Application

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

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

Submitted by:

August 5, 2014
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1. Provide the following information for the applicant group(s): a. name, address, telephone number, e-mail address, and website of the applicant group in Nebraska, and any national parent organization; b. composition of the group and approximate number of members in Nebraska; and c. relationship of the group to the occupation dealt with in the application. ............................................................................................................. 8

2a-c. Identify by title, address, telephone number, e-mail address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of any of the following: a. members of the same occupation or profession as that of the applicant group; b. members of the occupation dealt with in the application; c. employers of the occupation dealt with in the application; d. practitioners of the occupations similar to or working closely with members of the occupation dealt with in the application; ....... 8

2d-e. Identify by title, address, telephone number, e-mail address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of any of the following: e. educators or trainers of prospective members of the occupation dealt with in the application; ....................................................... 8

2f-g. Identify by title, address, telephone number, e-mail address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of any of the following: f. citizens familiar with or utilizing the services of the occupation dealt with in the application (e.g., advocacy groups, patient rights groups, volunteer agencies for particular diseases or conditions, etc.); and g. any other group that would have an interest in the application................................................................. 10

3. If the profession is currently credentialed in Nebraska, provide the current scope of practice of this occupation as set forth in state statutes. If a change in this scope of practice is being requested, identify that change. This description of the desired scope of practice constitutes the proposal. The application comprises the documentation and other materials that are provided in support of the proposal. ........................................ 11

4. If the profession is not currently credentialed in Nebraska, describe the proposed credential and the proposed scope of practice, and / or the proposed functions and procedures of the group to be reviewed. This description of the desired scope of practice and the proposed credential constitute the core of the proposal. Also, please describe how the proposal would be administered. The application comprises the documentation and other materials that are provided in support of the proposal................................................................. 14

5. Describe in detail the functions typically performed by practitioners of this occupation, and identify what if any specific statutory limitations have been placed on these functions. If possible, explain why the Legislature created these restrictions. ........................................................................................................... 14

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9. What actions, judgments, and procedures of this occupation can typically be carried out without supervision or orders? To what extent is this occupation, or portions of its practice, autonomous? ............................................. 20

10. Approximately how many people are performing the functions of this occupation in Nebraska, or are presenting themselves as members of this occupation? To what extent are these people credentialed in Nebraska? .................................................................................................................................................. 21

11. Describe the general level of education and training possessed by practitioners of this occupation, including any supervised internship or fieldwork required for credentialing. Typically, how is this education and training acquired? ............................................................................................................................................... 21

12. Identify the work settings typical of this occupation (e.g., hospitals, private physicians' offices, clinics, etc.) and identify the predominant practice situations of practitioners, including typical employers for practitioners not self-employed (e.g., private physician, dentist, optometrist, etc.). ................................................................................................................................. 22

13. Do practitioners routinely serve members of the general population? Are services frequently restricted to certain segments of the population (e.g., senior citizens, pregnant women, etc.)? If so, please specify the type of population served. ........................................................................................................................................ 22

14. Identify the typical reasons a person would have for using the services of a practitioner. Are there specific illnesses, conditions or situations that would be likely to require the services of a practitioner? If so, please specify. ........................................................................................................................................... 23

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1) What is the problem created by not regulating the health professional group under review, or by not changing the scope of practice of the professional group under review? ................................................................. 26

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

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

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

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

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

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

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

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

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

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

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

All dental hygienists have two years of dental education and a license to practice dental hygiene in Nebraska. Dental assistants are either trained in accredited dental assisting programs or can be “on the job” trained (OJT). Assistants neither are credentialed professionals nor are they registered. However, there are two procedures that dental assistants can perform with Board of Dentistry approved education. These duties are taking radiographs (x-rays of teeth) and coronal polishing (polishing teeth with a polishing cup above the gumline). In 2008, the Nebraska Dental Assistants Association submitted a 407 Application seeking to create three levels of dental assistants: a Dental Aide, Licensed Dental Assistant, and Expanded FunctionAssistant. The NDA and NDHA opposed the 407 and the Application did not result in a favorable Technical Review Report or legislative effort.

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

In 2009, the NDA presented legislation (LB 542) to allow the Board of Dentistry to define educational requirements for dental assistant duties. The NDHA and NDAA opposed this bill, resulting in the only bill filibustered in that Legislative Session.
In Nebraska, approximately 1/3 of Nebraska dentists see Medicaid. While numerous efforts have been made to get more dentists to see this population, the low reimbursement rates, among other administrative barriers, and challenges inherent in this patient population, have had little effect. Therefore, current focus has been on how to take dental practices that have successful models for seeing Medicaid and other high risk, high needs, low resources to pay individuals, and helping them (the dental practices) to become more efficient. It is not cost-effective for the most expensive, highest compensated person of the dental team (the dentist) to be spending their time doing procedures that are low risk and can be taught to be done by an expanded function dental assistant or expanded function dental hygienist. In addition, a dental hygienist has much more value to the overall care of a patient than simply “cleaning teeth” and discussing good brushing habits. The dental assistant in turn, is much more valuable to the team than “sucking out spit of the patient’s mouth” and handing instruments to the doctor. With the passing of the Affordable Care Act, it is anticipated that an even greater number of children and adults will be covered by Medicaid and/or private dental insurance, and as a result, demand will increase.

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

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

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

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

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

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

In summary, we hope the proposed models give dental assistants and hygienists more career stability, opportunities for career growth, and job satisfaction. Second, we hope the proposed model is good for Nebraskans who may have difficulty finding dental care by allowing dental clinics to operate more efficiently, thus potentially being able to increase their capacity to care for more Medicaid and needy populations. Finally, we believe, that by being proactive in looking at expanded models of care, we will better able to more effectively serve all Nebraskans who desire to receive it.
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<table>
<thead>
<tr>
<th>Dental Profession</th>
<th>Nebraska Dental Association</th>
<th>David O'Doherty, Executive Director</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>990 members</td>
<td>7160 S. 29th St., Ste #1</td>
</tr>
<tr>
<td></td>
<td>American Dental Association</td>
<td>Lincoln, NE 68516</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:davidodoherty@windstream.net">davidodoherty@windstream.net</a></td>
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<tr>
<td></td>
<td></td>
<td>(402) 406-1704</td>
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<tr>
<td></td>
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<td><a href="http://www.nedental.org">www.nedental.org</a></td>
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<thead>
<tr>
<th>Dental Assistants</th>
<th>Nebraska Dental Assistants Association</th>
<th>Crystal Stuhr, NDAA Legislative CoChair</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>214 members</td>
<td>5321 S Bristolwood Pl.</td>
</tr>
<tr>
<td></td>
<td>American Dental Assistants Association</td>
<td>Lincoln, NE 68516</td>
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<tr>
<td></td>
<td></td>
<td>402-437-2740</td>
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<td></td>
<td></td>
<td><a href="mailto:cstuhr@southeast.edu">cstuhr@southeast.edu</a></td>
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<td><a href="http://www.nebraskadentalassistants.org/">http://www.nebraskadentalassistants.org/</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cindy Cronick</td>
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<tr>
<td></td>
<td></td>
<td>NDAA Legislative CoChair</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1211 Manley Court</td>
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<tr>
<td></td>
<td></td>
<td>Plattsmouth, NE 68048</td>
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<tr>
<td></td>
<td></td>
<td>(402) 738-4676</td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:ccronick@mccneb.edu">ccronick@mccneb.edu</a></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Dental Hygiene Profession</th>
<th>Nebraska Dental Hygienists Association</th>
<th>521 First Street</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PO Box 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Milford, NE 68405</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(402) 761-2216</td>
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<td></td>
<td></td>
<td><a href="http://www.nedha.org">www.nedha.org</a></td>
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following: e. educators or trainers of prospective members of the occupation dealt with in the application;

<table>
<thead>
<tr>
<th>Education Programs for Dentists, Hygienists, and Assistants</th>
<th>UNMC College of Dentistry</th>
<th>40th and Holdrege St. Box 830740 Lincoln, NE 68583-0740 (402) 472-1301 unmc.edu/dentistry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creighton University School of Dentistry</td>
<td>2802 Webster Street Omaha, NE 68178 (402)280-5890 <a href="http://www.creighton.edu/dentschool/">http://www.creighton.edu/dentschool/</a></td>
<td></td>
</tr>
<tr>
<td>UNMC College of Dentistry, Dental Hygiene Program</td>
<td>40th &amp; Holdrege St. Lincoln, NE 68583-0740 (800) 626-8431 Program Director: Gwen Hlava</td>
<td></td>
</tr>
<tr>
<td>Central Community College Dental Hygiene Program</td>
<td>P.O. Box 1024 Hastings, NE 68902-1024 (402) 461-2470 Program Director: Wanda Cloet</td>
<td></td>
</tr>
<tr>
<td>Central Community College Dental Assisting Program</td>
<td>P.O. Box 1024 Hastings, NE 68902-102 <a href="http://www.cccneb.edu">www.cccneb.edu</a> Program Director: Ms. Marie Desmarais Phone: 402-461-2467 <a href="mailto:mdesmarais@cccneb.edu">mdesmarais@cccneb.edu</a></td>
<td></td>
</tr>
<tr>
<td>Metropolitan Community College Dental Assisting Program</td>
<td>P.O. Box 3777 Omaha, NE 68103-0777 <a href="http://www.mccneb.edu">www.mccneb.edu</a> Program Director: Ms. Joan Trimpey Phone: 402-738-4675 <a href="mailto:jtrimpey@mccneb.edu">jtrimpey@mccneb.edu</a></td>
<td></td>
</tr>
<tr>
<td>SE Community College Dental Assisting Program</td>
<td>8800 'O' Street Lincoln, NE 68520-1299 <a href="http://www.southeast.edu">www.southeast.edu</a> Program Director: Ms. Crystal Stuhr Phone: 402-437-2740 <a href="mailto:cstuhr@southeast.edu">cstuhr@southeast.edu</a></td>
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<tr>
<td>Vatterott College, Omaha Campus</td>
<td>11818 &quot;I&quot; Street Omaha, NE 68137 <a href="http://www.vatterott.edu/omaha.asp">www.vatterott.edu/omaha.asp</a> Program Director: Ms. Roberta Worm Phone: 402-891-9411 x142 <a href="mailto:roberta.worm@vatterott.edu">roberta.worm@vatterott.edu</a></td>
<td></td>
</tr>
<tr>
<td>Kaplan University-Omaha Dental Assisting Program</td>
<td>Dental Assisting Program 5425 N. 103rd Street Omaha, NE 68134 <a href="http://www.kaplanuniversity.edu/omaha-nebraska.aspx">www.kaplanuniversity.edu/omaha-nebraska.aspx</a></td>
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</table>
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<table>
<thead>
<tr>
<th>Other Non-Dental Related Groups with Interest in Proposal</th>
<th>Nebraska Pharmacists Association</th>
<th>6221 S 58th Street, Suite A Lincoln, Nebraska 68516 Phone: 402-420-1500 Fax: 402-420-1406 <a href="mailto:info@npharm.org">info@npharm.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-Plains Community College Dental Assisting Program</td>
<td>1101 Halligan Drive North Platte, NE 69101 <a href="http://www.mpcc.edu">www.mpcc.edu</a> Program Director: Ms. Lauri Rickley Phone: 308-535-3650 <a href="mailto:Rickleyl@mpcc.edu">Rickleyl@mpcc.edu</a></td>
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<tr>
<th>Nebraska Healthcare Association</th>
<th>1200 Libra Drive, Suite 100 Lincoln, NE 68512 Phone 402-435-3551 Fax 402-475-6289 E-mail <a href="mailto:nhca@nehca.org">nhca@nehca.org</a></th>
</tr>
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<tbody>
<tr>
<td>Nebraska Hospital Association</td>
<td>3255 Salt Creek Circle, Suite 100 Lincoln, NE 68504-4778 Phone (402) 742-8140 Fax (402) 742-8191</td>
</tr>
<tr>
<td>Nebraska Nurses Association</td>
<td>PO Box 82086 Lincoln, NE 68501 Phone: 402.475.3859</td>
</tr>
<tr>
<td>Nebraska Rural Health Association</td>
<td>John Roberts 2222 Stone Creek Loop South Lincoln, NE 68512 (402) 421-2356 phone (402) 421-2356 fax Email: <a href="mailto:jroberts@mwhc-inc.com">jroberts@mwhc-inc.com</a></td>
</tr>
<tr>
<td>Public Health Association of Nebraska</td>
<td>Rita Parris, Executive Director <a href="mailto:PublicHealthNe@cs.com">PublicHealthNe@cs.com</a> 1321 South 37th Street Lincoln, NE 68510 Phone - 402.483.1039 Fax - 402.483.0570</td>
</tr>
<tr>
<td>Nebraska Head Start Association</td>
<td>Suzan Obermiller, President PO Box 509</td>
</tr>
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</table>
3. If the profession is currently credentialed in Nebraska, provide the current scope of practice of this occupation as set forth in state statutes. If a change in this scope of practice is being requested, identify that change. This description of the desired scope of practice constitutes the proposal. The application comprises the documentation and other materials that are provided in support of the proposal.

Dental hygienists are licensed oral health professionals who focus on assessing, preventing and treating oral diseases-both to protect teeth and gums, and also protect patients’ overall oral health. Dental hygienists provide patient care under the general supervision of licensed dentists. Public Health Registered Dental Hygienists provide a limited scope of services in public health settings and health care facilities without the supervision of a dentist. *(See Exhibit A, Neb. Rev. Stat. §§ 38-1130 and 38-1131).*

The changes requested for the dental hygiene profession include:
1) An expansion of scope under general supervision which includes administration and titration of nitrous oxide, placing interim therapeutic restorations, and limited prescription writing for preventive products that reduce risk for tooth decay.

2) Expansion of the existing Public Health Dental Hygienist scope of practice which would allow a hygienist to place interim therapeutic restorations and write prescriptions for preventive products that reduce risk for tooth decay in public health settings.

3) Creation of a new tier called the Registered Dental Hygienist-Expanded Function (RDHEF). The RDHEF would place and finish restorations and under the indirect supervision of a dentist within a dental practice after the dentist has removed the decay/infection from a tooth.

**Proposed Modifications (in red)**

§ 38-1136 Dental hygienists; dental assistants; performance of duties; rules and regulations.
(a) The department, with the recommendation of the board, shall adopt and promulgate rules and regulations governing the performance of duties by licensed dental hygienists and dental assistants, including any educational requirements.

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

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

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

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

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

Proposed Modification (in red)

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

The licensed dentist assumes full responsibility for all the aforementioned procedures delegated to a
licensed dental hygienist, under his supervision.

002.01H Expanded Function Restorative Dental Hygienist
The Board shall issue an Expanded Function Restorative Dental Hygienist permit upon receipt of a completed application form, payment of the appropriate fee specified in the Uniform Credentialing Act, and proof that the dental hygienist has completed a board approved expanded functions training course. The requirements of this section must be completed within one (1) year of the date of submission of the application form. The board-issued expanded functions permit must be displayed in plain view in any facility where the dental hygienist will be providing expanded functions prior to delegation of expanded functions to that dental hygienist. Dental hygienists shall renew expanded functions permits in accordance with the requirements established by the Board of Dentistry. A licensed dental hygienist may use continuing education hours obtained for license renewal to renew an expanded functions permit. The Restorative Functions listed below may be performed under the indirect supervision of a dentist.

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

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

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

002.02A Diagnosis and treatment planning.

002.02B Surgery on hard or soft tissue.

002.02C Administering of local or general anesthetics.

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

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

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

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

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

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

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

   The applicants are seeking to propose the following:

1) Maintain the basic level of dental assisting which includes both recognizing dental assisting program graduates and OJT dental assistants. Added to their scope of practice would be monitoring nitrous oxide and placing topical local anesthetic.

2) Create a new level of dental assisting called the Licensed Dental Assistant (LDA). This credentialed individual would need to have additional education and testing and licensure so the Board of Dentistry has some measure of control over their education and quality of care provided. An LDA would be able to fit and cement crowns on primary (baby) teeth, monitor and titrate nitrous oxide per a dentist order, and take final impressions/records for dental prostheses. This would all be under indirect supervision of a licensed dentist.

3) Create a new level of dental assisting, called expanded function dental assistant (EFDA). This type of dental assistant, with appropriate education, credentials, and licensure would be able to place and finish restorations after the dentist removes the tooth decay/infection from the tooth. This level would perform under the indirect supervision of the dentist.

Proposed Modifications (in red)

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

   (a) The department, with the recommendation of the board, shall adopt and promulgate rules and regulations governing the performance of duties by licensed dental hygienists and dental assistants, including any educational requirements.

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

Proposed Modification (in red)

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

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

002.02A Diagnosis and treatment planning.
002.02B Surgery on hard or soft tissue.
002.02C Administering of local or general anesthetics.
002.02D Any other irreversible dental procedure or procedures which require the
professional judgment and skill of a licensed dentist.

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

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

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

003 SCOPE OF PRACTICE OF DENTAL AUXILIARIES.

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

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

003.03 APPLICATION FOR LICENSE TO PRACTICE DENTAL ASSISTING.

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

1. Satisfactorily completed and graduated from an educational program for dental assistants approved by the board and accredited by the Commission on Dental Accreditation and shall have taken the Dental Assistant Certification Examination administered by the Dental Assisting National Board (DANB) and currently be certified prior to the date of application or Board approved equivalent exam; or

2. Successfully completed high school (or its equivalent) and shall have and obtained at least 1,500 hours of chairside work experience as a dental assistant during the five-year period prior to making application for licensure, passed the Dental Assistant Certification Examination administered by DANB and currently be certified prior to the date of the application or Board approved equivalent exam.

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

1. A certification by the board of dentistry in every state or jurisdiction in which the applicant is a registered or licensed dental assistant verifying that the applicant's credential in that state or jurisdiction is in good standing;

2. Proof of the following, if applicable pursuant to (a) above:

   i. A certificate of graduation from an approved educational program in dental assisting in which the expanded functions or duties listed in 172 NAC 53.003.04 are taught;

   ii. A certificate of successful completion of an approved program in licensed or expanded functions in dental assisting. The Board shall recognize the following as providers of approved programs in expanded functions:

      (1) A program accredited by the Commission on Dental Accreditation;

      (2) In-service training programs conducted by the US military

3. Results from a criminal history background check conducted by the State of Nebraska pursuant to § 38-131; and

4. The application fee set forth in the Uniform Credentialing Act.

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

1. **Fixed Prosthodontics 1 Permit**
   A. Place retraction cord/material in preparation for fixed prosthodontic impressions; and
   B. Making impressions for the fabrication of any fixed prosthesis/appliance.

2. **Removable Prosthodontics 1 Permit**
   A. Placement of temporary soft liners in a removable prosthesis;
   B. Extra-oral adjustments of removable prosthesis during and after insertion; and
   C. Making impressions for the fabrication of any removable prosthesis/appliance.

3. **Pediatric Fixed 1 Permit**
   A. fit and cement crowns on deciduous teeth

4. **Monitor and Titrate Nitrous Oxide Analgesia Permit**
   A. Under indirect supervision if s/he—
   1. Has successfully completed formal training in a course approved by the Board; and
   2. Has successfully passed an approved competency test regarding the clinical and didactic training; or
   3. Has been certified in another state to assist in the administration of and monitor nitrous oxide subsequent to equivalent training and testing. The dental assistant may qualify to perform these functions by presenting proof of competence of this equivalent training and testing to the Board.

**003.05 CATEGORIES OF PRACTICE FOR EXPANDED FUNCTION DENTAL ASSISTANTS**

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

1. **Fixed Prosthodontics 2 Permit**— must be Licensed Dental Assistant with a current Fixed Prosthodontics 1 Permit;
   A. Extra-oral adjustments of fixed prosthesis;
   B. Final cementation of any permanent appliance or prosthesis

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

3. **Restorative II Permit**— must hold a current Restorative I Permit;
   A. Placing, condensing, carving, and finishing amalgam for Class II restorations;
   B. Placing and finishing composite/Glass Ionomer for Class II, III, IV restorations.
003.06 Expanded Functions Course Providers.

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

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

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

a) **Functions typically performed by dental hygienists**

The following duties are typically performed by hygienists:
- oral health care assessments that include the review of health history
- dental charting
- oral cancer screening
- hard tissue assessment
- evaluation of gum disease / health
- expose and process dental radiographs (x-rays)
- remove plaque and calculus (“tartar”) from above and below the gum line using dental instruments; including scaling and root planning/ non-surgical periodontal therapy
- apply cavity-preventive agents such as fluorides and sealants to the teeth and sub-gingival agents to treat periodontal disease
- administer local anesthetic
- educate patients on proper oral hygiene techniques to maintain healthy teeth and gums and counsel patients about plaque control and developing individualized at-home oral hygiene programs
- smoking cessation programs
- counsel patients on the importance of good nutrition for maintaining optimal oral health. (American Dental Hygiene Association)
Nebraska Regulation 172 NAC 53.002.02 places limitations placed on services:

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

- 002.02A Diagnosis and treatment planning.
- 002.02B Surgery on hard or soft tissue.
- 002.02C Administering of local or general anesthetics.
- 002.02D Any other irreversible dental procedure or procedures which require the professional judgment and skill of a licensed dentist.

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

- 002.03A Any intra-oral procedure which would lead to the fabrication of any prosthesis.
- 002.03B Placing or contouring of a final restoration.

b) Functions typically performed by dental assistants

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

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

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

Limitations included in 172 NAC 53.002.02 listed above.

6. Identify other occupations that perform some of the same functions or similar functions.
Dental hygienists can do any function that dental assistants can do. Assistants have some common functions with hygienists. Physicians perform smoking cessation programs, oral health screenings and nutrition counseling.

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

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

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

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

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

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

a) Dental Hygienists

Registered dental hygienists work under the general supervision of a dentist. General supervision means the directing of the authorized activities of a dental hygienist or dental assistant by a licensed dentist and shall not be construed to require the physical presence of the supervisor when directing such activities. However, some procedures such as titration of nitrous oxide and anesthetizing a patient, the dentist must be present.
The Public Health Registered Dental Hygienist works within the infrastructure of a public health setting or health care facility. Orders from a dentist are not required to provide limited services. They carry their own liability insurance. Under no circumstances can a hygienist render a diagnosis. They may bill Medicaid for limited preventative codes.

b) **Dental Assistants**

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

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

   a) **Dental Hygienists**

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

   b) **Dental Assistants**

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

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

   a) **Dental Hygienists**

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

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

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

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

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

a) Dental Hygienists

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

b) Dental Assistants

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

13. Do practitioners routinely serve members of the general population? Are services frequently restricted to certain segments of the population (e.g., senior citizens, pregnant women, etc.)? If so, please specify the type of population served.
Yes, both groups routinely care for the general population. This includes children, adults, seniors, developmentally disabled, incarcerated, etc.

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

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

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

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

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

No.

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

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

17. How is continuing competence of credentialed practitioners evaluated?

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

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

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

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

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

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

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

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

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

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

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

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

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

a) Increased risk of potential for harm without regulation

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

b) Inconsistency without regulation

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

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

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

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

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

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

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

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

e) **Registering the providers under review**
   None.

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

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

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

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

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

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

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

According to Domer (2005), he found that in Colorado, when high delegation dentists were asked how delegation had affected their practice, they answered they believed that expanded delegation had: 1) increased the number of patients seen, 2) increased productivity and
income, 3) reduced stress of practicing dentistry, and 4) produced reduced hours without a decrease in practice income.

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

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

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

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

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

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

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

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

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

According to the Missouri Dental Board, “As part of a comprehensive solution to the state’s oral health workforce needs, EFDA’s may be the most significant component (short term) to the problems of rural areas [http://moefda.org/programoverview.html].” Missouri has had expanded function assistants since 1996. (Exhibit J)
Minnesota has had restorative assistants and hygienists since 2003. The March 1, 2007 Journal of Dental Education published an article entitled: “Allied Restorative Function Training in Minnesota, A Case Study” (Cooper and Monison, 2007). The conclusions stated, “Our findings indicate training in restorative functions provides allied dental professionals the confidence and knowledge necessary to perform restorative function procedures, leading to delegation of these procedures by the dentist, which in turn could lead to an increase in the availability of dental care for the public.”

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

There is no expectation that the public would share in the costs to license these new groups except for tax payer support of public university and community colleges that receive state funding for higher education. We assume the Department of Health and Human Services will apply application fees that are similar to what other groups pay for processing a license application. It is likely that for the dentists who have practices that would utilize these expanded scope of practice models, the application fees would be paid by the dental practice. Fees for licensure would be recommended by the Board of Dentistry and collected by HHS. Fees could be set to ensure that costs are covered. Since this mechanism is in place for dentists and hygienists, we do not anticipate creation of a cumbersome system. It is anticipated that the number of assistants to credential would begin with a small number and grow, representing a small percentage of the total assistants in the state. For example, according to the Missouri Dental Board, EFDAs currently only constitute approximately 25% to 30% of the state’s 6,000 dental assistants. We believe this trend in Nebraska will start slowly and gradually increase over a period of years.

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

Many states already support dental assistants and dental hygienists providing expanded functions. The key is appropriate education, testing, supervision, and case selection. A dentist would not likely delegate a more difficult placement of a filling on a medically compromised or behaviorally challenged patient. This proposal did not go into detail in regards to the type or extent of education and testing. We believe that the Nebraska Board of Dentistry and our accredited dental education institutions will develop this curriculum and testing. It is important to note that one of the greatest barriers to states allowing expanded duty delegation is dentists’ attitudes. Cooper (1993) found that dentists’ positive response to delegating decreased with increasing age and years of practice. She also found that larger practices were more likely to delegate. Gilmore (1976) found that dentists opposed the delegation of irreversible duties, but were favorably disposed to the delegation of a number of reversible procedures. Young dentists favored the concept more than older dentists, and
specialists were more in favor than general practitioners. Furthermore, the study found respondents who were informed on research were more likely to delegate irreversible duties than those who were uninformed. Participation in an EFDA program increased the willingness of dental students to delegate procedures such as placing amalgams. The consumers (patients) did not seem overly concerned with who provided the dental care; they just didn’t like the services themselves (Gilmore 1976). We recognize that changing attitudes takes time and not until success stories emerge both from practitioners and the public, will more dentists and dental team members see the benefits of better team utilization.

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

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

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

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