



North Dakota State Board of Dental Examiners

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Senate Human Services Committee

Wednesday, September 21, 2016

Comments presented by Rita Sommers, Executive Director of the NDBDE

Good Morning Chairman Lee and Members of the Committee. My name is Rita Sommers. I serve as the executive director of the North Dakota Board of Dental Examiners (NDBDE). As requested, I am presenting comments regarding the ability of dental hygienists to perform outreach services and refer patients to a dental home without a dentist on site and recommended legislation to allow for outreach services and case management.

DENTAL HYGIENISTS AND OUTREACH SERVICES

Assuming the definition of ‘*outreach services*’ means any type of health service that mobilizes health care providers to deliver services to the population, away from traditional office locations where they are most commonly provided, it is helpful to understand that any ND licensed dental hygienist may presently perform such outreach services within their scope of practice and under the general supervision of a dentist who is not required to be on site. Since the inception of the 2009 laws hygienists have been authorized to provide duties authorized in advance in non-traditional locations under general supervision.

The ND Department of Health, Oral Health Program optimized by the new laws have utilized licensed hygienists in sealant programs, fluoride varnish programs, and providing screenings and assessments in school [and other?] settings which is a blueprint for how oral healthcare delivery can be further improved in our state utilizing the existing dental workforce.

Bridging the Dental Gap, in Bismarck, ND, a sliding-scale dental clinic, has also utilized the language to the full extent of the existing laws by taking it a step further. Bridging the Dental Gap offers an alternative location for dental hygiene treatment for patients who cannot easily be transported to a dental office. Dental Hygienists in North Dakota are currently providing outreach services in the form of dental hygiene duties in

nursing homes under the general supervision of a dentist or dentists by means of safety net clinics here in Bismarck.

To explain the laws further, in 2009 the Board amended the dental hygienists scope of practice with the insertion of the language in NDCC § 43-20-03 to read: “General supervision may be used *if the procedures are authorized in advance* by the supervising dentist, except procedures which may only be used under direct supervision as established by the board by rule.” The rules amendment which followed was also key in supplementing the new law. The definition of general supervision was amended to compliment and facilitate licensees in utilizing their training and education under a broader level of general supervision.

"General supervision" means the *dentist has authorized the procedures and they are to be carried out in accordance with the dentist's diagnosis, if necessary, and treatment plan*. The dentist is not required to be in the treatment facility. Limitations are contained in North Dakota Century Code section 43-20-03.” (Referring to local anesthesia which is prohibited under general supervision).

In 2014 the Board also worked to expand duties of the dental team by addressing public health setting duties for the dental assistant. The Board commented in 2014 that proposed rules introduce language to enable not only a broader scope of practice, but also a broader range of supervision requirements for the dental assistant to enable dental assistants to work in community settings providing yet more outreach to vulnerable populations by conducting basic screenings, oral hygiene instruction, case management, fluoride varnish, and linkage to a dental home (Dec. 8, 2014).” A dental assistant is currently authorized to provide the aforementioned duties and more under general supervision of a dentist. The 2014 amendment* reiterated the possible public health entities where auxiliary could work and highlighted two auxiliary groups working together.

North Dakota’s current laws allowing registered dental assistants to work with dental hygienists (again under general supervision) in schools and other community settings are, in the Board’s opinion, key components of the infrastructure required to reach greater numbers of Medicaid and other vulnerable populations while conducting

basic oral assessments, oral hygiene instruction, case management, fluoride varnish, sealants and linkage to a dental home.

CASE MANAGEMENT

A dental assistant, under current law and rule is qualified and authorized to carry out case management duties as described by the American Dental Association (ADA) which include clinical preventive services under general supervision of a dentist and providing community-based outreach duties, although the most important role is helping patients navigate the health care system. The “outreach” concept was a variation on the CDHC (the ADA’s Community Dental Health Coordinator).

RECOMMENDATIONS

I would like to address two statements made by The North Dakota Oral Health Coalition (NDOHC) in its Collaborative Practice Task Force Summary Report (attached).

- 1) “Extensive discussion regarding dental home and oral health reviews took place. All members agreed that the goal to link high-risk patients to a Dental Home without creating barriers to access to care was an important consideration. The specific timeframes within which an oral health exam should take place posed challenges that had the potential to become a barrier to care, particularly in the public health setting.”
- 2) “Task Force members actively solicited input from individuals who have prior experience with Collaborative Practice from an implementation and policy perspective. After much discussion, the Task Force decided to support the existing language in ND rules relating to collaborative practice, and that the all members and their respective organizations should make it a priority to educate dental professionals about current rules/law and focus on using the law to bring care to schools, nursing homes, etc. All members expressed interest in continuing the partnerships established through the Task Force.”

In my opinion there is a lack of the dental community's understanding of supervision laws as well as the logistics related to delivery of care. I believe this lack of understanding is manifested by the underutilization of the new laws. Dental hygienists may provide services without the physical presence of, or prior examination of a dentist. At present, services must be first authorized by a dentist. It is possible that dentists may be hesitant about authorizing services due to the fact that elderly and other affected populations are more likely to be medically compromised, more vulnerable, and require extra precautions before treatment can be safely administered.

To address these concerns my recommendation would be that in addition to a dentist, any physician or nurse practitioner who may have more frequent contact with or more routinely visit nursing home patients may also provide medical clearance authorization for dental hygiene services to be provided prior to a hygienist performing a prophylaxis in the alternate healthcare setting to ease this potential barrier. A dentist would be required to see the patient within one year following the prophylaxis for a complete evaluation before further services could be provided.

Further hampering deliver of care for nursing home patients can be the necessity to provide appropriate portable dental equipment needed for such care – which few if any dentists own. Perhaps agreements between practitioners and the Department of Health could be developed allowing for the use of such equipment.

Any patient seen for hygiene care in the alternative health setting would not become a patient of record to a dentist authorizing such care until the dentist performs the subsequent complete evaluation. The hygienist could present to the patient the option of 'adopting' the provider/dental home of her/his collaborative dentist or seek another dental home. Similar protocol is carried out in the delivery of sealants at schools to Medicaid eligible students.

"Alternate health setting" may require a definition within the administrative rules. Currently the administrative rules define a patient of record. "Alternate health setting" would likely mean a school, Head Start Program settings, nursing home or long term care facilities or institutions, federally-qualified health centers, public health programs, hospitals, free clinics, local health units, or other board approved setting(s).

Expanding supervision and scope of practice for both hygienists and registered dental assistants, particularly in ND's more rural locations, can be accomplished with cost efficiency while maintaining public safety. Additionally, the utilization of existing infrastructure and workforce provides important elements for the more rapid development of a financially feasible and effective work model.

In closing, I would like to advise the committee that any recommendations offered here today are limited to my personal opinion and have not been reviewed or approved by NDBDE due to the inability to convene the NDBDE on the short notice provided for today's committee meeting. The next meeting of the Board is scheduled for Friday, September 23, 2016.

Rita Sommers, Executive Director
NDBDE

LAWS PERTAINING TO COMMENTS

43-20-03. Dental hygienists - Practice by. As used in this chapter, "dental hygiene" and the practice thereof means the removal of accumulated matter from the natural and restored surfaces of teeth and from restorations in the human mouth, the polishing of such surfaces, and the topical application of drugs to the surface tissues of the mouth and to the surface of teeth if such acts are performed under the direct, indirect, or general supervision of a licensed dentist. General supervision may be used if the procedures are authorized in advance by the supervising dentist, except procedures which may only be used under direct supervision as established by the board by rule. Only a person licensed as a dental hygienist may be referred to as a dental hygienist. Additional tasks permitted to be performed by licensed dental hygienists may be outlined by the board of dental examiners by appropriate rules.

43-20-12. Dental hygienist - Scope of permitted practice. A licensed dentist may delegate to a competent dental hygienist those procedures over which the dentist exercises full responsibility, except those procedures that require professional judgment and skill such as diagnosis and treatment planning, the cutting of hard or soft tissue, or any intraoral procedure which would lead to the fabrication of any appliance that, when worn by the patient, would come in direct contact with hard or soft tissue and which could result in tissue irritation or injury. The board of dental examiners may adopt rules governing the scope of practice of dental hygienists.

43-20-13. Dental assistant - Scope of permitted practice. A dental assistant is an auxiliary to the practice of dentistry. To the extent applicable and to the extent they are not inconsistent with this chapter, the requirements and rules adopted by the board of dental examiners under chapter 43-28 apply to the practice of dental assistants. A dentist may delegate to a dental assistant who is under that dentist's direct, indirect, or general supervision (2006) procedures over which the dentist exercises full responsibility as provided by rules adopted by the board of dental examiners.

20-01-02-01. Definitions.

11. "Complete evaluation" means an examination, review of medical and dental history, the formulation of a diagnosis, and the establishment of a written treatment plan, documented in a written record to be maintained in the dentist's office or other treatment facility or institution.

19. "Evaluation" means the act or process by a dentist of assessing and determining the significance, quality or work of something such as the patient's oral health status, the progress of dental therapy, or the performance of the dental hygienist or dental assistant.

21. "General supervision" means the dentist has authorized the procedures and they are carried out in accordance with the dentist's diagnosis, if necessary, and treatment plan. The dentist is not required to be in the treatment facility. Limitations are contained in North Dakota Century Code section 43-20-03.

25. "Oral assessment" means the evaluation of data pertaining to the patient's condition to help identify dental problems leading to a professional treatment plan. The final diagnosis

of disease or treatment plan is the sole responsibility of the supervising or collaborative dentist.

26. "Oral hygiene treatment planning" is a component of a comprehensive treatment plan developed by the hygienist or dentist to provide the hygienist a framework for addressing the preventative, educational, and clinical treatment needs of the patient.

27. "Patient of record" means a patient who has undergone a complete dental evaluation performed by a licensed dentist.



North Dakota Oral Health Coalition (NDOHC) Collaborative Practice Task Force Summary Report

During the 2015 North Dakota Legislative Session, the North Dakota Oral Health Coalition (NDOHC) was brought forward by legislators as an organization that could help facilitate discussion around collaborative practice between North Dakota dentists, dental hygienists and other key stakeholders.

Collaborative practice is a concept in which the dentist and dental hygienist enter into a written agreement that authorizes the supervision of the Registered Dental Hygienist working under the general supervision of a dentist. Dentist-dental hygienist collaborative practice is "a commitment to interact on a professional level that empowers the participants to blend their talent to achieve a goal that neither can do alone." *D.J.Thompson, Florida Atlantic University*

On 08/06/15, the NDOHC Executive Director convened a collaborative practice planning meeting with key stakeholders including Bridging the Dental Gap, the ND Dental Association (NDDA), North Dakota Dental Hygienists' Association (NDDHA), North Dakota Department of Health Oral Health Program (NDDOH OHP) and the North Dakota Oral Health Coalition. This task force agreed to function through a consensus based process as the "Core Planning Group". An additional group of stakeholders, the "Advisory Group" were identified as potential partners and technical advisors to provide advice and other input as the process evolved.

Task Force Members

Cheryl Underhill –North Dakota Oral Health Coalition Executive Director, Facilitator

Kimberlie Yineman- North Dakota Department of Health Oral Health Program, Dental Director

Jaci Seefeldt-, North Dakota Department of Health Oral Health Program, Oral Health Prevention Coordinator

Rachelle Gustafson- North Dakota Dental Hygienists' Association, Past President,

Judy Bernat-NDDHA Alternate, President

Dr. Brent Holman- North Dakota Dental Association, Executive Director

Dr. Omar Chahal-NDDA Alternate, President

Marcia Olson- Bridging the Dental Gap, Executive Director and NDOHC Board President

8/6/15-9/25/15

Unfortunately, Marcia Olson passed away during this process; the group renewed their commitment to the process in honor of Marcia's dedication to oral health.

Members concluded that task force outcomes would maintain and improve current quality standards of care and safety for North Dakotans; be evidenced based; and allow for greater access to care with the best interests of the patient in mind.

The Core Group convened four times by teleconference and once in a half-day face-to-face meeting in Fargo to review, discuss and agree upon key elements of a collaborative practice definition for ND. Key elements of collaborative practice definitions were reviewed from other state's existing Collaborative Practice Agreements, particularly Minnesota and South Dakota.

Extensive discussion regarding dental home and oral health reviews took place. All members agreed that the goal to link high-risk patients to a Dental Home without creating barriers to access to care was an important consideration. The specific timeframes within which an oral health exam should take place posed challenges that had the potential to become a barrier to care, particularly in the public health setting.

Task Force members actively solicited input from individuals who have prior experience with Collaborative Practice from an implementation and policy perspective. After much discussion, the Task Force decided to support the existing language in ND rules relating to collaborative practice, and that the all members and their respective organizations should make it a priority to educate dental professionals about current rules/law and focus on using the law to bring care to schools, nursing homes, etc. All members expressed interest in continuing the partnerships established through the Task Force.

Outcome

The North Dakota Collaborative Practice Task Force concluded on 12/01/15 to leave existing NDCC 43-20-03, rules 20-04-01-01, and NDCC 43-20-01 (5), and NDCC 43-28-18 (14) law as is related to Collaborative Practice and Supervision.

Concluding Remarks

All members of the task force agreed that this process led to greater understanding of inter-professional issues and enhanced professional partnerships. Members should be commended for adhering to a challenging process in the interest of improved oral health access for all North Dakotans while representing their respective associations and professions in a diligent and thoughtful manner.

NDSBDE License Renewal Totals

	Dentists		Hygienists		Assistants		Inactive		Total
	In state / Total		In state / Total		In state / Total		DDS / RDH		
2011 (2/28/11)	363	417	480	699	432	541	24	49	1730
2012 (3/16/2012)	360	411	518	705	473	608	38	67	1829
2013 (4/26/2013)	385	446	521	756	488	585	34	60	1881
2013 (7/31/2013)	399	464	522	784	494	604	34	60	1946
2014 (1/7/2014)	410	458	562	789	519	643	45	50	1985
2015 (1/16/2015)	402	456	584	798	494	585	43	62	1944
2015 (2/10/2015)	402	458	584	799	505	598	43	66	1964
2015 (6/26/2015)	415	477	581	831	530	628	42	67	2045
2016 (1/15/2016)	397	425	604	743	561	674	48	69	1959
2016 (2/15/2016)	405	437	624	771	566	680	48	70	2006
2016 (6/3/2016)	411	447	627	779	573	689	50	77	2042
2016 (9/15/2016)	422	458	628	821	590	721	51	77	2128

Community Dental Health Coordinator

PROGRAM OVERVIEW AND PLANNING FOR COMMUNITIES



CDHCs encourage regular oral health services for special populations such as pregnant women, teething infants, diabetics and the elderly.



The Community Dental Health Coordinator (CDHC) is a new member of the dental team who fills an important role whether working with a health center or private practice.

The CDHC can perform clinical preventive services and community-based outreach duties. In addition to oral health promotion and disease prevention, they can interact directly with populations who are at risk for dental disease, but are unsure of how to access a dental program.

For many families, knowing which dental services are needed, how to schedule appointments and having the necessary transportation to get there is critical. The CDHC is able to help with those issues.

In addition, the CDHC can manage behaviors that frequently accompany dental treatment, such as fear and anxiety. By carefully explaining how dental disease starts and the various dental ways to prevent and treat it, parents gain understanding of their important role in safeguarding their child's oral health.

So while a CDHC may perform certain preventive services under the supervision of a dentist, such as sealants and topical fluoride applications, one of their most important roles is helping patients navigate the health care system.

CDHCs encourage regular oral health services for special populations such as pregnant women, teething infants, diabetics and the elderly. Optimal oral health throughout the life span helps build healthy populations!

The curriculum for this program may be offered in person or online. Many of the courses could be easily incorporated into an already existing dental hygiene or dental assisting program. The course work takes about a year with a brief internship to allow the CDHC to put what they have learned into practice.

Scholarships may be available for students who need financial support to complete this program. Acceptance of local students who will work within their communities to improve the oral health of their families and friends is encouraged.

For more information, contact:

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