unknown how many more clients will receive hygiene services and how many successful referrals for dental exams and treatment will result. A modest increase of between a 5 and 10 percent increase in clients for hygiene services is provided. Due to the limited number of hygienists currently providing services in public health settings (about 30), the smaller number of the range may be more realistic.
6. The services that will be impacted include screening assessments for adults and children [Medicaid reimbursement rate $13.19]; oral prophylaxis for adults [rate $33.95] and children [rate $23.28]; fluoride for children [$11.54], and sealants for children [$19.40 per tooth].
7. One screening and one prophy is assumed for each new adult client. One screening, one fluoride application, and one prophy is assumed for each child. It is unknown how many children already have sealants. However, FY2003 data from the Dept. of Public Health school based sealant program, shows that approximately 79% of children examined will need an average of 4.5 sealants placed on their primary teeth. This same rate of sealant placement in children will be assumed.
8. The number of Medicaid eligibles has grown every year. A 5% growth rate in eligibles is assumed.
9. All figures will be rounded to the nearest whole number.
10. The state/federal matching percentage for FY2003 was 63.34% federal funds to 36.66% state funds.
11. The rule will be effective January 1, 2004.

Describe how estimates were derived:

1. (Number of new clients with 5% increase) 172,958x.05 = 8,648 children; 71,019 x .05 = 3,551 adults
   (10% increase) 172,958x.05= 17,296 children; 71,019x.1= 7,102 adults
2. Adult services $13.19+33.95=$47.14 per adult x 3,551 = $167,394 with 5% increase
   Adult services $47.14 x 7,102 = $334,788 with 10% increase
3. Child services $13.19+23.28+11.54=$48.01 per child x 8,648 = $415,190 with 5% increase
   Child services $48.01 x 17,296 = $830,380 with 10% increase
4. Sealants for children – 8,648 x 79% = 6,832 children needing sealants with 5% increase;
   17,296 x 79% = 13,664 children needing sealants with 10% increase
5. Sealants placed $19.40/tooth x 4.5 sealants x 6,832 children=$596,434 sealant cost with 5% increase
   Sealants placed $19.40/tooth x 4.5 sealants x 13,664 children = $1,192,867 sealant cost with 10% inc.
6. Total costs year 1: $167,394+415,190+596,434= $1,179,018 with 5% increase
   Total costs year 1: $334,788+830,380+1,192,867= $2,358,035 with 10% increase
7. State share $1,179,018x36.66% = $432,228; fed share $746,790 with 5% increase
   State share $2,358,035x36.66% = $864,456; fed share $1,493,579 with 10% increase
8. Impact for FY2004 – divide figure above by half to determine impact for 6 months in FY2004.
   (432,228x.5=216,114 state; fed 746,790x.5=373,395 – 5% increase)
   (864,456x.5=432,228 state; fed 1,493,579x.5=746,790 – 10% increase)

9. Year 2 – assume additional 5% increase in Medicaid eligibles for adults and children
10. Costs of additional adult services: $167,394 x 1.05 = $175,764 to [334,788x1.05] $351,572
11. Costs of additional child services: $415,190 x 1.05 = $435,950 to [830,380x1.05] $871,899
12. Costs of additional sealants: $596,434 x 1.05 = $626,256 to [1,192,867x1.05] $1,252,510
13. Total costs year 2: 167,394+415,190+626,256= $1,237,970 to 2,475,981
14. Total state share year 2: $1,237,970 x 36.66% = 4453,840 to $907,695

Estimated Impact to the State by Fiscal Year

	Year 1 (FY 2004)	Year 2 (FY2005)
Revenue by Each Source:		
GENERAL FUND	0	0
FEDERAL FUNDS	0	0
Other (specify)	0	
TOTAL REVENUE	0	0
Expenditures:		
GENERAL FUND	216,114 to 432,228	453,840 - 907,695
FEDERAL FUNDS	373,395 to 746,790	784,130-1,568,286
Other (specify)		
TOTAL EXPENDITURES	589,509 - 1,179,018	1,237,970 to 2,475,981
NET IMPACT	($589,509 to $1,179,018)	($1,237,970 to $2,275,981)

___ This rule is required by State law or Federal mandate.
Please identify the state or federal law:

___ Funding has been provided for the rule change.
Please identify the amount provided and the funding source:

_x_ Funding has not been provided for the rule.
Please explain how the agency will pay for the rule change:
Medicaid funds are derived from a combination of federal and state funds.

Fiscal impact to persons affected by the rule:

The rule allows hygienists working in certain public health settings who have a supervisory agreement with a dentist to provide certain hygiene services prior to a dental exam. This will potentially increase access to services by both Medicaid eligible clients and other low income persons. This can increase access to preventive services in public health settings.

Fiscal impact to Counties or other Local Governments (required by Iowa Code 25B.6):
No impact

* If additional explanation is needed, please attach extra pages.

Agency Representative preparing estimate: Jennifer Hart
Telephone Number: 1-0997

ST. LUKE'S HOSPITAL
IOWA HEALTH SYSTEM

RECEIVED
JUN 3 0 2004
IOWA BOARD OF
DENTAL EXAMINERS

DENTAL HEALTH CENTER
MEDICAL PLAZA BLDG.
SUITE LL 1
855 A AVENUE NE
CEDAR RAPIDS, IA 52402
319 / 369-7730
FAX: 319 / 369-7494

June 25, 2004

Iowa Department of Public Health
Oral Health Bureau, 5th Floor
Attn: Public Health Supervision
321 E 12th St
Des Moines, IA 50319-0075

Dear Oral Health Bureau:

Our three public health dental hygienists have completed their Public Health Supervision Agreements.

Please take note that one agreement is 27 pages, another is 20 pages and the third is 10 pages. This was 57 pages of reporting, plus another 57 pages of copies for our dental public health program in East Central Iowa.

The process required considerable staff time. If this is an annual report, you must consider revising and limiting the agreement and reporting forms.

Sincerely,

Rhys B. Jones DDS

Rhys B. Jones, DDS, MS
Director, Dental Health Center

Cc: Iowa Board of Dental Examiners

RBJ/pb

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

IOWA BOARD OF DENTAL EXAMINERS
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

Memo

From: Iowa Board of Dental Examiners

Date: October 2006

RE: Public Health Supervision – Providing Access to Oral Health Care

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As you know, access to oral health care is a critical need for the citizens in the state of Iowa. Seventy-two counties in Iowa are designated as dental health professional shortage areas. Public health supervision agreements are one of the innovative ways that the Iowa Department of Public Health and the Board of Dental Examiners are working together to create opportunities to improve the health of Iowans and increase access to oral health care services. Public health supervision agreements allow dental hygienists, working under a written supervision agreement with a dentist, to provide hygiene services to a patient in a public health setting, prior to the patient seeing a dentist for an exam.

The Oral Health Bureau of the Iowa Department of Public Health is responsible for collecting data concerning the services provided by dental hygienists working under public health supervision. The bureau has compiled data from calendar year 2005 showing the amount of services provided under public health supervision. The bureau provides a summary report to the board on an annual basis. A copy of this report is attached. The report shows that there were over 17,000 sealants provided under public health supervision last year. Almost 19,000 assessment/screenings were completed and over 6,000 people received fluoride varnish. Over 6,300 children received referrals to dentists during the year, with over 1,600 of those children needing urgent care. There were about 600 adult referrals and over 90 of those were for urgent care needs.

The report demonstrates that just a few licensees can make a tremendous difference in the oral health care of Iowans. The Board of Dental Examiners would like to draw your attention to the success of this program and ask for your support of public health supervision as an innovative way to increase access to oral health care services in Iowa.

400 SW 8th STREET, SUITE D, DES MOINES, IA 50309-4687
PHONE:515-281-5157 FAX:515-281-7969 http://www.state.ia.us/dentalboard

Iowa Dental Hygienists' Association

October 15, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo;

This letter constitutes a petition to the Iowa Dental Board, pursuant to Administrative Rule 650-7.1, requesting an amendment to the current administrative rule regarding licensee responsibilities as part of public health supervision of dental hygienists, Administrative Rule 650-10.5(3). Paragraph (a)(3) of this rule requires a dentist to "(s)pecify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement." The proposed amendment would strike this requirement and replace it with a requirement on dental hygienists in paragraph (b) that the dental hygienist refer to a dentist each patient who receives treatment.

This proposed amendment is being submitted for the following reasons: (1) it will remove a barrier to preventive dental services and (2) it would make Iowa's law regarding access to public health services more consistent with other states. As the Dental Board is aware, the public health supervision program for dental hygienists has been very successful in expanding access to quality dental care to Iowans, especially low-income families. According to statistics collected by the Iowa Department of Public Health, nearly 19,000 patients were served by this program in 2005, and by 2007, that figure had grown to nearly 35,000, almost a 100% increase. The number of hygienists providing services in public health settings has also grown, from 21 in 2005 to 56 in 2007; the number of dentists participating in this program has also grown significantly.

Removing a barrier to Preventive Dental Services

However, the current requirement that patients participating by this program be examined by a dentist within no longer than twelve months after receiving treatment serves as a significant barrier to patients receiving the continued benefit of this program. Hygienists

practicing in a public health setting have experienced significant difficulty in determining whether this requirement has been met as they do not provide the examination. Additionally, at a recent dental summit, two school based sealant programs expressed concern that children who would benefit from additional sealants would be denied due to the annual exam requirement. For example, children receiving sealants as a 2nd grader prior to all teeth fully erupting are now ready in third grade have the rest of the teeth sealed, but lacking proof of exam, are not eligible to receive preventive services.

Sealant programs have addressed this by rotating dentists annually to differ sites so all would have an exam at least once a year. However this rotational system does not always work due to the child being absent during the time the dentist was examining or changing schools to a site where the dentist is not in the rotation to perform exams.

Consistency with Laws in other States

Iowa's dental examination requirement is not consistent with laws in other states regarding direct access to dental hygiene services. According to the American Dental Hygiene Association, twenty-eight states, including Iowa, allow for some sort of direct access to hygiene services. Among those twenty-eight states, Iowa currently is one of only five states which place a limit on continuation of preventive services. In contrast, six other states, including Maine, Montana, New Mexico, Oregon, Rhode Island, and Washington, have a referral requirement such as is being proposed in this petition.

At an oral health summit hosted earlier this year by the Iowa Public Health Association, the current exam requirement was identified as a major barrier to access to oral health preventive services, and there was strong support at this summit to replace this requirement with a referral requirement similar to what is proposed in this petition. Additionally, the Oral Health Bureau of the Iowa Department of Public Health has included this change in their policy recommendations for this year. This change is supported, as well, by the Iowa Prevention of Disabilities Council.

As President of the Iowa Dental Hygienists Association, I appreciate the board's consideration of this petition.

Sincerely,

Carol Van Aernam

Carol Van Aernam, President
Iowa Dental Hygienists Association

Hart, Jennifer [IBDE]

From: TOM COPE [tomwcope@msn.com]
Sent: Wednesday, October 22, 2008 8:53 AM
To: Hart, Jennifer [IBDE]
Subject: IDHA petition for Nov. 28 DH Committee meeting
Attachments: direct_access summary.pdf; Oral Health Bureau 1.jpg

Jennifer-

Later this morning, Carol Van Aernam, President of IDHA, will be faxing to you a petition to the DH Committee requesting a change in IDB rules as it relates to public health supervision of DHs. As we have discussed, IDHA would like to initiate consideration of this petition at the Nov. 28 meeting of the DH committee. In addition to Carol's petition, I am attaching a couple of documents that we request be sent to the members of the DH Committee:
(1) A summary compiled by the ADHA of various state laws/rules regarding direct access to patients for DHs
(2) A copy of IDPH's Oral Health Bureau's current policy recommendations--policy change #3 is consistent with Carol's petition.

I will give you a call this morning to discuss this.

Thanks!

Tom

Tom Cope
Avenson, Oakley & Cope
8532 Newbury Court
Johnston, IA 50131
515-278-7074-home
515-975-4590-mobile
tomwcope@msn.com

IOWA DEPARTMENT OF PUBLIC HEALTH - ORAL HEALTH BUREAU UPDATE
Tracy Rodgers, Community Health Consultant

I-Smile

Funding from DHS increased this year for the 23 Title V child health contracts. Agencies will receive $1,716,432 for SFY2009. The funding is distributed based on size of service area and Medicaid-enrolled children. Refer to the attachment for examples of activities provided by I-Smile coordinators.

OHB staff is working with Iowa Medicaid Enterprise to evaluate I-Smile. Specific data queries have been requested to review efficacy and impact. Dolores Malvitz, an epidemiologist formerly with CDC, is providing guidance to OHB on the evaluation measures.

School Dental Screening Requirement

This is the first school year that Iowa children are required to have proof of a dental screening prior to enrolling in kindergarten and ninth grade. Information and forms are available on the IDPH Website, trainings are being held, and there has been quite a bit of media coverage.

Local boards of health are responsible for audits – and I-Smile Coordinators are expected to coordinate systems within their service regions to assure completion of audits, reporting to boards of health, and reporting to IDPH. I-Smile Coordinators will also be integral in assisting families in having screenings completed.

Oral Health Bureau Codification

The administrative rules written to codify the Oral Health Bureau have been suspended. The Iowa Dental Association protested the definition of a dental home as written within the rules. The IDA opposes the inclusion of "nondental public and private health care professionals" in the definition. The legislature's Administrative Rules Review Committee agreed to suspend adoption of the rules, asking the IDPH and IDA to come to an agreement on the definition of a dental home.

Oral Health Policy Recommendations

1. Increase funding for the I-Smile dental home project to expand the dental workforce and increase preventive services for underserved children; to double Medicaid's preventive reimbursement for eligible providers; to allow physicians and primary care providers to bill for dental screenings outside of the EPSDT bundled well-child exam rate; and to improve Medicaid dental reimbursement rates or use a 3rd party billing system
2. Reinstate a 4-year bachelor's degree dental hygiene program in Iowa with public health service emphasis
3. Seek rules change by Iowa Dental Board for public health supervision to allow a dental hygienist to refer a patient to see a dentist, but not limit continued treatment if dental visit had not occurred within one year
4. Integrate oral health planning into the medical home initiative

DIRECT ACCESS STATES

For purposes of this document, direct access means that the dental hygienist can initiate treatment based on his or her assessment of patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and can maintain a provider-patient relationship.

Alaska 2008

AS 08.32.115

May provide services according to terms of collaborative agreement. No limit on settings. Dentist need not examine, diagnose, or be present.

Special requirements: 4,000 hours experience last 5 years. Board must approve collaborative agreement.

Services: Virtually entire scope of dental hygiene services, as long as agreement provides for them.

Arizona 2006

32-1289B

Dental hygienist working under contract for schools, public health settings and institutions may screen and apply fluoride unsupervised.

Arizona 2004

Sec. 32-1281 H, 3212-89

A dental hygienist with a written affiliated practice agreement with a dentist may assess for and perform dental hygiene services on patients under 18 years who meet certain financial criteria and are enrolled in a federal, state, county or local healthcare program

Special requirements: 5 years practice

Services: Any dental hygiene services specified in the affiliated practice agreement except root planing, local anesthesia, nitrous oxide or placing sutures.

- **Direct Medicaid reimbursement allowed.**

California 2002

Sec 1763 (a) 2002

Any dental hygienist may provide screening, apply fluorides and sealants without supervision in government created or administered public health programs.

California 1998

Sec. 1774, 1775

Dental hygienists endorsed as RDHAPs (registered dental hygienist in alternative practice) may provide services without supervision for homebound persons or at schools, residential facilities, institutions and in dental health professional shortage areas for up to 18 months, and provide further services if the patient obtains a prescription from a dentist or physician. RDHAP'S may own an alternative dental hygiene practice. Currently, there are more than 100 RDHAP's.

Special Requirements: Bachelors degree equivalent, 3 years clinical practice, completion of 150 clock hour special course and exam.
Services: Those services permitted under general supervision (which include oral prophylaxis, root planing, pit and fissure sealants, charting and examination of soft tissue).

- **In 2008, more than 200 RDHAP's registered.**
- **A dental hygienist mobile practice treats 25-35 disabled patients per week.**
- **Direct Medicaid reimbursement allowed.**

Colorado 1987

Sec. 12-35-122.5

Unsupervised practice in all settings for all licensed dental hygienists for the oral prophylaxis and preventive and therapeutic services. The dental hygienist may also own a dental hygiene practice.

Special Requirements: None.

Services: remove deposits, accretions, and stains, curettage without anesthesia, apply fluorides and other recognized preventive agents, oral inspection and charting, topical anesthetic. However, x-rays require general supervision and local anesthesia requires direct supervision.

- **Direct Medicaid reimbursement allowed. In fiscal year 2003-04, 16 independent RDH's provided 199,518 in services to 2,284 Medicaid children.**

Connecticut 1999

Section 20-126l

Dental hygienists with 2 years experience may practice without supervision in institutions, public health facilities, group homes and schools.

Special Requirements: 2 years experience.

Services: Oral prophylaxis, remove deposits, accretions and stains, root planning, sealants, assessment, and treatment planning.

- **Since 7/1/2003 hygienists have program has provided over 55,000 dental procedures – nearly 7,000 prophys/fluorides, 5,800 sealants and 15,000 exams.**
- **Direct Medicaid reimbursement allowed.**

Idaho 2004

I.C. 54-903 (9) / 54-904

Can provide services in hospitals, long term care facility, public health facility, health or migrant clinic or other board approved setting if dentist affiliated with setting authorizes services.

Special requirements: RDH must be an employee of the facility or obtain extended care permit. ECP requires 1,000 hours experience in last 2 years.

Services: As determined by authorizing dentist.

Iowa 2004

Rule 650-10.5 (153)

Dental hygienists may provide services based on standing orders and a written agreement with a dentist in schools, Head Start settings, FQHCs (Federally Qualified Health Centers), public health vans, free clinics, community centers and public health programs.
Special Requirements: RDH must have 3 years clinical experience and submit annual report on number of patients/services to department of health.

Services: All dental hygiene services (except local anesthesia and nitrous) may be provided once to each patient. To perform repeat services other than assessment, screening and fluoride, dentist must examine.

- **Active Public Health Supervision agreements in place between Iowa dentists and dental hygienists.**
- **Services in 2005: 17,332 clients received sealants, 18,942 received screenings, 6,098 received fluoride applications, over 281 received prophys, and 7,157 received education.**
- **As of 2007, 24 public health RDHs.**

Kansas 2003

Sec. 65-1456

Dental hygienist with an extended care permit I or II to treat patients in schools, head start programs, state correctional institutions, local health departments, indigent care clinics, adult care homes, hospital long term units, or at the home of homebound persons on medical assistance. No prior authorization is needed, but the hygienist must have an agreement with a sponsoring dentist who will monitor his/her practice.

Special requirements: 1,800 hours experience

Services: prophylaxis, application of fluoride, dental hygiene instruction, assessment of the patient's need for further treatment by a dentist and other services if delegated by the sponsoring dentist

- **As of 2007, there were 76 extended care permit dental hygienists.**

Maine 2008

Sec. B-1. 32 MRSA c. 16, sub-c. 3-B

A dental hygienist licensed as an independent practice dental hygienist may practice without supervision by a dentist in all settings.

Special Requirements: Possess a bachelor's degree from a CODA accredited dental hygiene program and 2,000 work hours of clinical practice in a private dental practice during the two years preceding the application or possess an associate degree from a CODA accredited dental hygiene program and 6,000 work hours of clinical practice in a private dental practice during the six years preceding the application. They are also required to provide a referral plan to patients in need of additional care by a dentist.

Services: Interview patients and record complete medical and dental histories; take and record the vital signs of blood pressure, pulse and temperature; perform oral inspections, recording all conditions that should be called to the attention of a dentist; perform complete periodontal and dental restorative charting; perform all procedures necessary for a complete prophylaxis, including root planing; apply fluoride to control caries; apply desensitizing agents to teeth; apply topical anesthetics; apply sealants; smooth and polish amalgam restorations, limited to slow speed application only; cement pontics and facings outside the mouth; take impressions for athletic mouth guards and custom fluoride trays; place and remove rubber dams; place temporary restorations in compliance with the protocol adopted by the board; and apply topical antimicrobials, excluding antibiotics, including fluoride, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The independent practice dental hygienist shall follow current manufacturer's instructions in the use of these medicaments.

Maine 2001
Rule 02 313 Chap. 1. Sec. 4
A dental hygienist may practice in a public or private school, hospital or other non-traditional practice setting under a public health supervision status granted by the dental board on a case-by-case basis. The hygienist may perform all services rendered under general supervision. The dentist should have specific standing orders and procedures to be carried out, although the dentist need not be present when the services have been provided. A written plan for referral or an agreement for follow-up shall be provided by the public health hygienist recording all conditions that should be called to the attention of the dentist. The supervising dentist shall review a summary report at the completion of the program or once a year.

Special Requirements: A dental hygienist must apply to the board to practice providing such information the board deems necessary. The board must take into consideration whether the program will fulfill an unmet need, whether a supervising dentist is available and that the appropriate public health guidelines and standards of care can be met and followed.

Services: All services that can be provided under general supervision. Dentist's diagnosis for sealants not needed in public health or school sealant programs.

- **From 3/02 through 10/04, over 5,500 patients were provided care in over 400 clinics. Nearly 30 dental hygienists are involved in this particular program.**
- **Direct Medicaid reimbursement allowed.**

Michigan 1991
Sec. 333.16625
A dental hygienist may administer dental hygiene services for a 2 year period to patients not assigned by a dental through a department of community Health designed "grantee health agency. Grantee health agencies must be a public or nonprofit entity, school, or nursing home that employs or contacts with at least one dentist or dental hygienist and provides care to an underserved population.

Special requirements: Entities seeking a grantee health agency status must submit a comprehensive form outlining how the program will be carried out, providing for oversight and direction, and including information for all dental personnel involved. A dental hygienist operating as a grantee health agency must ensure that the supervising dentist is available for consultation when necessary.

Services: those permitted under general supervision.

Minnesota 2001
Section 150A. 10, subd. 1a
A dental hygienist may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services without the patient first being examined by a licensed dentist if the dental hygienist has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

Health care facility is defined as a hospital, nursing home, home health agency, disabled/juvenile home, federal/state/local public health facility, community clinic, prison, tribal clinic school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.
A collaborative agreement means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services may be performed without the presence of a licensed dentist and may be performed at a setting other than the usual place of practice of the dentist or dental hygienist and without the dentist's diagnosis/treatment plan unless specified in the agreement.

Special Requirements: Has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years. Has documented participation in courses in infection control and medical emergencies within each continuing education cycle and maintains current certification in advanced or basic cardiac life support as recognized by the American Heart Association, the American Red Cross, or another agency that is equivalent to the American Heart Association or the American Red Cross.

Services: Removal of deposits and stains from the surfaces of the teeth, application of topical preventive and prophylactic agents, sealants, fluoride varnishes, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking x-rays and root planing.

- **There are now 2 dental hygienists volunteering in a community dental clinic providing restorative and preventive services to at least 10 patients each day they volunteer.**
- **At least 25 dental hygienists had qualified for collaborative practice in 2006.**
- **Direct Medicaid reimbursement allowed.**

Missouri 2001
Statute 332.311.2
Dental hygienists may provide services without supervision in public health settings to Medicaid eligible children and be directly reimbursed by Medicaid.

Special Requirements: 3 years experience.

Services: Oral prophylaxis, sealants, fluorides.

- **One particular dental hygienist has seen a sealant program grow from one school district to eight. Over 2,500 sealants have been placed on over 700 children.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, were 12 registered providers.**

Montana 2003
Sec. 37-4-405
Dental hygienists may obtain a limited access permit from the board allowing them to practice under public health supervision in a variety of federally funded health centers and clinics, nursing homes, extended care facilities, home health agencies, group homes for the elderly, disabled, and youth, head start programs, migrant work facilities and local and state public health facilities. Public health supervision means the hygienist can provide oral prophylaxis, fluoride, polish restorations, root plane, sealants, oral cancer screening, expose radiographs, and chart without the authorization of a dentist provided he or she follows protocols to be established by the board and refers any patients needing dental treatment.

- **Program took effect in September of '04, 10 permits in '06.**

Nebraska 2007
Sec. 71-193.18
The Department of Health may authorize an unsupervised RDH to provide public health related services in a public health setting or a healthcare or related facility.

Special requirements: 3000 hours experience in at least 4 of last 5 years; professional liability insurance.

Services: Prophylaxis for a health child, pulp vitality testing, preventive measures including fluorides & sealants.

New Hampshire 1993
Rule 302.02(d); 402.01 (c)
Under public health supervision dental hygienists may provide procedures authorized by a dentist in a public or private school, hospital or institution, or residence of a homebound patient provided the dentist reviews patient records once in a 12 month period.

Special Requirements: None.

Services: Instruction in oral hygiene, topical fluorides, oral prophylaxis, assess medical/dental history, periodontal probing/charting.

New Mexico 2007
Sec. 61-5-C
No supervision required for any dental hygienist to apply fluorides, and remineralization agents.

New Mexico 1999
Sec. 61-5A-4D
Rule 16.5.17
Collaborative practice permits [based on a written agreement between the dental hygienist and one or more consulting dentist(s)], dental hygienists to treat patients according to a protocol with collaborative dentist. Dental hygienists may own or manage a collaborative dental hygiene practice in any setting. Must refer patient for dental exam yearly.

Special Requirements: 2400 hours active practice in past 18 months or 3000 hours in 2 of past 3 years.

Services: Each collaborative practice agreement must contain protocols for care. Which provide for standing orders allowing the dental hygienist to provide routine services such as preliminary assessment, x- rays, oral prophylaxis and fluoride treatment without prior authorization. Case-by-case authorization required in some procedures (as sealants and root planning).

- **One collaborative practice arrangement that started in 2002, serves a base of 4,000 people-1/3 of which are Medicaid eligible.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, there were 35 collaborative practice RDHs.**

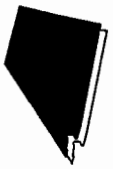
New York 2005
Rules Sec. 61.9
That a supervising dentist be available for consultation, diagnosis and evaluation, has authorized the dental hygienist to perform the services, and exercises that degree of supervision appropriate to the circumstances. A dental hygienist can work in any setting (private or public) and perform dental hygiene duties (listed below) without a dental examination or need to refer a patient to a dentist.

Dental hygiene services allowed include removing calcareous deposits, accretions and stains, including scaling and planning of exposed root surfaces; applying topical agents indicated for a complete dental prophylaxis; removing excess cement from surfaces of the teeth; providing patient education; placing and exposing X-ray films; performing topical anticariogenic agent applications, including but not limited to topical fluoride applications, and performing topical anesthetic applications; polishing teeth, including existing restorations; taking medical history including the measuring and recording of vital signs; charting caries and periodontal conditions

as an aid to diagnosis by the dentist; applying pit and fissure sealants; and applying desensitizing agents to the teeth.

In nursing homes a hygienist can perform a complete oral examination of a resident and then determine treatment priorities; plan for continuing oral hygiene and dental care.

- **In 2005, dental hygienists have screened and provided sealants for over 30,000 children.**
- **About 100,000 children in New York received care in school-based programs overseen by dental hygienists.**



Nevada 1998

Sec. 631.287

Dental hygienists may obtain approval to work as public health dental health hygienists in schools, community centers, hospitals, nursing homes and such other locations as the state dental health officer deems appropriate without supervision.

- **33 RDH's have gained board approval. Nevada Health Centers, Inc. where some RDH's are employed, provides services in eighteen different locations in Nevada. Dental hygienists with Public Health endorsement can also screen and place sealants without a dentist present. Additional locations include Saint Mary's, Huntridge Teen Center & Lyon Co. Healthy Smiles.**
- **Direct Medicaid reimbursement allowed.**

Oklahoma 2003

Sec. 328.34 C

A dentist may authorize in writing a dental hygienist to perform services one time on a patient in a setting outside the office prior to any dentist contact/exam if the hygienist refers the patient back to the authorizing dentist.

Special Requirements: 2 years experience

Oregon 1997

Sec. 680.200

Rule 818-035-0065

Dental hygienists who have obtained a limited access permit (LAP) may initiate services for patients in a variety of limited access settings such as extended care facilities, facilities for the mentally ill or disabled, correctional facilities, schools and pre-schools, and job training centers. RDH must refer the patient annually to a licensed dentist available to treat the patient.
12 hours of CE every two years (in addition to the 24 hours required for all dental hygienists) to renew permit.

Services--All dental hygiene services, except that some (local anesthesia, pit and fissure sealants, denture relines, temporary restorations, radiographs and nitrous oxide) must be preauthorized by a dentist.

- **In 2006, there were 70 LAP's.**
- **In the last year, LAP dental hygienists in 3 counties provided over 5,000 preventative procedures for children in Head start, Early Head start, WIC public health settings.**
- **Several LAP hygienists throughout Oregon continue to build practices serving the elderly in foster homes and extended care facilities.**
- **Direct Medicaid reimbursement allowed.**

Pennsylvania 2007

(Act 216) Sec. 2 (Definitions)

Dental hygienists licensed in Pennsylvania can practice as "public health dental hygiene practitioners," providing care in a variety of public health settings without the supervision or prior authorization of a dentist. Public health dental hygiene practitioners are required to take five hours of continuing education dedicated to public health matters during each licensure period.

Special requirements: 3,600 hours expense, liability insurance. Must complete 5 hours of CE in public health during each licensure period.

Services: educational, preventive, therapeutic, and intra-oral services, including complete prophylaxis and sealants, dental hygienists in the state are authorized to provide.

Rhode Island 2006

Sec. 5-31.1-6.1

Dental hygienists working under a dentist's general supervision can initiate dental hygiene treatment to residents of nursing facilities. Dental hygienists working in nursing facilities can treat patients, regardless of whether or not the patient is a patient of record, as long as documentation of services administered is maintained and necessary referrals for follow-up treatment are made.

Special requirements: None.

Services: Initial oral health screening assessments, prophylaxis, fluoride treatments, charting, and other duties delegable under general supervision.

South Carolina 2003

Sec. 40-15-110 (A) (10)

Dental hygienists employed by or contacted through the Department of Health and Environment Control may provide services under general supervision that does not require prior examination by a dentist in settings such as schools or nursing homes.

Special requirements: Dental hygienist must carry professional liability insurance.

Services: Prophylaxis, fluorides, sealants

Texas 2001

Sec. 262.1515

A dentist may delegate services without seeing the patient first to a dental hygienist practicing in a nursing facility or school based health center. The hygienist must refer the patient to a dentist following treatment. The hygienist may not perform a second set of services until the patient has been examined by a dentist.

Special Requirements: 2 years practice experience.

Services: No limitations.

Vermont 2008

Rule 10.2

Dental hygienists may provide hygiene services in public health settings under the supervision of a dentist via a general supervision agreement. The agreement authorizes the dental hygienist to provide services, agreed to between the dentist and the dental hygienist. The agreement does not require physical presence of the dentist but it stipulates that the supervising dentist review all patient records.

Special Requirements: Three years licensed clinical practice experience and in good standing in Vermont.

Services: Sealants, fluoride varnish, prophylaxis and x-rays. Periodontal maintenance and root planing may be provided on patients with mild periodontitis.

Washington 2001 (Washington has two different provisions for direct access)

Sec. 18.29.220

Dental hygienists who are school endorsed may assess for and apply sealants and fluoride varnishes in community-based sealant programs carried out in schools.

Special Requirements: Sealant/Fluoride Varnish Endorsement from Department of Health.

- **Data obtained through Medicaid indicates that dental hygienists working under these provisions saw 5,653 clients in 2002; 6,799 in 2003, and 4,265 through July of '04. Specifically in terms of sealants, over 19,200 sealants have been placed since Dec. 2003.**
- **Direct Medicaid reimbursement allowed.**

Washington 1984

Sec. 18.29.056

Unsupervised practice in hospitals, nursing homes, home health agencies, group homes (for the elderly, handicapped or youth), state institutions under department of health and human services, jails, and public health facilities provided the hygienist refers patient to a dentist for dental treatment and needed care.

Special requirements: Two years clinical experience within the last five years.

Services: removal of deposits and stains, application of topical preventive or prophylactic agents, polishing and smoothing restorations, root planing, curettage and local anesthesia. (The dental board has ruled that sealants are not included, but require general supervision).

West Virginia 2008

§5-1-8.5

Dental hygienists, who meet specific requirements, may provide dental hygiene services without the supervision of a dentist in hospitals, schools, correctional facilities, jails, community clinics, long term care facilities, nursing homes, home health agencies, group homes, state institutions under the Department of Health and Human Resources, public health facilities, homebound settings and Accredited Dental Hygiene Education programs.

Special requirements: 2 years and 3,000 hours of clinical dental hygiene experience; six additional continuing education hours this must include 3 hours in medical emergencies and 3 hours in general public health content. The dental hygienist and supervising dentist must submit an annual report to the West Virginia Board of Dental Examiners of services rendered.

Services: Dental hygiene education; nutritional counseling; oral screening with referral to dentist; apply fluoride; charting; recording medical history; complete prophylaxis (upon written prescription from a licensed dentist).

Wisconsin 2008

Wisconsin. Sec. 447.06

The statute does not require the presence or general supervision of a dentist in a public or private school, a dental or dental hygiene school or a facility owned by a local health department.

Price, Constance [IBDE]

From: Hart, Jennifer [IBDE]
Sent: Wednesday, November 26, 2008 11:50 AM
To: Larry Carl; jvlegs@hotmail.com; ensey4@yahoo.com
Cc: cvanaernam@aol.com; Price, Constance [IBDE]
Subject: Dental Hygiene Petition - Comments requested
Attachments: DH Petition NewNov08.pdf

Attached is a copy of a petition for rulemaking and supporting documents submitted by the Iowa Dental Hygienists' Association concerning public health supervision. I am forwarding a copy of this information to the associations to give you an opportunity to submit written comments on the petition for board consideration.

The petition will be considered by the Iowa Dental Board at their January 15, 2009, meeting. To give the board time to review your comments, it would be helpful for your to submit them no later than Monday, December 22. Comments may be submitted via mail to the board address or may be e-mailed to my attention. Please note that if the board chooses to grant the petition and initiates rulemaking, a public hearing will be scheduled and there will be an additional opportunity to submit written comments.

Jennifer Hart, Executive Officer
Iowa Dental Board
400 SW 8th St, Suite D
Des Moines, IA 50309
☎Phone (515) 281-0997 ☎Fax (515) 281-7969
http://www.dentalboard.iowa.gov

BE GREEN: Please consider the environment before printing this email.

Iowa Dental Hygienists' Association

November 25, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo;

This letter constitutes a petition to the Iowa Dental Board, pursuant to Administrative Rule 650-7.1, requesting an amendment to the current administrative rule regarding licensee responsibilities as part of public health supervision of dental hygienists, Administrative Rule 650-10.5(3). Paragraph (a)(3) of this rule requires a dentist to "(s)pecify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement." The proposed amendment would strike this requirement.

This proposed amendment is being submitted for the following reasons: (1) it will remove a barrier to preventive dental hygiene services and (2) it would make Iowa's law regarding access to public health services more consistent with other states. As the Dental Board is aware, the public health supervision program for dental hygienists has been very successful in expanding access to quality dental care to Iowans, especially low-income families. According to statistics collected by the Iowa Department of Public Health, nearly 19,000 patients were served by this program in 2005, and by 2007, that figure had grown to nearly 35,000, almost a 100% increase. The number of hygienists providing services in public health settings has also grown, from 21 in 2005 to 56 in 2007; the number of dentists participating in this program has also grown significantly.

A recent study conducted at the Black Hawk County school-based dental sealant program demonstrates how dental hygienists working in a public health setting are making dramatic improvements in the oral health of children in that county. In the four years prior to allowing public health supervision, 1590 screenings were conducted. In the four years since screenings were able to be conducted by dentists and dental hygienists, the

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number of screenings increased to 2046, nearly a 33% increase. Over that same time-period, the number of children receiving dental sealants also increased by nearly 10%.

The study also shows the benefit of additional screenings and sealant applications. Eighth graders who had previously participated in the dental sealant program had 7.6% of their teeth demonstrating a history of caries, compared to 20.3% for those children who did not previously participate.

Removing a barrier to Preventive Dental Services

As shown above, the current dental hygiene public health supervision program is helping expand access to quality dental care. However, the current requirement, that patients participating in this program must be examined by a dentist within no longer than twelve months after receiving treatment, serves as a significant barrier to patients receiving the continued benefit of this program. Hygienists practicing in a public health setting have experienced significant difficulty in determining whether this requirement has been met as they do not provide the examination.

Additionally, at a recent dental summit, two school based sealant programs expressed concern that children who would benefit from additional sealants would be denied due to the annual exam requirement. For example, children receiving sealants as a 2nd grader prior to all teeth fully erupting are now ready in third grade have the rest of the teeth sealed, but lacking proof of exam, are not eligible to receive preventive services.

The study of Black Hawk County schoolchildren again shows the problem of lack of access. When follow-up screenings were conducted on 3rd, 4th, and 5th graders, nearly 47% had not received dental treatment since either their previous screening or sealant application. Under the current administrative rules, those 47% of children would not be able to receive many continuing preventive services from dental hygienists, including the application of additional sealants.

Attached are letters from Jen Badger and Joyce Miller, two dental hygienists who practice in public settings that outline their real world experiences and how adopting this petition would improve access to quality dental care.

Consistency with Laws in other States

Iowa's dental examination requirement is not consistent with laws in other states regarding direct access to dental hygiene services. According to the American Dental Hygiene Association, twenty-eight states, including Iowa, allow for some sort of direct access to hygiene services. Among those twenty-eight states, Iowa currently is one of only five states which place a limit on continuation of preventive services. In contrast, six other states, including Maine, Montana, New Mexico, Oregon, Rhode Island, and Washington, have a referral requirement such as is being proposed in this petition.

At an oral health summit hosted earlier this year by the Iowa Public Health Association, the current exam requirement was identified as a major barrier to access to oral health preventive services, and there was strong support at this summit to replace this

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requirement with a referral requirement similar to what is proposed in this petition. Additionally, the Oral Health Bureau of the Iowa Department of Public Health has included this change in their policy recommendations for this year. This change is supported, as well, by the Iowa Prevention of Disabilities Council.

As President of the Iowa Dental Hygienists Association, I want it understood that dental hygienists believe in and recognize the important role that dentists and dental exams play in providing quality dental health care to Iowans. As is stated in Jen Badger's letter, dental hygienists working in a public health setting work very hard to match up their patients with a dentist who can provide an exam and needed additional care.

However, when an exam is not able to be conducted, which as the Black Hawk County data demonstrates quite often occurs, it is important that barriers to quality dental care be removed. IDHA believes strongly that this petition would accomplish that objective, and we appreciate the board's consideration of this request.

Sincerely,

Carol Van Aernam

Carol Van Aernam, President
Iowa Dental Hygienists Association

IOWA DEPARTMENT OF PUBLIC HEALTH - ORAL HEALTH BUREAU UPDATE
Tracy Rodgers, Community Health Consultant

I-Smile
Funding from DHS increased this year for the 23 Title V child health contracts. Agencies will receive $1,716,432 for SFY2009. The funding is distributed based on size of service area and Medicaid-enrolled children. Refer to the attachment for examples of activities provided by I-Smile coordinators.

OHB staff is working with Iowa Medicaid Enterprise to evaluate I-Smile. Specific data queries have been requested to review efficacy and impact. Dolores Malvitz, an epidemiologist formerly with CDC, is providing guidance to OHB on the evaluation measures.

School Dental Screening Requirement
This is the first school year that Iowa children are required to have proof of a dental screening prior to enrolling in kindergarten and ninth grade. Information and forms are available on the IDPH Website, trainings are being held, and there has been quite a bit of media coverage.

Local boards of health are responsible for audits – and I-Smile Coordinators are expected to coordinate systems within their service regions to assure completion of audits, reporting to boards of health, and reporting to IDPH. I-Smile Coordinators will also be integral in assisting families in having screenings completed.

Oral Health Bureau Codification
The administrative rules written to codify the Oral Health Bureau have been suspended. The Iowa Dental Association protested the definition of a dental home as written within the rules. The IDA opposes the inclusion of "nondental public and private health care professionals" in the definition. The legislature's Administrative Rules Review Committee agreed to suspend adoption of the rules, asking the IDPH and IDA to come to an agreement on the definition of a dental home.

Oral Health Policy Recommendations
1. Increase funding for the I-Smile dental home project to expand the dental workforce and increase preventive services for underserved children; to double Medicaid's preventive reimbursement for eligible providers; to allow physicians and primary care providers to bill for dental screenings outside of the EPSDT bundled well-child exam rate; and to improve Medicaid dental reimbursement rates or use a 3rd party billing system
2. Reinstate a 4-year bachelor's degree dental hygiene program in Iowa with public health service emphasis
3. Seek rules change by Iowa Dental Board for public health supervision to allow a dental hygienist to refer a patient to see a dentist, but not limit continued treatment if dental visit had not occurred within one year
4. Integrate oral health planning into the medical home initiative

DIRECT ACCESS STATES

For purposes of this document, direct access means that the dental hygienist can initiate treatment based on his or her assessment of patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and can maintain a provider-patient relationship.

Alaska 2008

AS 08.32.115

May provide services according to terms of collaborative agreement. No limit on settings. Dentist need not examine, diagnose, or be present.

Special requirements: 4,000 hours experience last 5 years. Board must approve collaborative agreement.

Services: Virtually entire scope of dental hygiene services, as long as agreement provides for them.

Arizona 2006

32-1289B

Dental hygienist working under contract for schools, public health settings and institutions may screen and apply fluoride unsupervised.

Arizona 2004

Sec. 32-1281 H, 3212-89

A dental hygienist with a written affiliated practice agreement with a dentist may assess for and perform dental hygiene services on patients under 18 years who meet certain financial criteria and are enrolled in a federal, state, county or local healthcare program

Special requirements: 5 years practice

Services: Any dental hygiene services specified in the affiliated practice agreement except root planing, local anesthesia, nitrous oxide or placing sutures.

- **Direct Medicaid reimbursement allowed.**

California 2002

Sec 1763 (a) 2002

Any dental hygienist may provide screening, apply fluorides and sealants without supervision in government created or administered public health programs.

California 1998

Sec. 1774, 1775

Dental hygienists endorsed as RDHAPs (registered dental hygienist in alternative practice) may provide services without supervision for homebound persons or at schools, residential facilities, institutions and in dental health professional shortage areas for up to 18 months, and provide further services if the patient obtains a prescription from a dentist or physician. RDHAP'S may own an alternative dental hygiene practice. Currently, there are more than 100 RDHAP's.

Special Requirements: Bachelors degree equivalent, 3 years clinical practice, completion of 150 clock hour special course and exam.
Services: Those services permitted under general supervision (which include oral prophylaxis, root planing, pit and fissure sealants, charting and examination of soft tissue).

- **In 2008, more than 200 RDHAP's registered.**
- **A dental hygienist mobile practice treats 25-35 disabled patients per week.**
- **Direct Medicaid reimbursement allowed.**

Colorado 1987

Sec. 12-35-122.5

Unsupervised practice in all settings for all licensed dental hygienists for the oral prophylaxis and preventive and therapeutic services. The dental hygienist may also own a dental hygiene practice.

Special Requirements: None.

Services: remove deposits, accretions, and stains, curettage without anesthesia, apply fluorides and other recognized preventive agents, oral inspection and charting, topical anesthetic. However, x-rays require general supervision and local anesthesia requires direct supervision.

- **Direct Medicaid reimbursement allowed. In fiscal year 2003-04, 16 independent RDH's provided 199,518 in services to 2,284 Medicaid children.**

Connecticut 1999

Section 20-126l

Dental hygienists with 2 years experience may practice without supervision in institutions, public health facilities, group homes and schools.

Special Requirements: 2 years experience.

Services: Oral prophylaxis, remove deposits, accretions and stains, root planning, sealants, assessment, and treatment planning.

- **Since 7/1/2003 hygienists have program has provided over 55,000 dental procedures – nearly 7,000 prophys/fluorides, 5,800 sealants and 15,000 exams.**
- **Direct Medicaid reimbursement allowed.**

Idaho 2004

I.C. 54-903 (9) / 54-904

Can provide services in hospitals, long term care facility, public health facility, health or migrant clinic or other board approved setting if dentist affiliated with setting authorizes services.

Special requirements: RDH must be an employee of the facility or obtain extended care permit. ECP requires 1,000 hours experience in last 2 years.

Services: As determined by authorizing dentist.

Iowa 2004

Rule 650-10.5 (153)

Dental hygienists may provide services based on standing orders and a written agreement with a dentist in schools, Head Start settings, FQHCs (Federally Qualified Health Centers), public health vans, free clinics, community centers and public health programs.
Special Requirements: RDH must have 3 years clinical experience and submit annual report on number of patients/services to department of health.

Services: All dental hygiene services (except local anesthesia and nitrous) may be provided once to each patient. To perform repeat services other than assessment, screening and fluoride, dentist must examine.

- **Active Public Health Supervision agreements in place between Iowa dentists and dental hygienists.**
- **Services in 2005: 17,332 clients received sealants, 18,942 received screenings, 6,098 received fluoride applications, over 281 received prophys, and 7,157 received education.**
- **As of 2007, 24 public health RDHs.**

Kansas 2003

Sec. 65-1456

Dental hygienist with an extended care permit I or II to treat patients in schools, head start programs, state correctional institutions, local health departments, indigent care clinics, adult care homes, hospital long term units, or at the home of homebound persons on medical assistance. No prior authorization is needed, but the hygienist must have an agreement with a sponsoring dentist who will monitor his/her practice.

Special requirements: 1,800 hours experience

Services: prophylaxis, application of fluoride, dental hygiene instruction, assessment of the patient's need for further treatment by a dentist and other services if delegated by the sponsoring dentist

- **As of 2007, there were 76 extended care permit dental hygienists.**

Maine 2008

Sec. B-1. 32 MRSA c. 16, sub-c. 3-B

A dental hygienist licensed as an independent practice dental hygienist may practice without supervision by a dentist in all settings.

Special Requirements: Possess a bachelor's degree from a CODA accredited dental hygiene program and 2,000 work hours of clinical practice in a private dental practice during the two years preceding the application or possess an associate degree from a CODA accredited dental hygiene program and 6,000 work hours of clinical practice in a private dental practice during the six years preceding the application. They are also required to provide a referral plan to patients in need of additional care by a dentist.

Services: Interview patients and record complete medical and dental histories; take and record the vital signs of blood pressure, pulse and temperature; perform oral inspections, recording all conditions that should be called to the attention of a dentist; perform complete periodontal and dental restorative charting; perform all procedures necessary for a complete prophylaxis, including root planing; apply fluoride to control caries; apply desensitizing agents to teeth; apply topical anesthetics; apply sealants; smooth and polish amalgam restorations, limited to slow speed application only; cement pontics and facings outside the mouth; take impressions for athletic mouth guards and custom fluoride trays; place and remove rubber dams; place temporary restorations in compliance with the protocol adopted by the board; and apply topical antimicrobials, excluding antibiotics, including fluoride, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The independent practice dental hygienist shall follow current manufacturer's instructions in the use of these medicaments.

Maine 2001
Rule 02 313 Chap. 1. Sec. 4
A dental hygienist may practice in a public or private school, hospital or other non-traditional practice setting under a public health supervision status granted by the dental board on a case-by-case basis. The hygienist may perform all services rendered under general supervision. The dentist should have specific standing orders and procedures to be carried out, although the dentist need not be present when the services have been provided. A written plan for referral or an agreement for follow-up shall be provided by the public health hygienist recording all conditions that should be called to the attention of the dentist. The supervising dentist shall review a summary report at the completion of the program or once a year.

Special Requirements: A dental hygienist must apply to the board to practice providing such information the board deems necessary. The board must take into consideration whether the program will fulfill an unmet need, whether a supervising dentist is available and that the appropriate public health guidelines and standards of care can be met and followed.

Services: All services that can be provided under general supervision. Dentist's diagnosis for sealants not needed in public health or school sealant programs.

- **From 3/02 through 10/04, over 5,500 patients were provided care in over 400 clinics. Nearly 30 dental hygienists are involved in this particular program.**
- **Direct Medicaid reimbursement allowed.**

Michigan 1991
Sec. 333.16625
A dental hygienist may administer dental hygiene services for a 2 year period to patients not assigned by a dental through a department of community Health designed "grantee health agency. Grantee health agencies must be a public or nonprofit entity, school, or nursing home that employs or contacts with at least one dentist or dental hygienist and provides care to an underserved population.

Special requirements: Entities seeking a grantee health agency status must submit a comprehensive form outlining how the program will be carried out, providing for oversight and direction, and including information for all dental personnel involved. A dental hygienist operating as a grantee health agency must ensure that the supervising dentist is available for consultation when necessary.

Services: those permitted under general supervision.

Minnesota 2001
Section 150A. 10, subd. 1a
A dental hygienist may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services without the patient first being examined by a licensed dentist if the dental hygienist has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

Health care facility is defined as a hospital, nursing home, home health agency, disabled/juvenile home, federal/state/local public health facility, community clinic, prison, tribal clinic school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.
A collaborative agreement means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services may be performed without the presence of a licensed dentist and may be performed at a setting other than the usual place of practice of the dentist or dental hygienist and without the dentist's diagnosis/treatment plan unless specified in the agreement.

Special Requirements: Has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years. Has documented participation in courses in infection control and medical emergencies within each continuing education cycle and maintains current certification in advanced or basic cardiac life support as recognized by the American Heart Association, the American Red Cross, or another agency that is equivalent to the American Heart Association or the American Red Cross.

Services: Removal of deposits and stains from the surfaces of the teeth, application of topical preventive and prophylactic agents, sealants, fluoride varnishes, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking x-rays and root planing.

- **There are now 2 dental hygienists volunteering in a community dental clinic providing restorative and preventive services to at least 10 patients each day they volunteer.**
- **At least 25 dental hygienists had qualified for collaborative practice in 2006.**
- **Direct Medicaid reimbursement allowed.**

Missouri 2001
Statute 332.311.2
Dental hygienists may provide services without supervision in public health settings to Medicaid eligible children and be directly reimbursed by Medicaid.

Special Requirements: 3 years experience.

Services: Oral prophylaxis, sealants, fluorides.

- **One particular dental hygienist has seen a sealant program grow from one school district to eight. Over 2,500 sealants have been placed on over 700 children.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, were 12 registered providers.**

Montana 2003
Sec. 37-4-405
Dental hygienists may obtain a limited access permit from the board allowing them to practice under public health supervision in a variety of federally funded health centers and clinics, nursing homes, extended care facilities, home health agencies, group homes for the elderly, disabled, and youth, head start programs, migrant work facilities and local and state public health facilities. Public health supervision means the hygienist can provide oral prophylaxis, fluoride, polish restorations, root plane, sealants, oral cancer screening, expose radiographs, and chart without the authorization of a dentist provided he or she follows protocols to be established by the board and refers any patients needing dental treatment.

- **Program took effect in September of '04, 10 permits in '06.**

Nebraska 2007
Sec. 71-193.18
The Department of Health may authorize an unsupervised RDH to provide public health related services in a public health setting or a healthcare or related facility.

Special requirements: 3000 hours experience in at least 4 of last 5 years; professional liability insurance.

Services: Prophylaxis for a health child, pulp vitality testing, preventive measures including fluorides & sealants.

New Hampshire 1993
Rule 302.02(d); 402.01 (c)
Under public health supervision dental hygienists may provide procedures authorized by a dentist in a public or private school, hospital or institution, or residence of a homebound patient provided the dentist reviews patient records once in a 12 month period.

Special Requirements: None.

Services: Instruction in oral hygiene, topical fluorides, oral prophylaxis, assess medical/dental history, periodontal probing/charting.

New Mexico 2007
Sec. 61-5-C
No supervision required for any dental hygienist to apply fluorides, and remineralization agents.

New Mexico 1999
Sec. 61-5A-4D
Rule 16.5.17
Collaborative practice permits [based on a written agreement between the dental hygienist and one or more consulting dentist(s)], dental hygienists to treat patients according to a protocol with collaborative dentist. Dental hygienists may own or manage a collaborative dental hygiene practice in any setting. Must refer patient for dental exam yearly.

Special Requirements: 2400 hours active practice in past 18 months or 3000 hours in 2 of past 3 years.

Services: Each collaborative practice agreement must contain protocols for care. Which provide for standing orders allowing the dental hygienist to provide routine services such as preliminary assessment, x- rays, oral prophylaxis and fluoride treatment without prior authorization. Case-by-case authorization required in some procedures (as sealants and root planning).

- **One collaborative practice arrangement that started in 2002, serves a base of 4,000 people-1/3 of which are Medicaid eligible.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, there were 35 collaborative practice RDHs.**

New York 2005
Rules Sec. 61.9
That a supervising dentist be available for consultation, diagnosis and evaluation, has authorized the dental hygienist to perform the services, and exercises that degree of supervision appropriate to the circumstances. A dental hygienist can work in any setting (private or public) and perform dental hygiene duties (listed below) without a dental examination or need to refer a patient to a dentist.

Dental hygiene services allowed include removing calcareous deposits, accretions and stains, including scaling and planning of exposed root surfaces; applying topical agents indicated for a complete dental prophylaxis; removing excess cement from surfaces of the teeth; providing patient education; placing and exposing X-ray films; performing topical anticariogenic agent applications, including but not limited to topical fluoride applications, and performing topical anesthetic applications; polishing teeth, including existing restorations; taking medical history including the measuring and recording of vital signs; charting caries and periodontal conditions

as an aid to diagnosis by the dentist; applying pit and fissure sealants; and applying desensitizing agents to the teeth.

In nursing homes a hygienist can perform a complete oral examination of a resident and then determine treatment priorities; plan for continuing oral hygiene and dental care.

- **In 2005, dental hygienists have screened and provided sealants for over 30,000 children.**
- **About 100,000 children in New York received care in school-based programs overseen by dental hygienists.**

Nevada 1998
Sec. 631.287
Dental hygienists may obtain approval to work as public health dental health hygienists in schools, community centers, hospitals, nursing homes and such other locations as the state dental health officer deems appropriate without supervision.

- **33 RDH's have gained board approval. Nevada Health Centers, Inc. where some RDH's are employed, provides services in eighteen different locations in Nevada. Dental hygienists with Public Health endorsement can also screen and place sealants without a dentist present. Additional locations include Saint Mary's, Huntridge Teen Center & Lyon Co. Healthy Smiles.**
- **Direct Medicaid reimbursement allowed.**

Oklahoma 2003
Sec. 328.34 C
A dentist may authorize in writing a dental hygienist to perform services one time on a patient in a setting outside the office prior to any dentist contact/exam if the hygienist refers the patient back to the authorizing dentist.

Special Requirements: 2 years experience

Oregon 1997
Sec. 680.200
Rule 818-035-0065
Dental hygienists who have obtained a limited access permit (LAP) may initiate services for patients in a variety of limited access settings such as extended care facilities, facilities for the mentally ill or disabled, correctional facilities, schools and pre-schools, and job training centers. RDH must refer the patient annually to a licensed dentist available to treat the patient.
12 hours of CE every two years (in addition to the 24 hours required for all dental hygienists) to renew permit.

Services--All dental hygiene services, except that some (local anesthesia, pit and fissure sealants, denture relines, temporary restorations, radiographs and nitrous oxide) must be preauthorized by a dentist.

- **In 2006, there were 70 LAP's.**
- **In the last year, LAP dental hygienists in 3 counties provided over 5,000 preventative procedures for children in Head start, Early Head start, WIC public health settings.**
- **Several LAP hygienists throughout Oregon continue to build practices serving the elderly in foster homes and extended care facilities.**
- **Direct Medicaid reimbursement allowed.**

Pennsylvania 2007

(Act 216) Sec. 2 (Definitions)

Dental hygienists licensed in Pennsylvania can practice as "public health dental hygiene practitioners," providing care in a variety of public health settings without the supervision or prior authorization of a dentist. Public health dental hygiene practitioners are required to take five hours of continuing education dedicated to public health matters during each licensure period.

Special requirements: 3,600 hours expense, liability insurance. Must complete 5 hours of CE in public health during each licensure period.

Services: educational, preventive, therapeutic, and intra-oral services, including complete prophylaxis and sealants, dental hygienists in the state are authorized to provide.

Rhode Island 2006

Sec. 5-31.1-6.1

Dental hygienists working under a dentist's general supervision can initiate dental hygiene treatment to residents of nursing facilities. Dental hygienists working in nursing facilities can treat patients, regardless of whether or not the patient is a patient of record, as long as documentation of services administered is maintained and necessary referrals for follow-up treatment are made.

Special requirements: None.

Services: Initial oral health screening assessments, prophylaxis, fluoride treatments, charting, and other duties delegable under general supervision.

South Carolina 2003

Sec. 40-15-110 (A) (10)

Dental hygienists employed by or contacted through the Department of Health and Environment Control may provide services under general supervision that does not require prior examination by a dentist in settings such as schools or nursing homes.

Special requirements: Dental hygienist must carry professional liability insurance.

Services: Prophylaxis, fluorides, sealants

Texas 2001

Sec. 262.1515

A dentist may delegate services without seeing the patient first to a dental hygienist practicing in a nursing facility or school based health center. The hygienist must refer the patient to a dentist following treatment. The hygienist may not perform a second set of services until the patient has been examined by a dentist.

Special Requirements: 2 years practice experience.

Services: No limitations.

Vermont 2008

Rule 10.2

Dental hygienists may provide hygiene services in public health settings under the supervision of a dentist via a general supervision agreement. The agreement authorizes the dental hygienist to provide services, agreed to between the dentist and the dental hygienist. The agreement does not require physical presence of the dentist but it stipulates that the supervising dentist review all patient records.

Special Requirements: Three years licensed clinical practice experience and in good standing in Vermont.

Services: Sealants, fluoride varnish, prophylaxis and x-rays. Periodontal maintenance and root planing may be provided on patients with mild periodontitis.

Washington 2001 (Washington has two different provisions for direct access)
Sec. 18.29.220
Dental hygienists who are school endorsed may assess for and apply sealants and fluoride varnishes in community-based sealant programs carried out in schools.

Special Requirements: Sealant/Fluoride Varnish Endorsement from Department of Health.

- **Data obtained through Medicaid indicates that dental hygienists working under these provisions saw 5,653 clients in 2002; 6,799 in 2003, and 4,265 through July of '04. Specifically in terms of sealants, over 19,200 sealants have been placed since Dec. 2003.**
- **Direct Medicaid reimbursement allowed.**

Washington 1984
Sec. 18.29.056
Unsupervised practice in hospitals, nursing homes, home health agencies, group homes (for the elderly, handicapped or youth), state institutions under department of health and human services, jails, and public health facilities provided the hygienist refers patient to a dentist for dental treatment and needed care.

Special requirements: Two years clinical experience within the last five years.

Services: removal of deposits and stains, application of topical preventive or prophylactic agents, polishing and smoothing restorations, root planing, curettage and local anesthesia. (The dental board has ruled that sealants are not included, but require general supervision).

West Virginia 2008
§5-1-8.5
Dental hygienists, who meet specific requirements, may provide dental hygiene services without the supervision of a dentist in hospitals, schools, correctional facilities, jails, community clinics, long term care facilities, nursing homes, home health agencies, group homes, state institutions under the Department of Health and Human Resources, public health facilities, homebound settings and Accredited Dental Hygiene Education programs.

Special requirements: 2 years and 3,000 hours of clinical dental hygiene experience; six additional continuing education hours this must include 3 hours in medical emergencies and 3 hours in general public health content. The dental hygienist and supervising dentist must submit an annual report to the West Virginia Board of Dental Examiners of services rendered.

Services: Dental hygiene education; nutritional counseling; oral screening with referral to dentist; apply fluoride; charting; recording medical history; complete prophylaxis (upon written prescription from a licensed dentist).

Wisconsin 2008
Wisconsin. Sec. 447.06
The statute does not require the presence or general supervision of a dentist in a public or private school, a dental or dental hygiene school or a facility owned by a local health department.

SCHOOL-BASED DENTAL SEALANT PROGRAM *

Table 1.[1] Screening Data 2000 - 2004

dds	# screenings	# children with	% children with	number of	average # caries	# sealants
	2nd graders	untreated caries	untreated caries	untx caries	per child	
2000-01	364	104	28.57	271	2.61	1199
2001-02	413	154	37.29	393	2.55	1444
2002-03	404	169	41.83	441	2.61	1296
2003-04	409	138	33.74	368	2.67	1563
TOTALS	**1590**	**565**	**35.53%**	**1473**	**2.61**	**5502**

Table 2.[2] Screening Data 2004 - 2008

dds	# screenings	# children with	% children with	number of	average # caries	# sealants
	2nd graders	untreated caries	untreated caries	untx caries	per child	
2004-05	245	94	38.36	246	2.62	778
2005-06	219	97	44.29	253	2.61	622
2006-07	222	67	30.18	172	2.57	641
2007-08	236	61	25.85	154	2.52	690
TOTALS	**922**	**319**	**34.59%**	**825**	**2.58**	**2731**
rdh						
2004-05	363	118	32.50	316	2.67	1175
2005-06	239	83	34.72	245	2.95	742
2006-07	251	89	35.46	185	2.09	706
2007-08	271	81	29.89	157	1.94	828
TOTALS	**1124**	**371**	**33.00%**	**903**	**2.43**	**3451**

Table 3.[3] Total # Screenings and Sealants

	Screenings	Sealants
	2nd graders	2nd grade
2000-04	1590	5502
2004-08	2046	6182

Table 4.[4] Treatment Status

	# of follow-up screenings for 3rd, 4th & 5th graders	# of children who HAVE received tx	# of children who HAVE NOT received tx
2001-02	71	30	41
2002-03	89	46	43
2003-04	79	46	33
2004-05	77	42	35
2005-06	133	88	45
2006-07	140	72	68
2007-08	100	42	58
TOTALS	**689**	**366**	**323**
%		**53.1%**	**46.9%**

Table 5.[5] Caries Experience of 8th Graders

Participants in Dental Sealant Program		
# of students	96	
# of first & second permanent molars [1]	695	
# of teeth with caries history	53	
Mean number of caries per student	0.55	(1.014 sd)[2]
Percent of teeth with caries history	**7.6%**	
Non-participants		
# of students	95	
# of first & second permanent molars [1]	684	
# of teeth with caries history	139	
Mean number of caries per student	1.46	(2.004 sd)[2]
Percent of teeth with caries history	**20.3%**	

[1] Does not include missing teeth or questionable caries

[2] *t(189) df = 3.97, p<.001*

Middle Schools 2004

* This data was collected from the Black Hawk County School-based Dental Sealant Program. The program has provided services to 15 elementary and 6 middle schools in 3 counties in Iowa.

[1] Table 1 contains the data collected during the four years that a licensed dentist did all of the screenings.

[2] Table 2 contains the data collected during the four years that both a licensed dentist and a licensed dental hygienist did screenings.
There appears to be no significant difference between the percent of children with untreated caries or the average # of caries per child if the screening was completed by a dentist or a dental hygienist.

[3] Table 3 contains a comparison of the number of screenings and sealants.
During the four years from 2004 -2008 that both a dentist and dental hygienist did screenings there were 456 more screenings and 680 more sealants than the four years that only a dentist did the screenings.

[4] Table 4 contains the data indicating the number of children who were screened in Grades 3,4 & 5 to determine if treatment for dental disease was completed. Almost 47% had not received treatment by a dentist.

[5] Table 5 contains the screening data of eighth graders from 3 middle schools. This outcome data indicates there is a significant difference in the caries experience of 8th graders. The students who did NOT participate in the school-based sealant program were almost 3 times more likely to experience tooth decay in their permanent molars.

Notes: In 2004 the Black Hawk County School-based Dental Sealant program began utilization of the public health supervision ruling in accordance with the requirements of Iowa Code Section 10.5 (153). This ruling has increased access to preventive services for high-risk children and provided significant improvements to the efficiency of the program.

When the dental hygienist does both the screenings and the sealant applications it 1) reduces the amount of time each student is out of the classroom; 2) reduces interruptions to the academic activities in the classroom; 3) reduces the amount of time between the screening and the placement of sealants, 4) reduces the number of clinical supplies needed; and 5) reduces the costs of compensating dentists for time and expenses to perform screenings.

In addition, this format 1) increases the possibility that students who were absent or have not yet returned a consent form will be able to participate in the program; 2) retains the referral process for students in need of dental treatment and 3) retains the ability to do follow-up screenings to determine if children have received the dental treatment they need.

The data collected from this school-based sealant program indicate that the program can be implemented more efficiently in terms of time and cost when a dental hygienist does the screenings and makes referrals to a dentist for dental treatment.

The data from this program also indicate that almost 47% of children who have been identified as having existing caries and are in need of treatment have not received treatment when a follow-up screening was done in subsequent years. Utilization of the time and clinical skills of licensed dentists may be more beneficial to these children if restorative services were provided rather than the time and expenses required to complete screenings in schools.

October 26, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo:

As a registered dental hygienist currently working under public health supervision, I am writing to you to express my support of the Iowa Dental Hygienists' Association's current request for an amendment to the public health supervision rules. I believe that the access-to-care issues we have been aware of are becoming even more evident as more hygienists begin a career in public health. In the 22 months that I have been working as an I-Smile Coordinator, I have had the need demonstrated to me time and again.

This proposed amendment – changing the requirement of a dental exam within 12 months following certain procedures to the requirement of a dental referral following the procedures – will allow myself and the other hygienists employed by our agency to address the access-to-care issues that we are seeing our clients experience. By being able to provide comprehensive dental hygiene services in spite of our clients' inability to be seen by a dentist, we will be a source of ongoing care.

I would like to provide you with two examples of ways in which this change will benefit the patients who are served by our agency.

- In our Child Health clinic in Perry, we are currently applying sealants. Because of the way our public health supervision agreement is set up with our supervising dentist, we can provide sealants after the client has had an exam and has been deemed caries-free. The dentists in the area are not applying sealants on a regular basis, even to children at a high risk for developing caries. After the child has seen a dentist, we apply sealants to the children's teeth. Occasionally, we see a child that has two or three of their molars erupted and ready for sealants so we apply sealants to those teeth. Because of the public health supervision rules, we cannot seal the remaining teeth after they have finished erupting until the child has seen a dentist again. For our children, that will be six to twelve months. With the amendment changed to a referral to the dentist, we could make that referral and then go ahead and seal the remaining teeth in three to four months after they have finished erupting. This would allow us to provide this preventive measure with the hope of decreasing dental caries on these teeth.
- We have recently begun providing dental hygiene services to our Maternal Health clients (pregnant mothers) at our WIC clinics. After a thorough assessment, a decision is

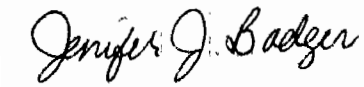
made regarding whether or not we feel we can provide a prophylaxis for the client. If appropriate, an appointment is scheduled for the prophy. We see our clients again in six months and would like to be able to provide a follow-up prophy at that time. Because of the public health supervision rules, we cannot do that unless the client has had an exam. For our clients who are uninsured and cannot afford to pay for a dental visit out-of-pocket, this becomes a serious impediment to ongoing dental care. Our clients who are enrolled in Medicaid also have a difficult time accessing care due to dentists' non-acceptance of Medicaid. If we could refer the client to the dentist and then proceed with the follow up visit, we could provide ongoing, comprehensive dental hygiene care to our clients.

Our programs are expanding and we hope to be able to provide dental hygiene services to clients of our agency's substance abuse treatment program. There is a significant need present in those clients and a change in the rules would allow us to provide ongoing dental hygiene care to these clients as well.

Lastly, I would like to express my continued support and cooperation with the dentists in our area. I always conclude every appointment with any of our clients with a statement of the need to be seen by a dentist. I also make sure all of our clients know that our assessment in no way replaces a dental exam and regular care by a dentist. Unfortunately, due to the shortage of dentists in certain parts of our service area, the shortage of dentists who accept Medicaid, and the inability of some of our clients to pay for out-of-pocket costs associated with dental care, several of our clients are simply unable to access dental care in a dental office. If we could provide ongoing dental hygiene preventive care until they are able to seek care in a dental office, the chances of needing significant dental work will be decreased. This care, along with proper education, will improve the dental health of our clients.

I appreciate your time in reading my letter and your consideration of the request for the amendment to the rules. Our clients are so appreciative of all we do for them because without us they would not be receiving care. Please consider the change to the rules so that we can enhance our services and provide ongoing care to those who need it most.

Sincerely,



Jenifer J Badger, RDH
Bagley, Iowa

October 26, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo,

I am writing to support an amendment to Administrative Rule 650-7.1 regarding the need for a dental exam after 12 months of preventive hygiene services and the discontinuation of these services if no dental examination is performed.

My dental hygiene career started about 31 years ago. During this time, I have been in private practice, worked as an adjunct clinical instructor at DMACC and currently have a public health position serving seven counties in Iowa. The majority of my time in the early years was patient education, prophylaxis, fluoride treatments and exposing radiographs. In the 1970s and 1980s, there was a high incidence of rampant decay and nursing caries, especially with the influx of Southeast Asians. It was routine to see "bombed-out" deciduous molars, incisors and first permanent molars. Children required extensive dental treatment, including extractions, crowns, space maintainers, large restorations with pulp caps and some endodontics. Because of the increase in education, preventative treatment, fluoride, sealants, regular recalls and increased third party payments, the extensive treatment we once provided is uncommon. Over the years, there have been many positive changes in dentistry and patients receive improved preventative services.

However, low-income clients, because of their dental insurance or lack of insurance, are unable to receive dental treatment, or receive only minimal treatment at best. This brings me to my current employment. Two months ago, I took a position with New Opportunities, Inc. in Carroll, IA. We provide screenings, fluoride varnishes, dental referrals, etc. as part of the I-Smile Program. If I were to describe the clients' needs in this program, I would have to describe the 1970s and 1980s when I started practicing.

After thirty years in private practice, seeing the well-maintained, disease-free, or successfully treated patients, I thought the dental diseases were decreasing. However, after three weeks with I –Smile Program, I quickly realized was so mistaken. I overestimated the percentage of people who actively seek and receive dental care. In just three days working at the Perry facility, we observed three children with suspected rampant decay, nursing caries and fistulas on deciduous incisors. As part of the screening visit, we provide a referral to a local dentist for an examination. This can be a verbal, a written referral or a call an office to schedule an appointment. Scheduling appointments is not as easy as it would seem, barriers may include:

1) the lack of dentists willing to treat Medicaid clients
2) the office is no longer seeing new Medicaid patients
3) patients dismissal because of missed appointments
4) clients failing scheduled appointments
5) dentists deferring treatment to The University of Iowa because the client is a probable surgery candidate
6) lack of transportation
7) lack of child care when at appointments
8) parents' lack of dental education recognizing dental disease
9) parents' lack of nutrition education
10) decreasing number of child health clinics

I wanted to work in public health to provide preventative care for the underserved, act as a bridge or connection between public health clients and dentists, and bring this group into the 21st century. Please allow public health hygienists to continue providing preventative services including referrals for our clients. If it were not for public health services and referrals, some may never visit a dentist. In addition, making the referral and scheduling an examination appointment does not always a guarantee treatment is provided. It is unfair to suspend all public health services after one year because a dentist did not provide a dental examination. Suspending all preventative therapy in the absence of a dental examination may eliminate the only opportunity the low-income, uninsured and underinsured may have to receive preventative services.

Thank you for your time and consideration.

Sincerely,

Joyce Miller, RDH, BS

IOWA DENTAL ASSOCIATION
A Constituent of the American Dental Association

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Johnston, IA 50131
(515) 986-5605 or (800) 828-2181
(515) 986-5626 (Fax)
info@iowadental.org (e-mail)

December 22, 2008

Iowa Dental Board
ATTN: Jennifer Hart, Executive Officer
400 SW 8th Street, Suite D
Des Moines, Iowa 50309-4687

RE: Iowa Dental Hygienists' Association Request for Rulemaking

Jennifer Hart:

On November 25, 2008, the Iowa Dental Hygienists' Association ("IDHA") submitted a request for rulemaking. The IDHA requests that the Iowa Dental Board ("the Board") strike the requirement set forth in Iowa Administrative Rule 650-10.5(3)(a)(3), which states as follows:

> The dentist providing public health supervision must: ...(3) Specify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement;...

Iowa Administrative Code r. 650-10.5(3)(a)(3). The Iowa Dental Association ("IDA") believes that the striking of this provision would be inappropriate for the following reasons.

First, the scope of any hygienists' practice is limited by the requirements in Iowa Code section 153.15. That section states as follows:

> A licensed dental hygienist may perform those services which are educational, therapeutic, and preventative in nature which attain or maintain the optimal oral health as determined by the board and may include but are not necessarily limited to complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, obtaining and preparing nonsurgical, clinical and oral diagnostic tests for interpretation by the dentist, and preparation of preliminary written records of oral conditions for interpretation by the dentist. ***Such services shall be performed under the supervision of a licensed dentist*** and in a dental office, a public or private school, public health agencies, hospitals, and the armed forces, but ***nothing herein shall be construed to authorize a dental hygienist to practice dentistry.***

Iowa Code § 153.15 (emphasis added). The Board has further defined the terms and standards utilized in Iowa Code section 153.15 in Iowa Administrative Code sections 650-10.3 and 650-10.5.

Dr. Heather Heddens, President ♦ Dr. Steven Bradley, President-Elect ♦ Dr. William Strohman, Vice-President ♦ Dr. Richard Hettinger, Immediate Past President
Mr. Larry Carl, CAE, Executive Director

IDA believes that deleting the twelve (12) month requirement set forth in Iowa Administrative Code section 650-10.5(3)(a)(3) would be in direct disregard of the statutory supervision requirement. The deletion of the requirement would also allow hygienists to cross the line into the practice of dentistry as diagnosis and analysis, which a dentist is trained to do, is necessary before and after certain types of services are provided.

Second, if the dentist is ultimately responsible for any liability arising from the care provided to the patients in the public health supervision program, few dentists will want to incur that liability if the patient is not required to see a dentist on at least an annual basis. It's hard to imagine any type of professional (i.e.: doctors, attorneys, architects) that would allow his/her own liability coverage be utilized by others without regular oversight.

Third, failure to have dentist oversight of certain procedures would be detrimental to the dental care of the very people the public health supervision program is meant to help. The application of sealants provides a good example and is the issue of most concern for IDA members. Whether and when sealants are appropriate must require an exam and diagnosis at some stage of the treatment regimen. This is an exam and diagnosis that a dentist, not a hygienist, is trained to provide. Furthermore, a dentist is trained to determine at any follow up visit the condition of those sealants and whether re-application is necessary. While IDA has no issue with hygienists applying the sealants, oversight by the dentist is necessary to determine the appropriateness and adequacy of the sealants. The dentist's knowledge and training allow him/her to make that determination to avoid any possible permanent damage to the patient's teeth. The current twelve month requirement is adequate to allow the dentist appropriate oversight to the hygienists' application of sealants and the performance of other hygiene services, while at the same time not prohibiting access to oral hygiene services on a regular basis.

Fourth, while IDA certainly does not question the level of reported success of the public health supervision program in addressing access to dental care in Iowa, the issues and concerns raised in IDHA's request for rulemaking are simply not tenable or could easily be remedied by the specific public health supervision agreements. Each of these assertions will be addressed in turn:

> 1. "Occasionally we see a child that has two or three of their molars erupted and ready for sealants so we apply sealants to those teeth. Because of the public health supervision rules, we cannot seal the remaining teeth after they have finished erupting until the child has seen a dentist again." (Letter from Jennifer J. Badger, RDH, p. 1)
>
> Response: Ms. Badger inaccurately asserts that the rules prevent her from sealing the remaining teeth. The twelve month requirement does not prevent this as the remaining teeth would erupt, as Ms. Badger recognizes, within the next three to four months. Ms. Badger's issue here is not with the rules, but with the particular public health supervision agreement governing the provision of her services. Thus, the asserted problem could be remedied by an amendment or revision to that agreement rather than the rules.
>
> 2. With regard to the services provided to pregnant mothers, Ms. Badger states as follows: "After a thorough assessment, a decision is made regarding whether or not we

feel we can provide a prophylaxis for the client. If appropriate, an appointment is scheduled for the prophy. We see our clients again in six months and would like to be able to provide a follow-up prophy at that time. Because of the public health supervision rules, we cannot do that unless the client has had an exam." (Letter from Jennifer J. Badger, RDH, pp. 1-2)

Response: Again, Ms. Badger seems to be confusing the rules with the public health supervision agreement governing the provision of her services. If she sees the client again within six months, she could provide a follow-up prophy, because it would be within the twelve month period. If the public health supervision agreement governing Ms. Badger provides a shorter period of time, then such issues can be addressed by revising that particular agreement.

3. There is a lack of dentists available to provide the necessary examinations and there is a lack of dentists willing to treat Medicaid clients. (Letter from Jennifer J. Badger, RPH, p. 2; Letter from Joyce Miller, RDH, BS, p. 2)

Response: IDA supports and encourages all dentists to do their part in addressing the oral health needs of all Iowans. While it is true that not every dentist will accept Medicaid patients, there are a significant number who do and will. For example, a statewide claims analysis conducted by Iowa Medicaid Enterprise states that well over 75 percent of Iowa dentists (over 1000) accepted Medicaid patients during the most recent state fiscal year.

IDHA's letter references a specific problem in Black Hawk County regarding access to examinations. After checking with dentists in the Black Hawk County area, it became clear that it was not that these dentists did not want to assist with the program, but that they hadn't been properly informed of the need nor effectively asked to participate. Thus, IDA questions whether the issue is really lack of access or whether it's a lack of knowledge about when and where a dentist's services are needed in the public health setting.

The experience of IDA's members is not that there is little or no access to dental care, but that the patients receiving care in the public health setting often fail to keep appointments for their dental care. The problem is not the lack of access, but the lack of follow through. The argument that dentists are not available, even if accurate, does not mean that this Board should revise its rules to allow hygienists to do the work of dentists. Iowa cannot lower the standard of care to persons in the public health realm on the unsupported claim that dentists are not available.

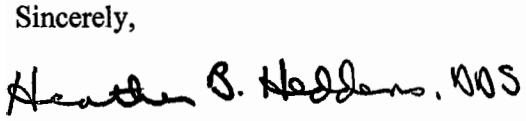
Finally, IDHA's claim that the requested revision would make Iowa more consistent with other states is inaccurate. In assessing the IDHA's comparison, it is important to remember that a particular statute or rule cannot be reviewed in a vacuum. Other statutes and rules in that state related to the matter at issue may not be the same as those in Iowa. For instance, Maine has a category of dental hygienist licensure called "independent practice dental hygienists." "Independent practice dental hygienists" are subject to increased education and training standards and are allowed to practice without certain supervision. Iowa does not have a similar

licensure category. In addition, Iowa Code section 153.15 specifically requires supervision by a dentist and thus, a similar rule in Iowa would not comply with the statutory requirements. Furthermore, IDHA's blanket conclusions regarding what is a "referral" state do not hold up under further scrutiny. In New Mexico, there is a yearly dental referral requirement and a specific exception for dentist authorization of certain procedures, such as sealants and root planning. Thus, New Mexico is not a "referral only" state. In addition, Oregon, contrary to IDHA's assertion, does have a twelve month requirement ("RDH must refer the patient annually to a licensed dentist available to treat the patient."). These corrections and clarifications were found by simply reviewing the "Direct Access States" document provided with IDHA's letter. Accordingly, it is likely that a more thorough review of each state would provide additional evidence that Iowa is not alone in its supervision requirement.

As set forth above, IDA believes that the IDHA's requested rulemaking is unnecessary, unwarranted and unsupported by Iowa law. Accordingly, IDA requests that the Board and the Dental Hygiene Committee deny IDHA's rulemaking request.

If you have questions or desire further discussion with the Iowa Dental Association, please contact Heather Heddens, DDS at (319) 653-5440. Thank you for the opportunity to comment on the request for rulemaking currently before you.

Sincerely,



Heather Heddens, D.D.S.
President, Iowa Dental Association

IOWA DENTAL ASSOCIATION
A Constituent of the American Dental Association

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December 22, 2008

Iowa Dental Board
ATTN: Jennifer Hart, Executive Officer
400 SW 8th Street, Suite D
Des Moines, Iowa 50309-4687

RE: Iowa Dental Hygienists' Association Request for Rulemaking

Jennifer Hart:

On November 25, 2008, the Iowa Dental Hygienists' Association ("IDHA") submitted a request for rulemaking. The IDHA requests that the Iowa Dental Board ("the Board") strike the requirement set forth in Iowa Administrative Rule 650-10.5(3)(a)(3), which states as follows:

> The dentist providing public health supervision must: ...(3) Specify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement;...

Iowa Administrative Code r. 650-10.5(3)(a)(3). The Iowa Dental Association ("IDA") believes that the striking of this provision would be inappropriate for the following reasons.

First, the scope of any hygienists' practice is limited by the requirements in Iowa Code section 153.15. That section states as follows:

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Mr. Larry Carl, CAE, Executive Director

IDA believes that deleting the twelve (12) month requirement set forth in Iowa Administrative Code section 650-10.5(3)(a)(3) would be in direct disregard of the statutory supervision requirement. The deletion of the requirement would also allow hygienists to cross the line into the practice of dentistry as diagnosis and analysis, which a dentist is trained to do, is necessary before and after certain types of services are provided.

Second, if the dentist is ultimately responsible for any liability arising from the care provided to the patients in the public health supervision program, few dentists will want to incur that liability if the patient is not required to see a dentist on at least an annual basis. It's hard to imagine any type of professional (i.e.: doctors, attorneys, architects) that would allow his/her own liability coverage be utilized by others without regular oversight.

Third, failure to have dentist oversight of certain procedures would be detrimental to the dental care of the very people the public health supervision program is meant to help. The application of sealants provides a good example and is the issue of most concern for IDA members. Whether and when sealants are appropriate must require an exam and diagnosis at some stage of the treatment regimen. This is an exam and diagnosis that a dentist, not a hygienist, is trained to provide. Furthermore, a dentist is trained to determine at any follow up visit the condition of those sealants and whether re-application is necessary. While IDA has no issue with hygienists applying the sealants, oversight by the dentist is necessary to determine the appropriateness and adequacy of the sealants. The dentist's knowledge and training allow him/her to make that determination to avoid any possible permanent damage to the patient's teeth. The current twelve month requirement is adequate to allow the dentist appropriate oversight to the hygienists' application of sealants and the performance of other hygiene services, while at the same time not prohibiting access to oral hygiene services on a regular basis.

Fourth, while IDA certainly does not question the level of reported success of the public health supervision program in addressing access to dental care in Iowa, the issues and concerns raised in IDHA's request for rulemaking are simply not tenable or could easily be remedied by the specific public health supervision agreements. Each of these assertions will be addressed in turn:

> 1. "Occasionally we see a child that has two or three of their molars erupted and ready for sealants so we apply sealants to those teeth. Because of the public health supervision rules, we cannot seal the remaining teeth after they have finished erupting until the child has seen a dentist again." (Letter from Jennifer J. Badger, RDH, p. 1)
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>
> 2. With regard to the services provided to pregnant mothers, Ms. Badger states as follows: "After a thorough assessment, a decision is made regarding whether or not we

feel we can provide a prophylaxis for the client. If appropriate, an appointment is scheduled for the prophy. We see our clients again in six months and would like to be able to provide a follow-up prophy at that time. Because of the public health supervision rules, we cannot do that unless the client has had an exam." (Letter from Jennifer J. Badger, RDH, pp. 1-2)

Response: Again, Ms. Badger seems to be confusing the rules with the public health supervision agreement governing the provision of her services. If she sees the client again within six months, she could provide a follow-up prophy, because it would be within the twelve month period. If the public health supervision agreement governing Ms. Badger provides a shorter period of time, then such issues can be addressed by revising that particular agreement.

3. There is a lack of dentists available to provide the necessary examinations and there is a lack of dentists willing to treat Medicaid clients. (Letter from Jennifer J. Badger, RPH, p. 2; Letter from Joyce Miller, RDH, BS, p. 2)

Response: IDA supports and encourages all dentists to do their part in addressing the oral health needs of all Iowans. While it is true that not every dentist will accept Medicaid patients, there are a significant number who do and will. For example, a statewide claims analysis conducted by Iowa Medicaid Enterprise states that well over 75 percent of Iowa dentists (over 1000) accepted Medicaid patients during the most recent state fiscal year.

IDHA's letter references a specific problem in Black Hawk County regarding access to examinations. After checking with dentists in the Black Hawk County area, it became clear that it was not that these dentists did not want to assist with the program, but that they hadn't been properly informed of the need nor effectively asked to participate. Thus, IDA questions whether the issue is really lack of access or whether it's a lack of knowledge about when and where a dentist's services are needed in the public health setting.

The experience of IDA's members is not that there is little or no access to dental care, but that the patients receiving care in the public health setting often fail to keep appointments for their dental care. The problem is not the lack of access, but the lack of follow through. The argument that dentists are not available, even if accurate, does not mean that this Board should revise its rules to allow hygienists to do the work of dentists. Iowa cannot lower the standard of care to persons in the public health realm on the unsupported claim that dentists are not available.

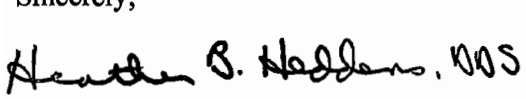
Finally, IDHA's claim that the requested revision would make Iowa more consistent with other states is inaccurate. In assessing the IDHA's comparison, it is important to remember that a particular statute or rule cannot be reviewed in a vacuum. Other statutes and rules in that state related to the matter at issue may not be the same as those in Iowa. For instance, Maine has a category of dental hygienist licensure called "independent practice dental hygienists." "Independent practice dental hygienists" are subject to increased education and training standards and are allowed to practice without certain supervision. Iowa does not have a similar

licensure category. In addition, Iowa Code section 153.15 specifically requires supervision by a dentist and thus, a similar rule in Iowa would not comply with the statutory requirements. Furthermore, IDHA's blanket conclusions regarding what is a "referral" state do not hold up under further scrutiny. In New Mexico, there is a yearly dental referral requirement and a specific exception for dentist authorization of certain procedures, such as sealants and root planning. Thus, New Mexico is not a "referral only" state. In addition, Oregon, contrary to IDHA's assertion, does have a twelve month requirement ("RDH must refer the patient annually to a licensed dentist available to treat the patient."). These corrections and clarifications were found by simply reviewing the "Direct Access States" document provided with IDHA's letter. Accordingly, it is likely that a more thorough review of each state would provide additional evidence that Iowa is not alone in its supervision requirement.

As set forth above, IDA believes that the IDHA's requested rulemaking is unnecessary, unwarranted and unsupported by Iowa law. Accordingly, IDA requests that the Board and the Dental Hygiene Committee deny IDHA's rulemaking request.

If you have questions or desire further discussion with the Iowa Dental Association, please contact Heather Heddens, DDS at (319) 653-5440. Thank you for the opportunity to comment on the request for rulemaking currently before you.

Sincerely,



Heather Heddens, D.D.S.
President, Iowa Dental Association

Iowa Dental Hygienists' Association

November 25, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo;

This letter constitutes a petition to the Iowa Dental Board, pursuant to Administrative Rule 650-7.1, requesting an amendment to the current administrative rule regarding licensee responsibilities as part of public health supervision of dental hygienists, Administrative Rule 650-10.5(3). Paragraph (a)(3) of this rule requires a dentist to "(s)pecify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement." The proposed amendment would strike this requirement.

This proposed amendment is being submitted for the following reasons: (1) it will remove a barrier to preventive dental hygiene services and (2) it would make Iowa's law regarding access to public health services more consistent with other states. As the Dental Board is aware, the public health supervision program for dental hygienists has been very successful in expanding access to quality dental care to Iowans, especially low-income families. According to statistics collected by the Iowa Department of Public Health, nearly 19,000 patients were served by this program in 2005, and by 2007, that figure had grown to nearly 35,000, almost a 100% increase. The number of hygienists providing services in public health settings has also grown, from 21 in 2005 to 56 in 2007; the number of dentists participating in this program has also grown significantly.

A recent study conducted at the Black Hawk County school-based dental sealant program demonstrates how dental hygienists working in a public health setting are making dramatic improvements in the oral health of children in that county. In the four years prior to allowing public health supervision, 1590 screenings were conducted. In the four years since screenings were able to be conducted by dentists and dental hygienists, the

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number of screenings increased to 2046, nearly a 33% increase. Over that same time-period, the number of children receiving dental sealants also increased by nearly 10%.

The study also shows the benefit of additional screenings and sealant applications. Eighth graders who had previously participated in the dental sealant program had 7.6% of their teeth demonstrating a history of caries, compared to 20.3% for those children who did not previously participate.

Removing a barrier to Preventive Dental Services

As shown above, the current dental hygiene public health supervision program is helping expand access to quality dental care. However, the current requirement, that patients participating in this program must be examined by a dentist within no longer than twelve months after receiving treatment, serves as a significant barrier to patients receiving the continued benefit of this program. Hygienists practicing in a public health setting have experienced significant difficulty in determining whether this requirement has been met as they do not provide the examination.

Additionally, at a recent dental summit, two school based sealant programs expressed concern that children who would benefit from additional sealants would be denied due to the annual exam requirement. For example, children receiving sealants as a 2nd grader prior to all teeth fully erupting are now ready in third grade have the rest of the teeth sealed, but lacking proof of exam, are not eligible to receive preventive services.

The study of Black Hawk County schoolchildren again shows the problem of lack of access. When follow-up screenings were conducted on 3rd, 4th, and 5th graders, nearly 47% had not received dental treatment since either their previous screening or sealant application. Under the current administrative rules, those 47% of children would not be able to receive many continuing preventive services from dental hygienists, including the application of additional sealants.

Attached are letters from Jen Badger and Joyce Miller, two dental hygienists who practice in public settings that outline their real world experiences and how adopting this petition would improve access to quality dental care.

Consistency with Laws in other States

Iowa's dental examination requirement is not consistent with laws in other states regarding direct access to dental hygiene services. According to the American Dental Hygiene Association, twenty-eight states, including Iowa, allow for some sort of direct access to hygiene services. Among those twenty-eight states, Iowa currently is one of only five states which place a limit on continuation of preventive services. In contrast, six other states, including Maine, Montana, New Mexico, Oregon, Rhode Island, and Washington, have a referral requirement such as is being proposed in this petition.

At an oral health summit hosted earlier this year by the Iowa Public Health Association, the current exam requirement was identified as a major barrier to access to oral health preventive services, and there was strong support at this summit to replace this

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requirement with a referral requirement similar to what is proposed in this petition. Additionally, the Oral Health Bureau of the Iowa Department of Public Health has included this change in their policy recommendations for this year. This change is supported, as well, by the Iowa Prevention of Disabilities Council.

As President of the Iowa Dental Hygienists Association, I want it understood that dental hygienists believe in and recognize the important role that dentists and dental exams play in providing quality dental health care to Iowans. As is stated in Jen Badger's letter, dental hygienists working in a public health setting work very hard to match up their patients with a dentist who can provide an exam and needed additional care.

However, when an exam is not able to be conducted, which as the Black Hawk County data demonstrates quite often occurs, it is important that barriers to quality dental care be removed. IDHA believes strongly that this petition would accomplish that objective, and we appreciate the board's consideration of this request.

Sincerely,

Carol Van Aernam

Carol Van Aernam, President
Iowa Dental Hygienists Association

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IOWA DEPARTMENT OF PUBLIC HEALTH - ORAL HEALTH BUREAU UPDATE
Tracy Rodgers, Community Health Consultant

I-Smile

Funding from DHS increased this year for the 23 Title V child health contracts. Agencies will receive $1,716,432 for SFY2009. The funding is distributed based on size of service area and Medicaid-enrolled children. Refer to the attachment for examples of activities provided by I-Smile coordinators.

OHB staff is working with Iowa Medicaid Enterprise to evaluate I-Smile. Specific data queries have been requested to review efficacy and impact. Dolores Malvitz, an epidemiologist formerly with CDC, is providing guidance to OHB on the evaluation measures.

School Dental Screening Requirement

This is the first school year that Iowa children are required to have proof of a dental screening prior to enrolling in kindergarten and ninth grade. Information and forms are available on the IDPH Website, trainings are being held, and there has been quite a bit of media coverage.

Local boards of health are responsible for audits – and I-Smile Coordinators are expected to coordinate systems within their service regions to assure completion of audits, reporting to boards of health, and reporting to IDPH. I-Smile Coordinators will also be integral in assisting families in having screenings completed.

Oral Health Bureau Codification

The administrative rules written to codify the Oral Health Bureau have been suspended. The Iowa Dental Association protested the definition of a dental home as written within the rules. The IDA opposes the inclusion of "nondental public and private health care professionals" in the definition. The legislature's Administrative Rules Review Committee agreed to suspend adoption of the rules, asking the IDPH and IDA to come to an agreement on the definition of a dental home.

Oral Health Policy Recommendations

1. Increase funding for the I-Smile dental home project to expand the dental workforce and increase preventive services for underserved children; to double Medicaid's preventive reimbursement for eligible providers; to allow physicians and primary care providers to bill for dental screenings outside of the EPSDT bundled well-child exam rate; and to improve Medicaid dental reimbursement rates or use a 3rd party billing system
2. Reinstate a 4-year bachelor's degree dental hygiene program in Iowa with public health service emphasis
3. Seek rules change by Iowa Dental Board for public health supervision to allow a dental hygienist to refer a patient to see a dentist, but not limit continued treatment if dental visit had not occurred within one year
4. Integrate oral health planning into the medical home initiative

DIRECT ACCESS STATES

For purposes of this document, direct access means that the dental hygienist can initiate treatment based on his or her assessment of patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and can maintain a provider-patient relationship.

Alaska 2008
AS 08.32.115
May provide services according to terms of collaborative agreement. No limit on settings. Dentist need not examine, diagnose, or be present.

Special requirements: 4,000 hours experience last 5 years. Board must approve collaborative agreement.

Services: Virtually entire scope of dental hygiene services, as long as agreement provides for them.

Arizona 2006
32-1289B
Dental hygienist working under contract for schools, public health settings and institutions may screen and apply fluoride unsupervised.

Arizona 2004
Sec. 32-1281 H, 3212-89
A dental hygienist with a written affiliated practice agreement with a dentist may assess for and perform dental hygiene services on patients under 18 years who meet certain financial criteria and are enrolled in a federal, state, county or local healthcare program

Special requirements: 5 years practice

Services: Any dental hygiene services specified in the affiliated practice agreement except root planing, local anesthesia, nitrous oxide or placing sutures.

- **Direct Medicaid reimbursement allowed.**

California 2002
Sec 1763 (a) 2002
Any dental hygienist may provide screening, apply fluorides and sealants without supervision in government created or administered public health programs.

California 1998
Sec. 1774, 1775
Dental hygienists endorsed as RDHAPs (registered dental hygienist in alternative practice) may provide services without supervision for homebound persons or at schools, residential facilities, institutions and in dental health professional shortage areas for up to 18 months, and provide further services if the patient obtains a prescription from a dentist or physician. RDHAP'S may own an alternative dental hygiene practice. Currently, there are more than 100 RDHAP's.

Special Requirements: Bachelors degree equivalent, 3 years clinical practice, completion of 150 clock hour special course and exam.
Services: Those services permitted under general supervision (which include oral prophylaxis, root planing, pit and fissure sealants, charting and examination of soft tissue).

- **In 2008, more than 200 RDHAP's registered.**
- **A dental hygienist mobile practice treats 25-35 disabled patients per week.**
- **Direct Medicaid reimbursement allowed.**

Colorado 1987

Sec. 12-35-122.5

Unsupervised practice in all settings for all licensed dental hygienists for the oral prophylaxis and preventive and therapeutic services. The dental hygienist may also own a dental hygiene practice.

Special Requirements: None.

Services: remove deposits, accretions, and stains, curettage without anesthesia, apply fluorides and other recognized preventive agents, oral inspection and charting, topical anesthetic. However, x-rays require general supervision and local anesthesia requires direct supervision.

- **Direct Medicaid reimbursement allowed. In fiscal year 2003-04, 16 independent RDH's provided 199,518 in services to 2,284 Medicaid children.**

Connecticut 1999

Section 20-126l

Dental hygienists with 2 years experience may practice without supervision in institutions, public health facilities, group homes and schools.

Special Requirements: 2 years experience.

Services: Oral prophylaxis, remove deposits, accretions and stains, root planning, sealants, assessment, and treatment planning.

- **Since 7/1/2003 hygienists have program has provided over 55,000 dental procedures – nearly 7,000 prophys/fluorides, 5,800 sealants and 15,000 exams.**
- **Direct Medicaid reimbursement allowed.**

Idaho 2004

I.C. 54-903 (9) / 54-904

Can provide services in hospitals, long term care facility, public health facility, health or migrant clinic or other board approved setting if dentist affiliated with setting authorizes services.

Special requirements: RDH must be an employee of the facility or obtain extended care permit. ECP requires 1,000 hours experience in last 2 years.

Services: As determined by authorizing dentist.

Iowa 2004

Rule 650-10.5 (153)

Dental hygienists may provide services based on standing orders and a written agreement with a dentist in schools, Head Start settings, FQHCs (Federally Qualified Health Centers), public health vans, free clinics, community centers and public health programs.
Special Requirements: RDH must have 3 years clinical experience and submit annual report on number of patients/services to department of health.

Services: All dental hygiene services (except local anesthesia and nitrous) may be provided once to each patient. To perform repeat services other than assessment, screening and fluoride, dentist must examine.

- **Active Public Health Supervision agreements in place between Iowa dentists and dental hygienists.**
- **Services in 2005: 17,332 clients received sealants, 18,942 received screenings, 6,098 received fluoride applications, over 281 received prophys, and 7,157 received education.**
- **As of 2007, 24 public health RDHs.**

Kansas 2003

Sec. 65-1456

Dental hygienist with an extended care permit I or II to treat patients in schools, head start programs, state correctional institutions, local health departments, indigent care clinics, adult care homes, hospital long term units, or at the home of homebound persons on medical assistance. No prior authorization is needed, but the hygienist must have an agreement with a sponsoring dentist who will monitor his/her practice.

Special requirements: 1,800 hours experience

Services: prophylaxis, application of fluoride, dental hygiene instruction, assessment of the patient's need for further treatment by a dentist and other services if delegated by the sponsoring dentist

- **As of 2007, there were 76 extended care permit dental hygienists.**

Maine 2008

Sec. B-1. 32 MRSA c. 16, sub-c. 3-B

A dental hygienist licensed as an independent practice dental hygienist may practice without supervision by a dentist in all settings.

Special Requirements: Possess a bachelor's degree from a CODA accredited dental hygiene program and 2,000 work hours of clinical practice in a private dental practice during the two years preceding the application or possess an associate degree from a CODA accredited dental hygiene program and 6,000 work hours of clinical practice in a private dental practice during the six years preceding the application. They are also required to provide a referral plan to patients in need of additional care by a dentist.

Services: Interview patients and record complete medical and dental histories; take and record the vital signs of blood pressure, pulse and temperature; perform oral inspections, recording all conditions that should be called to the attention of a dentist; perform complete periodontal and dental restorative charting; perform all procedures necessary for a complete prophylaxis, including root planing; apply fluoride to control caries; apply desensitizing agents to teeth; apply topical anesthetics; apply sealants; smooth and polish amalgam restorations, limited to slow speed application only; cement pontics and facings outside the mouth; take impressions for athletic mouth guards and custom fluoride trays; place and remove rubber dams; place temporary restorations in compliance with the protocol adopted by the board; and apply topical antimicrobials, excluding antibiotics, including fluoride, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The independent practice dental hygienist shall follow current manufacturer's instructions in the use of these medicaments.

Maine 2001
Rule 02 313 Chap. 1. Sec. 4
A dental hygienist may practice in a public or private school, hospital or other non-traditional practice setting under a public health supervision status granted by the dental board on a case-by-case basis. The hygienist may perform all services rendered under general supervision. The dentist should have specific standing orders and procedures to be carried out, although the dentist need not be present when the services have been provided. A written plan for referral or an agreement for follow-up shall be provided by the public health hygienist recording all conditions that should be called to the attention of the dentist. The supervising dentist shall review a summary report at the completion of the program or once a year.

Special Requirements: A dental hygienist must apply to the board to practice providing such information the board deems necessary. The board must take into consideration whether the program will fulfill an unmet need, whether a supervising dentist is available and that the appropriate public health guidelines and standards of care can be met and followed.

Services: All services that can be provided under general supervision. Dentist's diagnosis for sealants not needed in public health or school sealant programs.

- **From 3/02 through 10/04, over 5,500 patients were provided care in over 400 clinics. Nearly 30 dental hygienists are involved in this particular program.**
- **Direct Medicaid reimbursement allowed.**

Michigan 1991
Sec. 333.16625
A dental hygienist may administer dental hygiene services for a 2 year period to patients not assigned by a dental through a department of community Health designed "grantee health agency. Grantee health agencies must be a public or nonprofit entity, school, or nursing home that employs or contacts with at least one dentist or dental hygienist and provides care to an underserved population.

Special requirements: Entities seeking a grantee health agency status must submit a comprehensive form outlining how the program will be carried out, providing for oversight and direction, and including information for all dental personnel involved. A dental hygienist operating as a grantee health agency must ensure that the supervising dentist is available for consultation when necessary.

Services: those permitted under general supervision.

Minnesota 2001
Section 150A. 10, subd. 1a
A dental hygienist may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services without the patient first being examined by a licensed dentist if the dental hygienist has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

Health care facility is defined as a hospital, nursing home, home health agency, disabled/juvenile home, federal/state/local public health facility, community clinic, prison, tribal clinic school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.
A collaborative agreement means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services may be performed without the presence of a licensed dentist and may be performed at a setting other than the usual place of practice of the dentist or dental hygienist and without the dentist's diagnosis/treatment plan unless specified in the agreement.

Special Requirements: Has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years. Has documented participation in courses in infection control and medical emergencies within each continuing education cycle and maintains current certification in advanced or basic cardiac life support as recognized by the American Heart Association, the American Red Cross, or another agency that is equivalent to the American Heart Association or the American Red Cross.

Services: Removal of deposits and stains from the surfaces of the teeth, application of topical preventive and prophylactic agents, sealants, fluoride varnishes, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking x-rays and root planing.

- **There are now 2 dental hygienists volunteering in a community dental clinic providing restorative and preventive services to at least 10 patients each day they volunteer.**
- **At least 25 dental hygienists had qualified for collaborative practice in 2006.**
- **Direct Medicaid reimbursement allowed.**

Missouri 2001
Statute 332.311.2
Dental hygienists may provide services without supervision in public health settings to Medicaid eligible children and be directly reimbursed by Medicaid.

Special Requirements: 3 years experience.

Services: Oral prophylaxis, sealants, fluorides.

- **One particular dental hygienist has seen a sealant program grow from one school district to eight. Over 2,500 sealants have been placed on over 700 children.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, were 12 registered providers.**

Montana 2003
Sec. 37-4-405
Dental hygienists may obtain a limited access permit from the board allowing them to practice under public health supervision in a variety of federally funded health centers and clinics, nursing homes, extended care facilities, home health agencies, group homes for the elderly, disabled, and youth, head start programs, migrant work facilities and local and state public health facilities. Public health supervision means the hygienist can provide oral prophylaxis, fluoride, polish restorations, root plane, sealants, oral cancer screening, expose radiographs, and chart without the authorization of a dentist provided he or she follows protocols to be established by the board and refers any patients needing dental treatment.

- **Program took effect in September of '04, 10 permits in '06.**

Nebraska 2007
Sec. 71-193.18
The Department of Health may authorize an unsupervised RDH to provide public health related services in a public health setting or a healthcare or related facility.

Special requirements: 3000 hours experience in at least 4 of last 5 years; professional liability insurance.

Services: Prophylaxis for a health child, pulp vitality testing, preventive measures including fluorides & sealants.

New Hampshire 1993
Rule 302.02(d); 402.01 (c)
Under public health supervision dental hygienists may provide procedures authorized by a dentist in a public or private school, hospital or institution, or residence of a homebound patient provided the dentist reviews patient records once in a 12 month period.

Special Requirements: None.

Services: Instruction in oral hygiene, topical fluorides, oral prophylaxis, assess medical/dental history, periodontal probing/charting.

New Mexico 2007
Sec. 61-5-C
No supervision required for any dental hygienist to apply fluorides, and remineralization agents.

New Mexico 1999
Sec. 61-5A-4D
Rule 16.5.17
Collaborative practice permits [based on a written agreement between the dental hygienist and one or more consulting dentist(s)], dental hygienists to treat patients according to a protocol with collaborative dentist. Dental hygienists may own or manage a collaborative dental hygiene practice in any setting. Must refer patient for dental exam yearly.

Special Requirements: 2400 hours active practice in past 18 months or 3000 hours in 2 of past 3 years.

Services: Each collaborative practice agreement must contain protocols for care. Which provide for standing orders allowing the dental hygienist to provide routine services such as preliminary assessment, x- rays, oral prophylaxis and fluoride treatment without prior authorization. Case-by-case authorization required in some procedures (as sealants and root planning).

- **One collaborative practice arrangement that started in 2002, serves a base of 4,000 people-1/3 of which are Medicaid eligible.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, there were 35 collaborative practice RDHs.**

New York 2005
Rules Sec. 61.9
That a supervising dentist be available for consultation, diagnosis and evaluation, has authorized the dental hygienist to perform the services, and exercises that degree of supervision appropriate to the circumstances. A dental hygienist can work in any setting (private or public) and perform dental hygiene duties (listed below) without a dental examination or need to refer a patient to a dentist.

Dental hygiene services allowed include removing calcareous deposits, accretions and stains, including scaling and planning of exposed root surfaces; applying topical agents indicated for a complete dental prophylaxis; removing excess cement from surfaces of the teeth; providing patient education; placing and exposing X-ray films; performing topical anticariogenic agent applications, including but not limited to topical fluoride applications, and performing topical anesthetic applications; polishing teeth, including existing restorations; taking medical history including the measuring and recording of vital signs; charting caries and periodontal conditions

as an aid to diagnosis by the dentist; applying pit and fissure sealants; and applying desensitizing agents to the teeth.

In nursing homes a hygienist can perform a complete oral examination of a resident and then determine treatment priorities; plan for continuing oral hygiene and dental care.

- **In 2005, dental hygienists have screened and provided sealants for over 30,000 children.**
- **About 100,000 children in New York received care in school-based programs overseen by dental hygienists.**

Nevada 1998
Sec. 631.287
Dental hygienists may obtain approval to work as public health dental health hygienists in schools, community centers, hospitals, nursing homes and such other locations as the state dental health officer deems appropriate without supervision.

- **33 RDH's have gained board approval. Nevada Health Centers, Inc. where some RDH's are employed, provides services in eighteen different locations in Nevada. Dental hygienists with Public Health endorsement can also screen and place sealants without a dentist present. Additional locations include Saint Mary's, Huntridge Teen Center & Lyon Co. Healthy Smiles.**
- **Direct Medicaid reimbursement allowed.**

Oklahoma 2003
Sec. 328.34 C
A dentist may authorize in writing a dental hygienist to perform services one time on a patient in a setting outside the office prior to any dentist contact/exam if the hygienist refers the patient back to the authorizing dentist.

Special Requirements: 2 years experience

Oregon 1997
Sec. 680.200
Rule 818-035-0065
Dental hygienists who have obtained a limited access permit (LAP) may initiate services for patients in a variety of limited access settings such as extended care facilities, facilities for the mentally ill or disabled, correctional facilities, schools and pre-schools, and job training centers. RDH must refer the patient annually to a licensed dentist available to treat the patient.
12 hours of CE every two years (in addition to the 24 hours required for all dental hygienists) to renew permit.

Services--All dental hygiene services, except that some (local anesthesia, pit and fissure sealants, denture relines, temporary restorations, radiographs and nitrous oxide) must be preauthorized by a dentist.

- **In 2006, there were 70 LAP's.**
- **In the last year, LAP dental hygienists in 3 counties provided over 5,000 preventative procedures for children in Head start, Early Head start, WIC public health settings.**
- **Several LAP hygienists throughout Oregon continue to build practices serving the elderly in foster homes and extended care facilities.**
- **Direct Medicaid reimbursement allowed.**

Pennsylvania 2007

(Act 216) Sec. 2 (Definitions)

Dental hygienists licensed in Pennsylvania can practice as "public health dental hygiene practitioners," providing care in a variety of public health settings without the supervision or prior authorization of a dentist. Public health dental hygiene practitioners are required to take five hours of continuing education dedicated to public health matters during each licensure period.

Special requirements: 3,600 hours expense, liability insurance. Must complete 5 hours of CE in public health during each licensure period.

Services: educational, preventive, therapeutic, and intra-oral services, including complete prophylaxis and sealants, dental hygienists in the state are authorized to provide.

Rhode Island 2006

Sec. 5-31.1-6.1

Dental hygienists working under a dentist's general supervision can initiate dental hygiene treatment to residents of nursing facilities. Dental hygienists working in nursing facilities can treat patients, regardless of whether or not the patient is a patient of record, as long as documentation of services administered is maintained and necessary referrals for follow-up treatment are made.

Special requirements: None.

Services: Initial oral health screening assessments, prophylaxis, fluoride treatments, charting, and other duties delegable under general supervision.

South Carolina 2003

Sec. 40-15-110 (A) (10)

Dental hygienists employed by or contacted through the Department of Health and Environment Control may provide services under general supervision that does not require prior examination by a dentist in settings such as schools or nursing homes.

Special requirements: Dental hygienist must carry professional liability insurance.

Services: Prophylaxis, fluorides, sealants

Texas 2001

Sec. 262.1515

A dentist may delegate services without seeing the patient first to a dental hygienist practicing in a nursing facility or school based health center. The hygienist must refer the patient to a dentist following treatment. The hygienist may not perform a second set of services until the patient has been examined by a dentist.

Special Requirements: 2 years practice experience.

Services: No limitations.

Vermont 2008

Rule 10.2

Dental hygienists may provide hygiene services in public health settings under the supervision of a dentist via a general supervision agreement. The agreement authorizes the dental hygienist to provide services, agreed to between the dentist and the dental hygienist. The agreement does not require physical presence of the dentist but it stipulates that the supervising dentist review all patient records.

Special Requirements: Three years licensed clinical practice experience and in good standing in Vermont.

Services: Sealants, fluoride varnish, prophylaxis and x-rays. Periodontal maintenance and root planing may be provided on patients with mild periodontitis.

Washington 2001 (Washington has two different provisions for direct access)
Sec. 18.29.220
Dental hygienists who are school endorsed may assess for and apply sealants and fluoride varnishes in community-based sealant programs carried out in schools.

Special Requirements: Sealant/Fluoride Varnish Endorsement from Department of Health.

- **Data obtained through Medicaid indicates that dental hygienists working under these provisions saw 5,653 clients in 2002; 6,799 in 2003, and 4,265 through July of '04. Specifically in terms of sealants, over 19,200 sealants have been placed since Dec. 2003.**
- **Direct Medicaid reimbursement allowed.**

Washington 1984
Sec. 18.29.056
Unsupervised practice in hospitals, nursing homes, home health agencies, group homes (for the elderly, handicapped or youth), state institutions under department of health and human services, jails, and public health facilities provided the hygienist refers patient to a dentist for dental treatment and needed care.

Special requirements: Two years clinical experience within the last five years.

Services: removal of deposits and stains, application of topical preventive or prophylactic agents, polishing and smoothing restorations, root planing, curettage and local anesthesia. (The dental board has ruled that sealants are not included, but require general supervision).

West Virginia 2008
§5-1-8.5
Dental hygienists, who meet specific requirements, may provide dental hygiene services without the supervision of a dentist in hospitals, schools, correctional facilities, jails, community clinics, long term care facilities, nursing homes, home health agencies, group homes, state institutions under the Department of Health and Human Resources, public health facilities, homebound settings and Accredited Dental Hygiene Education programs.

Special requirements: 2 years and 3,000 hours of clinical dental hygiene experience; six additional continuing education hours this must include 3 hours in medical emergencies and 3 hours in general public health content. The dental hygienist and supervising dentist must submit an annual report to the West Virginia Board of Dental Examiners of services rendered.

Services: Dental hygiene education; nutritional counseling; oral screening with referral to dentist; apply fluoride; charting; recording medical history; complete prophylaxis (upon written prescription from a licensed dentist).

Wisconsin 2008
Wisconsin. Sec. 447.06
The statute does not require the presence or general supervision of a dentist in a public or private school, a dental or dental hygiene school or a facility owned by a local health department.

SCHOOL-BASED DENTAL SEALANT PROGRAM *

Table 1.[1] Screening Data 2000 - 2004

dds	# screenings	# children with	% children with	number of	average # caries	# sealants
	2nd graders	untreated caries	untreated caries	untx caries	per child	
2000-01	364	104	28.57	271	2.61	1199
2001-02	413	154	37.29	393	2.55	1444
2002-03	404	169	41.83	441	2.61	1296
2003-04	409	138	33.74	368	2.67	1563
TOTALS	**1590**	**565**	**35.53%**	**1473**	**2.61**	**5502**

Table 2.[2] Screening Data 2004 - 2008

dds	# screenings	# children with	% children with	number of	average # caries	# sealants
	2nd graders	untreated caries	untreated caries	untx caries	per child	
2004-05	245	94	38.36	246	2.62	778
2005-06	219	97	44.29	253	2.61	622
2006-07	222	67	30.18	172	2.57	641
2007-08	236	61	25.85	154	2.52	690
TOTALS	**922**	**319**	**34.59%**	**825**	**2.58**	**2731**
rdh						
2004-05	363	118	32.50	316	2.67	1175
2005-06	239	83	34.72	245	2.95	742
2006-07	251	89	35.46	185	2.09	706
2007-08	271	81	29.89	157	1.94	828
TOTALS	**1124**	**371**	**33.00%**	**903**	**2.43**	**3451**

Table 3.[3] Total # Screenings and Sealants

	Screenings	Sealants
	2nd graders	2nd grade
2000-04	1590	5502
2004-08	2046	6182

Table 4.[4] Treatment Status

	# of follow-up screenings for 3rd, 4th & 5th graders	# of children who HAVE received tx	# of children who HAVE NOT received tx
2001-02	71	30	41
2002-03	89	46	43
2003-04	79	46	33
2004-05	77	42	35
2005-06	133	88	45
2006-07	140	72	68
2007-08	100	42	58
TOTALS	**689**	**366**	**323**
%		**53.1%**	**46.9%**

Table 5.[5] Caries Experience of 8th Graders

Participants in Dental Sealant Program		
# of students	96	
# of first & second permanent molars [1]	695	
# of teeth with caries history	53	
Mean number of caries per student	0.55	(1.014 sd)[2]
Percent of teeth with caries history	**7.6%**	
Non-participants		
# of students	95	
# of first & second permanent molars [1]	684	
# of teeth with caries history	139	
Mean number of caries per student	1.46	(2.004 sd)[2]
Percent of teeth with caries history	**20.3%**	

[1] Does not include missing teeth or questionable caries

[2] *t(189) df = 3.97, p<.001*

Middle Schools 2004

* This data was collected from the Black Hawk County School-based Dental Sealant Program. The program has provided services to 15 elementary and 6 middle schools in 3 counties in Iowa.

[1] Table 1 contains the data collected during the four years that a licensed dentist did all of the screenings.

[2] Table 2 contains the data collected during the four years that both a licensed dentist and a licensed dental hygienist did screenings.
There appears to be no significant difference between the percent of children with untreated caries or the average # of caries per child if the screening was completed by a dentist or a dental hygienist.

[3] Table 3 contains a comparison of the number of screenings and sealants.
During the four years from 2004 -2008 that both a dentist and dental hygienist did screenings there were 456 more screenings and 680 more sealants than the four years that only a dentist did the screenings.

[4] Table 4 contains the data indicating the number of children who were screened in Grades 3,4 & 5 to determine if treatment for dental disease was completed. Almost 47% had not received treatment by a dentist.

[5] Table 5 contains the screening data of eighth graders from 3 middle schools. This outcome data indicates there is a significant difference in the caries experience of 8th graders. The students who did NOT participate in the school-based sealant program were almost 3 times more likely to experience tooth decay in their permanent molars.

Notes: In 2004 the Black Hawk County School-based Dental Sealant program began utilization of the public health supervision ruling in accordance with the requirements of Iowa Code Section 10.5 (153). This ruling has increased access to preventive services for high-risk children and provided significant improvements to the efficiency of the program.

When the dental hygienist does both the screenings and the sealant applications it 1) reduces the amount of time each student is out of the classroom; 2) reduces interruptions to the academic activities in the classroom; 3) reduces the amount of time between the screening and the placement of sealants, 4) reduces the number of clinical supplies needed; and 5) reduces the costs of compensating dentists for time and expenses to perform screenings.

In addition, this format 1) increases the possibility that students who were absent or have not yet returned a consent form will be able to participate in the program; 2) retains the referral process for students in need of dental treatment and 3) retains the ability to do follow-up screenings to determine if children have received the dental treatment they need.

The data collected from this school-based sealant program indicate that the program can be implemented more efficiently in terms of time and cost when a dental hygienist does the screenings and makes referrals to a dentist for dental treatment.

The data from this program also indicate that almost 47% of children who have been identified as having existing caries and are in need of treatment have not received treatment when a follow-up screening was done in subsequent years. Utilization of the time and clinical skills of licensed dentists may be more beneficial to these children if restorative services were provided rather than the time and expenses required to complete screenings in schools.

October 26, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo:

As a registered dental hygienist currently working under public health supervision, I am writing to you to express my support of the Iowa Dental Hygienists' Association's current request for an amendment to the public health supervision rules. I believe that the access-to-care issues we have been aware of are becoming even more evident as more hygienists begin a career in public health. In the 22 months that I have been working as an I-Smile Coordinator, I have had the need demonstrated to me time and again.

This proposed amendment – changing the requirement of a dental exam within 12 months following certain procedures to the requirement of a dental referral following the procedures – will allow myself and the other hygienists employed by our agency to address the access-to-care issues that we are seeing our clients experience. By being able to provide comprehensive dental hygiene services in spite of our clients' inability to be seen by a dentist, we will be a source of ongoing care.

I would like to provide you with two examples of ways in which this change will benefit the patients who are served by our agency.

- In our Child Health clinic in Perry, we are currently applying sealants. Because of the way our public health supervision agreement is set up with our supervising dentist, we can provide sealants after the client has had an exam and has been deemed caries-free. The dentists in the area are not applying sealants on a regular basis, even to children at a high risk for developing caries. After the child has seen a dentist, we apply sealants to the children's teeth. Occasionally, we see a child that has two or three of their molars erupted and ready for sealants so we apply sealants to those teeth. Because of the public health supervision rules, we cannot seal the remaining teeth after they have finished erupting until the child has seen a dentist again. For our children, that will be six to twelve months. With the amendment changed to a referral to the dentist, we could make that referral and then go ahead and seal the remaining teeth in three to four months after they have finished erupting. This would allow us to provide this preventive measure with the hope of decreasing dental caries on these teeth.
- We have recently begun providing dental hygiene services to our Maternal Health clients (pregnant mothers) at our WIC clinics. After a thorough assessment, a decision is

made regarding whether or not we feel we can provide a prophylaxis for the client. If appropriate, an appointment is scheduled for the prophy. We see our clients again in six months and would like to be able to provide a follow-up prophy at that time. Because of the public health supervision rules, we cannot do that unless the client has had an exam. For our clients who are uninsured and cannot afford to pay for a dental visit out-of-pocket, this becomes a serious impediment to ongoing dental care. Our clients who are enrolled in Medicaid also have a difficult time accessing care due to dentists' non-acceptance of Medicaid. If we could refer the client to the dentist and then proceed with the follow up visit, we could provide ongoing, comprehensive dental hygiene care to our clients.

Our programs are expanding and we hope to be able to provide dental hygiene services to clients of our agency's substance abuse treatment program. There is a significant need present in those clients and a change in the rules would allow us to provide ongoing dental hygiene care to these clients as well.

Lastly, I would like to express my continued support and cooperation with the dentists in our area. I always conclude every appointment with any of our clients with a statement of the need to be seen by a dentist. I also make sure all of our clients know that our assessment in no way replaces a dental exam and regular care by a dentist. Unfortunately, due to the shortage of dentists in certain parts of our service area, the shortage of dentists who accept Medicaid, and the inability of some of our clients to pay for out-of-pocket costs associated with dental care, several of our clients are simply unable to access dental care in a dental office. If we could provide ongoing dental hygiene preventive care until they are able to seek care in a dental office, the chances of needing significant dental work will be decreased. This care, along with proper education, will improve the dental health of our clients.

I appreciate your time in reading my letter and your consideration of the request for the amendment to the rules. Our clients are so appreciative of all we do for them because without us they would not be receiving care. Please consider the change to the rules so that we can enhance our services and provide ongoing care to those who need it most.

Sincerely,

Jenifer J. Badger

Jenifer J Badger, RDH
Bagley, Iowa

October 26, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo,

I am writing to support an amendment to Administrative Rule 650-7.1 regarding the need for a dental exam after 12 months of preventive hygiene services and the discontinuation of these services if no dental examination is performed.

My dental hygiene career started about 31 years ago. During this time, I have been in private practice, worked as an adjunct clinical instructor at DMACC and currently have a public health position serving seven counties in Iowa. The majority of my time in the early years was patient education, prophylaxis, fluoride treatments and exposing radiographs. In the 1970s and 1980s, there was a high incidence of rampant decay and nursing caries, especially with the influx of Southeast Asians. It was routine to see "bombed-out" deciduous molars, incisors and first permanent molars. Children required extensive dental treatment, including extractions, crowns, space maintainers, large restorations with pulp caps and some endodontics. Because of the increase in education, preventative treatment, fluoride, sealants, regular recalls and increased third party payments, the extensive treatment we once provided is uncommon. Over the years, there have been many positive changes in dentistry and patients receive improved preventative services.

However, low-income clients, because of their dental insurance or lack of insurance, are unable to receive dental treatment, or receive only minimal treatment at best. This brings me to my current employment. Two months ago, I took a position with New Opportunities, Inc. in Carroll, IA. We provide screenings, fluoride varnishes, dental referrals, etc. as part of the I-Smile Program. If I were to describe the clients' needs in this program, I would have to describe the 1970s and 1980s when I started practicing.

After thirty years in private practice, seeing the well-maintained, disease-free, or successfully treated patients, I thought the dental diseases were decreasing. However, after three weeks with I –Smile Program, I quickly realized was so mistaken. I overestimated the percentage of people who actively seek and receive dental care. In just three days working at the Perry facility, we observed three children with suspected rampant decay, nursing caries and fistulas on deciduous incisors. As part of the screening visit, we provide a referral to a local dentist for an examination. This can be a verbal, a written referral or a call an office to schedule an appointment. Scheduling appointments is not as easy as it would seem, barriers may include:

1) the lack of dentists willing to treat Medicaid clients
2) the office is no longer seeing new Medicaid patients
3) patients dismissal because of missed appointments
4) clients failing scheduled appointments
5) dentists deferring treatment to The University of Iowa because the client is a probable surgery candidate
6) lack of transportation
7) lack of child care when at appointments
8) parents' lack of dental education recognizing dental disease
9) parents' lack of nutrition education
10) decreasing number of child health clinics

I wanted to work in public health to provide preventative care for the underserved, act as a bridge or connection between public health clients and dentists, and bring this group into the 21st century. Please allow public health hygienists to continue providing preventative services including referrals for our clients. If it were not for public health services and referrals, some may never visit a dentist. In addition, making the referral and scheduling an examination appointment does not always a guarantee treatment is provided. It is unfair to suspend all public health services after one year because a dentist did not provide a dental examination. Suspending all preventative therapy in the absence of a dental examination may eliminate the only opportunity the low-income, uninsured and underinsured may have to receive preventative services.

Thank you for your time and consideration.

Sincerely,

Joyce Miller, RDH, BS

Larry Carl

From: Hart, Jennifer [IBDE] [Jennifer.Hart@iowa.gov]
Sent: Wednesday, November 26, 2008 11:50 AM
To: Larry Carl; jvlegs@hotmail.com; ensey4@yahoo.com
Cc: cvanaernam@aol.com; Price, Constance [IBDE]
Subject: Dental Hygiene Petition - Comments requested
Follow Up Flag: Follow up
Due By: Monday, December 08, 2008 12:00 AM
Flag Status: Red
Attachments: DH Petition NewNov08.pdf

Attached is a copy of a petition for rulemaking and supporting documents submitted by the Iowa Dental Hygienists' Association concerning public health supervision. I am forwarding a copy of this information to the associations to give you an opportunity to submit written comments on the petition for board consideration.

The petition will be considered by the Iowa Dental Board at their January 15, 2009, meeting. To give the board time to review your comments, it would be helpful for your to submit them no later than Monday, December 22. Comments may be submitted via mail to the board address or may be e-mailed to my attention. Please note that if the board chooses to grant the petition and initiates rulemaking, a public hearing will be scheduled and there will be an additional opportunity to submit written comments.

Jennifer Hart, Executive Officer
Iowa Dental Board
400 SW 8th St, Suite D
Des Moines, IA 50309
☎Phone (515) 281-0997 ☎Fax (515) 281-7969
http://www.dentalboard.iowa.gov

BE GREEN: Please consider the environment before printing this email.

January 5, 2009

RECEIVED
JAN 08 2009
IOWA DENTAL BOARD

Deena Kuempel, DDS
Chairperson, Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309

Dear Dr. Kuempel

I understand that the Iowa Dental Board will be discussing the public health supervision rules at a meeting in January 2009. While I am not able to attend the meeting I would like the attached information taken into consideration. I have provided clinical coordination of the Black Hawk County school-based dental program since its inception in 1999. For the past four years I have provided services under the public health supervision rules. Although I believe some data from the school-based program has already been forwarded to the Board, I am enclosing a current copy in this correspondence.

As an advocate for high-risk children who have limited access to preventive and operative dental care, I sincerely request that the rules be amended to eliminate the twelve month dental screening requirement. The current requirement reduces the possibility of preventive services being provided to all eligible school children. Eight years of in-school screenings by both dentists and dental hygienists indicate there is no significant difference in the screening outcomes or judgments about which teeth to seal or not to seal. There appears to be no clinical benefit for these children in having a dentist doing the initial screenings or any subsequent screenings. The data also indicate that one of the most serious unmet needs for the children who have been identified with existing disease is getting treatment and follow-up care by a dentist. That is a service we hope more dental clinicians will be willing to provide in the future.

As part of our school-based program we provide in-service programs for the teachers and staff at each of the participating schools. I have enclosed a copy of one of the handouts. It is sometimes difficult to look at all the data and see the individual children the numbers represent. These school-age children are in a critical stage of their dental development. What does or doesn't happen for them during their early development has a serious impact on their future health and well-being. They are impoverished, uninsured or underinsured and in pain. Even when they have toothaches and discomfort they often continue to go to school and struggle through their school hours to pay attention, eat lunch and enjoy recess.

Dr. Kuempel, I would like to take this opportunity to clarify comments that were forwarded to me regarding the availability of dentists to do screenings for our program in Black Hawk County. Since the beginning of the program in 1999 we have had dentists who were willing to help with

the in-school screenings every year. I do not know the origin of the misinformation stating that local dentists were not available or willing to do screenings.

Please share this correspondence and attachments with all of the Board members and extend to each of them an invitation to come and visit our school-based program. They can contact me by phone or email to arrange a visit at any of the schools. Thank you.

Sincerely,

Joan L. Gilpin, RDH, MA
Coordinator, School-Based Dental Program
Black Hawk County Health Department
jlgilpin@cfu.net; ph. 319-277-1843

Cc: Rhonda J. Bottke, MA, ARNP, CPNP
Division Manager, Black Hawk County Health Department

Carol Van Aernam RDH, BA
President, Iowa Dental Hygienists' Association

Robert Russell, DDS, MPH
Public Health Dental Director, Iowa Department of Public Health

5-Jan-09

BLACK HAWK COUNTY HEALTH DEPARTMENT

SCHOOL-BASED DENTAL PROGRAM *

Table 1.[1] Screening Data 2000 - 2004

dds	# screenings 2nd graders	# children with untreated caries	% children with untreated caries	number of untx caries	average # caries per child	# sealants
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TOTALS	**1124**	**371**	**33.00%**	**903**	**2.43**	**3451**

Table 3.[3] Total # Screenings and Sealants

	Screenings 2nd graders	Sealants 2nd grade
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Table 4.[4] **Treatment Status**

	# of follow-up screenings for 3rd, 4th & 5th graders	# of children who HAVE received tx	# of children who HAVE NOT received tx
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TOTALS	**689**	**366**	**323**
%		**53.1%**	**46.9%**

Table 5. [5] **Caries Experience of 8th Graders**

Participants		
# of students	96	
# of first & second permanent molars [1]	695	
# of teeth with caries history	53	
Mean number of caries per student	0.55	(1.014 sd)[2]
Percent of teeth with caries history	**7.6%**	
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# of students	95	
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Mean number of caries per student	1.46	(2.004 sd)[2]
Percent of teeth with caries history	**20.3%**	

[1] Does not include missing teeth or questionable caries

[2] *t(189) df = 3.97, p<.001*

Middle Schools 2004

* The data in Tables 1 - 5 were collected during the implementation of the Black Hawk County School-based Dental Program. Children in 15 elementary and 6 middle schools in 3 counties in Iowa are provided preventive services through this public health program.

[1] Table 1 contains the screening data collected during the four years that a dentist did all of the screenings.

[2] Table 2 contains the screening data collected during the four years that either a dentist or a dental hygienist did the screenings. *There appears to be no significant difference in the clinical judgments of the dentists and the dental hygienists.*

[3] Table 3 contains a comparison of the total number of screenings and sealants for each four year period. During the four years from 2004 -2008 that a dental hygienist did screenings under the public health supervision rules, there were *456 more screenings and 680 more sealants provided to high risk children.*

[4] Table 4 contains the data indicating the number of children who had follow-up screenings in grades 3,4 & 5 to determine if treatment for dental disease was completed. *Almost 47% had not received treatment after referral to a dentist.*

[5] Table 5 contains the screening data of eighth graders from 3 middle schools. The outcome data indicate that students who participated in the school-based program were almost 3 times less likely to have cavities in their permanent molars.

Notes: In 2004 the Black Hawk County School-based Dental Sealant program began utilization of the public health supervision ruling in accordance with the requirements of Iowa Code Section 10.5 (153). This ruling has increased access to preventive services for high-risk children and has provided significant improvements to the efficiency of the program.

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The data collected from this school-based sealant program indicate that preventive services can be provided to more high-risk children when a dental hygienist does the screenings. The data also indicate that almost 47% of children who have been identified as having existing caries and are in need of treatment have not received treatment when a follow-up screening was done in subsequent years. These children would benefit from the time and unique clinical skills of a dentist.

Respectfully submitted by:
Joan L. Gilpin, RDH, MA
Coordinator, School Based Dental Program
Black Hawk County Health Department
ph 319-277-1843 jlgilpin@cfu.net

ST. LUKE'S HOSPITAL
IOWA HEALTH SYSTEM

RECEIVED
JUN 3 0 2004
IOWA BOARD OF
DENTAL EXAMINERS

DENTAL HEALTH CENTER
MEDICAL PLAZA BLDG.
SUITE LL 1
855 A AVENUE NE
CEDAR RAPIDS, IA 52402
319 / 369-7730
FAX: 319 / 369-7494

June 25, 2004

Iowa Department of Public Health
Oral Health Bureau, 5th Floor
Attn: Public Health Supervision
321 E 12th St
Des Moines, IA 50319-0075

Dear Oral Health Bureau:

Our three public health dental hygienists have completed their Public Health Supervision Agreements.

Please take note that one agreement is 27 pages, another is 20 pages and the third is 10 pages. This was 57 pages of reporting, plus another 57 pages of copies for our dental public health program in East Central Iowa.

The process required considerable staff time. If this is an annual report, you must consider revising and limiting the agreement and reporting forms.

Sincerely,

Rhys B. Jones DDS

Rhys B. Jones, DDS, MS
Director, Dental Health Center

Cc: Iowa Board of Dental Examiners

RBJ/pb

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

IOWA DENTAL BOARD
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

June 2009

Dear Licensee:

Public health supervision of dental hygienists has been an important step in improving access to preventive dental care for many underserved Iowans. Our records indicate that you currently have a public health supervision agreement with a dentist on file with the Oral Health Bureau of the Iowa Department of Public Health.

As you renew your dental hygiene license, we want to remind those of you with public health supervision agreements of the following:

- It is your responsibility – not your employer's – to oversee all aspects of your written supervision agreement and ensure that you are following board rules related to these agreements, including reporting requirements.
- Board rules require you to submit a report concerning the services rendered. These reports must be submitted in a timely manner to the Oral Health Bureau by January 31 of each year.
- Please be sure that the agreement on file is current. If there are changes in public health settings or service locations, a new or amended agreement signed by you and the supervising dentist must be submitted to the Oral Health Bureau.
- Review your agreement with your supervising dentist periodically. If there are any changes, a new or amended agreement signed by you and the supervising dentist must be submitted to the Oral Health Bureau.
- If you are no longer practicing under public health supervision, please advise the Oral Health Bureau in writing.

If you have questions about public health supervision, board rules, or how you can become involved in providing services for underserved Iowans, please contact either the Iowa Dental Board or the Oral Health Bureau of the Iowa Department of Public Health at (866) 528-4020.

400 SW 8th STREET, SUITE D, DES MOINES, IA 50309-4687
PHONE:515-281-5157 FAX:515-281-7969 http://www.dentalboard.iowa.gov