THE EFFECTS OF STATE DENTAL PRACTICE LAWS ALLOWING ALTERNATIVE MODELS OF PREVENTIVE ORAL HEALTH CARE DELIVERY TO LOW-INCOME CHILDREN

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EXECUTIVE SUMMARY

The Center for Health Services Research and Policy (CHSRP) was funded by the Centers for Disease Control and Prevention’s (CDC) Public Health Practice Program Office to examine state dental practice laws that permit alternative models of delivering preventive oral health care to low-income children1.

BACKGROUND

Although the incidence of tooth decay has decreased considerably over the past two decades, the prevalence of caries among children and adolescents remains high. Minorities and low-income populations experience more dental decay than those with higher incomes, and they are also more likely to have a higher proportion of untreated decayed teeth.2 Low oral health care utilization is the primary reason for higher tooth decay among low-income and minority populations. Low use of dental services among low-income and minority children is related to several factors that reduce their access to such services, which include low dentist Medicaid participation, shortage of dentists, mal-distribution of dentists, restrictive state laws, patients' lack of health insurance, and families' lack of understanding and awareness of the need for preventive oral health care.

PROJECT OVERVIEW

Project Purpose

The purpose of this project was to examine state dental practice laws and the extent to which they encourage alternative models of delivering preventive oral health care. This project encompassed two distinct study components: 1) an analysis of existing state dental statutes and regulations; and 2) case studies to examine the enactment of public health-oriented provisions encouraging alternative models of delivering preventive oral health care to low-income children; and the development and implementation of such alternative models.

1 This project was funded under the grant "Research on the Impact of Laws and Policies on Public Health" (grant number R06/CCR318771) from the CDC Public Health Law Program. The contents of this report are solely the responsibility of the authors and do not necessarily represent the official views of CDC, or the Public Health Law Program. The George Washington University Institutional Review Board (non-Medical) approved this study and provisions regarding informed consent in approval number 100026ER."

METHODS

Review State Dental and Medical Practice Laws

We reviewed state dental practice acts for the 50 states and the District of Columbia to determine how they address the delivery of preventive oral health care services by dentists and dental hygienists. We also examined any applicable exemptions for physicians and nurses to deliver oral health care. In addition, we reviewed the statutes for supervision requirements for dental hygienists, consultation between dentists and hygienists when delivery of oral health services is unsupervised or independent, and the educational and competency requirements for dental hygienists.

Case Studies

We opted to study six states that had: 1) enacted a statute that permitted/encouraged an alternative model; and/or 2) had or had not yet implemented the alternative model. We chose to examine two types of alternative models: 1) a model that uses dental hygienists working under either general supervision or without a dentist’s supervision (but not independent practice) to provide preventive services; and 2) a model that uses physicians to provide screening, education, and in some cases, topical fluoride application to very young children. Our study states included Connecticut, Iowa, New Mexico, North Carolina, South Carolina, and Washington.

FINDINGS

Analysis of State Health Professions Laws

The licensing of dentists, as with other health professionals, is governed by state law. Health professions licensing statutes are implemented by boards dominated by the relevant professionals themselves. In the case of dental practice, definitions and scope of practice provisions become important when considering the role of dental hygienists. Generally, dental hygienists are subject to governance by boards of dentistry, which define and in many jurisdictions limit the scope of permissible practice.

The licensing system and self-regulation by the dental and medical professions have profound implications for low-income children. In many jurisdictions, state laws restrict the delivery of preventive oral health care to dentists. In other jurisdictions, restrictive licensing laws restrict the scope of practice of dental hygienists. These legal restrictions operate as a barrier to the provision of preventive oral health services to low-income children by limiting the number of individuals who can provide such services.

3 We reviewed state dental and medical practice laws during 2000-2001. The full report contains a full description of the scope of our review.
Although some states have begun to loosen their practice acts to allow dental auxiliaries to perform more preventive oral health services, these focus primarily on hygienists. Many jurisdictions require a dentist to be on-site and sign-off on preventive oral health services provided by dental auxiliaries. Although many state dental licensing laws provide exemptions for the delivery of preventive oral health care by physicians, other obstacles limit such delivery (e.g., training and equipment).

State Options

Our analysis revealed that states have elected to use one of three options in changing existing laws to allow for alternative models of oral health care delivery: 1) a state legislature can pass a new statute that explicitly permits an alternative model; 2) a state agency or dental/medical board can establish new regulations or rules (based on existing law) allowing an alternative model; and 3) a state agency, dental/medical board, or group of providers can reinterpreting an old law or set of regulations/rules, usually with a broader interpretation, and implement an alternative model.

Supervision Requirements for Dental Hygienists

Two key issues stand out in the design of alternative delivery models for the delivery of preventive health services to low-income children: 1) whether a dentist has to be on the premises when services are provided; or 2) whether a dentist has to sign-off on the work performed prior to patient discharge.

The review of the dental practice laws demonstrates that for the four identified preventive oral health services, most state dental practice laws require supervision of a dentist at some level (direct, indirect, general) for the delivery of preventive oral health services by dental hygienists. Colorado has an independent practice law that allows dental hygienists to provide oral health services without the supervision of a dentist, and Washington state allows independent practice under certain conditions. The more restrictive the supervisory requirements are, the less flexibility states will have in designing alternate models of preventive oral health delivery by dental hygienists. The efforts to control dental auxiliaries by procedure and varying degrees of supervision lead to confusion in what can be done, where, with what level of supervision and approval. This confusion, in itself, is a deterrent to designing alternate delivery models.

Case Studies

Our findings reveal that making a change in the law does not result in an immediate change to the oral health care delivery system. In fact, in three of the cases (IA, NC, and WA) the alternative model could be developed without the creation of a new public health-oriented law. In these states, existing dental and medical practice laws, accompanied by changes to rules, regulations, or administrative policies, were sufficient to permit a new model. In the remaining cases the alternative model could not be pursued unless the law was changed. Where laws are changed, it may take a substantial amount of time for the dental profession and the market to respond to such
changes. However, in all cases we learned that the success of the alternative oral health care models lay not merely in the laws themselves, but in certain factors essential to their implementation.

Our findings suggest that a combination of essential factors is required for the implementation of an alternative oral health care delivery model, whether or not a new public health-oriented law has been enacted. The factors that facilitated the implementation of alternative models for delivering preventive oral health care are summarized below:

- Gaining the support of dentists, either through their organizational representatives or through the leadership of individual dentists is perhaps the most important factor in the success of an alternative model.
- Creating a reimbursement mechanisms for providers in the alternative model.
- Gaining state Medicaid agency support is essential.
- The lack of a formal referral mechanism severely hindered the successful implementation of most of the alternative models.
- The type of alternative model may predetermine how easily it is implemented in a state.
- Alternative models that utilize an incremental approach seem to have more success.
- Outreach and training are necessary.
- Professional recognition and acceptance of the need for the alternative model.

CONCLUSION

The alternative models we studied have had little impact on the preventive oral health care delivery systems in our study states. In states with dental hygienist alternative models (CT, NM, and SC), the law and models have not yet significantly changed the way that dental hygienists work. In all three states, dental hygienists provide the same services they did before the law or model was enacted or implemented (e.g., treatment planning, prophylaxis, and care coordination). Prior to the law, dental hygienists worked under some degree of supervision by a dentist, and they continue to do so currently. Until a reimbursement mechanism can be instituted, thus creating a provider number to allow for direct billing, dental hygienists will be forced to maintain their ties to a dentist of record. As we have seen, this can encourage the old models of general supervision (or indirect supervision), and discourage increased
access since dental hygienists interested in the alternative model will have to rely on a dentist to bill for their services.

Given the arduous task of implementing an alternative oral health care model, and the slow progress that accompanies such an endeavor, we conclude that states planning to undertake such an effort should be mindful of several factors: 1) it is difficult to make changes in the scope of practice of one class of professionals who are overseen by a different group of professionals; 2) action should be taken at deliberate speed, and incremental steps should be made; 3) preventive oral health care providers operating within the model must have the ability to self-regulate; 4) viable funding mechanisms must be set up prior to implementing the program; and 5) careful consideration should be given to the type of model the state seeks to implement, the types of providers it will include, and the political viability of such a model.

RECOMMENDATIONS

This study did not focus on dentist workforce training and supply issues, and, therefore, our recommendations do not address these factors. Instead we focus on those elements that facilitate the development and implementation of alternative models of delivering preventive oral health care services.

- Public health leadership is needed to create a greater awareness of the need for oral health among poor children.

- Public health and dental professional leadership is needed to destigmatize the services provided by non-dentists. Disseminating the results of recent studies indicating that dental hygienists provide safe care may facilitate these efforts.

- Federal and state Medicaid officials can be effective leaders in implementation and reimbursement issues. In particular, officials can follow the example of the North Carolina Medicaid agency and its leadership in promoting the alternative oral health care model.

- Federal government and professional societies should address outreach and training issues associated with implementation of these models.

- Even without legal changes, Medicaid and public health officials can encourage the role of pediatricians regarding applying fluoride varnish. In most states physicians are already permitted to provide such services.

- Further study is needed on successfully implemented preventive oral health care models. Study should be undertaken at the individual provider level to learn exactly what elements are necessary to make a particular model successful.
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This report would not have been possible without the cooperation and support we received from informants in each of the study states. We would like to thank the numerous state and public health officials, dental and/or dental hygienist board representatives, spokespeople from various dental, dental hygienist, and pediatric associations, state legislators and providers who were willing to share their valuable time and experience with us.

We would also like to extend a special thanks to Elizabeth Wehr, JD, who was instrumental in the conception and development of this project. Her interest and expertise in the oral health care of low-income children was valuable.

We appreciate very much the generous support for this project from the Centers for Disease Control and Prevention (CDC.) We are grateful for the opportunity to explore the effects of state dental practice laws that allow for alternative models of delivering oral health care to low-income children. This project was funded under the grant "Research on the Impact of Laws and Policies on Public Health" (grant number R06/CCR318771) from the CDC Public Health Law Program. The contents of this report are solely the responsibility of the authors and do not necessarily represent the official views of CDC, or the Public Health Law Program. The George Washington University Institutional Review Board (non-Medical) approved this study and provisions regarding informed consent in approval number 100026ER."
THE EFFECTS OF DENTAL PRACTICE LAWS ALLOWING ALTERNATIVE MODELS OF PREVENTIVE ORAL HEALTH CARE DELIVERY TO LOW-INCOME CHILDREN

The Center for Health Services Research and Policy (CHSRP) was funded by the Centers for Disease Control and Prevention’s (CDC) Public Health Practice Program Office to examine state dental practice laws that permit alternative models of delivering preventive oral health care to low-income children. Although the oral health of the nation’s children has improved markedly over the past two decades (due largely to increased fluoride exposure through community water fluoridation and fluoridated toothpaste, and the application of sealants\(^5\)), low-income and minority children continue to have disproportionately poor oral health outcomes. These disparities exist because there are critical differences in access to oral health services among these populations.

Many states have passed laws and/or regulations permitting alternative models of delivering oral health care to address these disparities. CHSRP undertook two major tasks in evaluating states’ laws permitting alternative models of preventive oral health care delivery:

1) we collected and analyzed existing state dental practice statutes and regulations pertaining to the performance and competencies of dentists and dental hygienists; and
2) we conducted case studies of six states’ alternative models of delivering preventive oral health care permitted by state dental practice laws.

This study does not focus on the delivery of dental treatment services. In addition, although some state laws allow dental assistants to provide certain oral health services, we limited the study’s scope and case studies to dental hygienists. Dental assistants are not licensed, and the majority of state dental practice acts do not define dental assistants or their scope of practice.\(^6\)

BACKGROUND ON THE PROBLEM

Although the incidence of tooth decay has decreased considerably over the past two decades, the prevalence of caries among children and adolescents remains high. While the incidence of caries is not race or ethnicity specific, rates of oral health treatment are sensitive to both race/ethnicity and socio-economic status. Minorities and low-income populations experience more dental decay than those with higher incomes.

\(^5\) Sealants are thin plastic coatings that seal crevices in permanent teeth and act as a physical barrier to prevent oral bacteria from collecting and creating the acid environment that promotes the development of tooth decay.

They are also more likely to have a higher proportion of untreated decayed teeth.\(^7\) Low oral health care utilization is the primary reason for higher tooth decay among low-income and minority populations. Disparities in treatment rates persist despite the fact that low-income and minority children enjoy the highest rates of dental coverage due to Medicaid and the State Children's Health Insurance Program (SCHIP).\(^8\)

**Why Low-Income Children Lack Access to Oral Health Care**

Low use of dental services among low-income and minority children is related to several factors that reduce their access to such services. These include:

- **Low Dentist Medicaid Participation:** Despite the fact that one in five U.S. children is enrolled in the Medicaid program, many cannot find a participating dentist. One study suggested that only 10 percent of dentists participate in Medicaid nationwide.\(^9\) Reasons for non-participation include Medicaid’s low reimbursement rates, bureaucracy, and complicated billing procedures. Some dentists refuse to participate because they perceive Medicaid patients to be unreliable and inappropriately behaved.\(^10\)

- **Shortage of Dentists:** The number of dentists relative to the nation’s population has been in decline since its peak in 1990. The number of dental schools has also declined by six (from a high of 60 during the 1980s), along with an accompanying decrease in dental school class size.\(^11\) Nationwide, there are only 3,500 pediatric dentists who specialize in treating young children.\(^12\) This is significant since many general dentists are reluctant to serve children under age five because treating them can be difficult (i.e., keeping them still, opening their mouths) and more time consuming.

- **Mal-distribution of Dentists:** Most dental practices are concentrated in urban and more affluent areas. Only six percent of the dental needs were met in 1198 health

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professional shortage areas.\textsuperscript{13} Minority dental providers, who may be more likely to serve low-income and minority populations, account for a small percent of active dentists in the U.S. (only 2.2 percent are African-Americans, and 2.8 percent are Hispanic).\textsuperscript{14}

- **Restrictive State Laws:** Many state laws prohibit the expansion of dental hygienists’ or other dental auxiliaries’ scope of practice. Loosening restrictions could allow these providers to deliver more services, increase dentists' efficiencies and productivity, and may help to increase patients’ access to preventive oral health care. Few, if any, statutory restrictions prohibit physicians from providing preventive oral health care services, since virtually all such services fall within physicians’ scope of practice. However, physicians have little motivation to provide dental treatment services since they do not receive extensive dental training, and dental equipment is costly and requires a dental operatory. Some physicians may be willing to provide limited preventive oral health care services (e.g., topical fluoride treatments) that do not require such equipment or space.

- **Patients’ Lack of Health Insurance:** One study found that among children uninsured for all or part of the previous year, nearly 17 percent had unmet dental care needs compared with 7 percent of publicly insured children and 5.7 percent of privately insured children.\textsuperscript{15}

- **Families’ Lack of Understanding and Awareness:** Some families are simply not aware of the need for regular, preventive care for their children and only seek dental services when there is an acute need for treatment. Of those who reported no dental visit in the past year, 47 percent said that they perceived no dental problems and therefore did not seek care.\textsuperscript{16}

**General Overview of Health Professions Law**

The licensing of dentists, as with other health professionals, is governed by state law. Under the authority of the police power, states protect the health, safety, and welfare of citizens by legislating requirements for entry into the dental profession through licensing statutes.\textsuperscript{17} In addition to governing entry, licensing statutes define the


scope of permissible practice, specify disciplinary matters, and prohibit the unauthorized
delivery of health services by unlicensed persons. ¹⁸

Health professions licensing statutes are implemented by boards dominated by
the relevant professionals themselves. ¹⁹ Indeed, professional groups play a large role
in the drafting and passage of such statutes. Although state boards of medicine and
dentistry typically include lay members and make decisions subject to judicial review,
the boards operate with a large degree of autonomy. Thus, the medical and dental
professions largely regulate themselves.

The self-regulation of the professions of medicine and dentistry result in tension
between the two groups over the scope of practice of each. Each group naturally
attempts to define its boundaries as broadly as possible to resist encroachment by the
other. In the case of dental practice, definitions and scope of practice provisions
become even more important when considering the role of dental hygienists. Generally,
dental hygienists are subject to governance by boards of dentistry, which define and in
many jurisdictions limit the scope of permissible practice.

The licensing system and self-regulation by the dental and medical professions
have profound implications for low-income children. In many jurisdictions, state
licensing laws restrict the delivery of preventive oral health care to dentists. In other
jurisdictions, restrictive licensing statutes restrict the scope of practice of dental
hygienists. These legal restrictions operate as a barrier to the provision of preventive
oral health services to low-income children by limiting the number of individuals who can
provide such services. Although many state dental licensing laws provide exemptions
for the delivery of preventive oral health care by physicians, other obstacles limit such
delivery (e.g., training and equipment). When combined with other obstacles, therefore,
dental licensing laws leave a vacuum in the access of low-income children to preventive
health services.

Ironically, the dental licensing laws intended to protect the health, safety, and
welfare of low-income children fail to do so by restricting the provision of preventive oral
health services. Thus, at its core, this is a study of how the law affects the provision of
preventive oral health services to low-income children.

¹⁸This overview of health professions law is intended to address scope of practice issues. Other issues
related to licensing (e.g., disciplinary matters, unauthorized practice and patient safety) are beyond the
scope of this overview.
¹⁹ See Furrow et. al, supra note 13, at 59. See also Orentlcher D, “The Role of Professional Self
Regulation” in Regulation of the Healthcare Professions at 129 (Timothy S. Jost, ed. 1997).
PROJECT OVERVIEW

Project Purpose

The purpose of this project was to examine state dental practice laws and the extent to which they encourage alternative models of delivering preventive oral health care. This project encompassed two distinct study components. The first component was an analysis of existing state dental statutes and regulations. The second used a descriptive and qualitative approach to determine the extent to which public health laws impact the delivery of health care. Under this latter component we conducted case studies to obtain a detailed picture of public health-oriented dental practice laws and their effect on the development of alternative models of delivering preventive oral health care services. Specifically the case studies examine: 1) which factors contribute to enactment of public health-oriented provisions in state dental practice laws that encourage development of alternative models for delivering preventive oral health care to low income children?; and 2) which factors contribute to the development and implementation of alternative models for delivering preventive oral health care to low-income children?

Focus on State Laws

This study focuses on statutes enacted by states that permit alternative models of oral health care delivery. With regard to the case studies, we initially thought it would be fairly simple to discern the impact such laws may or may not have on the implementation of alternative models. We anticipated that we would be able to isolate the intervention (the law) and establish whether it alone made any difference in how oral health care services are delivered to low-income children in a particular state. However, upon beginning our inquiries, we learned that there are many confounding variables that interact and ultimately determine whether a new law or a change in the law will affect the delivery of oral health care services to low-income children. Many of the variables discussed earlier influence whether or not an alternative model is implemented, such as, a particular dentist’s willingness to participate in Medicaid, or organized dentistry’s opposition to loosening restrictive scope of practice laws regulating dental hygienists.
METHODS

State Dental Practice Laws

We reviewed state dental practice acts for the 50 states and the District of Columbia to determine how they address the delivery of preventive oral health care services by dentists and dental hygienists. We also examined any applicable exemptions, including the ability of physicians and nurses to provide such services generally or in cases of emergencies or institutional settings. In addition, we reviewed the statutes for supervision requirements for dental hygienists, consultation between dentists and hygienists when delivery of oral health services is unsupervised or independent, and the educational and competency requirements for dental hygienists. Summaries of state laws related to the practice of dentistry and provisions regarding dental hygienists are located in Appendix A.

State Medical Practice Laws

We reviewed state medical practice acts for the 50 states and the District of Columbia to determine whether and how they address the delivery of preventive oral health care services by physicians.

Case Studies

We opted to study six states that had: 1) enacted a statute that permitted/encouraged an alternative model; and/or 2) had or had not yet implemented the alternative model. Based on our findings from the review of state statutes and regulations discussed above, we chose to examine two types of alternative models. The first model uses dental hygienists working under either general supervision or without a dentist’s supervision (but not independent practice) to provide preventive services. The second model uses physicians to provide screening, education, and in some cases, topical fluoride application to very young children.

We set out to study four states that had successfully implemented an alternative model and two states whose models had not yet been implemented. After conducting a national review of alternative models, consulting with CDC, and speaking with key informants familiar with the models, we selected the following states for study:

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20 We reviewed state dental and medical practice laws during 2000-2001. While we have revised our study as we became aware of new changes to dental and medical practice laws in 2002, we have not revisited the laws of all 50 jurisdictions as of November 2002 to reflect changes to them during 2002. Therefore, there may be very recent changes to dental or medical practice laws that are not reflected in this report. Our snapshot of dental and medical practice acts during 2000-2001 is consistent with the practice of the American Dental Association of periodically surveying its members on legal provisions regarding hygienists “since Practice Acts tend to only change every couple of years.” American Dental Association. 2001. 2000 Survey of Legal Provisions for Delegating Intraoral Functions to Chairside Assistants and Dental Hygienists. Chicago, IL: American Dental Association Survey Center, at p. 1.
Connecticut, Iowa, New Mexico, North Carolina, South Carolina, and Washington. These states fall into the following categories:

TABLE 1
STUDY STATE CHARACTERISTICS

<table>
<thead>
<tr>
<th>State</th>
<th>Type of Alternative Model</th>
<th>Enacted new law</th>
<th>New Regulation/Rules/Administrative Policy</th>
<th>Model Implemented?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>Dental Hygienist</td>
<td>✓</td>
<td>In process</td>
<td>✓</td>
</tr>
<tr>
<td>Iowa</td>
<td>Physician</td>
<td></td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Dental Hygienist</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Physician</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Dental Hygienist</td>
<td>✓</td>
<td>✓</td>
<td>Limited</td>
</tr>
<tr>
<td>Washington</td>
<td>Physician</td>
<td></td>
<td>✓</td>
<td>Limited</td>
</tr>
</tbody>
</table>

We conducted open-ended, semi-structured telephone interviews with state officials, legislators, public health and medical assistance administrators, professional society and association representatives, advocates, and providers. These interviews focused on how and why states chose a particular model and their experience implementing it. The following major research questions guided our discussions with informants:

- What motivating factors spurred enactment of the public health-oriented provisions in the states’ dental practice laws?
- What was the planning process for development of such provisions?
- To what extent and how are such provisions implicated in the development and implementation of alternative models for delivering preventive oral health care to low-income children? (implemented states only)
- Have such provisions encouraged a change in the way preventive oral health care is delivered to low-income children through the alternative oral health care model? (implemented states only)
- Are there interim outcomes that suggest that such provisions improve access to, or utilization of, preventive oral health care services by low-income children? (implemented states only)
- What were the factors that led to the defeat of attempts to adopt such provisions/impliment the alternative model? (non-implemented states only)

We conducted interviews with a total of 64 informants from a wide range of backgrounds between March and July 2001. Interviews averaged 60 minutes in length. In each state we solicited the participation of representatives from the state public health dental office, state Medicaid dental office, state dental board and/or dental hygienist board, state dental association, state legislators who sponsored the legislation, state dental hygienist association or state pediatric association, providers.

21 During the study state selection process, expert informants reported that South Carolina had not yet implemented its program, and that Washington State's program was fully implemented. However, it became clear after beginning our interviews that both states had implemented their programs to a limited capacity.
delivering services under the model, and advocates. Many of the individuals we contacted agreed to participate in the study, others referred us to colleagues who could better answer our questions, and some declined an interview. In all but a very few cases, we interviewed every key player involved in the creation, planning and implementation of the alternative model. Since our informants were promised anonymity we will not disclose their names or their professional affiliations due to the highly politicized nature of the subject.

Table 2 is meant to provide our readers with some context with regard to the number and type of informants we interviewed in each state. It should be noted that as the models and their evolution differed in each state, so does the potential panel of informants. For example in both Connecticut and New Mexico it was essential to speak with the state legislators who sponsored the legislation because they were intimately involved in the conception of the alternative model. In contrast, the legislation enacted in South Carolina was developed by both the state dental association and state dental hygienist associations and introduced into the state legislature. Therefore, it was not essential to interview the state legislator who sponsored the legislation since she did not actually draft the language. Additionally, we also note that some of our informants fall into more than one category, although we have only counted them once in the following table. For example, many of the informants coded as representatives of the dental hygienist association or pediatric association are also providers. Likewise, many of those in the “other” category are also medical or dental providers. However, they are coded based on their primary involvement in creating, planning and/or implementing the alternative model, and the information they provided us.

<table>
<thead>
<tr>
<th>INFORMANT TYPE</th>
<th>CT</th>
<th>IA</th>
<th>NC</th>
<th>NM</th>
<th>SC</th>
<th>WA</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>State Public Health dental office</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>State Medicaid office</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>--</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>State dental board/dental hygienist board/medical board</td>
<td>--</td>
<td>--</td>
<td>1</td>
<td>--</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>State dental association</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>State dental hygienist association/State pediatric association</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>--</td>
<td>11</td>
</tr>
<tr>
<td>State legislators</td>
<td>1</td>
<td>--</td>
<td>1</td>
<td>1</td>
<td>--</td>
<td>--</td>
<td>3</td>
</tr>
<tr>
<td>Providers</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Advocates</td>
<td>1</td>
<td>--</td>
<td>--</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>--</td>
<td>4</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>7</td>
<td>13</td>
<td>12</td>
<td>9</td>
<td>11</td>
<td>64</td>
</tr>
</tbody>
</table>

A copy of the short interview guide can be found as Appendix F. The George Washington University Institutional Review Board (non-Medical) approved the study.
FINDINGS

This section will describe the research undertaken for this project. First, we provide a general overview of medical and dental practice acts. Second, we will describe our analysis of the state laws pertaining to dental hygienists and the exemptions that allow physicians to provide oral health care services. Third, we will present the major findings from the case studies, and in particular, the extent to which a new law or an interpretation of existing law promoted a change in the oral health care delivery system in six states.

Analysis of State Health Professions Laws

State law governs the licensing of physicians, dentists, nurses and other health professionals. Under the authority of the police power, states protect the health, safety, and welfare of citizens by legislating requirements for entry into the health professions through licensing statutes that define the practice of medicine and dentistry, outline the scope of permissible practice, specify disciplinary matters, and prohibit the unauthorized delivery of health services by unlicensed persons.22

States define the practice of medicine and the practice of dentistry broadly. Table 5 provides the definitions for South Carolina, one of our study states that has typical definitions of the practice of medicine and the practice of dentistry. Appendix B contains a table of definitions for all six study states.

TABLE 3
DEFINITIONS OF THE PRACTICE OF MEDICINE AND DENTISTRY

<table>
<thead>
<tr>
<th>State</th>
<th>Practice of Medicine Definition</th>
<th>Practice of Dentistry Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Carolina</td>
<td>Any person shall be regarded as practicing medicine within the meaning of this article who (a) shall as a business treat, operate on or prescribe for any physical ailment of another, (b) shall engage in any branch or specialty of the healing art or (c) shall diagnose, cure, relieve in any degree or profess or attempt to diagnose, cure or relieve any human disease, ailment, defect, abnormality or complaint, whether of physical or mental origin, by attendance or advice, by prescribing, using or furnishing any drug, appliance, manipulation, adjustment or method or by any therapeutic agent whatsoever. S.C. Code Ann. § 40-47-40 (2001).</td>
<td>A person is practicing dentistry who: (1) uses the word &quot;dentist&quot;, &quot;dental surgeon&quot;, or the letters &quot;D.D.S.&quot;, &quot;D.M.D.&quot;, or other letters or titles in connection with his name which in any way represents him as engaging in the practice of dentistry or in the administration of any dental health program; or (2) for a fee or other consideration: (a) shall profess or indicate in any manner that he can or will attempt to perform dental procedures in the oral cavity and</td>
</tr>
</tbody>
</table>

associated adjacent structures; or
(b) shall diagnose or treat or profess to
diagnose or treat any diseases or lesions or
conditions of the oral cavity and associated
adjacent structures; or
(c) shall extract teeth, correct malpositions
of the teeth or jaws, or take impressions, or
construct, supply, repair, reline, or duplicate
artificial teeth as substitutes for natural
teeth, or adjust such substitutes, or do any
practice included in the curricula of dental
colleges accredited by the Commission on
Dental Accreditation, or administer or
prescribe drugs or therapy utilized in the
treatment of dental or oral diseases, or shall
use X ray for dental treatment or dental
diagnostic purposes, or shall administer
anesthetics, local or general, for dental
procedures; or
(d) shall teach or profess to teach any
phase of dental practice or related

In addition to broad definitions of the practice of medicine and dentistry, health
professions acts specify the entry requirements to practice. For example, in order to
obtain a license to practice medicine in South Carolina, a physician must demonstrate
to the South Carolina Board of Medical Examiners that she graduated from an
accredited medical school, obtained postgraduate training, and passed the United
States Medical Licensing Examination or other acceptable national board
examinations.23 Most states have similar entry requirements.

In order to obtain a license to practice general dentistry in South Carolina, a
dentist must demonstrate to the Board of Dentistry that she:

- graduated from an accredited dental school;
- passed the National Board Examination within the last 15 years (if longer than
  15 years, the dentist must retake part of the exam);
- passed the Southern Regional Testing Agency Examination (SRTA) after
  1/1/96;
- provided documentation the National Practitioner’s Data Bank (NPDB) if out
  of dental school one year or longer, or if she is or ever has been licensed in
  another state; and
- passed the South Carolina Dental Practice Act Examination.24

Most states have similar entry requirements for the practice of dentistry. Appendix B contains a table with the entry requirements for medicine and dentistry.

Health professions licensing statutes are implemented by boards dominated by the relevant professionals themselves. Indeed, professional groups play a large role in the drafting and passage of such statutes. Although state boards of medicine and dentistry typically include lay members and make decisions subject to judicial review, the boards operate with a large degree of autonomy. Thus, the medical and dental professions largely regulate themselves.

The licensing system and self-regulation by the dental and medical professions have profound implications for low-income children. In many jurisdictions, state licensing laws restrict the delivery of certain preventive oral health services to dentists. In other jurisdictions, restrictive licensing statutes restrict the scope of practice of dental hygienists, which is addressed below.

Although some states have begun to loosen their practice acts to allow dental auxiliaries to perform more preventive oral health services, these focus primarily on hygienists. Many jurisdictions require a dentist to be on-site and sign off on preventive oral health services provided by dental auxiliaries. Although many state dental licensing laws provide exemptions for the delivery of preventive oral health care by physicians, other obstacles limit such delivery (e.g., training and equipment).

**State Options**

Our analysis revealed that states have elected to use one of three options in changing existing laws to allow for alternative models of oral health care delivery. A state legislature can pass a new statute that explicitly permits an alternative model. Second, a state agency or dental/medical board can establish new regulations or rules (based on existing law) that allow an alternative model. Finally, by reinterpreting an old law or set of regulations/rules, usually with a broader interpretation, a state agency, dental/medical board, or group of providers can implement an alternative model of providing oral health care services.

**Analysis of Existing State Dental Practice Laws and Regulations**

Existing state laws define and specify the scope of practice for dentists and dental hygienists. Appendix A provides a summary of dental practice laws in each state and the District of Columbia. Many state laws provide exemptions that allow physicians and nurses to provide preventive oral health care services, which will be addressed below.

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25 For a review of the composition of the boards of dentistry for the 51 U.S. jurisdictions, see the summaries of the state dental practice acts in Appendix A.

26 See Appendix A.
In determining which states allowed alternative delivery models for preventive oral health services, we focused our analysis on the scope of practice laws for dental hygienists. These dental auxiliaries are authorized to provide a broad range of preventive oral health services, which include complete prophylaxis, application of topical fluoride, pit/fissure sealants, and patient education. Depending on the jurisdiction, they may provide these services with a range of dentist supervision. Appendices C and D include tables that identify these services by level of supervision by jurisdiction.

It is useful to consider the range of services that dental auxiliaries may perform and the level of dentist supervision required. For each of the preventive oral health services, jurisdictions specify the level of dentist supervision required. Such supervision generally falls along the following continuum (moving left to right from least supervision to most):

**FIGURE 1**  
RANGE OF DENTIST SUPERVISION FOR DENTAL HYGIENISTS

<table>
<thead>
<tr>
<th>Practice</th>
<th>Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomous</td>
<td>No</td>
</tr>
<tr>
<td>No</td>
<td>General</td>
</tr>
<tr>
<td>Indirect</td>
<td>Direct</td>
</tr>
</tbody>
</table>

**A: Autonomous Practice:** Dental hygienists permitted to provide preventive dental health services without dentist supervision in independently owned practices. Dentist must provide consultation.

**N: No supervision:** Dental hygienists are permitted to provide services without supervision.

**G: General Supervision:** Dentist not required to be on treatment premise while services are provided. Dentist has authorized the procedures. Dentist must be available for consultation.

**I: Indirect Supervision:** Dentist is required to be on treatment premises while services are provided. Dentist must authorize the procedure but need not sign off on the procedure before patient dismissal.

**D: Direct Supervision:** Dentist is required to be on treatment premises while services are provided. Dentist must authorize the procedure and sign off on the services provided before patient dismissal.
Two Key Issues: Dentist on Premises and Dentist Approval of Work

Along the continuum of supervision of dental hygienists, two key issues stand out in the design of alternative delivery models for the delivery of preventive health services to low-income children:

(1) whether a dentist has to be on the premises when services are provided;

For the first three levels along the continuum (Autonomous, No Supervision, and General Supervision), a dentist does not have to be on the premises when the services are delivered. Jurisdictions that allow these three levels of supervision have more flexibility in designing alternate delivery systems. For the remaining two levels of supervision (Indirect and Direct), a dentist must be on the premises while the services are delivered.

(2) whether a dentist has to sign off on the work performed prior to patient discharge.\(^27\)

A dentist must sign off or approve the work performed by a dental auxiliary only in jurisdictions that require Direct Supervision.

SUPERVISION REQUIREMENTS FOR DENTAL HYGIENISTS

With respect to dental hygienists, forty-four (44) states and the District of Columbia allow dental hygienists to deliver complete prophylaxis services, topical fluoride, and pit/fissure sealants with general supervision. Five (5) states (Alabama, Georgia, Hawaii, Louisiana and Oklahoma) require direct supervision by a dentist for all preventative services delivered by a dental hygienist, including education. Hawaii and Louisiana require only general supervision if the dental hygienist is employed by a public health clinic. Colorado has an independent practice law that allows dental hygienists to provide oral health services without the supervision of a dentist, and Washington state allows independent practice under certain conditions. See Appendix C for more information.

Thirty-eight (38) states and the District of Columbia allow dental hygienists to provide preventive oral health education with general supervision, as defined above. Five (5) states require direct supervision, and seven (7) states allow dental hygienists to provide preventive oral health education without any supervision.

\(^{27}\) This study focuses on the two key issues identified (dentist on premises and dentist sign-off on performed work) because these issues arose most often in the case study discussions regarding the design of alternate delivery systems for oral health services and in state dental practice laws themselves. This does not suggest that these are the only key issues involved in the design of alternate delivery systems.
Figure 2 graphs the frequency of supervision requirements for dental hygienists in the 50 states and the District of Columbia.

FIGURE 2: Supervision Requirements for the Provision of Preventive Oral Health Services by Dental Hygienists

As the data indicate, most state dental practice laws require at least general supervision for the delivery of the four identified preventive oral health services by dental hygienists. Although more flexible than direct supervision, the general supervision standard still requires a dentist to authorize the services and be available for consultation – which may present a barrier in some communities. Appendix C contains a table of the supervision requirements by procedure for all 50 states and the District of Columbia.
Exemptions for Delivery of Preventive Oral Health Services by Physicians and Registered Nurses

The final step in our review of state statutes and regulations was to examine the exemptions to state dental practice laws for the delivery of preventive oral health services by physicians and registered nurses.

Thirty-two (32) states provide general exemptions to the dental practice law for physicians, which means that physicians can provide preventive oral health services. Four (4) states provide general exemptions to the dental practice law for registered nurses, and four other (4) states allow exemptions only for registered nurse anesthetists to provide anesthesia.

Thirteen (13) states provide qualified exemptions to the dental practice law for physicians, which means that physicians can provide limited oral health services (generally limited to extraction of teeth) only in emergencies and in certain institutional settings (e.g., nursing homes, public health clinics). No states specifically make qualified exemptions for registered nurses.

Figure 4 graphs the frequency of exemptions that allow the delivery of preventive oral health services by physicians and registered nurses. Appendix E contains a table of the exemptions for all 50 states and the District of Columbia.

FIGURE 4: Frequency of State Exemptions That Allow the Delivery of Preventive Oral Health Services by Physicians and Registered Nurses

As the data indicate, most states provide an exemption (either general or qualified) to dental practice laws that allows physicians to provide preventive oral health services. Very few states provide such exemptions to registered nurses.
Summary: Review of Dental Practice Laws

The review of the dental practice laws demonstrates that for the four identified preventive oral health services, most state dental practice laws require supervision of a dentist at some level (direct, indirect, general) for the delivery of preventive oral health services by dental hygienists. The more restrictive the supervisory requirements are, the less flexibility states will have in designing alternate models of preventive oral health delivery by dental hygienists.

The efforts to control dental auxiliaries by procedure and varying degrees of supervision lead to confusion in what can be done, where, with what level of supervision and approval. This confusion, in itself, is a deterrent to designing alternate delivery models.

Against this often confusing regulatory backdrop, we turned to a case study analysis of alternative models of delivering preventive oral health care services to examine the experience of six states whose laws permit alternative delivery models.

Case Studies

As we described earlier, the case study component of this study involved an in-depth review of six states’ alternative models of delivering preventive oral health care services to low-income and underserved children. We studied the experiences of the following states: Connecticut, Iowa, New Mexico, North Carolina, South Carolina, and Washington. Specifically we examined the process by which these states passed legislation and/or rules and regulations allowing an alternative model; and whether the alternative model created a change in the delivery system for preventive oral health care services.
Alternative Models Studied

TABLE 4A
DESCRIPTION OF ALTERNATIVE MODELS STUDIED
DENTAL HYGIENIST MODEL

<table>
<thead>
<tr>
<th>State</th>
<th>Description of the Alternative Model</th>
<th>How The Alternative Model Works</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>Dental hygienists with at least two years experience are permitted to work without a dentist's supervision in public health facilities. Direct reimbursement is permitted¹, however, to date no dental hygienists has been issued a Medicaid provider number.</td>
<td>Dental hygienists provide services (oral assessment, cleaning, oral prophylaxis) under a “dentist of record”. ² Dental hygienists must refer patients for treatment needs outside the dental hygienist’s scope of practice and coordinate the referral for treatment to dentists.</td>
</tr>
<tr>
<td>NM</td>
<td>Dental hygienists provide services under “Collaborative Practice” in any setting. Dental hygienists are permitted to own their own practices. Direct reimbursement prohibited.</td>
<td>Dental hygienists work under a signed collaborative agreement with one or more consulting dentist(s). The collaborative agreement defines the dental hygienists’ scope of practice (most often to include educational, assessment, preventive, clinical and other therapeutic services). Services outside of the dental hygienists’ scope of practice must be referred. Dental hygienists perform services and bill under the dentist’s provider number.</td>
</tr>
<tr>
<td>SC</td>
<td>Licensed dental hygienists may provide a select range of services in public health settings without prior authorization from a dentist. Dental hygienists must refer patients with treatment needs to a dentist. Direct billing prohibited.</td>
<td>Dental hygienists working independently or under contract provide services (screenings, oral prophylaxis, and sealants) in public health settings (particularly schools). Dental hygienists may provide oral health “flashlight” screenings after obtaining consent from the individual school. Dental hygienists may provide additional treatment services after receiving authorization from a consulting dentist. Services outside of the dental hygienists’ scope of practice must be referred. Dental hygienists bill for services using a consulting dentist’s provider number.</td>
</tr>
</tbody>
</table>

¹ Under managed care dental hygienists are credentialed by each individual MCO; however, FFS Medicaid reimbursement for dental hygienists is still being implemented. The state DSS (Department of Social Services) is in the process of developing regulations that would allow dental hygienists to be directly reimbursed; however, dental hygienists may only bill under certain circumstances. See Connecticut case study (Appendix G).
² A supervising dentist who agrees to oversee their work, consult on cases, and potentially provide treatment services and allow the facility to use his/her Medicaid provider number for billing purposes.
TABLE 4B
DESCRIPTION OF ALTERNATIVE MODELS STUDIED
MEDICAL MODEL

<table>
<thead>
<tr>
<th>Description of the Alternative Model</th>
<th>How the Alternative Model Works</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA</td>
<td>Physicians and delegated auxiliaries may provide fluoride varnish to children ages 0-3 years old.</td>
</tr>
<tr>
<td></td>
<td>Fluoride varnish application is recommended twice per year.</td>
</tr>
<tr>
<td></td>
<td>Direct billing.</td>
</tr>
<tr>
<td></td>
<td>Physicians and delegated auxiliaries screen the child’s teeth to assess for risk factors for caries, check for visible plaque and lesions, and review history of decay.</td>
</tr>
<tr>
<td></td>
<td>Teeth are toothbrush cleaned and fluoride varnish applied.</td>
</tr>
<tr>
<td></td>
<td>Physicians are expected to make an effort to refer patients or facilitate referral for comprehensive dental care.</td>
</tr>
<tr>
<td></td>
<td>Physicians are reimbursed fee for service from Medicaid.</td>
</tr>
<tr>
<td>NC</td>
<td>Duly licensed physician or surgeon may provide dental services in appropriate clinical settings so long as such services are delivered within the practice of the physician’s profession.</td>
</tr>
<tr>
<td></td>
<td>Up to six applications are allowed over a 3-year period.</td>
</tr>
<tr>
<td></td>
<td>Direct billing.</td>
</tr>
<tr>
<td></td>
<td>Licensed physicians or designated clinical provider functioning under standing orders provide initial and periodic oral screening, patient education, the application of fluoride varnish.</td>
</tr>
<tr>
<td></td>
<td>Physicians bill Medicaid directly and are reimbursed at bundled rate ($43 for an initial assessment and $35 for follow up visits).</td>
</tr>
<tr>
<td></td>
<td>Physicians are expected to develop referral networks with local dental providers and refer patients in need of treatment services.</td>
</tr>
<tr>
<td>WA</td>
<td>Physicians, registered nurses, licensed practical nurses and physician assistants may provide preventive oral health services to children 0-18 years of age, developmentally disabled adults, people over 65 years of age and people with xerostemia.</td>
</tr>
<tr>
<td></td>
<td>No service limits.</td>
</tr>
<tr>
<td></td>
<td>Direct billing.</td>
</tr>
<tr>
<td></td>
<td>Medical personnel provide fluoride varnish; oral health exams.</td>
</tr>
<tr>
<td></td>
<td>Physicians are expected to coordinate referral for treatment to dentists.</td>
</tr>
</tbody>
</table>

Case Study Findings

Our findings reveal that making a change in the law does not result in an immediate change to the oral health care delivery system. In fact, we learned in three of the cases (Iowa, North Carolina, and Washington) that the alternative model could be developed without the creation of a new public health-oriented law. In these states, existing dental and medical practice laws, accompanied by changes to rules, regulations, or administrative policies, were sufficient to permit a new model. In the remaining cases (Connecticut, New Mexico and South Carolina), the alternative model could not be pursued unless the law was changed. Where laws are changed, it may take a substantial amount of time for the dental profession and the market to respond to such changes. However, in all cases we learned that the success of the alternative oral
health care models lay not merely in the laws themselves, but in certain factors essential to their implementation.

Table 5 demonstrates the status of the alternative models' implementation at the time of our interviews. It is clear that in most cases, the alternative models have not had an immediate impact on the oral health care delivery system.

<table>
<thead>
<tr>
<th>STATE</th>
<th>PROVIDERS/PRACTICES INCLUDED IN MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>Less than 20</td>
</tr>
<tr>
<td>Iowa</td>
<td>Not implemented</td>
</tr>
<tr>
<td>North Carolina</td>
<td>192 medical practices trained to provide preventive oral health services</td>
</tr>
<tr>
<td>New Mexico</td>
<td>1 dental hygienist</td>
</tr>
<tr>
<td>South Carolina</td>
<td>1 dental hygienist-owned company provided 12,763 screenings, 3,500 preventive services (cleanings, prophylaxis and fluoride), and 1,772 sealants over the course of the first seven months of business</td>
</tr>
<tr>
<td>Washington</td>
<td>Limited to Spokane and Seattle, Medicaid has no figures on the number of physicians providing oral health care services.</td>
</tr>
</tbody>
</table>

Our findings suggest that a combination of essential factors is required for the implementation of an alternative oral health care delivery model, whether or not a new public health-oriented law has been enacted. This section describes the factors that facilitated the implementation of alternative models for delivering preventive oral health care. These factors include:

- Support from the dental profession;
- Reimbursement mechanisms for providers in the alternative model;
- State Medicaid agency support;
- A referral mechanism for treatment services;
- The type or design of the alternative model and the providers involved;
- An incremental approach to changing the oral health care delivery system;
- Outreach and training on the alternative model; and
- Professional recognition and acceptance of the need for the alternative model.

Our findings also support our conclusion, to be discussed in more detail later, that it is difficult to make changes in the scope of practice of one class of professionals who are overseen by a different group of professionals. We also conclude that even in states where alternative models have been considered and implementation has begun, progress has been slow and changes have been modest. Lastly, we determine that before any attempt is made to implement an alternative oral health care model, states must ensure that a viable funding mechanism with adequate resources has been constructed. To do otherwise would diminish the model's chance of success.

Support from the Dental Profession
Gaining the support of dentists, either through their organizational representatives or through the leadership of individual dentists is perhaps the most important factor in the success of an alternative model. In all the case studies, we learned that it was much more difficult to implement a model in a state where dentists were not supportive. Conversely, where dentists were involved and encouraging, the implementation of the alternative model was much more successful.

For example, in North Carolina the alternative model gained the support of the state’s dental school and state Academy of Pediatric Dentists. In fact the School of Dentistry was one of six collaborating organizations that had equal input in designing and implementing the alternative model. In addition, the School’s former dean, who is a pediatric dentist, initially advocated the use of fluoride varnish. He also conducted the initial training for pediatric physician groups for assessing children’s teeth and applying the varnish. In addition, project partners met with the former president of the North Carolina Dental Society and a new member of the Board of Dental Examiners to brief them on the project. County dental societies were also consulted for their input on the model’s implementation in several pilot sites.

Similarly in Washington state, dental association members and dental providers were part of a group of key stakeholders interested in improving low-income children’s access to dental services. Some of these key stakeholders formed the Washington Oral Health Coalition, which began the planning process for a number of initiatives, including the alternative model allowing physicians and their designees to provide preventive oral health care services to children. Dentists consented to the model after learning that physicians’ involvement would not affect them economically.

Opposition from both organized dentistry and individual dentists can make it difficult to implement the alternative model. In the remaining states (Connecticut, Iowa, New Mexico, and South Carolina) dentists were adamantly opposed to the alternative model and were very vocal in their opposition. In Connecticut, organized dentistry takes the position that the alternative model would create a two-tiered system of care by disassociating the preventive oral health care needs of low-income children from those who can afford to see a dentist. In other words, under the alternative model, poor children only have access to a system of preventive care through dental hygienists who work without general supervision and without formal links to resources or facilities capable of caring for their treatment needs.

In New Mexico, organized dentistry has expressed concern about the safety of dental hygienists’ unsupervised practice.28 Furthermore there is concern that people may not get yearly dental exams and evaluations if dental hygienists provide preventive services independently. Many informants of varying types (i.e., public health, dental

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hygienists, others involved in drafting the legislation) reported that it is difficult to find dentists willing to enter into collaborative agreements with dental hygienists. Some informants reported that dentists in small rural communities feel pressure from their peers not to engage in such agreements, and are reportedly hesitant to assume liability for the dental hygienist.

In South Carolina, although the state dental association was involved in the passage of the law allowing the alternative model, subsequently both the association and the dental board were opposed to the manner in which the alternative model was being implemented. In particular, both entities are opposed to a dental hygienist in the state who owns her own company and who seeks direct reimbursement for her services. A number of informants, including dental hygienists and advocates, reported that dentists have refused to accept referrals from the dental hygienists working under the alternative model. In July 2001, the state dental board, with support from the dental association, issued an emergency regulation that seems to reverse the changes permitted under the new law. Both organizations are now defendants in a lawsuit challenging the emergency regulations.

Finally, in Iowa, although the state dental association supports the goals of early dental screening, it was not in full agreement with the final Medicaid rules issued by the state. According to physicians and state officials, the dental community is reportedly reluctant to support the alternative model because they fear that the fluoride varnish will be misapplied. In addition, these informants also report they believe dentists are concerned about physicians’ encroachment on their turf. An informant representing organized dentistry reported that their primary concerns revolve around the fact that no surveillance model was built-in to measure the outcomes of the model, and that there is no mechanism to follow-up on physicians providing oral health care services.

Additionally, one dentist informant with knowledge of the training program for physicians reported that Iowa’s dental association has been effective in discouraging training sessions for physicians sponsored by the state dental school. Reportedly, the state dental association expressed its dismay that the dental school was providing such training, and subsequently, the informant reports that the dental school has placed little to no priority on conducting the training course.

It should be noted that in a number of cases (Connecticut, Iowa, New Mexico, and South Carolina) organized dentistry ultimately did not formally oppose the passage of the new laws/administrative rules. In fact, the associations were often involved in helping to shape the language of the laws, regulations or administrative policies. Many types of informants reported that although organized dentists did not often support the alternative model enabled by these changes in law/policy, dental associations understood that since dentist participation in Medicaid was so low, they were not in a position to object to the new model. However, these same informants report that despite the fact that there was no formal opposition, many dentists continue to informally oppose the new models.
Reimbursement Mechanisms for Providers in the Alternative Model

The second most important factor in implementing an alternative model is the existence of a reimbursement mechanism. To be financially viable, providers participating in the alternative model must have the ability to bill Medicaid (and other third party providers) directly under their own provider numbers. Otherwise, they must use other providers’ billing numbers, which leaves them dependent on the other providers, and potentially invites levels of supervision or control not anticipated by the alternative model.

In Connecticut, New Mexico, and South Carolina, dental hygienists working under the alternative model are not permitted to bill Medicaid directly for their services. Instead, each dental hygienist must rely on a collaborating or supervising dentist to facilitate Medicaid reimbursement, and thus rely on the dentist to get paid for providing these services. This significantly inhibits their ability to practice under the alternative model. For example, one collaborative practice dental hygienist in New Mexico reported that she must rely on her consulting dentist to submit her bills. On some occasions the dentist has refused to submit billing on her behalf until after he has seen the patient on referral, which significantly delays her reimbursement. The dental hygienist is not aware of which services the dentist has billed for, or when the bills were submitted. She is not given a copy of the invoices sent to Medicaid or private commercial providers.

In all three states (i.e., Connecticut, New Mexico and South Carolina), the Medicaid departments have not consented to giving dental hygienists their own provider numbers. No state laws (either the health professions practice act, or any other law) prohibit dental hygienists from billing Medicaid (or private insurance) directly; however, there is no statute that explicitly requires that they be paid directly either. In 1997 the federal Health Care Financing Administration issued a statement recognizing that dental hygienists could be Medicaid providers and paid directly for their services; however, this was not mandated. Nonetheless, the issue of reimbursement for dental hygienists has remained unresolved.

Reimbursement has not been an issue in states that have implemented a medical model for delivering preventive oral health care services (North Carolina and Washington). Physicians who already have provider numbers have not faced the same

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29 At the time of our case study, Connecticut was considering giving dental hygienists working in public health settings their own provider numbers. State officials in New Mexico stated that collaborative practice dental hygienists would eventually be given provider numbers after they demonstrated they could safely serve patients under the alternative model.

30 Letter from the Health Care Financing Administration (HFCA) (currently known as the Centers for Medicare and Medicaid Services (CMS)) to the American Dental Hygienist Association (ADHA) April 24, 1997. The letter stated that dental hygienists may be reimbursed at the state’s discretion under 42 CFR 440.60 which requires a dental hygienist be licensed and practicing in keeping with the scope of practice as defined under state law. Hence, dental hygienists in states with laws that permit general supervision or no supervision may receive reimbursement directly from Medicaid.
issues dental hygienists have. However, these states, as well as Iowa, were required to create new billing codes to allow physicians to bill for preventive oral health care services.

Reimbursement Rates

Nearly all our study states pay, or plan to pay, providers in the alternative model the same rates as those paid to dentists. Only Connecticut intends to pay dental hygienists less than dentists. Dental hygienists working in public health facilities without general supervision will receive 90 percent of the rate paid to dentists for procedure codes that fall under the dental hygienist’s scope of work once they are awarded direct reimbursement.

State Medicaid Agency Support

The support of the state Medicaid agency is another factor essential to the successful implementation of an alternative model. Medicaid agencies are more likely than private insurers to be on the vanguard of implementing such alternative models. And after achieving success, Medicaid agencies can be instrumental in convincing other third party payers to join in the effort.

All our informants in North Carolina reported that a statewide model would not have been possible without the involvement of the Medicaid agency. Medicaid took the lead on the development and implementation of the model by developing physician-delivered oral health reimbursement codes, setting comparable rates, and developing the service package. Medicaid was also responsible for expanding the pilot project into a statewide initiative. Because the Medicaid agency is the grantee for many oral health grants awarded to the state, it could assemble multiple funding sources and coordinate grant activities to implement the statewide program. Similarly the Medicaid agencies in both Washington and Iowa were instrumental in developing the alternative models, creating new administrative policy/rules allowing the alternative model, assigning new billing codes, and identifying funding sources to cover the cost of the services.

Other states have not enjoyed such proactive support from their Medicaid agencies. For example, the Medicaid agencies in both Connecticut and New Mexico have not been assertive in establishing direct reimbursement for providers in the alternative model.

Referral Mechanism for Treatment Services

Our findings suggest that the lack of a formal referral mechanism severely hindered the successful implementation of most of the alternative models. Nearly all the models were designed to focus solely on providing preventive services and do not include a formal referral mechanism for treatment services. The few models that do require providers (dental hygienists or physicians) to have a referral network do not have any built-in incentives to encourage dentists to participate in the model. Two
alternative models (New Mexico and South Carolina) explicitly require dental hygienists to have a formal arrangement with a dentist(s) to whom they can refer patients for treatment. The remaining states have a more general requirement that physicians/dental hygienists are expected to develop referral networks with local dental providers and refer patients in need of treatment services. It can be difficult to comply with this expectation when few dentists have traditionally agreed to take Medicaid patients, and/or when local dentists oppose the alternative model.

Design or Type of Alternative Model and the Providers Involved

The type of alternative model may predetermine how easily it is implemented in a state. For example, in states where dentists and dental hygienists battle over turf issues, it may be impractical to introduce a model where dental hygienists are permitted to practice without general supervision or independently. In a case such as this, it may be more realistic to implement an alternative model using providers whom dentists regard as peers. For example, in North Carolina, many informants from varying disciplines reported that most dentists consider physicians as their peers and are willing to accept referrals from them. Other North Carolina informants reported that dentists’ opposition to the model may have been greater if the model had included the use of dental hygienists. Similarly, in South Carolina, nearly all our informants reported that there is a long history of conflict between the dental and dental hygienist communities. A comparable history exists in New Mexico. In both states, many of our informants reported that the alternative model has been resisted by dentists who consistently raise concerns about the safety of dental hygienists practicing without direct or general supervision of a dentist.

Incremental Approaches

Alternative models that utilize an incremental approach seem to have more success. One particular approach – serving very young patients for whom there are few or no pediatric dentists – seems to have the most promise. The alternative models in North Carolina and Iowa restrict their reimbursement to services delivered to children age 0-3. There are few pediatric dentists able to serve the great demand reported in low-income populations in each of these states. Understanding this, general dentists in both North Carolina and Iowa could not argue with the alternative model’s design. Furthermore, such a model does not pose a threat to the typical dentist’s patient case load, since the model attempts to serve children who likely have no existing relationship with a dentist. Some North Carolina informants from a variety of disciplines reported that opposition from dentists would have been greater had the model been expanded to cover children of all ages, and/or included the placement of sealants. Dentists were also comforted by the fact that North Carolina physicians only sought to apply fluoride varnish, a treatment used by only a small percentage of dentists in the state. In Iowa,

31 Of course, physicians can provide oral screenings, patient education, and fluoride varnish to children over aged three, but they can not receive reimbursement from Medicaid.
32 It is estimated that fewer than 10 percent of private dental practices in North Carolina use fluoride varnish; most prefer to use chlorhexidine gel instead.
organized dentistry spearheaded a compromise to ensure that administrative rules specified that reimbursement only be available for services provided to children age 0-3; and clarify that physicians could only apply “FDA-approved topical fluoride varnish.”

Outreach and Training

Providers operating in the alternative models must be made aware of the existence of the program to generate enthusiasm for the model. In addition, medical providers must be properly trained to provide preventive oral health care services.\textsuperscript{33, 34} Without these two key components, the alternative model can not be implemented successfully.

North Carolina provides an example of how outreach and training should be conducted.\textsuperscript{35} Six key organizations in the state have been involved in developing and implementing the alternative model.\textsuperscript{36} These organizations ensured that their constituents were aware of the need for such a model, the model’s structure, and its potential benefits. The Medicaid agency stipulated that all providers participating in the model must receive training before being allowed to receive Medicaid reimbursement. A formal training program was thus created. Currently, a dental hygienist at the Academy of Family Physicians provides the training, which is funded by a federal grant. Normally one person from a physician’s office attends the training and then trains his or her co-workers. Training sessions have been approved by the American Medical Association for 1.5 continuing education credits. At the time of our interviews, 192 medical practices had been trained to provide preventive oral health care services.

Implementation of Washington’s model has stalled due to a lack of outreach and training. The state has no formal campaign or outreach mechanism to educate medical providers about their ability to provide and be reimbursed for applying topical fluoride to low-income children’s teeth. It is not clear whether such information has even been published in the state Medicaid newsletter which is sent periodically to licensed medical


\textsuperscript{34} Training was only an issue among the states with medical models. In states with dental hygienist models it was clear that dental hygienists were already well trained to provide preventive oral health care services.

\textsuperscript{35} In fact a recent study found that pediatric primary care providers can achieve an adequate level of accuracy in identifying children with cavitated carious lesions after a brief 2 hour training session. The study also found that dental screenings can easily be incorporated into a busy pediatric practice. See Pierce KM, Rozier G, Vann WF. Accuracy of pediatric primary care providers’ screening and referral for early childhood caries. Pediatrics 2002;109(5).

\textsuperscript{36} These include the Division of Medical Assistance (Medicaid), Division of Public Health, University of North Carolina School of Dentistry, UNC School of Public Health, North Carolina Academy of Family Physicians, and the North Carolina Pediatric Society.
professionals. None of the professional associations or advocacy organizations has undertaken outreach efforts either. In addition, there is little to no formal training available to prepare physicians to provide the topical fluoride varnish. State University staff, under agreement with the state of Washington, have provided some training and education services to physician and nurse practitioners on an individual basis.

Earlier, we reported that physician training courses in fluoride varnish application have been given low priority at the University of Iowa’s College of Dentistry. Only one training session was ever conducted and it was poorly attended. No future training sessions are planned. Due to the state’s budget deficit it is unlikely that the state will offer money to help facilitate outreach and training. This lack of outreach and training has largely contributed to the failure of the alternative model in Iowa.

Professional Recognition and Acceptance of the Need for the Alternative Model

Before it can be implemented, an alternative model must be seen to address a demonstrated need. In nearly all our study sites there is a clear need to increase children’s access to preventive oral health care services. However, this need is not evident in Iowa. Nearly all our Iowa informants reported that access to dental care is not as severe a problem in Iowa as it is in other states. Dentist participation in Medicaid is higher than in other states. For example, 95 percent of Iowa’s dentists are registered as Medicaid providers in the state; however, only 76 percent of those dentists provided dental services to Medicaid patients between July 2000 and July 2001. Of course, some counties have greater needs. In particular we learned that Ames, Dubuque, and Sioux City counties have low dentist Medicaid participation rates. Although many dentists are registered as Medicaid providers throughout the state, many do not see large numbers of Medicaid patients. However, these dentists are willing to take referrals from physicians when there is a child in need. Physicians reported that this was not the case in Storey and Scott Counties – finding a dentist to see low-income children with dental needs was difficult. Physicians from these two counties spearheaded the alternative model’s development, assuming that other physicians throughout the state faced the same difficulties. However, it was soon discovered that interest in such a model was isolated to only these counties. It seems that physicians in other underserved areas continue to obtain appointments for their patients from local dentists. The urgent need has diminished in one of the counties since physicians were able to recruit a young pediatric dentist to the county. This pediatric dentist now has a practice with 50 percent Medicaid patients.
CONCLUSION

As noted above, we learned that making a change in the law does not make an immediate change to the oral health care delivery system. In three of our study cases (Iowa, North Carolina, and Washington), an alternative model could be developed without the creation of a new public health-oriented law. In these states, existing dental and medical practice laws accompanied by changes to rules, regulations, or administrative policies, were sufficient to permit a new model. In the remaining cases (Connecticut, New Mexico and South Carolina), changes in the law were necessary. Where such changes to dental practice laws occur, however, it may take a substantial amount of time for the dental profession and the market to adjust to the new legal landscape. In all cases, we learned that the success of the alternative oral health care models lay not merely in the laws themselves, but also in certain factors essential to their implementation. Our findings section described several essential factors that, in combination, help to spur an alternative model’s success. However, the mere existence of one or more of these factors in a state does not guarantee that an alternative model will be successfully implemented.

The following section describes our conclusion that the alternative models we studied have had little impact on the preventive oral health care delivery systems in our study states. Given the arduous task of implementing an alternative oral health care model, and the slow progress that accompanies such an endeavor, we conclude that states planning to undertake such an effort should be mindful of several factors: 1) it is difficult to make changes in the scope of practice of one class of professionals who are overseen by a different group of professionals; 2) action should be taken at deliberate speed, and incremental steps should be made; 3) preventive oral health care providers operating within the model must have the ability to self-regulate; 4) viable funding mechanisms must be set up prior to implementing the program; and 5) careful consideration should be given to the type of model the state seeks to implement, the types of providers it will include, and the political viability of such a model.

Alternative Models Have Thus Far Had Little Impact

Our case study findings indicate that these public health-oriented laws and alternative models have thus far had little impact on the service delivery system for preventive oral health care services. Although most have been implemented for several years, it may be too soon to understand which alternative model(s) may ultimately be successful. As noted, changes in the legal landscape and delivery system require a substantial amount of time to take hold with the dental profession and market as a whole.

In states with dental hygienist alternative models (Connecticut, New Mexico, and South Carolina), the law and models have not yet significantly changed the way that dental hygienists work. Less than 20 dental hygienists are working under the alternative model in Connecticut; one is working under the new model in New Mexico; and one
A dental hygienist in South Carolina has started a business that employs 14 dental hygienists, 4 dentists, 2 dental assistants, and 6 administrative staff. In all three states, dental hygienists provide the same services they did before the law or model was enacted or implemented (e.g., treatment planning, prophylaxis, and care coordination). Prior to the law, dental hygienists worked under some degree of supervision by a dentist, and they continue to do so currently. Until a reimbursement mechanism can be instituted, thus creating a provider number to allow for direct billing, dental hygienists will be forced to maintain their ties to a dentist of record. As we have seen, this can encourage the old models of general supervision (or indirect supervision), and discourage increased access since dental hygienists interested in the alternative model will have to rely on a dentist to bill for their services.

Although the private business owned by a dental hygienist described in the South Carolina case study has generated significant numbers of screenings (12,763), preventive services (cleanings, prophylaxis and fluoride - 3,500), and sealants (1,772) over the course of seven months, it is important to note that this is not a public health model. It does not focus on serving children in underserved areas. Over time the business may apply for and be granted public health contracts from the state to provide services to low-income and underserved children, but at the time of our interviews, no such public/private partnership existed. Due to financial reasons, the private company currently serves schools in all areas, and seeks to treat children with all types of insurance (although Medicaid and uninsured children are also seen, as required by law). In addition, the future of the business is threatened by the emergency regulation issued by the Dental Board, and impending lawsuits.

**Incremental Steps are Essential**

States should expect to proceed slowly in implementing these models. Even when all parties support the initiative, deliberate speed should be taken during the planning process and when attempting to implement the model. Incremental approaches have a higher likelihood of success since all players have the time to acclimate to the new changes, and systems can be developed to accommodate such changes.

Those involved in the planning process should also be mindful of keeping the scope of the alternative models small. Alternative models that attempt to provide a large range of preventive oral health care services to large groups and types of people are likely to face opposition from organized dentistry. Much of the success of North Carolina’s alternative model is a result of limiting the program to children between 0 - 3 years of age.

**Power to Self-Regulate is Key**

Even in states where the dialogue has moved to consider increasing the scope of permissible practice by dental hygienists, that dialogue has not progressed very far. This is largely due to the fact that dental hygienists are generally not self-regulating, and
must depend upon state dental boards with majority dentist representation to approve potential expansions in their scope of practice. Whenever one profession is responsible for overseeing the regulation of another, it is difficult to loosen restrictions and increase the autonomy of the subordinate group.

**Viable Reimbursement Mechanisms are Necessary**

We conclude that a lack of a viable funding mechanism has stunted the implementation of the alternative model. Even in states such as Connecticut and New Mexico that have passed laws allowing an alternative model, and where the various parties have agreed to the concept of such a model, its implementation has stalled because participating providers cannot receive payment. Therefore, it is essential to ensure that adequate funds are available and a payment mechanism exists early in the planning process for an alternative method.

**Importance of Provider Type Used in Alternative Model**

Our findings show that, at this time, some in the organized dental community are uncomfortable with providing dental hygienists the professional latitude necessary for some alternative models to succeed. Unless dental hygienists are permitted to work without supervision, or under general supervision, these types of alternative models are unlikely to flourish. Instead, these models may be restricted to smaller areas, serving more limited populations, and therefore have less effect on low-income populations. It may be more effective to design models that utilize providers who already have more autonomy. States may find it easier to implement alternative preventive oral health care models that use physicians and other medical personnel such as nurses. Such providers are self-regulating and therefore control their scope of practice. As we learned in the case of our medical model states (Iowa, North Carolina, and Washington) there was little opposition to the inclusion of physicians in the model.

**Success Depends Upon the Convergence of Several Factors**

We have isolated many reasons that contribute to the success of an alternative oral health care model. No one factor can assure the success of any particular model. However one factor, such as lack of a reimbursement mechanism, can ensure that the model will stall. Washington's alternative model, for example, has had mixed success. Although it is operational in a few pilot sites, physicians are unlikely to participate unless the state undertakes a formal outreach and training program. Iowa's program has not been implemented due to a combination of factors, including a lack of outreach or training and little urgent need for the alternative model.

One published study supports our findings that a model's success will take a multi-layered approach. Results from a national survey suggest that pediatricians may be very willing to become more involved in oral health screening, counseling families on the prevention of caries, and applying fluoride varnish. In fact, many respondents
already believe they have an important role to play in their patients’ oral health and already provide anticipatory guidance. However, the study found that physicians will need adequate training and physicians’ perceived difficulties referring patients for professional dental care will have to be addressed.37

North Carolina’s experience illustrates that several of the factors we described earlier must be present to facilitate the likelihood of the models’ success. Our analysis found that this model has the most potential for changing the health care delivery system and may impact children’s oral health outcomes. According to state Medicaid data, over 5,000 children have received oral health assessments from a physician or physician extender and over 500 have received follow-up care in just a few short months; a related program provided 2,000 fluoride varnish applications from 1999 – 2001. It seems that children are receiving initial care, but there is concern about the seemingly large drop-off of children returning for follow-up care. The state estimates that close to 170,000 children could eventually qualify for the service under Medicaid.

In North Carolina, a combination of essential factors converged during the planning and implementation processes for the alternative model:

- substantial support from dentists throughout the development and implementation of the alternative model;
- a reimbursement stream was made available, with separate physician-only billing codes;
- the Medicaid agency was instrumental in implementing the program state-wide (and obtaining grant funding to do so);
- although not entirely resolved, it is hoped that physicians can generate informal referral networks for treatment services;
- dentists in North Carolina view physicians as peers and are not threatened by them;
- the model took incremental steps: reimbursement is restricted to fluoride varnish application on children age 0-3;
- extensive outreach and training have been provided; and
- a demonstrated and accepted need for such an alternative model (i.e., lack of access to dental services for very young, low-income children).

It is also interesting to note that North Carolina’s model did not require a change in the law; rather, the alternative model was enabled by a change in Medicaid policy allowing physicians reimbursement for preventive oral health care services. This demonstrates that new public health-oriented laws are not required to implement a change in the health care delivery system, per se. Alternative models can be authorized by a change in rules, regulations, or policy. However, alternative models can only be implemented successfully if a majority of the factors we described above are present.

LIMITATIONS

Case studies are designed to present an in-depth analysis of particular “cases,” and thus are not meant to be representative of all groups involved in similar activities. Case studies typically produce a set of unique findings that reflect the individual experiences of an organization or group of organizations. It should be noted that the models studied in each state were at differing points in their development and implementation. Furthermore we did not conduct any analysis on outcome measures to indicate the success or failure of the models in increasing access to preventive dental services by underserved children.

To increase the generalizability of our findings to other states, we selected six states already involved in developing/implementing an alternative preventive oral health delivery model. We developed an analytic framework to guide our investigation with common instruments, and systematic data collection, and analyses. This final report presents the experiences of all our study sites, and contains analysis of issues that were found to be similar across sites. This cross-cutting analysis provides the basis for practical recommendations for addressing the best practices and lessons learned by states when developing and implementing alternative models of providing preventive oral health care.

RECOMMENDATIONS

This study did not focus on dentist workforce training and supply issues, therefore our recommendations do not address these factors. Instead we focus on those elements that facilitate the development and implementation of alternative models of delivering preventive oral health care services.

• Public health leadership is needed to create a greater awareness of the need for oral health among poor children.

• Public health and dental professional leadership is needed to destigmatize the services provided by non-dentists. Disseminating the results of recent studies indicating that dental hygienists provide safe care may facilitate these efforts.

• Federal and state Medicaid officials can be effective leaders in implementation and reimbursement issues. In particular, officials can follow the example of the North Carolina Medicaid agency and its leadership in promoting the alternative oral health care model.

• Federal government and professional societies should address outreach and training issues associated with implementation of these models.

• Even without legal changes, Medicaid and public health officials can encourage the role of pediatricians regarding applying fluoride varnish. In most states physicians are already permitted to provide such services.
Further study is needed on successfully implemented preventive oral health care models. Study should be undertaken at the individual provider level to learn exactly what elements are necessary to make a particular model successful. Specific factors, and their likelihood for leading to greater success, should be studied including: the model selected, the training program for providers under the model, reimbursement mechanisms and their impact, providers providing the service under the model (nurses versus pediatricians), and how the preventive services are delivered (i.e., topical application of varnish versus chlorhexidine gel). Where possible, process and outcome measures should be collected and evaluated. Such measures can include the number of fluoride applications administered (and number of follow-up delivered), and any change in the caries rate among the providers’ population over time.
APPENDICES
APPENDIX A

STATE SUMMARIES OF DENTAL AND MEDICAL PRACTICE LAWS

ALABAMA

Summary:

The practice of dentistry is defined as any “dental operation or dental service of any kind” which includes treating “disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws, or adjacent structure, or extract[ing] human teeth, remov[ing] tumors, abnormal growths or other lesions in the human gums, jaws and adjacent structures,” or treating “surgically or mechanically the fractures of the human jaw, adminster[ing] general or local anesthesia in the treatment of any dental lesion.” Code of Ala. § 34-9-6.

Licensed physicians and surgeons providing services defined within the scope of their practice are exempt from the statute, provided that they do not practice dentistry as a specialty. Code of Ala. § 34-9-7 The statute also makes exemptions for dentists or dental surgeons in the US armed services, and public health services, dentists from other states, dental hygienists practicing under the supervision of a dentist, certified nurse anesthetist, and nurses under specialized conditions. Code of Ala. § 34-9-7

The statute defines the practice of dental hygiene narrowly to include the removal of calcareous deposits, accretions or stains from the teeth, and perform any intra-oral procedures allowed by the Board, and assist licensed dentist in his or her practice. § 34-9-27.

Specific scope of services or area of practice for dental assistants are not defined in the statute.

1. DENTIST

What constitutes practicing dentistry?

Any person shall be deemed to be practicing dentistry “who performs…any dental operation or dental service of any kind…, makes impressions of human teeth, jaws, or adjacent tissues, supplies artificial substitutes for natural teeth, furnishes, supplies reproduces or repairs any prosthetic denture, repairs or fills cavities in human teeth, uses roentgen or X-ray machine for the purpose of taking dental X-rays, administers anesthetic, and attempts to perform any dental or clinical operations.” Code of Ala. § 34-9-6.

38 These summaries do not cover the laws comprehensively; they have been edited to focus on preventive oral health services. Laws covering specific practice by dental students and other practices by ancillary dental providers have been omitted.
The statute prohibits anyone other than a licensed dentist or a dental professional service organization from operating dental services site (dental office, clinic, or other specified facilities), employing a dental hygienist in the operation of a dental office, and retaining ownership or control of dental equipment. This provision, however, does not pertain to state, county, municipal or city institutions, but includes any individual, firm, partnership, corporation or other entity not licensed to practice dentistry. Code of Ala. § 34-9-9.

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

A dental hygienist is permitted to “work only under the direct supervision of a licensed dentist.” Dental Hygienists are permitted to “take, develop, and mount X-rays, remove calcareous deposits, accretions or stains from the teeth, perform any intra-oral procedures allowed by the Board, and assist licensed dentist in his or her practice.”

The statute does not explicitly state where dental hygienists may practice.

In order to practice dental hygiene, the individual must complete the curriculum for dental hygiene at a dental school approved by the Board.

3. OTHER MID-LEVEL PROVIDERS

The statute makes no specific references to the regulation of dental assistants.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The statute shall not apply to licensed physicians or surgeons, “provided he or she shall not practice dentistry as a specialty.” Code of Ala. § 34-9-7

5. NURSING

May a nurse provide any of the services that are defines as dental or dental hygienist services?

The statute also shall not apply to “the use of a nurse in the practice of professional or practical nursing, as defined in § 34-21-26.” Code of Ala. § 34-9-7
6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the state dental practice board?

The Board consists of five dentists who have been actively engaged in the practice of dentistry in the State for at least five years preceding the election. No member of the Board shall be a member of the faculty of any dental school, dental college, or dental hygiene school. The Board also consists of one licensed dental hygienist who has been actively engaged in the practice of dental hygiene in the State for at least five years preceding his/her appointment to the Board. Code of Ala. § 34-9-40.

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may take disciplinary actions against any dentist or dental hygienists who is found guilty of “employing, allowing or permitting any unlicensed person or persons to perform any work in his or her office which, under this chapter can only be legally done by a person or persons holding a license to practice dentistry or dental hygiene.” Code of Ala. § 34-9-18.

ALASKA

Summary:

A person who “performs…dental operations, diagnoses, treats, operates on, corrects, attempts to correct, or presets for, a disease, lesion, pain, injury, deformity, deficiency, or physical condition, malocclusions or malposition of the human teeth, alveolar process, gingiva, maxilla, mandible, or adjacent structures…” is engaged in the practice of dentistry. Alaska Stat. § 08.36.360

The statute makes general exemptions for physicians or surgeons, dentists providing care in an isolated and dentally underserved area, dentists in the US armed forces, dentists in the US Public Health Service, dental students, dental interns, an individual licensed to practice dentistry in any other state while making a clinical demonstration before a dental society, and dentists licensed in another state who provide emergency care to an injured or ill person who reasonably appears to the dentist to be in need of emergency aid. Alaska Stat. § 08.36.350

A dental hygienist may “remove calcareous deposits, accretions, and stains from the exposed surface of the teeth…. apply topical preventive or prophylactic agents, apply pit and fissure sealants…” under the general supervision of a licensed dentist. Alaska Stat. § 08.32.110(a)

The Board shall issue an annual permit authorizing the treatment of residents in a dentally under-served area, who are not entitled to dental care by state or federal government, by a dentist employed by a United States Public Health Service or a
qualified member of the armed services who serves in that area. Alaska Stat. § 08.36.010

Dental assistants may “apply topical preventive or prophylactic agents or pit and fissure sealants when those services have been delegated to the assistant” by a licensed dentist under his/her direct or indirect supervision. Alaska Stat. § 08.36.010

1. DENTIST

What constitutes practicing dentistry?

A person who “performs or holds out to the public as being able to perform dental operations, diagnoses, treats, operates on, corrects, attempts to correct, or prescribes for, a disease, lesion, pain, injury, deformity, deficiency, or physical condition, malocclusion or malposition of the human teeth, alveolar process, gingiva, maxilla, mandible, or adjacent structures, performs or attempts to perform an operation incident to the replacement of teeth, furnishes…dentures…, extracts or attempts to extract human teeth, and exercises control over professional dental matters of the operation of dental equipment in a facility…” is engaged in the practice of dentistry. Alaska Stat. § 08.36.360

The practice of dentistry or dental hygiene or the attempt to practice dentistry or dental hygiene without a valid license and current registration is prohibited in the state of Alaska. Alaska Stat. § 08.36.100 Anyone who practices dentistry or dental hygiene without a valid license and current registration shall be guilty of class B misdemeanor. Alaska Stat. § 08.36.340

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

A dental hygienist may “remove calcareous deposits, accretions, and stains from the exposed surface of the tooth beginning at the epithelial attachment by scaling and polishing techniques, apply topical preventive or prophylactic agents, apply pit and fissure sealants, perform root planing and periodontal soft tissue curettage, perform other dental operations and services delegated by a licensed dentist if the dental operations and services are not prohibited by the Board” under the general supervision of a licensed dentist. Alaska Stat. § 08.32.110(a)

Dental hygienist, certified in anesthesia, may also administer local anesthetic agents under the direct or indirect supervision of a licensed dentist. Alaska Stat. § 08.32.110(6)

Dental hygienist may practice in a dental office of a licensed dentist, private school or welfare center, incorporated eleemosynary dental dispensary or infirmary, or federal or state health department. Alaska Stat. § 08.32.100
Dental hygienists shall not be involved in the “diagnosis, treatment planning, writing prescriptions for drugs, writing authorizations for restorative, prosthetic, or orthodontic appliances, and operative surgical procedures on soft or hard tissues.” Alaska Stat. § 08.32.020

In order to practice dental hygiene in Alaska, hygienists must be licensed by the Alaska Board of Dental Examiners. To qualify for a license as a dental hygienist, individual must: be at least 18 years of age, be a graduate of an accredited high school, graduate of an dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation that provides at least a two academic years of curriculum, and pass dental hygiene examinations which include both a written theory examination and examinations testing applicants' knowledge of basic biomedical sciences. Both examinations are administered by the board. Alaska Stat. § 08.32.020

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may “apply topical preventive or prophylactic agents or pit and fissure sealants when those services have been delegated to the assistant” by a licensed dentist under his/her direct or indirect supervision. Alaska Stat. § 08.36.010

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may presumably provide any of the services that are defined as dental or dental hygiene services. The statute does not apply to “a physician or surgeons.” Alaska Stat. § 08.36.350(3)

5. NURSING

The statute makes no reference to physicians or surgeons.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may suspend or revoke the license of any dentist who employed, directly or indirectly, any unlicensed or uncertified person to perform any act requiring licensure or certification under this chapter. Alaska Stat. § 08.36.310
Who serves on the dental board?

The Board of Dental Examiners consists of nine members, of whom six are licensed dentists who have been engaged in the practice of dentistry in Alaska for at least five years immediately preceding their appointment. Two members are dental hygienists who have been engaged in the practice of dental hygiene in Alaska for at least five years immediately preceding their appointment. The remaining one member is a public member. Alaska Stat. § 08.36.010

ARIZONA

Summary:

A person is deemed to be practicing dentistry who “performs an operation or administers an anesthetic in connection with an operation, diagnoses or treats any condition, disease or lesion, takes an impression, corrects a malposition, treats a fracture, or removes calcareous deposits…with specific reference and application to the teeth, gums, jaws, oral cavity or tissues adjacent thereto in living persons…” A.R.S. § 32-1202

There are exemptions for dental students, dental faculty, dentists in the US armed forces, clinicians of other states making clinical demonstrations before dental societies in Arizona, and the state director of dental public health. A.R.S. § 32-1231

The practice of dental hygiene includes “prophylaxis, scaling, closed subgingival curettage, root planing, administering local anesthetics and nitrous oxide, placing of periodontal sutures, polishing, examining oral cavity, periodontal examination, recording clinical findings, and compiling case histories.” A dental hygienist “shall practice under the general supervision of a dentist licensed in this state.” A.R.S. § 32-1281

Dental assistants may expose radiographs for dental diagnostic purposes under the general supervision of a licensed dentist if the assistant has passed an examination by the Board. For all other services, dental assistants must work under the direct supervision of a licensed dentist. A.R.S. § 32-1291

1. DENTIST

What constitutes practicing dentistry?

A person is deemed to be practicing dentistry who “by himself or an agent, employee, servant or contractor, and with specific reference or application to the teeth, gums, jaws, oral cavity or tissues adjacent thereto in living persons…performs an operation or administers an anesthetic in connection with an operation, diagnoses or treats any condition, disease or lesion, takes an impression, corrects a malposition, treats a fracture, or removes calcareous deposits, replaces missing anatomy with artificial
A.R.S. § 32-1202

The statute prohibits anyone other than a licensed dentist from practicing without a license, except for those exempted by the statute. A.R.S. § 32-1261

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene includes “prophylaxis, scaling, closed subgingival curettage, root planing, administering local anesthetics and nitrous oxide, placing of periodontal sutures, polishing, examining oral cavity, periodontal examination, recording clinical findings, and compiling case histories.” A.R.S. § 32-1281

The Board shall prescribe circumstances under which a hygienist may “expose and process dental radiographs, perform all functions authorized and deemed appropriate for dental assistants, apply preventive and therapeutic agents, used in relation to dental hygiene procedures, to hard and soft tissues.” A.R.S. § 32-1281(D)

A hygienist “shall practice under the general supervision of a dentist licensed in this state.” Dental hygienist shall practice under direct supervision of a licensed dentist when “administering local anesthetics, administering nitrous oxide, and placing sutures. A.R.S. § 32-1281(F)

• General supervision means that the dentist is available for consultation, whether or not the dentist is in his office, over procedures which the dentist has authorized and for which the dentist remains responsible.

• Direct supervision means that the dentist is present in the office while the dental hygienist is treating a patient and is available for consultation regarding procedures that the dentist authorizes and for which he is responsible.

Dental hygienist may practice in a dentist’s office, in a health care facility, nursing home, in public health agency or institution on patients who have been examined by a dentist within the previous year, and in a homebound setting on patients who have been examined by a dentist within the previous year. A.R.S. § 32-1281(G)

Dental hygienist must obtain a license from the Board before practicing dental hygiene in the state of Arkansas. To obtain a license, hygienists must fulfill the following criteria: graduate from an accredited dental hygiene program and pass dental hygiene examinations administered by the Board. A.R.S. § 32-1287 Practicing dental hygiene without a license is considered a class 2 misdemeanor. A.R.S. § 32-1288
3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may expose radiographs for dental diagnostic purposes under the general supervision of a licensed dentist if the assistant has passed an examination by the Board. For all other services, dental assistants must work under the direct supervision of a licensed dentist. A.R.S. § 32-1291

The statute does not define other specific scope of services or areas of practice for dental assistants, nor does it delineate any prerequisites to practicing as a dental assistant.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The statute does not make any reference to physicians, nor does it cite physicians in the chapter on exemptions.

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

“A person is guilty of a class 2 misdemeanor who employs, contracts with, or by any means procures the assistance of, or association with, for the purposes of practicing dentistry, a person not having a valid license therefor.” A.R.S. § 32-1268

Who makes up the dental board?

The Board shall consist of six licensed dentists, two licensed dental hygienists, and three public members appointed by the Governor for a four-year term. A.R.S. § 32-1203
ARKANSAS

Summary:

The practice of dentistry is broadly defined as the “evaluation, diagnosis, prevention, and treatment by nonsurgical, surgical, or related procedures of diseases, disorders, and conditions of the oral cavity, maxillofacial area, and the adjacent and associated structures that impact on the human body, but not for the purpose of treating diseases, disorders, and conditions unrelated to the oral cavity, maxillofacial area, and adjacent associated structures.” Ark. Stat. Ann. §17-82-102

The statute does not prohibit a “licensed physician from extracting teeth in an emergency when…it is unnecessary and when it is not practicable or reasonable to secure the services of a licensed dentist…” Ark. Stat. Ann. §17-82-102 (c) The statute also makes exemptions for a dental medical officer of the US armed forces, dental students, dental interns or residents, and dentists engaged in the teaching of dentistry. Hospitals, public health institutions, and universities are also exempted from the dental practice laws. Ark. Stat. Ann. §17-82-302

The practice of dental hygiene is defined as “removing of calculus, plaque, and stains from the teeth…, taking radiographs of teeth, the alveolar process or any parts involved therewith.” A dental hygienist may practice in the office of a licensed dentist under direct supervision. Ark. Stat. Ann. §17-82-102 (b)

Specific scope of services and areas of practice for dental assistants is not defined in the statute. The statute does delineates, however, permit requirements for practicing as a dental assistant. Ark. Stat. Ann. §17-82-401

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry is broadly defined as “evaluation, diagnosis, prevention, and treatment by nonsurgical, surgical, or related procedures of diseases, disorders, and conditions of the oral cavity, maxillofacial area, and the adjacent and associated structures that impact on the human body, but not for the purpose of treating diseases, disorders, and conditions unrelated to the oral cavity, maxillofacial area, and adjacent associated structures.” Ark. Stat. Ann. §17-82-102

The statute prohibits anyone other than a licensed dentist or dental hygienist from practicing dentistry or dental hygiene. The statute also prohibits anyone other than a licensed dentist or a dental professional service organization from operating dental services site (dental office, clinic, or other specified facilities). Ark. Stat. Ann. §17-82-301
2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene is limited to “removing of calculus, plaque, and stains from the teeth…, taking radiographs of teeth, the alveolar process or any parts involved therewith.” A dental hygienist may practice in the office of a licensed dentist under direct supervision. Ark. Stat. Ann. §17-82-102 (b)

Registered licensed dental hygienist working under at an Arkansas Dept. of Correction facility may work under the general supervision of licensed dentist. Ark. Stat. Ann. §17-82-104

General supervision is defined with several components, namely:
1. “The dentist shall establish a written office protocol which specifically indicates when a hygienist may treat a patient and when a patient is to be seen by a dentist.”
2. “The hygienist shall specifically adhere to the protocol for treatment developed by dentist.
3. General supervision is limited to prophylaxis, application of sealants, root planning, and any duties normally assigned to dental assistants.
4. The dentist reviews and countersigns all entries made in patient’s chart by hygienist…
5. All hygienist working under general supervision shall be certified in cardiopulmonary resuscitation
6. Hygienists shall review a patient’s dental health history prior to treatment.

Specific areas of practice for dental hygienists is undefined in the statute.

Dental hygienists must be licensed and registered by the Board to practice in Arkansas. To obtain a license a dental hygienist must fulfill practice requirements, which include graduation from accredited dental hygiene program with minimum two years of academic curriculum and successful completion of examinations. Ark. Stat. Ann. §17-82-104

7. OTHER MID-LEVEL PROVIDERS

Specific scope of services and areas of practice for dental assistants is not defined in the statute. The statute does delineates, however, permit requirements for practicing as a dental assistant. Ark. Stat. Ann. §17-82-401

A dental assistant who desires to perform expanded duties, which include prophylaxis under general supervision, must obtain a permit. To obtain a permit, applicants must: pass written and oral examinations and fulfill additional work requirements. Ark. Stat. Ann. §17-82-404
8. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide dental services only in an emergency when “it is unnecessary and when it is not practicable or reasonable to secure the services of a licensed dentist…” Ark. Stat. Ann. §17-82-102 (c)

9. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

Statute makes no references to nurses.

10. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

It is unlawful for a dentist or a dental hygienist to “aid or assist in any manner any unlicensed person to practice dentistry or dental hygiene or any branch thereof.”

CALIFORNIA

Summary:

The practice of dentistry is the “diagnosis or treatment, by surgery or other method, of diseases and lesions and the correction of malpositions of the human teeth, alveolar process, gums, jaws, or associated structures…” Cal Bus & Prof Code § 1625

The statute makes qualified exemptions for physicians or surgeons, dentists in the US armed forces, US federal services on federal reservations, US Public Health Service, Veteran’s Administration, Bureau of Indian Affairs, dental students, dental hygiene students engaged in the practice of dental hygiene, dental interns, and dentists licensed to practice dentistry in any other state or country while making a clinical demonstration before a dental society or dental association. Cal Bus & Prof Code § 1626

Dental hygienists may provide “removal of deposits, accretions and stains from the unattached surface of the teeth, and application of topical agents essential to complete prophylaxis under the general supervision of a licensed dentist.” Cal Bus & Prof Code § 1760
Dental hygienists may practice “as an employee of a dentist or of another registered
dental hygienist in an alternative practice, or as an independent contractor, or as a sole
proprietor of an alternative dental hygiene practice.”
Registered dental hygienist “in an alternative practice may perform…in residences of
the homebound, schools, residential facilities, and dental health professional shortage
areas, as certified by the Office of Statewide Health Planning and Development.” Cal
Bus & Prof Code § 1770

Licensed dental assistants may provide supportive services under the direct or general
supervision of a licensed dentist. Cal Bus & Prof Code § 1753

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry is the “diagnosis or treatment, by surgery or other method, of
diseases and lesions and the correction of malpositions of the human teeth, alveolar
process, gums, jaws, or associated structures; such diagnosis may include all
necessary and related procedures as well as the use of drugs, anesthetic agents, and
physical evaluation.” Cal Bus & Prof Code § 1625
A person practicing dentistry “performs, or offers to perform, an operation of any kind, or
treats diseases or lesions of the human teeth, alveolar process, gums, jaws, or
associated structures, or corrects malposed positions thereof…” Cal Bus & Prof Code §
1625

The practice of dentistry or dental hygiene or the attempt to practice dentistry or dental
hygiene, either privately or as an employee of a governmental agency or political
subdivision, without a valid and current license is unlawful in the state of California. Cal
Bus & Prof Code § 1626

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

Dental hygienists may provide “removal of deposits, accretions and stains from the
unattached surface of the teeth, and application of topical agents essential to complete
prophylaxis under the general supervision of a licensed dentist.” Cal Bus & Prof Code §
1760

Dental hygienists may practice “as an employee of a dentist or of another registered
dental hygienist in a n alternative practice, or as an independent contractor, or as a sole
proprietor of an alternative dental hygiene practice.” Cal Bus & Prof Code § 1770
Registered dental hygienist “in an alternative practice may perform…in residences of
the homebound, schools, residential facilities, and dental health professional shortage
areas, as certified by the Office of Statewide Health Planning and Development.” Cal
Bus & Prof Code § 1770
Registered dental hygienist in alternative practice must provide to the Board documentation of existing relationship with at least one dentist for referral, consultation, and emergency services. Cal Bus & Prof Code § 1770(g) A registered dental hygienist in alternative practice may perform dental hygiene services for a patient who presents to the registered hygienist a written prescription for dental hygiene services issued by a dentist or physician and surgeon licensed to practice in California who has performed a physical examination and a diagnosis of the patient prior to a prescription being provided. Cal Bus & Prof Code § 1770(h)

A registered dental hygienist in alternative practice shall not do any of the following: provide any type of dental health diagnosis beyond evaluating a patient’s dental hygiene status, providing a dental hygiene treatment plan, and providing associated dental hygiene services. Cal Bus & Prof Code § 1770(c)

Dental hygienists must satisfy all of the following requirements in order to be licensed and practice in California. The requirements include: completion of an educational program for registered dental hygienists, approved by the Board and accredited by the Commission on Dental Accreditation, and conducted by a degree-granting, post secondary institution; satisfactory performance on examinations required by the Board; and satisfactory completion of a national written dental hygiene examination approved by the Board. Cal Bus & Prof Code § 1758

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental Assistants may provide services under the direct or general supervision of a licensed dentist. Cal Bus & Prof Code § 1753

Dental assistants must graduate from an educational program approved by the Board, successfully complete both written and oral examinations required by the Board, and fulfill work experience requirements of 18 months as a dental assistant in California to be licensed by the Board. Cal Bus & Prof Code § 1753

MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may only provide some dental services in emergent cases. “The practice of oral surgery by a physician and surgeon licensed under the Medical Practice Act” is exempt from the Dental Practice Act. Cal Bus & Prof Code § 1626
4. NURSING

There are no references to nurses in the statute.

5. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The “aiding or abetting of any unlicensed person to practice dentistry” by any dentist is unlawful in the state of California. Anyone found in violation of this chapter is guilty of misdemeanor. Cal Bus & Prof Code § 1680

Who serves on the dental board?

The Dental Board of California, which is a part of the Department of Consumer Affairs, consists of 8 practicing dentists, one registered dental hygienist, one registered dental assistant, and four public members. All members, except the public members, must be actively and legally engaged in the practice of dentistry in California for at least five years preceding their appointment to the Board. The dental assistant must be a registered dental assistant in the state of California. All members are appointed by the governor for a four-year term. The Board is organized into standing committees dealing with examinations, enforcement, and other subjects the Board deems necessary. Cal Bus & Prof Code § 1601.5

There also exists a Committee on Dental Auxiliaries that has authority over educational requirements for dental auxiliary programs and authorization over examination and licensure of dental auxiliaries. Cal Bus & Prof Code § 1742

COLORADO

Summary:

Under Colorado law, a person shall be deemed to be practicing dentistry if the person “performs, or attempts to perform, any dental operation or oral surgery or dental diagnostic or therapeutic services of any kind.” C.R.S. § 12-35-110(1). Dental practice includes taking “impressions of the human tooth, teeth, or jaws” and performing “any phase of any operation incident to the replacement of a part of a tooth.” Id.

Nothing in the statute’s definition of dental practice is intended “to prohibit a dental hygienist or dental auxiliary from providing preventive dental or nutritional counseling, education, or instruction services.” Id.

Licensed physicians and surgeons providing services defined within the scope of their practice are exempt from the statute, provided that they do not practice dentistry as a
specialty. C.R.S. § 12-35-111. The statute also makes exemptions for dentists or dental surgeons in the US armed services and public health services, dentists from other states, dental hygienists practicing under the supervision of a dentist, registered nurse anesthetist, and dental interns in an American Dental Association approved internship program. See id.

The statute defines the practice of dental hygiene to include activities of one who

- removes deposits, accretions, and staings by scaling with hand, ultrasonic, or other devices from all surfaces of the tooth and smooths and polishes natural and restored tooth surfaces;
- removes granulation and degenerated tissue from the gingival wall of the periodontal pocket through the process of gingival curettage;
- provides preventive measures including the application of fluorides and other recognized topical agents for the prevention of oral disease;
- gathers and assembles information including, but not limited to, fact-finding and patient history, oral inspection, and dental and periodontal charting; and
- administers a topical anesthetic to a patient in the course of providing dental care.

C.R.S. § 12-35-122.5. The statute also allows for the practice of “unsupervised” dental hygiene for the above tasks. C.R.S. § 12-35-122.5.

A “dental auxiliary” under Colorado law is “any person not a dentist or dental hygienist licensed in Colorado who may be assigned or delegated to perform dental tasks or procedures as authorized by [this statute or the dental board].” C.R.S. § 12-35-103.

6. DENTIST

What constitutes practicing dentistry?

A person shall be deemed to be practicing dentistry in Colorado if, in the course of legitimate professional practice, such person:

- performs, or attempts or professes to perform, any dental operation or oral surgery or dental diagnostic or therapeutic services of any kind;*
- is a proprietor of a place where dental operation, oral surgery, or dental diagnostic or therapeutic services are performed;*
- directly or indirectly, by any means or method, takes impression of the human tooth, teeth, or jaws or performs any phase of any operation incident to the replacement of a part of a tooth or supplies artificial substitutes for the natural teeth;*
- furnishes, supplies, constructs, reproduces, or repairs any prosthetic denture, bridge, appliance, or other structure to be worn in the human mouth other than on the written laboratory work order of a duly licensed and practicing dentist, or places such appliance or structure in the human mouth, or adjusts or attempts or professes to adjust the same, or delivers the same to any person other than the dentist upon whose laboratory work order the work was performed;
• professes to the public by any method to furnish, supply, construct, reproduce, or repair any prosthetic denture, bridge, appliance, or other structure to be worn in the human mouth;
• examines, diagnoses, plans treatment, or treats natural or artificial structures or conditions associated with, adjacent to, or functionally related to the oral cavity or the maxillofacial area;
• extracts, or attempts to extract, human teeth, or corrects, or attempts to correct, malformations of teeth or of the jaws;
• repairs or fills cavities in the human teeth;
• prescribes ionizing radiation or the use of an X ray for the purpose of taking dental X rays or roentgenograms (these procedures may be delegated to appropriately trained personnel);
• gives, or professes to give, interpretations or readings of dental X-rays or roentgenograms;*
• represents him or herself to an individual or the general public as practicing dentistry, by using the words “dentist” or “dental surgeon,” or by using the letters “D.D.S,” “D.M.D.,” “D.D.S./M.D.,” or “D.M.D./M.D.”*
• states, permits to be stated, or professes by any means or method whatsoever that he or she can perform or will attempt to perform dental oerations or render a diagnosis connected therewith;
• prescribes such drugs or medications and administers such general or local anesthetics, anesthesia, or analgesia as may be necessary for the proper practice of dentistry;*
• prescribes, induces, and sets dosage levels for inhalation anesthesia; or
• gives or professes to give interpretations or readings of dental charts or records or gives treatment plans or interpretations of treatment plans derived from examinations, patient records, dental X rays, or roentgenograms.*

C.R.S. § 12-35-110.

The Colorado law specifies that for the provisions marked with an asterik (*) above, the statute does not prohibit dental hygienists or dental auxiliaries from performing certain tasks or procedures, or providing preventive dental or nutritional counseling, education or instruction services. See id.

7. Dental Hygienist

What constitutes practicing as a dental hygienist?

The statute defines the practice of dental hygiene to include activities of one who

• removes deposits, accretions, and staines by scaling with hand, ultrasonic, or other devices from all surfaces of the tooth and smooths and polishes natural and restored tooth surfaces;
• removes granulation and degenerated tissue from the gingival wall of the periodontal pocket through the process of gingival curettage;
• provides preventive measures including the application of fluorides and other recognized topical agents for the prevention of oral disease;
• gathers and assembles information including, but not limited to, fact-finding and patient history, oral inspection, and dental and periodontal charting; and administers a topical anesthetic to a patient in the course of providing dental care.

C.R.S. § 12-35-122.6.

8. OTHER MID-LEVEL PROVIDERS

The statute defines “dental auxiliaries” as “any person not a dentist or dental hygienist licensed in Colorado who may be assigned or delegated to perform dental tasks or procedures as authorized by [this statute or the dental board].” C.R.S. § 12-35-103.

A dental auxiliary may not:
• diagnose;
• plan treatment;
• prescribe therapeutic measures;
• perform any procedure that contributes to or results in an irremediable alteration of the oral anatomy;
• administer local anesthesia;
• scaling, as it pertains to the practice of dental hygiene;
• root planning;
• soft tissue curettage;
• periodontal probing.

C.R.S. § 12-35-125.

A dental auxiliary may perform the following tasks under the personal direction of a licensed dentist:

• smoothing and polishing natural and restored tooth surfaces;
• provision of preventive measures including the application of fluorides and other recognized topical agents for the prevention of oral disease;
• gathering and assembling information including but not limited to fact-finding and patient history, oral inspection, and dental and periodontal charting;
• administering topical anesthetic to a patient in the course of providing dental care; and
• any other task or procedure that does not require the professional skill of a licensed dentist.

C.R.S. § 12-35-125.
9. MEDICINE

What constitutes the practice of medicine?

Colorado law defines the "practice of medicine" as:

- holding out one's self to the public within [Colorado] as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, pain, injury, deformity, or physical or mental condition, whether by the use of drugs, surgery, manipulation, electricity, telemedicine, the interpretation of tests, including primary diagnosis of pathology specimens, images, or photographs, or any physical, mechanical, or other means whatsoever;

- suggesting, recommending, prescribing, or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition, or defect of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever;

- the maintenance of an office or other place for the purpose of examining or treating persons afflicted with disease, injury, or defect of body or mind;

- using the title M.D., D.O., physician, surgeon, or any word or abbreviation to indicate or induce others to believe that one is licensed to practice medicine in [Colorado] and engaged in the diagnosis or treatment of persons afflicted with disease, injury, or defect of body or mind, except as otherwise expressly permitted by the laws of this state enacted relating to the practice of any limited field of the healing arts;

- performing any kind of surgical operation upon a human being; or

- the practice of midwifery, except:

  (I) Services rendered by certified nurse-midwives properly licensed and practicing in accordance with the provisions of [Colorado law]; or

  (II) Services rendered by a person properly registered as a direct-entry midwife and practicing in accordance with [Colorado law];

- the delivery of telemedicine, which means the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data, or education related to health care services using interactive audio, interactive video, or interactive data communication. Nothing in this paragraph (g) shall be construed to limit the delivery of health services by other licensed professionals, within the professional's scope of practice, using advanced technology, including, but not limited to, interactive audio, interactive video, or interactive data communication.
C.R.S. § 12-36-106.

May a physician provide any of the services that are defined as dental or dental hygiene services?

The statute exempts licensed physicians or surgeons “unless the physician or surgeon practices dentistry as a specialty.” C.R.S. § 12-35-111.

10. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

The only service specified in the Colorado dental statute that nurses may provide is “the giving by a qualified anesthetist or registered nurse of an anesthetic for a dental operation under the direct supervision of a licensed dentist.” C.R.S. § 12-35-111.

11. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the state dental practice board?

The Colorado Board of Dental Examiners shall consist of five dentist members, two dental hygienist members, and three members from the public at large. Each member is to be appointed by the governor for a term of four years. C.R.S. 12-35-104. To be eligible, an individual has to be a legal resident of Colorado, currently licensed as a dentist or dental hygienist, and actively engaged in a clinical practice for at least five years immediately preceding appointment to the Board. C.R.S. § 12-35-105.

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may take disciplinary actions against any dentist or dental hygienist who is “aiding and abetting, in the practice of dentistry or dental hygiene, of any person not licensed to practice dentistry or dental hygiene.” C.R.S. § 12-35-118.

CONNECTICUT

Summary:

Dental practice is defined broadly to include "any operation ...or examination...in the mouth and surrounding and associated structures." Anyone other than a dentist is prohibited from practicing as a dentist, but there are exceptions for hospitals, community health centers, schools, institutional settings and public health settings." There is a qualified exception for physicians to "treat lesions or diseases of the mouth or jaws..."

A dental hygienist may provide "educational, preventive and therapeutic services" including prophylaxis, scaling, applications of sealants and "topical solutions," "dental
hygiene assessment[s]...and collaboration in the implementation of the oral health care regimen.” In general, a hygienist must practice under "general supervision" of a dentist in a dental office, but also may practice in "any public or private institution" or "convalescent home." "General supervision" means that the supervising dentist has "knowledge" of the procedures the hygienist will provide but need not be on the premises when they are provided.

Also, hygienists "with two years' experience" may be employed in an "institution [except not a hospital], a community health center, a group home or school setting without dental supervision."

Dental assistants may perform any procedures delegated by dentists, under "supervision and control" of the delegating dentist.

1. DENTIST

What constitutes practicing dentistry?

“Any person who owns or carries on a dental practice or business, or who, by himself or by his servants or agents or by contract with others, performs any operation in or makes examination of, with intent of performing or causing to be performed any operation in, the mouth and surrounding and associated structures...or who diagnoses or treats diseases or lesions of the mouth and surrounding and associated structures...shall be deemed as practicing dentistry or dental medicine...:” Con Gen Stat §20-123.

The statute generally prohibits anyone other than a dentist or a dental professional service organization from operating a dental services site (dental office, other specified facilities). However, the state’s Dental Commission may make exceptions for “hospitals, community health centers, public or parochial schools, or convalescent homes, or institutions under control of an agency of the state of Connecticut, or the state or municipal board of health, or a municipal board of education; or those educational institutions treating their students, or to industrial institutions or corporations rendering treatment to their employees on a non-profit basis...” Conn Gen Stat §20-122.

2. DENTAL HYGIENIST

What constitutes practicing as a dental hygienist?

The ‘practice of dental hygiene’ means the performance, under the general supervision of a licensed dentist of educational, preventive and therapeutic services including: Complete prophylaxis; the removal of calcareous deposits, accretions and stains from the supragingival and subgingival surfaces of the teeth by scaling, root planing and polishing; the application of pit and fissure sealants and topical solutions to exposed portions of the teeth...dental hygiene assessment, treatment planning and evaluation; and collaboration in the implementation of the oral health care regimen.” Conn Gen Stat §20-1261(b)
May a dental hygienist provide any services in settings other than a dental office? Yes. A hygienist may practice under general supervision in a dental office “or in any public or private institution or in any convalescent home.” “General supervision...means supervision that authorizes dental hygiene procedures to be performed with the knowledge of...[a] licensed dentist, whether or not the dentist is on the premises when such procedures are being performed.” Con Gen Stat20-1261(a),(c).

In addition, a dental hygienist “with two years of experience may be employed as a dental hygienist in an institution [but not a hospital]...a community health center, a group home or a school setting without dental supervision.” CHECK: this authority is shown as a pilot program w/ report due, intended to increase access to “preventive dental care” particularly for Medicaid, uninsured and underinsured children and elderly. JAN says “it's now law” Conn Gen Stat §19a-7k.(b)

Also, it appears that a hygienist, under general supervision of a dentist, would be able to provide services in schools and certain other sites under the exception for operating dental service sites shown above. Arguably, a dental hygienist could provide a dental service in “[a] controlled investigation[ ] of dental health services within accredited dental schools or schools of dental hygiene...under the supervision of a licensed dentist or physician...,” as allowed by the statute. Con Gen Stat §20-1261

3. OTHER MID-LEVEL DENTAL PROVIDERS

With specific exceptions relating to treatment and restoration, a dentist “may delegate to dental assistants such dental procedures as he may deem advisable” so long as the procedures are done “under his supervision and control.” The dentist is “responsible” for the delegated procedures. Conn Gen Stat 20-112a.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygienist services? Yes. The dental practice “provisions shall not prevent any practicing physician or surgeon from treating lesions or diseases of the mouth and jaws or from extracting teeth...” Conn Gen Stat §20-123. Arguably, a physician could provide a dental service in “[a] controlled investigation[ ] of dental health services within accredited dental schools or schools of dental hygiene...under the supervision of a licensed dentist or physician...,” as allowed by the statute. Con Gen Stat §20-1261
5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

6. SELECTED OTHER ELEMENTS OF STATE PRACTICE LAWS


Is facilitating unlicensed dental or dental hygienist practice prohibited specifically? Yes. A dentist may not employ an “unlicensed person” for anything other than “mechanical purposes” in practicing dentistry and also may not “aid[ ] or abet[ ]” anyone “in the practice of dentistry, dental medicine or dental hygiene” if that person is not licensed in the state. Conn Gen Stat §20-114(a)(4),(6)

Dental hygienists are not “allow[ed]...to practice beyond the parameters of the general supervision of a licensed dentist...” (Con Gen Stat §20-126w). Anyone who “employs or permits” anyone except a licensed dental hygienist to provide dental hygiene services is subject to “penalties” Conn Gen Stat §20-1261(c)

DELAWARE

Summary:

The practice of dentistry is defined as the “diagno[sis] or treat[ment] of lesions of human teeth, jaws, oral tissue and associated structures, mechanically, medicinally, surgically or by the use of radiograms, X rays or fluoroscopic methods, or correct[i]on of malpositions thereof, or taking impressions for the replacement of teeth…” 24 Del. C. § 1121

There are general exemptions for physicians, dental students, dental faculty, dental surgeons or dentists in the US armed forces, Public Health Services, and the US Veteran’s Administration, and dentists of other states making clinical demonstrations before dental societies in Delaware. 24 Del. C. § 1121

The practice of dental hygiene includes the “remov[al] of calculus deposits, plaque, accretions, and stains from all surfaces of the teeth..., providing prophylactic or preventive measures in the case of teeth, including the application of chemicals to the teeth, designed and approved for the prevention of dental caries...” 24 Del. C. § 1157

Dental Hygienist may practice under the general supervision of the Delaware State Dental Director in state institutions, federally qualified health centers, non-profit organizations or other locations as designated by the Delaware Health Care Commission. 24 Del. C. § 1157
The statute does not make specific reference to the practice of dental assistants.

1. DENTIST

What constitutes practicing dentistry?

Any person who “diagnoses or treats lesions of human teeth, jaws, oral tissue and associated structures, mechanically, medicinally, surgically or by the use of radiograms, X rays or fluoroscopic methods, or correct[i]on of malpositions thereof, or takes impressions for the replacement of teeth, for a fee or salary or other reward…” is engaged in the practice of dentistry. 24 Del. C. § 1121

Anyone who is a “manager, proprietor, operator or conductor of a place for performing dental operations…” is also engaged in the practice of dentistry. 24 Del. C. § 1121

“No person not licensed as a dentist…shall practice dentistry within [Delaware] unless previously qualified as provided for in this statute.” 24 Del. C. § 1129

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

A registered dental hygienist may “remove calculus deposits, plaque, accretions, and stains from all surfaces of the teeth, make instrumental examinations of the teeth for cavities and assemble all necessary information for use by the dentist in diagnosis and treatment planning, provide prophylactic or preventive measures in the case of teeth, including the application of chemicals to the teeth, designed and approved for the prevention of dental caries, but shall not perform any other operation on the tissues of the mouth.” 24 Del. C. § 1157

Dental hygienist may perform services under general direction or supervision of a licensed dentist in offices of a licensed dentist and in public institutions or school authority. 24 Del. C. § 1157

Dental Hygienist may also practice under the general supervision of the Delaware State Dental Director in state institutions, federally qualified health centers, non-profit organizations or other locations as designated by the Delaware Health Care Commission.
24 Del. C. § 1157

While general supervision is not explicitly defined in this chapter of the statute, it is inferred as supervision whereby a dentist authorizes the procedures being carried out, but is not required to be present when the authorized procedures are being performed. The authorized procedures may be performed at a place other than the dentist’s usual place of practice. The issuance of a work authorization to a commercial dental laboratory by a dentist does not constitute general supervision.
“No person shall follow the occupation of a dental hygienist in [Delaware] without having first obtained a valid license and registered as a dental hygienist in this state.”
To obtain a license, applicants must: graduate from an accredited dental hygiene program and complete dental hygiene examinations administered by the Florida Board of Dentistry. 24 Del. C. § 1158

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

The statute does not make specific reference to the practice of dental assistants.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide services defined as dental or dental hygiene services due to a broad exemption in the statute. Nothing in the statute “shall prevent a legally qualified physician or surgeon from extracting teeth or treating pathological conditions about the mouth, teeth or oral tissues of radiographing such tissues unless the person practices dentistry as a specialty.” 24 Del. C. § 1134

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

“Whoever employs a person who is not a licensed dentist to perform dental operations as defined in this statute or permits such persons to practice dentistry in his or her office…shall be fined.” 24 Del. C. § 1172

Who makes up the dental board?

The Board consists of 9 members, appointed by the Governor, who are residents of this State. Five of the members are dentists licensed under this statute who have been actively practicing dentistry in Delaware for at least 5 years immediately preceding their appointment to the Board. One member is a dental hygienist who has been actively practicing dental hygiene in Delaware for a period of 5 years immediately preceding his/her appointment to the Board. The remaining 3 are public members who are residents of Delaware. The public members shall not be, nor ever have been,
dentists or dental hygienists, nor members of the immediate family of a dentist or dental hygienist; shall not have been employed by a dentist; and shall not have a material interest in the providing of goods and services to dentists or dental hygienists, nor have been engaged in an activity directly related to dentistry or dental hygiene. 24 Del. C. § 1101

In addition, there is a Dental Hygiene Advisory Committee which serves the Board on all matters pertaining to the policy and practice of dental hygiene. 24 Del. C. § 1101

DISTRICT OF COLUMBIA

Summary:

The practice of dentistry means the “diagnosis, treatment, operation or prescription for any disease, disorder, pain, injury, deficiency, deformity, defect, or physical condition of the human teeth, alveolar process, gums, or jaws, maxilla, mandible, or adjacent tissues or structures of the oral cavity…” D.C. Code § 2-3301.2

The statute makes no reference to individuals exempt from the Dental Practice Law.

The practice of dental hygiene means the “preliminary dental examination; a complete prophylaxis, including the removal of any deposit, accretion, or stain from the surface of a tooth or a restoration; or the polishing of a tooth or a restoration; application of a medicinal agent to a tooth for prophylactic purposes…” under the general supervision of a licensed dentist. D.C. Code § 2-3301.2

Specific scope of services or area of practice for dental assistants is not defined in the statute.

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry means the “diagnosis, treatment, operation or prescription for any disease, disorder, pain, injury, deficiency, deformity, defect, or physical condition of the human teeth, alveolar process, gums, or jaws, maxilla, mandible, or adjacent tissues or structures of the oral cavity, including the removal of stains, accretions, or deposits from the human teeth; extraction of a human tooth or teeth; performance of any phase of any operation relative or incident to the replacement or restoration of all or a part of the human tooth or teeth with an artificial substance…, correction of malposition or malformation of the human teeth; administration of anesthetic agent…; taking impressions of the human teeth, gums, or jaws…” D.C. Code § 2-3301.2

The practice of dentistry or dental hygiene without a valid and current license is prohibited in the District of Columbia. D.C. Code § 2-3305.1
2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene means the “preliminary dental examination; a complete prophylaxis, including the removal of any deposit, accretion, or stain from the surface of a tooth or a restoration; or the polishing of a tooth or a restoration; charting of cavities during preliminary examination, prophylaxis, or polishing; application of a medicinal agent to a tooth for prophylactic purposes; taking of dental x-rays; instruction of individuals or groups of individuals in oral health care; and any other functions included in the curricula of approved educational programs in dental hygiene” under the general supervision of a licensed dentist. D.C. Code § 2-3301.2

Dental hygienist may perform services in the office of any licensed dentist, or public school or institution rendering dental services. The Mayor may issue rules identifying where and under what degree of supervision dental hygienist may perform certain services. D.C. Code § 2-3301.2

In order to practice dental hygiene in the District of Columbia, hygienists must be licensed by the D.C. Board of Dentistry. To qualify for a license as a dental hygienist, applicants must establish to the satisfaction of the Board of Dentistry that the individual is a graduate of an dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation that provides at least a two academic years of curriculum and is approved by the Board. D.C. Code § 2-330.4

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Specific scope of services or area of practice for dental assistants is not defined in the statute.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The statute makes no reference to physicians or surgeons.

5. NURSING

The statute makes no reference to nurses.
6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

Anyone who “willfully practices a health occupation with an unauthorized person or aids an unauthorized person in the practice of a health occupation” in the District of Columbia may be subject to revocation, suspension, or denial of a license privilege. The person may also be subject to civil penalties. D.C. Code § 2-3305.14

Who serves on the dental board?

The board of dentistry consists of seven members appointed by the Mayor with the advice and consent of the Council. The Board shall regulate both the practice of dentistry and dental hygiene. Five of the seven members are dentists licensed in the District, one is a dental hygienist licensed in the District, and one is a consumer member. All members are appointed for a three-year term. D.C. Code § 2-3302.1

FLORIDA

Summary:

The practice of dentistry is defined as “the healing art which is concerned with the examination, diagnosis, treatment planning, and care of conditions within the human oral cavity and its adjacent tissues and structures.” It includes “the performance or attempted performance of any dental operation, or oral-maxillofacial surgery and any procedures adjunct thereto…” Fla. Stat. § 466.003

There is a general exception for licensed physicians or surgeons engaged in the practice of their profession “including surgical procedures involving the oral cavity.” Fla. Stat. § 466.002 There are also exemptions for qualified anesthetists, graduate dentists or dental surgeons in the US armed forces, US Public Health Service, or the US Department of Veterans Affairs, dental students, dental faculty, and dentists of other states or countries at meetings of dental organizations approved by the Florida Board of Dentistry. Fla. Stat. § 466.002

The practice of dental hygiene is defined as the “rendering of educational, preventive, and therapeutic dental services… and any related extra-oral procedure required to in the performance of such services.” Fla. Stat. § 466.003 Dental hygienist may provide educational programs, faculty and staff training programs, authorize fluoride rinse programs, and other services which do not involve diagnosis or treatment of dental conditions without supervision. Fla. Stat. § 466.023

Dental assistants may perform services only under the direct or indirect supervision of a licensed dentist. Fla. Stat. § 466.003
1. DENTIST

What constitutes practicing dentistry?

Any person who is involved in the “examination, diagnosis, treatment planning, and care of conditions within the human oral cavity and its adjacent tissues and structures, including the performance or attempted performance of any dental operation, or oral-maxillofacial surgery and any procedures adjunct thereto including physical evaluation directly related to such operation or surgery pursuant to hospital rules and regulations, taking impressions of the human tooth, teeth, or jaws, directly or indirectly, supplying artificial substitutes for natural teeth…” is involved in the practice of dentistry. Fla. Stat. § 466.003

The practice of dentistry also includes “any dental service of any kind gratuitously or for any remuneration paid, or to be paid, directly or indirectly, to any person or agency.” Fla. Stat. § 466.003

The practice of dentistry or dental hygiene without a current or valid license is prohibited. Fla. Stat. § 466.003

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene is defined as the “rendering of educational, preventive, and therapeutic dental services and any related extra-oral procedure required in the performance of such services.” Fla. Stat. § 466.003

Specifically, this includes “removing calculus deposits, accretions, and stains from exposed surfaces of the teeth…, performing root planing, applying topical preventive and prophylactic agents, and performing all other tasks approved by the Board and delegable by the dentist.” Fla. Stat. § 466.023

Dental hygienist may perform services in offices of a licensed dentist, in public health programs and institutions of the Department of Children and Family Services under general supervision, Department of Health, Department of Juvenile Justice, licensed public health facilities, public and private educational institutions, home of a nonambulatory patient, and other places in accordance with the Board. Fla. Stat. § 466.023

Dental hygienist may provide educational programs, faculty and staff training programs, authorize fluoride rinse programs, and other services which do not involve diagnosis or treatment of dental conditions without supervision. Fla. Stat. § 466.023 The Board will determine which additional services performed by hygienists requires indirect, direct, or general supervision.
• **Direct supervision** is supervision whereby a dentist diagnoses the condition to be treated, authorizes the procedure to be performed, remains on the premises while the procedures are performed, and approves the work performed before the dismissal of the patient.

• **Indirect supervision** is supervision whereby a dentist authorizes the procedure and remains on the premises while the procedures are performed.

• **General supervision** is supervision whereby a dentist authorizes the procedures being carried out but need not be present when the authorized procedures are being performed. The authorized procedures may be performed at a place other than the dentist’s usual place of practice. The issuance of a work authorization to a commercial dental laboratory by a dentist does not constitute general supervision.

The following tasks are not permitted to be performed by dental hygienist or dental assistants: “taking impressions for study casts, placing periodontal dressing, removing sutures, placing or removing rubber dams, applying cavity liners, polishing crowns…” Fla. Stat. § 466.024

Practice of dental hygiene without a valid license from the Florida Board of Dentistry is prohibited and punishable by a fine and/or imprisonment. Fla. Stat. § 466.011
In order to be licensed as a dental hygienist, the applicant must graduate from an accredited dental hygiene program, and must pass dental hygiene examinations administered by the Florida Board of Dentistry. Fla. Stat. § 466.007

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may perform services only under the direct or indirect supervision of a licensed dentist. Fla. Stat. § 466.003 Scope and area of practice for dental assistants are undefined in the statute.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide services defined as dental or dental hygiene services due to a broad exemption in the statute. Essentially, nothing in the statute shall apply to “the practice of his or her profession including surgical procedures involving the oral cavity by a physician or surgeon licensed as such under the laws of [Florida].” Fla. Stat. § 466.002
5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

Employment of any unlicensed person by a licensed dentist to perform any procedures performed by dentists or dental hygienist shall constitute a misdemeanor of the second degree. Fla. Stat. § 466.021

Who makes up the dental board?

The Board of Dentistry consists of 11 members appointed by the Governor and subject to confirmation by the Senate. Seven members of the Board are licensed dentists actively engaged in the clinical practice of dentistry, two members are dental hygienists actively engaged in the clinical practice of dental hygiene, and the remaining two persons are laypersons unassociated with the profession. Fla. Stat. § 466.004

GEORGIA

Summary:

Any person who “operates or performs part of any dental operation of any kind upon the human oral cavity, teeth, gingiva, alveolar process, maxilla, mandible or associated structures, or associated contiguous masticatory structures for the treatment of disease or lesions of such structure…” shall be deemed to be practicing dentistry. O.C.G.A. § 43-11-17

The statute does not “apply to physicians licensed in [Georgia] in extracting teeth or performing surgical operations.” The statute also does not apply to “any person who extracts exfoliating deciduous teeth.” O.C.G.A. § 43-11-22

Dental hygienist shall perform duties only “under the direct supervision of a licensed dentist.” The requirement of direct supervision shall not apply to the performance of dental hygiene duties at approved dental facilities of the Department of Human Resources, county boards of health, or the Department of Corrections. O.C.G.A. § 43-11-74.

Dental assistants may perform services “only under the direct and personal supervision of a licensed dentist. No dental assistant shall practice dentistry, dental hygiene, or do any kind of dental work other than those acts, services, procedures, and practices prescribed by rule or regulation of the board.” O.C.G.A. § 43-11-81
1. **DENTIST**

What constitutes practicing dentistry?

Any person who “operates or performs part of any dental operation of any kind upon the human oral cavity, teeth, gingiva, alveolar process, maxilla, mandible or associated structures, or associated contiguous masticatory structures for the treatment of disease or lesions of such structure, extracts teeth or attempts to correct a malposition thereof, fills or crowns teeth, does any dental operation whatsoever on the human oral cavity, teeth, gingiva, alveolar process maxilla, mandible…, examines human oral cavity, teeth, gingival…, undertakes to perform any physical evaluation of a patient in his or her office…incident to any dental services” shall be deemed to be practicing dentistry. O.C.G.A. § 43-11-17

In addition, any person who “by any means makes it know, implies, or holds out to the public in any fashion that such person will do any of the procedures…” outlined above is engaged in the practice of dentistry. O.C.G.A. § 43-11-17

Any person, firm, partnership, corporation, or other entity who practices dentistry in [Georgia] without obtaining a license to practice from the Board shall be guilty of a misdemeanor upon conviction. O.C.G.A. § 43-11-50

2. **Dental Hygienist**

What constitutes practicing as a dental hygienist?

A dental hygienist may “remove calcareous deposits, secretions, and stains from the surfaces of the teeth, apply ordinary wash or washes…, and perform only those acts authorized by the Board.” O.C.G.A. § 43-11-74 These “acts” are not defined in any further detail in the statute.

However, the statute states that a dental hygienist may only perform services under the direct supervision of a dentist. The requirement of direct supervision shall not apply to the performance of dental hygiene duties at approved dental facilities of the Department of Human Resources, county boards of health, or the Department of Corrections. O.C.G.A. § 43-11-74

- While direct supervision is not explicitly defined in the statute, we infer it to mean a dentist personally diagnoses the condition to be treated, personally authorizes the procedure and is somewhere in the treatment facility while the procedure is being performed by the dental hygienist.

Dental hygienists are not permitted to “diagnose, prescribe, determine the initial dosage, or increase the initial dosage of nitrous oxide, practice dentistry or do any kind of dental work other than…those acts, services, procedures, and practices which the board shall prescribe by rule or regulation.” O.C.G.A. § 43-11-74
To obtain a license in Georgia, applicants must: file an application for licensure by the Board of Dental Examiners, graduate from an accredited program of dental hygiene, and pass clinical examinations administered by the Board. O.C.G.A. § 43-11-71

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may perform services “only under the direct and personal supervision of a licensed dentist. No dental assistant shall practice dentistry, dental hygiene, or do any kind of dental work other than those acts, services, procedures, and practices prescribed by rule or regulation of the board.” O.C.G.A. § 43-11-81

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

Presumably a physician may provide only certain services such as extraction of teeth in both emergency and nonemergency situations. The statute does not “apply to physicians licensed in [Georgia] in extracting teeth or performing surgical operations.” The statute also does not apply to “any person who extracts exfoliating deciduous teeth.” O.C.G.A. § 43-11-22 The statute, however, does not explicitly prohibit physicians from providing preventive dental services.

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

Aiding or abetting any unlicensed person to practice dentistry or dental is prohibited in Georgia. Any person found in violation of this statute, shall upon conviction, such be guilty of misdemeanor. O.C.G.A. § 43-11-51

HAWAII

Summary:

A person practices dentistry who represents himself as “being able to diagnose, treat, operate or prescribing for any disease, pain, injury, deficiency, deformity, or physical
The practice of dental hygiene is the “removal of hard and soft deposits and stains…, the application of preventive chemical agents to the coronal surfaces of teeth…” and any other preventive and educational services provided to maintain the oral health of individuals. HRS § 447-3

Dental hygienists may practice only under the direct supervision of a licensed dentist in a dental office. Dental hygienist may practice under the general supervision of a licensed dentist in legally incorporated eleemosynary dental dispensary or infirmary, private schools, or welfare center, or State or county agencies. HRS § 447-1

Dental assistants may provide supportive services “assigned to them under the supervision, direction and responsibility of a licensed dentist.” HRS § 447-1

1. DENTIST

What constitutes practicing dentistry?

A person practices dentistry who represents himself as “being able to diagnose, treat, operate or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaws, and adjacent tissues…, or to take impressions of the teeth or jaws; or who owns, maintains, or operates an office for the practice of dentistry; or who engages in any of the practices included in the curricula of recognized and approved dental schools…” is engaged in the practice of dentistry. HRS § 448-1

The practice of dentistry or dental hygiene, either gratuitously or for pay, without a valid and current license is prohibited in Hawaii. HRS § 448-2

No person, organization, or agency who manages or conducts as a manager, proprietor, conductor or otherwise a place where dental services are performed shall employ any person to practice dentistry who is not duly licensed by the laws of [Hawaii]. Anyone found in violation of this statute shall be subject to both monetary and criminal penalties. HRS § 448-3(a-c)

2. Dental Hygienist

What constitutes practicing as a dental hygienist?
The practice of dental hygiene is the “removal of hard and soft deposits and stains from
the portion of the crown and root surfaces to the depth of the gingival sulcus, polishing
natural and restored surfaces of teeth, the application of preventive chemical agents to
the coronal surfaces of teeth, and use of mouth washes as are approved by the board.”
HRS § 447-3
The practice of dental hygiene shall not include “performing of any repair work…, and
any operation on the teeth or tissues of the mouth.” HRS § 447-3(b)

Dental hygienist may perform services in the office of any licensed dentist, legally
incorporated eleemosynary dental dispensary or infirmary, private school, or welfare
center, or State or county agencies under the general supervision of a licensed dentist.
Hygienists practicing in a dental office must be under the direct supervision of a
licensed dentist. No dental hygienist may establish or operate any separate care facility
which exclusively renders dental hygiene services. HRS § 447-3(c)

In order to practice dental hygiene in Hawaii, hygienists must be licensed by the state
Board of Dental Examiners. Applicants must: file an application with the board, be
eighteen years of age or over, graduate from a dental hygiene program accredited by
the American Dental Association Commission on Dental Accreditation that provides at
least two years of academic curriculum in dental hygiene, be officially certified in the
administration of intra-oral infiltration local anesthesia and intra-oral block anesthesia by
an accredited dental hygiene school, and pass dental hygiene examinations
administered by the Board. HRS § 447-1

The Board may issue a temporary license, without examination, to any qualified dental
hygienist to practice in a State or county agency, private school, or welfare center. The
temporary license shall authorize the person to practice clinical dental hygiene
exclusively while employed by the aforementioned agencies. HRS § 447-1

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may provide supportive services “assigned to them under direct or
indirect supervision, direction and responsibility of a licensed dentist.” HRS § 447-1

Specific scope of services for dental assistants is not defined in the statute.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene
services?
A physician may provide dental services in emergency situations. “The rendering of dental relief in emergency cases in the practice of one’s profession by a physician or surgeon, licensed as such and registered under the laws of [Hawaii], unless one undertakes to reproduce or reproduces lost parts of the human teeth in the mouth or to restore or replace in the human mouth lost or missing teeth” is exempt from this statute. HRS § 448-1

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

“Employing, procuring, inducing, aiding, or abetting a person not licensed or registered as a dentist to engage in the practice of dentistry” is unlawful. The board may refuse to issue, or revoke any license issued to any person who employs or facilitates unlicensed dental or dental hygiene practice. HRS § 448-17

Who serves on the dental board?

The Board of Dental Examiners consists of twelve members, eight of whom are practicing dentists engaged in the practice of dentistry for at least five years preceding their appointment to the board; two are dental hygienists engaged in the practice of dental hygiene for at least five years preceding their appointment to the board; and two are public members not connected with or financially interested in the practice of dentistry. HRS § 448-5

IDAHO

Summary:

The practice of dentistry is broadly defined as “examining for diagnosis, treatment, extraction, repair, replacement, substitution, or correction; diagnosing of disease, pain, injury deficiency, deformity, or physical condition; treating, operating, prescribing, extracting, taking impressions, fitting, replacing, and administering anesthetics or medicaments in connection with any of the foregoing.” Idaho Code § 54-901

The statute makes general exemptions for “physician or surgeon, duly authorized to practice in the Idaho from treating diseases of the mouth or performing operations in oral surgery.” Idaho Code § 54-930 The statute also exempts dental students, dental hygiene students, and dental faculty.
The practice of dental hygiene is “cleaning, polishing, removing stains or concretions, performing nonsurgical periodontal therapy, administering prescribed anesthetics or medicaments, applying preventive agents, performing nonsurgical, clinical and laboratory oral diagnostic tests for interpretation by a dentist…” Idaho Code § 54-902 Dental hygienist must be qualified and annually licensed by the laws of Idaho to practice dental hygiene. Dental hygienist may work under general, direct, or indirect supervision of a dentist depending upon the type of service they render.

Dental assistants “need not be licensed under this statute, but must work under the direct supervision of a dentist and must be adequately trained and qualified according to standards established by the Board to perform specific dental services authorized by the dentist. Idaho Code § 54-903.

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry is broadly defined as “examining for diagnosis, treatment, extraction, repair, replacement, substitution, or correction; diagnosing of disease, pain, injury deficiency, deformity, or physical condition; treating, operating, prescribing, extracting, taking impressions, fitting, replacing, and administering anesthetics or medicaments in connection with any of the foregoing.” Idaho Code § 54-901

The statute prohibits anyone other than a licensed dentist or dental hygienist from practicing dentistry. Idaho Code § 54-905

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene is “cleaning, polishing, removing stains or concretions, performing nonsurgical periodontal therapy, administering prescribed anesthetics or medicaments, applying preventive agents, performing nonsurgical, clinical and laboratory oral diagnostic tests for interpretation by a dentist and other services specified by a dentist unless prohibited by the Board.” Idaho Code § 54-902 Dental hygienist must be qualified and annually licensed by the laws of Idaho to practice dental hygiene.

Dental hygienist may practice under general, direct, or indirect supervision depending upon the type of services they render. Idaho Code § 54-903

- Direct supervision is the supervision of a dental assistant or dental hygienist requiring that a dentist diagnose the condition to be treated, a dentist authorize the procedure to be performed, a dentist remain in the dental office while the procedure
is performed, and that before the dismissal of the patient, a dentist approves the work performed by the dental assistant or dental hygienist.

- General supervision is supervision of a dental hygienist requiring that a dentist authorize the procedure to be performed, but not requiring that a dentist be in the office when the authorized procedure is performed.

- Indirect supervision is supervision of a dental hygienist requiring that a dentist authorize the procedure to be performed and that a dentist be in the office while the procedure is performed by the hygienist.

3. OTHER MID-LEVEL PROVIDERS

Dental assistants “need not be licensed under this statute, but must work under the direct supervision of a dentist and must be adequately trained and qualified according to standards established by the Board to perform specific dental services authorized by the dentist. Idaho Code § 54-903.

Scope of Services not defined by statute.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The statute shall not prohibit a “physician or surgeon, duly authorized to practice in the Idaho from treating diseases of the mouth or performing operations in oral surgery.” Idaho Code § 54-930

5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

Statute makes no references to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

Not referenced in the statute.
ILLINOIS

Summary:

Dentistry is broadly defined as the “healing art which is concerned with the examination, diagnosis, treatment planning and care of conditions within the human oral cavity and its adjacent tissues and structures.” § 225 ILCS 25/4

Any person who “treats, prescribes, or operates for any disease, pain, deformity, deficiency, injury, or physical condition of the human tooth, teeth, alveolar process, gums or jaw…who is a manager or proprietor… of a business where dental operations are performed, who extracts human tooth or teeth…” is deemed to be practicing dentistry.
§ 225 ILCS 25/17

The statute makes a qualified exemption for physicians and surgeons in emergency cases, and general exemptions for dentists is any branch of the US Armed Services, clinical instructors, dental students, and licensed dentists of other states at meetings of Illinois Dental Society or component thereof. § 225 ILCS 25/17(1-e)

A dental hygienist may perform the preventive services under the general supervision of a dentist if those services are provided in a dentist’s office, federal, State, county or municipal agency or institution, public or private school, public clinic, long-term care facility licensed by the State of Illinois, or a mental health or developmental disability facility operated by the Department of Human Services. § 225 ILCS 25/18(b) A dental hygienist may provide educational services without the supervision of a dentist. § 225 ILCS 25/18(c)

Dental assistants may provide intraoral services under the supervision and full responsibility of a licensed dentist. § 225 ILCS 25/17(1-e)

1. DENTIST

What constitutes practicing dentistry?

Any person who “represents himself as being able to diagnose, treat, prescribe, or operate for any disease, pain, deformity, deficiency, injury, or physical condition of the human tooth, teeth, alveolar process, gums or jaw…who is a manager or proprietor of a business where dental operations are performed, who extracts human tooth or teeth, or corrects or attempts to correct malpositions of the human teeth or jaws, who offers…to diagnose, treat or remove stains, calculus, and bonding materials from human teeth or jaws, who takes impression of human teeth…” is deemed to be practicing dentistry.
§ 225 ILCS 25/17

Any person who “employs a dentist, dental hygienist, or other entity providing dental services, directs or controls the use of dental equipment or material, directs, controls, or interferes with a dentist’s or dental hygienist’s oral judgment, exercises direction or
control over a dentist, dental hygienist, or other entity providing dental services” is also considered to be engaged in the practice of dentistry. § 225 ILCS 25/37

Any person who practices, offers to practice, attempts to practice, or holds oneself out to practice dentistry without being licensed under this [statute] shall be subject to monetary penalties. § 225 ILCS 25/8.5

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

Dental hygienist may perform “operative procedures of dental hygiene, consisting of oral prophylactic procedures, exposure and processing of X-rays, application to the surfaces of teeth or gums of chemical compounds...for the prevention of dental caries or periodontal disease, all services performed by dental assistants, and administration of nitrous oxide upon successful completion of training.” § 225 ILCS 25/18(a)

A dental hygienist may perform the aforementioned services under the general supervision of a dentist if those services are provided in a long-term care facility licensed by the State of Illinois or a mental health or developmental disability facility operated by the Department of Human Services. § 225 ILCS 25/18(b) A dental hygienist may provide educational services without the supervision of a dentist. § 225 ILCS 25/18(c)

Dental hygienist may be employed only in the office of a dentist, a federal, State, county or municipal agency or institution, by a public or private school, or by a public clinic operating under the direction of a hospital or federal, State, county, municipal or other public agency or institution. § 225 ILCS 25/18

In order to practice dental hygiene in Illinois, applicants must obtain a license from the Department of Professional Regulations. To obtain a license, applicants must: be a high school graduate, present satisfactory evidence of having received two academic years of credit or its equivalent in an approved program of dental hygiene, hold a cardiopulmonary resuscitation certificate, and pass an examination authorized or given by the Illinois Department of Professional Regulation. § 225 ILCS 25/13

3. OTHER MID-LEVEL PROVIDERS

Dental assistants may provide intraoral services under the direct supervision and full responsibility of a licensed dentist. § 225 ILCS 25/17(1-e) Dental assistants may not provide any of the following services: any and all diagnosis of treatment of disease, pain, deformity, deficiency, injury or physical condition, removal of, or restoration of hard or soft tissues in the oral cavity, any and all correction of malformation, and removal of calculus from the teeth. § 225 ILCS 25/17(1-e)

4. MEDICINE
What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may only provide dental services in cases of emergency. Nothing in the statute prohibits "the rendering of dental relief in emergency cases in the practice of his or her profession by a physician or surgeon, licensed as such under the laws of [Illinois], unless he undertakes to reproduce or reproduces lost parts of the human teeth in the mouth or to restore or replace missing teeth in the mouth." § 225 ILCS 25/17(a)

5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

Statute makes no references to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the state dental practice board?

The dental board consist of eleven members, eight of whom have been dentists for a period of 5 or more years, 2 of whom have been dental hygienists for a period of 5 or more years, and one public member. None of the members shall be employed by or be an officer of any dental college, dental or dental hygiene department of any institution of learning. All members are appointed for a period of 4 years. The membership of the Board shall include only residents from various geographic areas of [Illinois]. § 225 ILCS 25/6

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

It is unlawful for a dentist or dental hygienist to employ or permit the practice of dentistry by an unlicensed person. § 225 ILCS 25/8.5

INDIANA

Summary:

Any person shall be said to be practicing dentistry who “offers to diagnose or treats any of the lesions or diseases of the human oral cavity, teeth, gums, or maxillary or mandibular structures, extracts human teeth, administers dental anesthetics, uses X-ray for dental diagnostic purposes…” Burns Ind. Code Ann. § 25-14-1-23
The statute makes qualified exceptions for licensed physicians or surgeons and general exceptions for commissioned officers of the US armed services, US Public Health Service, or US Department of Veterans Affairs in the discharge of their official duties, dental students, dental interns, and dental faculty. Burns Ind. Code Ann. § 25-14-1-22

A dental hygienist may provide the following services without supervision: dental prophylaxis for children up to and including grade 12 (if the hygienist is employed by the state department of health, the department of education, and elementary or secondary schools with a dental clinic) and screening and referrals for any person in a public health setting. Burns Ind. Code Ann. § 25-13-1-10. All other services must be provided under the direct or indirect supervision of a dentist.

The statute makes no references to dental assistants

1. DENTIST

What constitutes practicing dentistry?

Any person who proclaims to be a “dentist” or “dental surgeon” “directs and controls the treatment of patients within a place where dental services are performed, offers to diagnose or professes to diagnose or treats any of the lesions or diseases of the human oral cavity, teeth, gums, or maxillary or mandibular structures, extracts human teeth, administers dental anesthetics, uses X-ray for dental diagnostic purpose, makes impressions of oral tissues, is the employer of a dentist who is hired to provide dental services, directs or controls the use of dental equipment, directs, controls, or interferes with a dentist’s clinical judgment, exercises direction or control over a dentist through a written contract, and selects a patient’s course of treatment pertaining to the mouth” is engaged in the practice of dentistry. Burns Ind. Code Ann. § 25-14-1-23

The statute prohibits anyone other than a licensed dentist or dental hygienist from practicing dentistry. Burns Ind. Code Ann. § 25-14-1-1

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene includes “removal of calcific deposits or accretions from the surfaces of human teeth, polishing, application of antiseptic sprays, washes, or medicaments for the control or prevention of dental caries, treatment of gum disease, and use of impressions for treatment purposes.” Burns Ind. Code Ann. § 25-13-1-11

A dental hygienist may provide the following services without supervision: dental prophylaxis for children up to and including grade 12 (if the hygienist is employed by the state department of health, the department of education, and elementary or secondary
schools with a dental clinic) and screening and referrals for any person in a public health setting. Burns Ind. Code Ann. § 25-13-1-10

A dental hygienist may practice dental hygiene in the office of a legally practicing proprietor dentist, public or private schools, hospitals, dental clinics of industrial or commercial establishment. Burns Ind. Code Ann. § 25-13-1-10

Anyone desiring to practice dental hygiene in Indiana must procure a license. In order to procure a license, the applicant must submit a proof of graduation from a dental hygiene program approved by the Board and must pass an dental hygiene examination administered by the Board. Burns Ind. Code Ann. § 25-13-1-4

3. OTHER MID-LEVEL PROVIDERS

Statute makes no references to dental assistants

4. MEDICINE

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide certain services that are defined as dental or dental hygiene services. “Licensed physicians or surgeons who are authorized to take x-ray pictures of the human teeth or jaws, to extract teeth, and to perform surgical operations upon the teeth or jaws at their usual office” are exempt from this statute. Burns Ind. Code Ann. § 25-14-1-22

“A Duly licensed practitioner of medicine” is also exempt from the statute pertaining to services provided by a dental hygienist. Burns Ind. Code Ann. § 25-13-1-12

5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

Statute makes no references to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the state dental practice board?

The board consists of nine practicing dentists (who must have been in practice in the state for a minimum of five years), one practicing dental hygienist, and one member to represent the general public who must be a resident of the state. All eleven members are appointed by the Governor for a three year term. The nine dentist members each represent a district set forth by the Board. Ind. Code Ann. § 25-14-1-2
Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

It is unlawful for a dentist of dental hygienist to aid or abet in the practice of dentistry by an unlicensed person in the state of Indiana. Burns Ind. Code Ann. § 25-14-1-1

IOWA

Summary:

The practice of dentistry is broadly defined as “examination, diagnosis, treatment, and attempted correction by any medicine, appliance, surgery, or other appropriate method of any disease, condition, disorder, lesion, injury, deformity, or defect of the oral cavity and maxilofacial area, including teeth, gums, jaws, and associated structures, and tissues which methods by education, background experience…” There is a qualified exception for licensed “physicians and surgeons or licensed osteopaths and surgeons who extract teeth or treat diseases of the oral cavity, gums, teeth, or maxillary bones as an incident to the general practice of their profession.” Iowa Code § 153.14

A dental hygienist may perform educational, therapeutic, and preventive services which attain or maintain “optimal oral health”. This may include but is not limited to “complete oral prophylaxis, application of preventive agents to oral structures, preparing diagnostic tests…” In general hygienist may practice under supervision of a licensed dentist in a dental office, a public or private school, public health agencies, and hospitals…” Iowa Code § 153.15

Dental assistants may provide extraoral services under general or direct supervision of a licensed dentist depending upon their training. Expanded function dental assistants may also provide intraoral services under the direct supervision of a licensed dentist. Dental assistants must fulfill examination requirements, a “six-months of work” requirement, and register as a dental assistant with the Board to work as dental assistant.

1. DENTIST

What constitutes practicing dentistry?

Any person “publicly professing to be dentists, dental surgeons, or skilled in the science of dentistry, or publicly professing to assume the duties incident to the practice of dentistry” in “examination, diagnosis, treatment, attempted correction by any medicine, appliance, surgery, or other appropriate method of any disease, condition, disorder, lesion, injury, deformity, or defect of the oral cavity and maxilofacial area, including teeth, gums, jaws, and associated structures, and tissues which methods by education, background experience and expertise” are deemed to be practicing dentistry. Iowa Code § 153.14
The statute prohibits anyone other than a licensed dentist or a dental professional service organization from operating dental services site (dental office, clinic, or other specified facilities).

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene encompasses any educational, therapeutic, and preventive services and may include but is not limited to “complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, obtaining and preparing nonsurgical, clinical and oral diagnostic tests for interpretation by the dentist, preparation of preliminary written records of oral condition…” Dental hygienist services “shall be performed under supervision of a licensed dentist in a dental office, a public or private school, public health agencies, hospitals and the armed forces…” Iowa Code § 153.15 All services provided by a dental hygienist shall be performed under general supervision of a licensed dentist. General supervision means the “dentist has examined the patient and has prescribed authorized services to be provided by a dental hygienist. The dentist need not be present in the facility while these services are being provided.” 650 IAC 10.3(153) (1)

A dental hygienist, holding a current local anesthesia permit, may administer local anesthesia only under the “direct supervision” of a dentist. “Direct supervision of the dental hygienist requires that the supervising dentist by physically present in the treatment room.” 650 IAC 10.3(153) (1)

A dental hygienist “shall not practice independent from the supervision of a dentist nor… establish or maintain an office or other workplace separate or independent from the office or other workplace in which the supervision of a dentist is provided." 650 IAC 10.3(153)

A dental hygienist must fulfill practice requirements which include graduation from accredited dental hygiene program with minimum two years of academic curriculum, a valid certificate from nationally recognized cardiopulmonary resuscitation program, and successful completion of examinations.

3. OTHER MID-LEVEL PROVIDERS

A dental assistant is any person who “performs extra-oral services including infection control, dental radiography, or use[s] hazardous materials or performs intra-oral services on patients” under the “supervision” of a dentist. 650 IAC 20.2 (153,78GA, ch1002)
A registered dental assistant “may perform all extraoral duties in the dental office or dental clinic” as delegated by a licensed dentist. “Expanded function dental assistants who have completed formal training may also perform in intraoral procedures under the direct supervision of a licensed dentist. 650 IAC 20.4 (3) (153, 78GA, ch1002). Dentists exercising supervision are fully responsible for all acts performed by the dental assistant.

- “Direct supervision” means that the dentist is present in the treatment facility, but it is not required that the dentist be physically present in the treatment room while the dental assistant is performing acts assigned by the dentist.”
- “General supervision means that a dentist has delegated the services to be provided by the dental assistant. The dentist need not be present in the facility while these services are being provided.”
- “Personal supervision means the dentist is physically present in the treatment room to oversee and direct the services of the dental assistant.” 650 IAC 20.3 (153, 78GA, ch 1002)

The following procedures may not be delegated to a dental assistant: “diagnosis, examination, treatment planning, prescription, surgical procedures on hard and soft tissues within the oral cavity, administration of local anesthesia, placement of sealant, removal of plaque, stain, or hard natural or synthetic material, floss, or rubber cup coronal polish, or removal of any calculus.” 650 IAC 20.3 (153, 78GA, ch 1002)

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The statute shall not prevent “licensed physicians and surgeons or licensed osteopaths or surgeons who extract teeth or treat diseases of the oral cavity, gums, teeth, or maxillary bones as an incident to the general practice of their profession.” Iowa Code § 153.14 (2)

5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

Statute makes no references to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the state dental practice board?
The board shall be composed of five licensed dentists, two dental hygienists, and two members representing the general public not licensed to practice either dentistry or dental hygiene. 650 IAC 5.1 (153)

A three-member dental hygiene committee is also created, consisting of two dental hygienist members of the board and one dentist member of the board. The committee has the authority to adopt recommendation regarding the practice, discipline, education, examination and licensure of dental hygienists. Iowa Code § 153.33A

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

“No person owning or conducting any place where dental work of any kind is done or contracted for, shall employ or permit any unlicensed dentist to practice dentistry in the said place.” Iowa Code § 153.18

KANSAS

Summary:

Any person who “diagnoses, prescribes for, or treats disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, corrects or attempts to correct, malformations of teeth or of the jaws.” is engaged in the practice of dentistry. K.S.A.. § 65-1422.

There is a general exemption for licensed and registered physicians and surgeons, unless “such persons practice dentistry as a specialty.” K.S.A.. § 65-1423. There are also exemptions for registered nurse anesthetist, dentists or dental surgeons in the discharge of their official duties in the US armed forces, public health services, or the veteran’s administration. K.S.A.. § 65-1423.

The practice of dental hygiene includes “educational, preventive, and therapeutic procedures which result in the removal of extraneous deposits, stains, and debris from the teeth...” A dental hygienist must perform services under the direct or general supervision of a licensed dentist at the dentist office K.S.A.. § 65-1456(b) The practice of dental hygiene may be performed at an adult care home, hospital long-term care unit, state institution, local health department or indigent health care clinic on a resident of a facility as long as a licensed dentist has delegated the performance of the service, task, or procedure. K.S.A.. § 65-1456(e)

Dental assistants may perform

1. DENTIST

What constitutes practicing dentistry?
Any person who “performs or attempts or professes to perform, any dental operation or oral surgery or dental service of any kind, gratuitously or for a salary, fee, money or other remuneration paid, or to be paid directly indirectly, to himself or to any other person or agency who is a….who directly or indirectly takes impression of human tooth, teeth, jaws, or performs any phase of operation incident to the replacement of a part of a tooth, or supplies artificial substitutes for natural teeth..., or who diagnoses, or professes to diagnose, prescribe for, or professes to treat disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, corrects or attempts to correct, malformations of teeth or of the jaws..” is engaged in the practice of dentistry. K.S.A.. § 65-1422.

The statute prohibits anyone other than a licensed dentist or a dental professional service organization from practicing dentistry or operating dental services site (dental office, clinic, or other specified facilities). K.S.A.. § 65-1421

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene shall include education, preventive, and therapeutic procedures which entail “instruction of the patient as to daily personal care, protecting teeth from dental caries, scaling and polishing, planning of root surfaces, cutterage of soft tissues...” K.S.A.. § 65-1456(b) A dental hygienist may give fluoride treatments as prophylactic measure, remove overhanging restoration margins by hand scaling, and administer local anesthesia and nitrous oxide under direct supervision of a dentist. K.S.A.. § 65-1456(g) In addition, the Board may designate which procedures may be performed by a dental hygienist under general or direct supervision.

- Direct supervision means a dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and before dismissal of the patient, evaluates the performance.

- General supervision is when a licensed dentist may delegate verbally or by written authorization the performance of a service, task or procedure to a licensed dental hygienist under the supervision and responsibility of the dentist, if the dental hygienist is licensed to perform the function, and the supervising dentist examines the patient at the time the dental hygiene procedure is performed or during the 12 calendar months preceding the performance of the procedure. A dentist is not required to be on the premise.

Dental hygienist are not permitted to diagnose a dental disease or ailment, prescribe any treatment or regime thereof, prescribe, order or dispense medication or perform any procedure which is irreversible or which involves intentional cutting of the soft or hard tissue by any means.
The practice of dental hygiene may be performed at an indigent health clinic so long as a:
1) a licensed dentist has delegated the performance of the service
2) the dental hygienist is under the supervision and responsibility of the dentist
3) either the supervising dentist is personally present or the services, tasks and procedures are limited to the cleaning of the teeth, education, and preventive care
4) supervising dentist examines the patient at the time the dental hygiene procedure is performed or has examined the patient during 12 months preceding the performance of the procedure.

Dental hygienist providing dental education in a school setting are exempt from this provision.

No personal shall practice as a dental hygienist until such person has passed a clinical examination by the Board, graduated from an accredited dental hygiene program, and applied for a license by the State Board of Dental Examiners to practice in the State. K.S.A. § 65-1455

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

No specific reference to dental assistants cited in the statute.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

Nothing in the statute shall be construed to prevent “the practice of a person licensed to practice medicine and surgery under the laws of this state, unless such person practices dentistry as a specialty.” K.S.A.. § 65-1423.

5. NURSING

Nothing in the statute shall be construed to prevent “the performance by a licensed nurse of a task as part of the administration of an anaesthetic for a dental operation under the direct supervision of a licensed dentist or person licensed to practice medicine...” K.S.A.. § 65-1423.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS
Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Kansas Dental Board may suspend or revoke the license of any dentist or dental hygienist who "employed, allowed or permitted any unlicensed person or persons to perform any work in the licensee’s office which constitutes the practice of dentistry or dental hygiene under the provisions of the Dental Practice Law." K.S.A.. § 65-1436(5)

KENTUCKY

Summary:

Any person who “for a fee, salary, or other reward…, diagnoses or treats disease or lesions of human teeth or jaws, or diagnoses or treats disorders or deficiencies of the oral cavity and adjacent associated structures, or who takes impressions of the human teeth…” is engaged in the practice of dentistry. KRS § 313.010

Exemptions are made for dental students, dental faculty. Kentucky dental practice law does not make any references to physician exemptions.

The practice of dental hygiene is defined as the “treatment of human teeth by scaling, polishing, planing and removing therefrom calcerous deposits, and may include other dental activities not specifically prohibited by this statute.” KRS § 313.010 Dental hygienists must provide services under the supervision of a licensed dentist. Supervision is not specifically defined in the statute.

The scope of services and areas of practices for dental assistants are undefined in the statute.

1. DENTIST

What constitutes practicing dentistry?

Any person who “for a fee, salary, or other reward paid…performs or advertises to perform, dental operations of any kind, or who diagnoses or treats disease or lesions of human teeth or jaws, or attempts to correct malpositions thereof, or who diagnoses or treats disorders, or deficiencies of the oral cavity and adjacent associated structures, or who take impression of the human teeth or jaws…” is engaged in the practice of dentistry. KRS § 313.010

The statute prohibits anyone other than a licensed dentist or dental hygienist from practicing or attempting to practice dentistry unless the person is licensed by the Board. KRS § 313.020

2. Dental Hygienist
What constitutes practicing as a dental hygienist?

The practice of dental hygiene is the “treatment of human teeth by scaling, polishing, planing and removing therefrom calcereous deposits, and by removing accumulated accretion from beneath the free margin of the gums, and may include other dental activities not specifically prohibited by this statute.” KRS § 313.010 “Nothing in the [statute] shall be construed to authorize any dental hygienist to perform any operation in a patient’s mouth without supervision of a dentist.” KRS § 313.010

A dental hygienist must fulfill the following criteria in order to practice in Kentucky: be a graduate of an accredited high school, successfully completed a training program in a school of dental hygiene accredited by the Council on Dental Education of the American Dental Association, and successfully pass clinical examinations for the practice of dental hygiene. KRS § 313.290

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

No specific reference to dental assistants cited in the statute.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

No reference to physician or surgeons in statute

5. NURSING

No reference to nurses in this statute.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the dental board?

The Board consist of nine members of which seven are licensed dentists, one member from the general community who is not associated in the practice, and one dental hygienist. Each dentist and dental hygienist shall have been an actual resident an licensed practicing dentist for a minimum of five years preceding his appointment to the Board. All members of the Board are appointed by the Governor. KRS § 313.200

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?
It is unlawful for any dentist or dental hygienist to “employ directly or indirectly an unlicensed dentist or other person to perform operations of any kind, or to treat lesions of the human teeth or jaws, or correct malpositions or malformations thereof.” KRS § 313.140

LOUISIANA

Summary:

The practice of dentistry is broadly defined as the “evaluation, diagnosis, prevention and treatment, including non-surgical, surgical, or related procedures of disease, disorders, and conditions of the oral cavity, maxillofacial areas and the adjacent and associated structures and their impact on the human body.” These services are provided by a dentist “within the scope of his education, training, and experience, in accordance with the ethics of the profession and applicable law.” La. R.S. 37:751

There is a qualified exception for licensed and registered physicians and surgeons “rendering dental relief in emergency cases in the practice of their profession and if they do not reproduce or undertake to reproduce lost parts of the human teeth in the mouth or restore or replace missing teeth in the mouth.” The statute also exempts dental students, dental faculty, and dentists of other states who have obtained a temporary license to practice in Louisiana, and dentists in the armed services of the US, the US Public Health Service, or the US Veterans Bureau. La. R.S. 37:752

A registered dental hygienist may operate only in the office of a licensed dentist under his direct supervision on the premises, except when employed by a public school or state institution where the hygienist may operate under the general supervision and direction of a licensed dentist also employed by the public school or state institution. La. R.S. 37:766

Practice of Dental Hygiene not defined specifically

Dental assistants may perform duties only under the “direct on-premises supervision, direction, and responsibility of the dentist who employs him or her or a dentist who assumes responsibility for the treatment of that patient, and as ordered by the dentist. La. R.S. 37:792.1

Practice of dental assistants is not defined specifically.

1. DENTIST

What constitutes practicing dentistry?
The practice of dentistry is broadly defined as the “evaluation, diagnosis, prevention and treatment, including non-surgical, surgical, or related procedures of disease, disorders, and conditions of the oral cavity, maxillofacial areas and the adjacent and associated structures and their impact on the human body.” These services are provided by a dentist “within the scope of his education, training, and experience, in accordance with the ethics of the profession and applicable law.” La. R.S. 37:751

The statute prohibits anyone other than a licensed dentist or a dental professional service organization from operating dental services site (dental office, clinic, or other specified facilities). La. R.S. 37:751

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene not defined specifically.

A registered dental hygienist may operate only in the office of a licensed dentist under his direct supervision on the premises, except when employed by a public school or state institution where the hygienist may operate under the general supervision and direction of a licensed dentist also employed by the public school or state institution. La. R.S. 37:766

To be licensed in the state of Louisiana, a dental hygienist must fulfill practice requirements which include: graduation from accredited dental hygiene program approved by Louisiana State Board of Dentistry, pass examinations administered by the Joint Commission on National Dental Examinations, pass dental hygiene examination administered by the Board, and successfully complete Cardiopulmonary Resuscitation Health Care Provider course by the American Heart Association. La. R.S. 37:764.

3. OTHER MID-LEVEL PROVIDERS

Dental assistants may perform duties only under the “direct on-premises supervision, direction, and responsibility of the dentist who employs him or her or a dentist who assumes responsibility for the treatment of that patient, and as ordered by the dentist. La. R.S. 37:792.1

Expanded duty dental assistant is a person who is employed by a licensed practicing dentist and has completed a specialized course approved by the Louisiana State Board of dentistry that consists of a minimum of 30 hours of academic instruction, or who has graduated from a dental assisting program accredited by the Commission on Dental Accreditation of the American Dental Association. La. R.S. 37:751. An expanded duty dental assistants may also perform duties only under “direct on-premises supervision, direction, and responsibility of the dentist who employs him or her or a dentist who
assumes responsibility for the treatment of that patient, and as ordered by the dentist. La. R.S. 37:792.1

The following procedures may not be delegated to a dental assistant: “removal of deposits, or accretions from the natural and restored surfaces of exposed teeth, root planing, or smoothing, and any other procedures which are prohibited by the Board.” La. R.S. 37:792.1

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The licensing provisions of this statute do not apply to “rendering dental relief in emergency cases by physicians or surgeons in the practice of their profession and if they do not reproduce or undertake to reproduce lost parts of the human teeth in the mouth or restore or replace missing teeth in the mouth.” La. R.S. 37:752

5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

Statute makes no references to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the state dental practice board?

The board shall be composed of ten licensed dentists (one from each dental district and except district 5 which will have two dentists) and one dental hygienist. La. R. S. 37:753

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may refuse to issue or may suspend or revoke any license or permit or impose probationary or other limits or restrictions on any dental license issued if a dentist or dental hygienist is involved in “employing, procuring, inducing, aiding, or abetting a person not licensed or registered as a dentist to engage in the practice of dentistry or to possess an ownership interest of any kind in a dental practice…” La. R.S. 37:776
MAINE

Summary:

A person is considered to be practicing dentistry if he “perform, or attempts or professes to perform, a dental operation or oral surgery or dental service of any kind, gratuitously or for a salary, fee, money, or other remuneration paid…who diagnoses or professes to diagnose…treats disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws or adjacent structures…” 32 M.R.S. § 1081

There are general exemptions for licensed physicians or surgeons, nurse anesthetist, graduate dentists or dental surgeons in the US armed forces, persons serving in the public health service or employed by the Veteran’s Administration, registered dentists of other states at meetings of Maine State Dental Association or its affiliates, dental students, and dental faculty. 32 M.R.S. § 1081(2)

A dental hygienist must practice under the supervision of a dentist. Specific scope of services and areas of practice for dental hygienists are undefined by this statute. 32 M.R.S. § 1095

Duties of dental assistants must be defined and governed by the Board of Dental Examiners. Duties of dental assistants are also undefined is this statute. 32 M.R.S. §1100-A

1. DENTIST

What constitutes practicing dentistry?

A person is considered to be practicing dentistry if he “perform, or attempts or professes to perform, a dental operation or oral surgery or dental service of any kind, gratuitously or for a salary, fee, money, or other remuneration paid, directly or indirectly to the person or to any other person or agency who is a proprietor of a place where dental operations, dental surgery, or dental services are performed…, who diagnoses or professes to diagnose, treats or professes to treat disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws or adjacent structures…, who by any means or method, takes impression of a human tooth, teeth, jaw or performs a phase of an operation incident to the replacement of a part of a tooth, supplies artificial substitutes for natural teeth…, corrects or attempts to correct malformations of teeth or of the jaws…, repairs or fills cavities, diagnoses, makes and adjusts appliances to artificial casts or malposed teeth for treatment, who administers anesthetics, and who takes and interprets dental X-rays…” 32 M.R.S. § 1081

The statute prohibits anyone other than a licensed dentist or dental hygienist from practicing dentistry or dental hygiene. The statute also prohibits anyone other than a licensed dentist or dental organization from operating dental services site (dental office, clinic, or other specified facilities). 32 M.R.S. § 1092
2. Dental Hygienist

What constitutes practicing as a dental hygienist?

A dental hygienist must practice under the supervision of a dentist. Specific scope of services and areas of practice for dental hygienists are undefined by this statute. 32 M.R.S. § 1095

General Supervision means the supervising dentist is not required to be physically present in the dental office while procedures are being performed on a patient of record. 32 M.R.S. § 1100-I

The statute does not specifically state where dental hygienists may practice.

A dental hygienist must fulfill practice requirements which include “successful completion of 2 years training in a school of dental hygiene approved by the board, or who is a full-time dental student who has satisfactorily completed at least half of the prescribed course of study in an accredited dental college, and pass Dental Hygiene Examinations administered by the Board. 32 M.R.S. § 1096

3. OTHER MID-LEVEL PROVIDERS

Duties of dental assistants must be defined and governed by the Board of Dental Examiners. Duties of dental assistants are also undefined in this statute. 32 M.R.S. §1100-A

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may presumably provide any of the services that are defined as dental or dental hygiene services, provided that he does not practice dentistry as a specialty. Nothing in the [statute] applies to “the practice of the profession by a licensed physician or surgeon under the laws of this State, unless the person practices dentistry as a specialty.” 32 M.R.S. § 1081(2A)

5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

Nothing in the [statute] applies to “the giving by a qualified nurse anesthetist of an anesthetic for a dental operation; the giving by a certified registered nurse of an
anesthetic for a dental operation under the direct supervision of either a licensed dentist who holds a valid anesthesia permit or a licensed physician; and the removing of sutures, the dressing of wounds, the application of dressings and bandages and the injection of drugs subcutaneously or intravenously by a certified registered nurse under the direct supervision of a licensed dentist or physician.” 32 M.R.S. § 1081(2B)

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

Employment of a unlicensed person by a dentist to practice as a dentist or dental hygienist is prohibited. 32 M.R.S. § 1081

MARYLAND

Summary:

The practice of dentistry means to “diagnose, treat…any disease, injury, malocclusion, or malposition of a tooth, gums, or jaws if the service, operation, or procedure is included in the curricula of an accredited dental school…” Md. Health Occupations Code Ann. § 4-101

The statute makes general exemptions for physicians. Md. Health Occupations Code Ann. § 4-102 The statute also makes general exceptions for dental students, dental interns, a dentist while performing official duties in a federal dental service, and an individual licensed to practice dentistry in any other state or foreign country while making a clinical demonstration before a dental society. Md. Health Occupations Code Ann. § 4-301

The practice of dental hygiene means to “perform preliminary dental examination; perform complete prophylaxis…; chart cavities, restorations, missing teeth, periodontal conditions…” Md. Health Occupations Code Ann. § 4-202

Generally dental hygienists may practice under the general supervision of a licensed dentist. However, the board may waive, on a case by case basis only, the supervision requirements for dental hygiene practice in “a dental facility owned and operated by the federal, the State, or the local government…” Md. Health Occupations Code Ann. § 4-102

Specific scope of services or area of practice for dental assistants is not defined in the statute.

1. DENTIST

What constitutes practicing dentistry?
The practice of dentistry means to “be a manager, a proprietor, or a conductor of or an operation in any place in which a dental service or dental operation is performed intra-orally, to perform or attempt to perform any intraoral dental service or intraoral dental operation, to diagnose, treat, or attempt to diagnose or treat any disease, injury, malocclusion, or malposition of a tooth, gums, or jaws if the service, operation, or procedure is included in the curricula of an accredited dental school..., perform dental laboratory work, place or adjust a dental appliance in the human mouth, and administer anesthesia.” Md. Health Occupations Code Ann. § 4-101

The practice of dentistry or dental hygiene without a valid and current license is prohibited in the state of Maryland. Md. Health Occupations Code Ann. § 4-315

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene means to “perform preliminary dental examination; perform complete prophylaxis, including the removal of any deposit, accretion, or stain from the surface of a tooth or a restoration; polish a tooth or a restoration; chart cavities, restorations, missing teeth, periodontal conditions, and other feature observed during preliminary examination, prophylaxis, or polishing; apply medicinal agent to a tooth for prophylactic purposes; take of dental C-rays; instruct individuals or groups of individuals in oral health care; and any other intra-oral functions authorized by the board...” under the general supervision of a licensed dentist. Md. Health Occupations Code Ann. § 4-202

General Supervision is defined as “supervision of a dental hygienist by a dentist, where the dentist may or may not be present when the dental hygienist performs the dental hygiene procedures but is available on the premises.” Md. Health Occupations Code Ann. § 4-101

Dental hygienist may practice in a dental office, dental clinic, hospital, school, charitable institution, or HMO certified by the State Insurance Commissioner, under the general supervision of a licensed dentist. The Board may waive, on a case by case basis only, the supervision requirements for dental hygiene practice in “a dental facility owned and operated by the federal, the State, or the local government; a health facility licensed by the Department of health and Mental Hygiene; A facility providing medical care to the poor, elderly, or handicapped that is owned and operated by the state or local government, a bona fide charitable organization, or any other setting authorized under regulations adopted by the Board.” Md. Health Occupations Code Ann. § 4-102

In order to practice dental hygiene in Maryland, hygienists must be licensed by the Maryland Board of Dental Examiners. To qualify for a license as a dental hygienist, individual must be a graduate of an dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation that provides at least a two
academic years of curriculum and is approved by the Board and pass dental hygiene examinations administered by the Board. Md. Health Occupations Code Ann. § 4-102

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Specific scope of services or area of practice for dental assistants is not defined in the statute.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide any of the services that are defined as dental or dental hygiene services. “The provisions of this [statute] do not affect a physician while practicing medicine, unless the physician practices dentistry as a specialty.” Md. Health Occupations Code Ann. § 4-102

5. NURSING

The statute makes no reference to physicians or surgeons.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may suspend or revoke the license of any dentist who “permits an unauthorized individual to practice dentistry or dental hygiene…” Md. Health Occupations Code Ann. § 4-601

Who serves on the dental board?

The State Board of Dental Examiners consists of 15 members appointed by the Governor, with the advice of the Secretary. Nine of the members are licensed dentists practicing in [Maryland] for at least five years immediately before appointment and are residents of the State. Three members are licensed dental hygienists practicing dental hygiene in [Maryland] for at least three years before appointment and are residents of Maryland. The remaining three members are consumers who may not be or ever have been a dentist or a dental hygienist or in training to become either and have no financial interest in either dentistry or dental hygiene. All members are appointed for a four-year term. Md. Health Occupations Code Ann. § 4-202
MASSACHUSETTS

Summary:

The practice of dentistry is defined as the “diagnos[is], treat[ment], prescri[pton] of any disease, pain, injury, deficiency, deformity or other condition of the human teeth, alveolar process, gums or jaws, and associated parts, intra-orally or extra-orally…” Mass. Ann. Laws ch. 112, § 50

There are general exemptions for physicians, registered dentists of other states operating at a public clinic under the auspices of a duly organized and reputable dental college or association, dental students, and dental faculty. Mass. Ann. Laws ch. 112, § 53

A dental hygienist may perform all acts performed by a dental assistant and under appropriate supervision provide educational, therapeutic, prophylactic and preventive services. A dental hygienist may not perform acts or services such as “diagnosis, treatment planning, surgical or cutting procedures, prescription of medications.” Mass. Ann. Laws ch. 112, § 51.

“Hygienist may practice only in public or private institutions such as schools, hospitals, or orphan asylums and sanitariums, and in the office of a duly qualified dentist, under the general direction of a licensed and qualified dentist.” 234 CMR 2.03

Dental assistants may provide services only under the general or direct supervision of a licensed dentist depending upon their training. Dental assistants may only aid or assist a dentist in the delivery of patient care and perform only those services delegated or authorized by the licensed dentist. Mass. Ann. Laws ch. 112, § 43A

1. DENTIST

What constitutes practicing dentistry?

Any person who is “able to or offers or undertakes by any method to diagnose, treat, operate, or prescribe for any disease, pain, injury, deficiency, deformity or other condition of the human teeth, alveolar process, gums or jaws, and associated parts, intraorally or extraorally…” is engaged in the practice of dentistry. Mass. Ann. Laws ch. 112, § 50

The statute prohibits anyone other than a licensed dentist or dental hygienist from practicing dentistry or dental hygiene. The statute also prohibits anyone other than a licensed dentist or dental organization from operating dental services site (dental office, clinic, or other specified facilities). Mass. Ann. Laws ch. 112, § 52

2. Dental Hygienist
What constitutes practicing as a dental hygienist?

A dental hygienist may perform all acts performed by a dental assistant and under appropriate supervision provide educational, therapeutic, prophylactic and preventive services. A dental hygienist may not perform acts or services such as “diagnosis, treatment planning, surgical or cutting procedures, prescription of medications.” Mass. Ann. Laws ch. 112, § 51

A dental hygienist may “remove all tartar deposits, accretions, stains from exposed surfaces of teeth…” However, hygienist shall not “perform any other operation on the teeth or mouth or any diseases tissues of the mouth or attempt diagnosis or treatment of such diseased tissues.” 234 CMR 2.03

“Hygienist may practice only in public or private institutions such as schools, hospitals, or orphan asylums and sanitariums, and in the office of a duly qualified dentist, under the general direction of a licensed and qualified dentist.” 234 CMR 2.03 Operating or owning a commercial dental laboratory and continuing in the active practice of dentistry is prohibited by dental hygienist. 234 CMR 2.04

A dental hygienist must fulfill practice requirements which include graduation from a dental hygiene program accredited by the Commission Accreditation of Dental and Dental Auxiliary Educational Programs of the American Dental Association requiring a course with minimum one year of academic curriculum approved by the Board, or who is a full time dental student and has completed four semesters in an accredited dental college and pass Dental Hygiene Examinations administered by the Board. Mass. Ann. Laws ch. 112, § 51

3. OTHER MID-LEVEL PROVIDERS

Dental assistants may provide services only under the general or direct supervision of a licensed dentist depending upon their training. Dental assistants may only aid or assist a dentist in the delivery of patient care and perform only those services delegated or authorized by the licensed dentist. Mass. Ann. Laws ch. 112, § 43A

- Direct supervision: dentist is physically present in a dental facility.
- General supervision: supervision of dental procedures based on instructions given by a licensed dentist but not requiring the physical presence of a supervising dentist during the performance of those procedures.

Certified Dental Assistants (CDA) who are certified by the Dental Assisting National Board may take radiographs under the general supervision of a dentist. CDAs must complete two years of work experience prior to being eligible to work under general supervision of a licensed dentist. 234 CMR 2.04

4. MEDICINE
What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may presumably provide any of the services that are defined as dental or dental hygiene services. “Nothing in the [statute] shall apply to treatment by a registered physician not practicing dentistry, in cases where he deems treatment necessary for the relief of his patients.” Mass. Ann. Laws ch. 112, § 53

5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

Statute makes no references to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

Employment of a unlicensed person by a dentist to practice as a dentist or dental hygienist is prohibited. Mass. Ann. Laws ch. 112, § 52

MICHIGAN

Summary:

The practice of dentistry is broadly defined as “diagnosis, treatment, prescription, or operation for a disease, pain, deformity, deficiency, injury or physical condition of the human tooth, alveolar process, gums or jaws, or their dependent tissues, or an offer, undertaking, attempt to do, or holding oneself out as able to do any of these acts.” MSA § 14.15 (16601)

There is a qualified exception for physicians and surgeons extracting teeth in emergency situations or involved in the surgical repair of the jaw in a nonemergency situation. MSA § 14.15 (16601)

A dental hygienist may deliver preventive services and oral health education “at the assignment of a dentist.” This may include but is not limited to “complete oral prophylaxis, application of preventive agents to oral structures, preparing diagnostic tests...” Assignment means that “a dentist has designated a patient of record upon whom services are to be performed and has described the procedures to be performed. The dentist need not by physically present in the office or in the treatment room at the time the procedure is being performed.” MSA § 14.15 (16601) In general hygienist may practice under the supervision of a licensed dentist as “part of a program for dentally
underserved populations in the state conducted by local, state, or federal grantee health agency for patients who are not assigned by a dentist.” MSA § 14.15 (16625)

Dental assistants may provide extra-oral services under general supervision and certain intra-oral services under direct supervision of a licensed dentist depending upon their training. Mich. Admin. Code R. § 338.11403.

1. DENTIST

What constitutes practicing dentistry?

Any person involved in the “diagnosis, treatment, prescription, or operation for a disease, pain, deformity, deficiency, injury or physical condition of the human tooth, alveolar process, gums or jaws, or their dependent tissues, or an offer, undertaking, attempt to do, or holding oneself out as able to do any of these acts” is deemed to be practicing dentistry. MSA § 14.15 (16601)

The statute prohibits anyone other than a licensed dentist or a dental professional service organization from practicing dentistry or operating dental services site (dental office, clinic, or other specified facilities). MSA § 14.15 (16601)

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene means “the practice at the assignment of a dentist in that specific area of dentistry based on specialized knowledge, formal education, and skill with particular emphasis on preventive services and oral health education.” MSA § 14.15 (16601)

A licensed dentist may delegate certain intra-oral procedures to licensed dental hygienists under general supervision such as placement of sealants and application of topical fluoride. Mich. Admin. Code. R. § 338.11405

Supervision within the statute is defined as the “overseeing of or participation in the work of any other individual by a licensed dentist in situations where at least one of the following criteria are met:
1) “continuous availability of direct communication in person or by telephone between the supervised individual and a licensed dentist”
2) “availability of a licensed dentist on a regularly scheduled basis to review the practice of supervised individual, to provide consultation to the supervised individual, to review records…”
3) “provision by the licensed dentist of predetermined procedures and drug protocol”

MSA § 14.15 (16625)
A dental hygienist must fulfill practice requirements which include graduation from accredited dental hygiene program, successful completion of the dental hygiene national board examination that is conducted and scored by the Joint Commission of National Dental Examiners, successful completion of the combined regional dental hygiene examination conducted and scored by the Northeast Regional Board of Dental Examiners, and submit an application for licensure to the State Dental Board. Mich. Admin. Code. R. § 338.11221

3. OTHER MID-LEVEL PROVIDERS

A dental assistant is any person who “assist in the clinical practice of dentistry based on formal education, specialized knowledge, and skill at the assignment and under the supervision of a dentist.” MSA § 14.15(16601)


Direct supervision means that the dentist is present in the treatment facility, but it is not required that the dentist be physically present in the treatment room while the dental assistant is performing acts assigned by the dentist.

The following procedures may not be delegated to a dental assistant or a dental hygienist: “diagnosis, examination, treatment planning, prescription, surgical procedures on hard and soft tissues within the oral cavity, administration of local anesthesia, nitrous oxide analgesia, irrigation and medication of root canals.” Mich. Admin. Code. R. § 338.11401.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

“A practicing physician and surgeon who has not been licensed as a dentist may not engage in the practice of dentistry nor advertise that he does so practice. Nothing in the statute prohibits surgeons from repairing fractured jaws in non-emergency situations.” MSA § 14.15 (16601)

5. NURSING
May a nurse provide any of the services that are defined as dental or dental hygienist services?

Statute makes no references to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the state dental practice board?

The Michigan board of dentistry consists of 19 voting members of which 8 are dentists, 4 are dental hygienists, 2 are dental assistants, and 3 are public members. Board members who are dental hygienists or dental assistants vote as equal members of the board in all matters except those that apply only to dentists and not to dental hygienists or dental assistants. MSA § 15.15 (16621)

MINNESOTA

Summary:

The practice of dentistry is broadly defined as “diagnos[is], treat[ment], prescri[ption], or operat[ion] for any disease, pain, deformity, deficiency, injury, or physical condition of the human tooth, teeth, alveolar process, gums or jaw, or adjacent or associated structures.” Minn. Stat. § 150A.05

The statute makes no reference to physician exemptions.

There are exemptions for personnel in any branch of the armed services of the US, US Public Health Service, or the US Veterans Administration. There are also exceptions for dental students, dental faculty, and dentists and dental hygienists of other states. Minn. Stat. § 150A.05.

A dental hygienist may provide care that is “educational, preventive, therapeutic through observation, assessment, evaluation, counseling, and therapeutic services to maintain oral health.” This may include but is not limited to “evaluation of patient health status through review of medical and dental histories, assessment and planning of dental hygiene care needs, performing prophylaxis, including complete removal of calciferous deposits, accretions and stains by scaling polishing, and performing root planning, administering local anesthesia and nitrous oxide analgesia…” Dental hygienist may perform these services either under general supervision or indirect supervision depending upon their training. Minn. Stat. § 150A.05

Dental assistants may perform all duties not directly related with performing dental treatment or services on patients. These include “assisting with the placement or
removal of rubber dam and accessories used for its placement, provide assistance in the placement of articles and topical medication under specific direction and direct supervision of a licensed dentist.” Minn. R. 3100.8400

1. DENTIST

What constitutes practicing dentistry?

Any person who uses a dental degree, manages, owns, or operates a dental office, and performs dental operations of kind gratuitously, or for a fee, compensation or reward to any person or agency is deemed to be practicing dentistry. Minn. Stat. § 150A.05

The practice of dentistry includes “uses of roentgen X-ray for dental treatment, extrac[tion] of human teeth, correction or attempt to correct malpositions of human teeth and/or jaw, taking impressions of human teeth/jaws, or performing any operation incident to the replacement of a part of tooth, a tooth, teeth, or associated tissues, furnishing, construction, or repair of prosthetic dentures, and performing clinical operation included in the curricula of dental schools or colleges.” Minn. Stat. § 150A.05

The statute prohibits anyone other than a licensed dentist or a dental professional service organization from practicing dentistry or operating dental services site (dental office, clinic, or other specified facilities). Minn. Stat. § 150A.05

2. DENTAL HYGIENIST

What constitutes practicing as a dental hygienist?

The practice of dental hygiene is broadly defined as “providing educational, preventive, assessment, evaluation, counseling, and therapeutic services to establish or maintain oral health.” Minn. Stat. § 150A.05.

A dental hygienist may perform the following duties under general supervision: complete prophylaxis, preliminary charting of oral cavity, dietary analysis, application of pit and fissure sealants, removal of excess bond material, and replacement of crowns.

A dental hygienist may perform the following duties under indirect supervision: remove marginal overhangs, administer local anesthesia, and administer nitrous oxide. Minn. R. 3100.8700.

• General supervision means a dentist has authorized services to the hygienist and the hygienist carries out the services in accordance with the dentist treatment plan. The dentist need to be present in the treatment facility.

• Indirect supervision means a dentist authorizes the procedures and remains in the facility while the procedures are being performed.
A dental hygienist must fulfill practice requirements which include graduation from accredited dental hygiene program that provides a minimum of two academic years of dental hygiene curriculum, successful completion of the National Board of Dental Hygiene Examination that is conducted and scored by the Joint Commission of National Dental Examiners, successful completion of an examination testing the applicant’s knowledge of the laws of Minnesota relating to the practice of dentistry and of the rules of the Board. Minn. Stat. § 150A.06.

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

A registered dental assistant may perform the following duties under general supervision of a licensed dentist: cut arch wires and provide palliative treatment. The following duties may be performed under indirect supervision by a dentist: taking radiographs, application of topical medications, placement and removal of rubber dams, placement and removal of periodontal dressings.

A dental assistant may provide these duties only under direct supervision: removing excess bond material, application of pit and fissure sealants, making preliminary adaptation of temporary crowns, and removal of temporary crowns.” Minn. R. 3100.8500.

- Direct supervision requires that the dentist personally diagnose the condition to be treated, personally authorizes the procedure, and evaluates the performance of the assistant before dismissing the patient.

The following procedures may not be delegated to a dental assistant or a dental hygienist: “diagnosis, examination, treatment planning, prescription, surgical procedures on hard and soft tissues within the oral cavity, administration of local anesthesia, nitrous oxide analgesia, irrigation and medication of root canals.” Minn. R. 3100.8400.

A registered dental assistant must submit an application, a diploma or equivalent awarded to the person by a training school for dental assistants, and must successfully complete a clinical examination administered by the Board as well as pass an examination testing the applicant’s knowledge of the laws of Minnesota relating to the practice of dentistry and of the rules of the Board. Minn. Stat. § 150A.06.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The statute makes no reference to physicians.
5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

Statute makes no references to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the state dental practice board?

The Minnesota Board of Dentistry consists of two public members, five qualified resident dentists, one qualified resident registered dental assistant, and one qualified resident dental hygienist all appointed by the governor.

Each member who is a dentist, dental assistant, or dental hygienist shall have been lawfully in active practice in the State for at least five years immediately preceding the appointment. Minn. Stat. § 150A.05

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may refuse or by order suspend or revoke…any license to practice dentistry or dental hygiene or the registration of any dental assistant if the dentist, dental hygienist or dental assistant engages in “employing, assisting, or enabling in any manner an unlicensed person to practice dentistry.” Minn. Stat. § 150A.05

MISSISSIPPI

Summary:

The practice of dentistry is broadly defined as “evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or adjacent and associated structures and their impact on the human body.” These services must be “provided by a dentist, within the scope of his education, training and experience, in accordance with the ethics of the profession and applicable law.” Miss. Code Ann. § 73-9-3

There is a general exemption for licensed and registered physicians under the laws of the State “unless he practices dentistry as a specialty.” There are also exemptions for dental faculty, dental students, and dental residents. Miss. Code Ann. § 73-9-3
A dental hygienist may provide “treatment that helps to prevent oral disease such as dental caries and periodontal disease and educate patients in the prevention of these and other dental problems.” Miss. Code Ann. § 73-9-5

Dental hygienist may perform these services only under the “direct supervision of the dentist while working in the office of a regularly licensed and registered dentist.” Dental hygienist employed by the State Board of Health or public school boards shall be limited to only performing oral hygiene instruction and screening when under general supervision and direction of regularly licensed registered dentist. Miss. Code Ann. § 73-9-5

Dental assistants may perform all duties not directly related with performing dental treatment or services on patients. Dental assistants may perform services only under the “direct supervision of the dentist while working in the office of a regularly licensed and registered dentist.” Miss. Code Ann. § 73-9-5

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry includes “evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or adjacent and associated structures and their impact on the human body.” These services must be “provided by a dentist, within the scope of his education, training and experience, in accordance with the ethics of the profession and applicable law.” Miss. Code Ann. § 73-9-3

The statute prohibits anyone other than a licensed dentist or a dental professional service organization from practicing dentistry or operating dental services site (dental office, clinic, or other specified facilities). Miss. Code Ann. § 73-9-1

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene is broadly defined as providing “treatment that helps to prevent oral disease such as dental caries and periodontal disease and educate patients in the prevention of these and other dental problems.” Miss. Code Ann. § 73-9-5

A dental hygienist may provide, as an auxiliary to a dentist, preventive services that include, but are not limited to, scaling, and polishing only under the direct supervision of a dentist.

Direct supervision is not specifically defined in the statute.
A dental hygienist must fulfill practice requirements which include graduation from accredited dental hygiene program, successful completion of the National Board of Dental Hygiene Examination that is conducted and scored by the Joint Commission of National Dental Examiners, and is licensed by the State Board of Dental Examiners to provide preventive services. Miss. Code Ann. § 73-9-5

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may perform all duties not directly related with performing dental treatment or services on patients. Dental assistants may perform services only under the “direct supervision of the dentist while working in the office of a regularly licensed and registered dentist.” Miss. Code Ann. § 73-9-5

Supervision not defined.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide any of the services that are defined as dental or dental hygiene services. Nothing in the statute shall be construed to prevent “the practice of his profession by a regularly licensed and registered physician under the laws of this state unless he practices dentistry as a specialty.” Miss. Code Ann. § 73-9-3

5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygiene services?

Statute makes no references to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the state dental practice board?

The Mississippi Board of Dentistry shall consist of seven regularly licensed, registered, and practicing dentists practicing within the State for at least 5 years and one regularly licensed, registered dental hygienist appointed by the Governor. Miss. Code Ann. § 73-9-1
Is facilitating unlicensed dental or dental hygiene practice prohibited specifically?

Employing, assisting, or enabling an unlicensed person to practice dentistry or dental hygiene is prohibited by the statute. Miss. Code Ann. § 73-9-3

MISSOURI

Summary:

A person or entity practices dentistry who “undertakes to do or perform dental work or dental services or dental operations or oral surgery, by any means or methods…, diagnoses…, prescribes for…, treats…, any disease, pain, deformity, deficiency, injury or physical condition of the human teeth or adjacent structures or treats or professes to treat any disease or disorder or lesions of the oral regions…” § 332.071 R.S.Mo

There are qualified exemptions for licensed physicians or surgeons and general exemptions for dentists or dental surgeons in the US armed services or in the United States Public Health Service, or persons employed by the US Veteran’s Administration, registered dentists of other states making clinical demonstrations in Missouri, dental students, and dental faculty. § 332.081(1) R.S.Mo

Any person who “undertakes to remove hard and soft deposits from teeth…performs clinical examinations of teeth and surrounding tissues for diagnosis…under the supervision of a registered and licensed dentist” is engaged in the practice of dental hygiene. § 332.091 R.S.Mo. A dental hygienist shall only practice under the supervision of a dentist who is duly registered and currently licensed in Missouri. § 332.311 R.S.Mo

Any person who “provides patient services in cooperation with and under the direct supervision of a currently registered and licensed dentist…” is practicing as a dental assistant. §332.093 R.S. Mo

1. DENTIST

What constitutes practicing dentistry?

A person or entity practices dentistry who “undertakes to do or perform dental work or dental services or dental operations or oral surgery, by any means or methods, gratuitously or for a salary or fee or other reward, paid directly or indirectly to the person or to any other person or entity, diagnoses or professes to diagnose, prescribes for…, treats…, any disease, pain, deformity, deficiency, injury or physical condition of the human teeth or adjacent structures or treats or professes to treat any disease or disorder or lesions of the oral regions, attempts to restore a part or portion of the human tooth, interprets…dental radiographs, undertakes to remove hard and soft deposits from or polishes natural and restored surface of the teeth, directly owns or leases, operates,
maintains, manages or conducts an office or establishment of any kind in which dental services…are performed…” § 332.071 R.S.Mo

The statute prohibits anyone other than a licensed dentist or dental hygienist from practicing dentistry or dental hygiene. The statute also prohibits anyone other than a licensed dentist or dental organization from operating dental services site (dental office, clinic, or other specified facilities). Anyone found guilty of practicing dentistry or dental hygiene without a valid Maine license, except for those exempted, is guilty of a Class A misdemeanor. § 332.111 R.S.Mo

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

Any person who “undertakes to remove hard and soft deposits from teeth, polishes natural and restored surfaces of teeth, polishes restoration of teeth, performs clinical examinations of teeth and surrounding tissues for diagnosis…and who performs such other procedures as may be delegated by the supervising registered and licensed dentist under the degree of supervision set by rules of the Board” is engaged in the practice of dental hygiene. § 332.091 R.S.Mo

A duly registered and currently licensed dental hygienist may only practice as a dental hygienist “so long as the dental hygienist is employed by a dentist who is duly registered and currently licensed in Missouri,….” § 332.311 R.S.Mo

Supervision is not explicitly defined in this statute.

A dental hygienist must be registered and obtain a certificate from the board before practicing dental hygiene. To obtain certificate/license from the board a dental hygienist must: complete a course in dental hygiene in an accredited dental hygiene school and pass examinations administered by the Board. § 332.231 R.S.Mo

3. OTHER MID-LEVEL PROVIDERS

Any person who “provides patient services in cooperation with and under the direct supervision of a currently registered and licensed dentist…” is practicing as a dental assistant. §332.093 R.S.Mo

An expanded-functions dental assistant is any dental assistant who has passed a basic dental assisting skills mastery examination or a certified dental assistant, either of whom has successfully completed a board-approved expanded-functions course, passed competency examination, and can now prove competency in a specific expanded function to the Missouri dental board. §332.011 R.S.Mo

4. MEDICINE
What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may presumably provide any of the services that are defined as dental or dental hygiene services, provided that he does not practice dentistry as a specialty. “Nothing in this [statute] shall be construed as to make it unlawful for a legally qualified and licensed physician or surgeon, who does not practice dentistry as a specialty, from extracting teeth.” § 332.081 R.S.Mo

5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

There are no references to nurses in this statute.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

Employment of a unlicensed person by a dentist to practice as a dentist or dental hygienist is prohibited. § 332.111 R.S.Mo

MONTANA

Summary:

A person is deemed to be practicing dentistry who “performs, attempts, advertises to perform…dental operations, oral surgery, or dental service of any kind…diagnoses, prescribes for…or treats any disease, pain deformity, deficiency, injury or physical condition of the human teeth, jaws, or adjacent structures… gratuitously or for a salary, fee, money or other remuneration paid, directly or indirectly, to the person, or any agency.” Mont. Code Anno., § 37-4-101

There are exemptions for “qualified physicians or surgeon,” dental students, dental faculty, dentists or dental surgeons in the US armed forces, dentists in the Public Health Service, dentists in the Veteran’s Administrations, or dentists of other states making clinical demonstrations before dental societies in the State. Mont. Code Anno., § 37-4-103 (2)

The statute also “does not prevent a licensee from entering into a contract with or being employed by the following clinics: university clinics, correctional facilities, federally funded community health centers, migrant health centers, or programs for health
services for the homeless established pursuant to Public Health Services Act, 42 U.S.C. 254b.” Mont. Code Anno., § 37-4-103 (6)

The practice of dental hygiene “is services that are educational, therapeutic, prophylactic, or preventive in nature…that may be performed under general supervision of a dentist.” Mont. Code Anno., § 37-4-401

Dental hygienist “with the permission of a supervising dentist may practice in the office of a licensed and actively practicing dentist, in public or private institutions, under the board of health, or in a public clinic authorized by the board, under the general supervision of a licensed dentist.” However, a dental hygienist “may give instruction in oral hygiene without the supervision of a licensed dentist in a public or private institution or hospital or extended care facility or under a board or in a public clinic.” Mont. Code Anno., § 37-4-405

Dental assistants may perform intra-oral tasks only under the direct supervision of a licensed dentist. Mont. Code Anno., § 37-4-408

1. DENTIST

What constitutes practicing dentistry?

Any person who “performs, attempts, advertises to perform, or instructs in the performance of dental operations, oral surgery, or dental service of any kind gratuitously or for a salary, fee, money or other remuneration paid, directly or indirectly, to the person, or any agency, is a manager, proprietor, of a place where dental services are performed, diagnoses, professes to diagnose, treats or professes to treat disease, pain, deformity, deficiency, injury or physical condition of the human teeth, jaws, or adjacent structures, extracts or attempts to extract human teeth or corrects…malpositions of the teeth…” is engaged in the practice of dentistry. Mont. Code Anno., § 37-4-101

Any person who “practices dentistry or does an act of dentistry without first secured a certificate to practice dentistry from the department…is guilty of misdemeanor and on conviction in a district court may be fined to a maximum of $1000 or be confined to for a period not exceeding 6 months in the county jail.” Mont. Code Anno., § 37-4-327

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene is “performed by a licensed preventive oral health practitioner…that are educational, therapeutic, prophylactic, or preventive procedures in nature, as the Board authorizes, and that may be performed under the general supervision of a dentist.” The practice of dental hygiene also includes “administration of local anesthetic agents by a licensed dental hygienist certified by the Board to
administer the agents only under direct supervision and authorization of a licensed dentist.” Mont. Code Anno., § 37-4-401

Dental hygienist “with the permission of a supervising dentist may practice in the office of a licensed and actively practicing dentist, in public or private institutions, under the board of health, or in a public clinic authorized by the board, under the general supervision of a licensed dentist.” However, a dental hygienist “may give instruction in oral hygiene without the supervision of a licensed dentist in a public or private institution or hospital or extended care facility or under a board or in a public clinic.” Mont. Code Anno., § 37-4-405(1)

Supervision is defined as follows:

- **Direct supervision** means treatment by a dental auxiliary or licensed dental hygienist provided with the intent and knowledge of the dentist. The treatment must be performed while the dentist is on the premises.

- **General supervision** means treatment, except the administration of local anesthesia, by a licensed dental hygienist provided with the intent and knowledge of the dentist licensed and residing in the state of Montana. The supervising dentist need not be on the premises. Mont. Code Anno., § 37-4-405(2a,b)

A dental hygienist may not perform “diagnosis, treatment planning, prescription, surgical procedures on soft and hard tissues other than root planing and subgingival curettage, restorative procedures, or provide prescription for drugs or medications.” Mont. Code Anno., § 37-4-401 (1-4)

Dental hygienist must obtain a license from the Board before practicing dental hygiene in the state of Montana. To obtain a license, hygienists must fulfill the following criteria: graduate from an accredited dental hygiene program and pass dental hygiene examinations consisting of oral and clinical components administered by the Board, and successfully complete a jurisprudence examination. Mont. Code Anno., § 37-4-402(3)

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

The statute does not define specific scope or area of services for dental assistants, nor does it delineate any prerequisites to practicing as a dental assistant. The statute does state that “all dental auxiliaries must be under the direct supervision of a licensed dentist” and may perform certain “intra-oral” tasks. Mont. Code Anno., § 37-4-408

4. MEDICINE

What constitutes the practice of medicine?
May a physician provide any of the services that are defined as dental or dental hygiene services?

Presumably, a physician may provide any of the services that are defined as dental or dental hygiene services because the statute does not apply to “a legally qualified physician or surgeon.” Mont. Code Anno., § 37-4-103

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

Nothing explicitly stated in the statute.

NEBRASKA

Summary:

Any person shall be deemed to be practicing dentistry who “performs, or attempts or professes to perform, any dental operation or oral surgery or dental service of any kind…diagnoses, prescribes for, treats pain, deformity, deficiency, injury or physical condition of the human teeth, jaws, or adjacent structures… gratuitously or for a salary, fee, money or other remuneration paid, or to be paid directly or indirectly, to himself or to any other person or agency who is a proprietor of a place where dental operations, oral surgery, or dental services are performed.” R.R.S. Neb. § 71-183

There are exemptions for “licensed physicians or surgeon…unless he or she practices dentistry as a specialty,” dental faculty, dental students, dentists or dental surgeons in the US armed forces, dentists in the Public Health Service, dentists in the Veteran’s Administrations, or dentists of other states at meetings of the Nebraska Dental Association or before dental societies in the state of Nebraska. R.R.S. Neb. § 71-183.01

The practice of dental hygiene includes oral prophylaxis, and educational procedures intended to maintain optimal oral health. R.R.S. Neb. § 71-193.19 A licensed dental hygienist shall perform “traditional dental hygiene functions” only when authorized to do so by a licensed dentist who shall be responsible for the total oral health care of the patient. The Department of Health and Human Services may authorize a licensed dental hygienist to “conduct preliminary charting and screening examinations, provide oral health education for patients including teaching of appropriate plaque control techniques, and perform all of the duties that any dental assistant is authorized to perform.” R.R.S. Neb. § 71-193.15
Dental hygienist may provide preventive measures such as the application of fluorides, sealants, and other recognized topical agents for the prevention of oral disease under **general supervision**. R.R.S. Neb. § 71-193.17(8)

Dental assistants are “employed by a licensed dentist for the purpose of assisting in the performance of the [dentist’s] clinical and clinical-related duties.” R.R.S. Neb. § 71-183.02

1. **DENTIST**

What constitutes practicing dentistry?

Any person shall be deemed to be practicing dentistry who “performs, or attempts or professes to perform, any dental operation or oral surgery or dental service of any kind gratuitously or for a salary, fee, money or other remuneration paid, or to be paid directly or indirectly, to himself or to any other person or agency who is a proprietor of a place where dental operations, oral surgery, or dental services are performed.” R.R.S. Neb. § 71-183. Some of these dental services include “taking impression of human tooth, teeth, jaws, or performing any operation incident to the replacement of a part of a tooth, diagnosis, prescribing for, treating pain, deformity, deficiency, injury or physical condition of the human teeth, jaws, or adjacent structures, extracting human teeth, correcting malposition, administering anesthetics…” R.R.S. Neb. § 71-183(1-6)

2. **Dental Hygienist**

What constitutes practicing as a dental hygienist?

A licensed dental hygienist shall perform “traditional dental hygiene functions” only when authorized to do so by a licensed dentist who shall be responsible for the total oral health care of the patient. The Department of Health and Human Services my authorize a licensed dental hygienist to “conduct preliminary charting and screening examinations, provide oral health education for patients including teaching of appropriate plaque control techniques, and perform all of the duties that any dental assistant is authorized to perform.” R.R.S. Neb. § 71-193.15

Some of the duties of a licensed dental hygienist under **general supervision** include: scaling of teeth, polishing, conducting preliminary charting and screening examinations, periodontal probing and charting, gingival cutterage, removing sutures, providing preventive measures such as the application of fluorides, sealants, and other recognized topical agents for the prevention of oral disease, providing impressions for study casts, providing radiograph exposures, providing oral health education for patients, and performing all duties a dental assistant is authorized to perform. R.R.S. Neb. § 71-193.17

Dental hygienist may also administer general anesthesia and nitrous oxide under the **direct supervision** of a licensed dentist. R.R.S. Neb. § 71-193.28
Supervision is defined as follows: R.R.S. Neb. § 71-193.16

- **Indirect supervision:** the licensed dentist authorizes the procedure to be performed by a dental hygienist or dental assistant and the licensed dentist is physically present on the premises when such procedure is being performed by the dental hygienist.

- **General supervision:** 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.

In order to practice dental hygiene, hygienists must be at least 18 years of age, must graduate from an accredited dental hygiene school approved by the Board of Dentistry that requires minimum two years of academic curriculum, and pass dental hygiene examinations administered by the Board. R.R.S. Neb. § 71-183(1-6)

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Any licensed dentist, public institution, or school may employ dental assistants. Dental assistants may perform duties that are prescribed in accordance with rules and regulations adopted by the Department of Health and Human Services Regulation and Licensure. Dental assistants must work under the supervision of a licensed dentist. R.R.S. Neb. § 71-193.13

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

Presumably, a physician may provide some of the services that are defined as dental or dental hygiene under limited conditions. The statute "shall not apply to the practice of his or her profession by a physician or surgeon licensed as such under the laws of this state unless he or she practices dentistry as a specialty." R.R.S. Neb. § 71-183.01(1)

Further the statute also states that “licensed physicians and surgeons who extract teeth or treat diseases of the oral cavity, gums, teeth or maxillary bones as an incident to the general practice of their profession” are also exempt. R.R.S. Neb. § 71-184

5. NURSING
Nothing in the statute shall apply to “the giving by a qualified anesthetist or registered nurse of an anesthetic for a dental operation under the direct supervision of a licensed dentist or physician.” R.R.S. Neb. § 71-183.01(2)

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

No person “owning operating or conducting any place where dental work of any kind is done or contracted for, shall employ or permit any unlicensed dentist to practice dentistry in such place.” R.R.S. Neb. § 71-190

NEVADA

Summary:

Any person shall be deemed to be practicing dentistry who “diagnoses, professes to diagnose or treats or professes to treat any of the diseases or lesions of the oral cavity, teeth, gingiva or the supporting structures thereof, extracts teeth, administers or prescribes such remedies, medicinal or otherwise, as are needed in the treatment of dental or oral disease.” Nev. Rev. Stat. Ann. § 631.215(1)

There are exemptions for dental faculty, dental students, and dentists of other states appearing as a clinician for demonstration before dental societies. Nev. Rev. Stat. Ann. § 631.215(2) Exemptions for physicians or surgeons are not explicitly stated in the statute.

The practice of dental hygiene is the “performance of educational, preventive and therapeutic periodontal treatment including scaling, curettage and planing of roots and any related and required extraoral procedures that a dentist is authorized to assign to a dental hygienist he employs.” Nev. Rev. Stat. Ann. § 631.030

“Unless authorized to do so by the Board, a dental hygienist shall not provide services unless that person is a patient of a dentist who authorized the performance of those services.” Nev. Rev. Stat. Ann. § 631.310

Dental assistants may provide specific intra-oral services only under the direct or indirect supervision of a licensed dentist of Nevada.

1. DENTIST

What constitutes practicing dentistry?

Any person shall be deemed to be practicing dentistry who “diagnoses, professes to diagnose or treats or professes to treat any of the diseases or lesions of the oral cavity,
teeth, gingiva or the supporting structures thereof, extracts teeth, corrects malpositions of teeth or jaws, takes impressions of teeth, examines a person for artificial substitutes, uses X-ray radiation for dental treatment, and administers or prescribes such remedies, medicinal or otherwise, as are needed in the treatment of dental or oral disease.” Nev. Rev. Stat. Ann. § 631.215(1)

The statute prohibits the practice of dentistry or dental hygienist, or ownership or proprietorship, of any place where dental services are rendered by an unlicensed person. Any person “who engages in the illegal practice of dentistry” as defined above is “guilty of gross misdemeanor.” Nev. Rev. Stat. Ann. § 631.400

2. Dental Hygienist

What constitutes practicing as a dental hygienist?


“Unless authorized to do so by the Board, a dental hygienist shall not provide services unless that person is a patient of a dentist who authorized the performance of those services.” Nev. Rev. Stat. Ann. § 631.310

Supervision is broadly defined as 1) a dentist is physically present in the office where the procedures to be supervised are being performed while these procedures are being performed and 2) a dentist is capable of responding immediately if any emergency should arise. Nev. Rev. Stat. Ann. § 631.105

Dental hygienist may practice in the office of a licensed dentist, in a clinic or clinics in the public schools of Nevada as an employee of the health division of the department of human resources, in a clinic or clinics in a state institution, in a clinic established by a hospital approved by the board, in an accredited school of dental hygiene. Nev. Rev. Stat. Ann. § 631.310

In order to practice dental hygiene, hygienists must be at least 18 years of age, must be a US citizen or permanent resident, graduate from an accredited dental hygiene program, and pass dental hygiene examinations administered by the Board. Nev. Rev. Stat. Ann. § 631.105

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants
Dental assistants may provide specific intra-oral services only under the direct or indirect supervision of a licensed dentist of Nevada. Nev. Rev. Stat. Ann. § 631.313
Specific scope of practice for dental assistants is not defined in the statute.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The statute makes no reference to physicians or surgeons.

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

“Employing, procuring, inducing, aiding or abetting a person not licensed or registered as a dentist to engage in the practice of dentistry” is prohibited by the Board. Nev. Rev. Stat. Ann. § 631.346

NEW HAMPSHIRE

Summary:

A person shall be regarded as practicing dentistry who “undertakes, by any means or method… to diagnose, to treat, or prescribe for any of the lesions, diseases, disorders, deficiencies of the human oral cavity, teeth, gums, maxilla, or mandible or adjacent associated structures.” RSA § 317-A:20(I)

There is a broad exemption for physicians and general exemption for dental faculty, and dental students. RSA § 317-A:20(III)

The practice of dental hygiene includes the “assessment of medical and dental histories, including preliminary inspection of the oral cavity, surrounding structures, and periodontal charting, performance of complete prophylaxis including the removal of calciferous deposits…” Dental hygiene services shall be provided under the supervision of licensed dentist. RSA § 317-A:21-c
The statute prohibits the independent practice of dental hygienists. RSA § 317-A:21-d
The scope of services for dental assistants is not explicitly stated in the statute. However it is inferred from the statute that dental assistants may only work under the direct or indirect supervision of a licensed dentist.

1. DENTIST

What constitutes practicing dentistry?

A person shall be regarded as practicing dentistry who “owns, leases, maintains, or operates a dental business...performs dental operations of any kind, undertakes, by any means or method, gratuitously or for a salary, fee, or other reward paid or granted directly or indirectly...to diagnose or profess to diagnose, to treat or profess to treat, or prescribe for or profess to prescribe for any of the lesions, diseases, disorders, deficiencies of the human oral cavity, teeth, gums, maxilla, or mandible or adjacent associated structures, extracts human teeth, corrects malpositions, administers dental anesthetics, and engages in any of the practices included in the curricula of dental colleges.”
RSA § 317-A:20(I)

Any person who practices dentistry or dental hygiene without a valid license shall be guilty of misdemeanor. RSA § 317-A:33 Further, a “manager proprietor, partnership, association, or corporation owning managing, or controlling any place where dental work is done...shall employ only licensed dentists to practice dentistry and licensed dental hygienists to practice dental hygiene.” RSA § 317-A:28

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene includes the “assessment of medical and dental histories, including preliminary inspection of the oral cavity, surrounding structures, assessment of the patient to collect and evaluate complete data to identify dental hygiene needs, periodontal charting, performance of complete prophylaxis including the removal of calciferous deposits, excess bond materials from the orthodontic appliances, accretions, and stains from the supragingival and subgingival surfaces of the teeth by scaling root planning, and polishing, and the performance of procedures requiring additional education.” RSA § 317-A:21-c

Dental hygiene services shall be provided under the supervision of licensed dentist. RSA § 317-A:21-c Supervision is not explicitly defined in the statute.

The following procedures may not be performed by a dental hygienist: diagnosis, treatment planning, and prescriptions for drugs and medicaments, surgical procedures. RSA § 317-A:23

In order to practice dental hygiene in New Hampshire, hygienists must be licensed or registered by the state Board. To obtain a license, applicants must: graduate from an
accredited dental hygiene program with a minimum of 2 years of academic curriculum and pass dental hygiene examinations administered by the Board. RSA § 317-A:21

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

The scope of services for dental assistants is not explicitly defined in the statute.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide any of the services that are defined as dental or dental hygiene services. Nothing in the statute “shall prevent regularly licensed physicians or surgeons from treating or prescribing for lesions, diseases, disorders or deficiencies of human oral cavity, teeth, gums, maxilla, or mandible or adjacent associated structures, extracting human teeth or administering anesthetics, using or prescribing drugs or other remedies. RSA § 317-A:20(III)

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

“Employing, procuring, inducing, aiding or abetting a person not licensed or registered as a dentist to engage in the practice of dentistry” is prohibited by the Board. RSA § 317-A:28

Who serves on the dental board?

There is a 9 member Board of Dental Examiners comprising of 6 dentists, 2 dental hygienists, and one public member, each appointed by the Governor, with approval of the council, to a term of 5 years. RSA § 317-A:2
NEW JERSEY

Summary:

A person shall be regarded as practicing dentistry who “performs dental operations of any kind gratuitously, or for a fee..., offers and undertakes…to diagnose, treat or remove stains or concretions from human teeth or jaws, takes impressions..., corrects malpositions..., is a manager, proprietor, operator, or conductor of a place where dental services are performed…” NJ Stat. § 45:6-19

There statute makes general exemptions for physicians and surgeons, licensed dentists of other states or countries at meetings of the American Dental Association or component parts there of, dental interns, dental students, dental faculty, and dentists in the discharge of their duties in the US armed forces, the Public Health Service, and the Veteran’s Bureau. NJ Stat. § 45:6-19

The practice of dental hygiene includes “educational, preventive, and therapeutic services and procedures...such as intra-oral clinical services which are primarily concerned with preventive dental procedures, including, but not limited to, complete prophylaxis, applying indicated topical agents...” under the general supervision of a licensed and registered dentist. NJ Stat. § 45:6-49

The statute prohibits a licensed dental hygienist to establish an independent office for the purpose of performing traditional hygienist services whether or not there is general supervision or direct supervision of a licensed dentist. NJ Stat. § 45:6-64

Registered dental assistants, dental assistants, or limited dental assistants may perform limited intra-oral services under the direct supervision of a licensed dentist. NJ Stat. § 45:6-49

1. DENTIST

What constitutes practicing dentistry?

A person shall be regarded as practicing dentistry who “performs dental operations of any kind gratuitously, or for a fee, compensation or other reward, paid or to be paid, either to himself or to another person or agency, offers and undertakes…to diagnose, treat or remove stains or concretions from human teeth or jaws, extracts a human tooth or teeth, or corrects or attempts to correct malpositions of human teeth or jaws, administers local or general anesthetics, takes impressions..., and is a manager, proprietor, operator, or conductor of a place where dental services are performed…” NJ Stat. § 45:6-19

License dentists whose credentials have been approved and who have been granted privileges by the medical staff of a public or private licensed hospital may “diagnose and treat patients admitted for acute or chronic illness, injury or deformity within the province of the human jaw and associated structures…” NJ Stat. § 45:6-19.5
Any person who practices dentistry or dental hygiene without a valid license or without being registered to practice in the state of New Jersey shall be subject to a monetary penalty. NJ Stat. § 45:6-13

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene includes “educational, preventive, and therapeutic services and procedures…such as intra-oral clinical services which are primarily concerned with preventive dental procedures, including, but not limited to, complete prophylaxis, removing all hard and soft deposits and stains from the surfaces of human teeth to the depth of the gingival sulcus, polishing natural and restored surfaces of the teeth, applying indicated topical agents surveying intra and extra-oral structures, noting deformities, defects and abnormalities thereof, and providing clinical instructions to promote the maintenance of dental health” NJ Stat. § 45:6-49

Dental hygienist may perform services in the office of any licensed dentist or in any appropriately equipped school, licensed clinic, or public or private institution under the supervision of a licensed dentist. NJ Stat. § 45:6-49

• Supervision is defined as acts performed pursuant to a dentist’s written order, control and full professional responsibility, whether or not he is physically present. NJ Stat. § 45:6-49

In order to practice dental hygiene in New Jersey, hygienists must be licensed or registered by the state Board. To obtain a license, the applicant must graduate from an accredited dental hygiene program with a minimum of 2 years of academic curriculum and pass dental hygiene examinations administered by the Board. NJ Stat. § 45:6-49

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

A limited registered dental assistant may conduct limited intra-oral procedures under the direct supervision of a licensed dentist. NJ Stat. § 45:6-49

Registered dental assistants are defined as “any person who has fulfilled the requirements of registration established by this [statute] and who has been registered by the Board. A registered dental assistant shall work under the direct supervision of a licensed dentist. NJ Stat. § 45:6-49

Direct supervision means acts performed in the office of a licensed dentist wherein he is physically present at all times during the performance of such acts and such acts are
performed pursuant to his order, control and full professional responsibility. NJ Stat. § 45:6-49

To practice as a dental assistant or a limited dental assistant, applicants must have graduated from a training program for dental assistants accredited by the American Dental Association’s Commission on the Accreditation of Dental and Dental Auxiliary Educational program and approved by the board, have a high school diploma, complete at least six months’ work experience as a dental assistant. NJ Stat. § 45:6-55

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide any of the services that are defined as dental or dental hygiene services. “The treatment of the diseases of the mouth and the practice of oral surgery, in the practice of his profession, by a physician or surgeon, licensed as such under the laws of this State, unless he undertakes to reproduce or reproduces lost parts of the human teeth in the mouth or to restore or replace lost or missing teeth…” shall not be prohibited by this statute. NJ Stat. § 45:6-19

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

“No person shall employ, for a stated salary or otherwise, or give aid or assist any person not regularly licensed to practice dentistry or dental hygiene…” Anyone who is found guilty of violating this provision will be subject to monetary penalties. NJ Stat. § 45:6-13

Who serves on the dental board?

The New Jersey State Board of Dentistry consists of two public members, eight dentists who are residents of NJ and have practiced dentistry in NJ for at least 10 years each immediately preceding their appointments and one dental hygienist, endorsed by the New Jersey Dental Hygienists Association. All members are appointed by the Governor for a 4-year term. NJ Stat. § 45:6-1
NEW YORK

Summary:

The practice of dentistry is defined as “diagnosing, treating, operation, or prescribing for any disease, pain, injury, deficiency, deformity, or physical condition of the human mouth, including the teeth, alveolar process, gums, or jaws, and adjacent tissues.” The practice of dentistry may include performing physical evaluations in conjunction with the provision of dental treatment. NY CLS Educ § 6601

The statute makes qualified exemptions for physicians. NY CLS Educ § 6601
The statute also generally exempts dental students, dental faculty, and dentists of other states making clinical demonstrations before a regularly organized dental or medical society or group. NY CLS Educ § 6610

The practice of dental hygiene is the performance of dental services which include “applying topical agents indicated for complete prophylaxis..., performing topical fluoride applications..., taking medical histories, charting caries, providing patient education...” under the general supervision of a licensed dentist. NY CLS Educ § 6606

Dental assistants may provide supportive services in the office of any licensed dentist or in any appropriately equipped school or public institution but must provide services under the direct personal supervision of a licensed dentist. NY CLS Educ § 6608

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry is defined as “diagnosing, treating, operation, or prescribing for any disease, pain, injury, deficiency, deformity, or physical condition of the human mouth, including the teeth, alveolar process, gums, or jaws, and adjacent tissues..., furnishing, supplying, constructing, reproducing, or repairing prosthetic dentures...in the treatment of abnormal conditions of the teeth or jaws or adjacent tissues.” The practice of dentistry may include performing physical evaluations in conjunction with the provision of dental treatment. NY CLS Educ § 6601

The practice of dentistry or dental hygiene without a valid New York license, except for those exempted, is prohibited. NY CLS Educ § 6611

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene is the performance of dental services which include “removing calcareous deposits, accretions and stains from the exposed surfaces of the teeth..., attachment and applying topical agents indicated for complete prophylaxis,
removing cement, placing or removing rubber dam, removing sutures, placing matrix band, providing patient education, applying topical medication, placing and exposing X-ray, performing topical fluoride applications and topical anesthetic applications, polishing teeth, taking medical histories, charting caries, taking impressions of study casts, placing and removing temporary restorations” and any other functions delegated by a dentist under the general supervision of a licensed dentist. NY CLS Educ § 6606

Dental hygienist may perform services in the office of any licensed dentist or in any appropriately equipped school, licensed clinic, or public or private institution under the supervision of a licensed dentist. NY CLS Educ § 6606

In order to practice dental hygiene in New York, hygienists must be licensed by the state Board. To qualify for a license as a dental hygienist, applicants must: file an application with the board, be a high school graduate, graduate from an accredited dental hygiene program, pass dental hygiene examinations administered by the Board, be at least 17 years of age, and be a US citizen or permanent resident. NY CLS Educ § 6609

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

The practice of certified dental assisting is defined as “providing supportive services to a dentist in his/her performance of dental services.” Such services include “providing patient education, taking preliminary medical histories and vital signs…, placing and removing rubber dams, selecting and prefitting dental crowns, selecting and prefitting orthodontic bands…, removing periodontal dressings” and other supportive services authorized by the Board. Dental assistants may perform services under the direct personal supervision of a licensed dentist. NY CLS Educ § 6608

Dental assistants may provide services in the office of any licensed dentist or in any appropriately equipped school or public institution but must provide services under the direct personal supervision of a licensed dentist. NY CLS Educ § 6608

Direct personal supervision means supervision of dental procedures based on instructions given by a licensed dentist who remains in the dental office while supportive services are being performed, personally diagnoses the condition to be treated, personally authorizes the procedures, and before the dismissal of the patient, evaluates the services performed by the dental assistant. NY CLS Educ § 6608

All supportive services provided by dental assistants may also be performed by dental hygienists. NY CLS Educ § 6608
4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may not provide any of the services that are defined as dental or dental hygiene services except in emergency situations. “Persons not duly licensed and registered as dentists may not lawfully extract teeth under medical supervision except in emergency or other circumstances specified by the law.” NY CLS Educ § 6601

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

Not specifically prohibited in the statute.

Who serves on the dental board?

The board of regents, on recommendation of the commissioner, appoints the state board of dentistry. The board consists of a minimum of thirteen licensed dentists licensed in New York for at least five years, a minimum of three dental hygienists licensed in New York for at least five years, and a minimum of one dental assistant licensed in New York for a minimum of one year. NY CLS Educ § 6603

NEW MEXICO

Summary:

Dental practice is broadly defined under Dental Health Care Act as “the diagnosis, treatment, correction, prevention…operation…or examination…involving both the functional and aesthetic aspects of the teeth, jaws, oral and maxiofacial regions, and any associated structures.” N.M. Stat. Ann. § 61-5A-4

Anyone other than a licensed dentist, licensed dental hygienist, or a licensed dental assistant is prohibited from practicing dentistry or an area of dentistry without a dental license.

There are exceptions for dental students practicing under the indirect supervision of dentists in hospitals, institutional or public health settings, and community health centers.
and dental hygiene students practicing within the scope of dental hygienist practice. Commissioned dental officers of the uniformed forces are also exempt from this statute. There are qualified exceptions for physicians or surgeons in “extracting teeth or treating any disease coming within the province of the practice of medicine.” N.M. Stat. Ann. § 61-5A-5.

A dental hygienist may provide educational, preventive, and therapeutic services including, “prophylaxis, application of pit and fissure sealant, fluorides, and other topical therapeutic and preventive agents, screening, and other closely related services” under the general supervision of a dentist in settings such as “office of licensed dentists, clinics operated or approved by the executive agency of the State, hospitals, state licensed nursing home or long term care facility, and school regulated by the N.M Dept. of Education.” N.M. Stat. Ann. § 61-5A-4.

In addition, dental hygienists may also enter in Collaborative Practice Agreement with dentists and provide educational, preventive, and therapeutic services in a dental hygiene practice independent from a dentist practice located within reasonable distance from the consulting dentist. Dental hygienists may provide these services “without general supervision” as, set forth by rules jointly established by the Board and the Dental Hygiene Committee. The scope of dental hygienist services in a collaborative practice are defined in further detail below.

Dental assistants may “apply topical fluoride, under the indirect supervision” of a licensed dentist or dental hygienist. 16 NMAC 5.39.9 Indirect supervision means the “dentist is present in the treatment facility while authorized treatments are being performed by the dental hygienist, dental assistant, or dental student.” N.M. Stat. Ann. § 61-5A-3 (J).

1. Dentist

What constitutes practicing dentistry?

“Any person who performs a physical evaluation of a patient in an office or in a hospital, clinic, or other medical or dental facility prior to, incident to and appropriate to the performance of any dental services or oral maxofacial surgery, or who performs surgery, an extraction or any other operation or administers anesthetic in connection therewith, or diagnosing or treating any condition, disease, pain, deformity, deficiency, lesion or physical condition, or corrects malposition, or treats a fracture, or removes calcereous deposits, or replaces missing anatomy with an artificial substitute is engaged in the practice of dentistry.” N.M. Stat. Ann. § 61-5A-4.

The Dental Health Care Act defines the practice of dentistry as “the diagnosis, treatment, correction, change, relief, prevention, prescription of remedy, surgical operation, and adjunctive treatment for any disease, pain, deformity, deficiency, injury, defect, lesion, or physical condition involving both the functional and aesthetic aspects of the teeth, gingivae, jaws, and adjacent hard and soft tissue of the oral and
maxiofacial regions, including prescription or administration of any drug, medicine, biologic, apparatus, brace, anesthetic, or other therapeutic or diagnostic substance or technique by an individual or his agent or employee gratuitously or for any fee, reward, or any other form of compensation whether direct or indirect…” N.M. Stat. Ann. § 61-5A-4.

What constitutes practicing as a dental hygienist?

Practice of a dental hygienist is defined as “science of prevention and treatment of oral disease through the provision of educational, assessment, preventive, clinical, and other therapeutic services under general supervision of a dentist.”

Dental hygienist must have graduated from an accredited dental hygiene program providing a minimum of two years of academic curriculum and fulfill dental hygiene examination requirements to practice as dental hygienist in the state. 16 NMAC 5.17.8

Dental hygiene practice includes “prophylaxis, removing diseased crevicular tissue, application of pit and fissure sealant, fluorides, and other topical therapeutic and preventive agents, exposing and referring to oral radiographs, screening, preliminary assessment of periodontal conditions, and other closely related services as permitted by the rules and regulations of the board.” N.M. Stat. Ann. § 61-5A-4. In addition, dental hygienists with specialized training may administer local anesthesia under the indirect supervision of a dentist.

Dental hygienists “shall not perform, or attempt to perform…removal of, or addition to, hard or soft tissues of the oral cavity, placement or insertion of any permanent filling material, diagnosis and dental treatment planning, fittings, final impressions for restoration, irrigation and medication of canal, and other services defined as practice of dentistry unless exempted by regulation.” 16 NMAC 5.29.9.

May a dental hygienist operate an independent office and provide services within the scope of his/her practice?

A dental hygienist may provide services in an independent office under the collaborative practice agreement. Dentists, dental hygienists, and dental assistants may participate in the collaborative practice arrangements. 16 NMAC 5.17.2. Collaborative practice of dental hygiene is the “science of prevention and treatment of oral disease through the provision of educational, assessment, preventive, clinical and other therapeutic services… in a cooperative working relationship with a consulting dentist, but without general supervision as set forth by the rules jointly established by the Dental Hygiene Committee and the Board.” 16 NMAC 5.17.7

Collaborative Practice Agreements are required to contain protocols such as “standing orders for routine dental hygiene services, which my include prophylaxis, scaling, fluoride, preliminary assessment, and screening radiographs.” Agreements shall also include provision for case by case authorization for more extensive therapies, including
root planning, sealant application, administration of therapeutic agents and other services defined as within the scope of dental hygiene practice but which require a dentist’s diagnosis. 16 NMAC 5.17.13

The Board, based on the recommendations of the Dental Hygienists Committee certifies qualified dental hygienists for collaborative practice. A dental hygienist must meet requirements for certification, which include educational requirements, work requirements (including more than “2400 hours of active practice,” or engaged in a “total of 3,000 hours of active practice for two of past three years”), and continuing education, to be eligible for collaborative practice. 16 NMAC 5.17.8

A “collaborative practice dental hygienist may own and/or manage a dental hygiene practice, or enter into a contractual arrangement…” 16 NMAC 5.17.12 Collaborative practice dental hygienist may also work with and supervise dental assistants. 16 NMAC 5.17.14

A “collaborative practice dental hygienist shall not administer local anesthesia except under the indirect supervision of a dentist; administer a drug or medication, except those directly indicated as topical therapeutic or preventive agents…, diagnose dental disease, or perform high risk oral health procedures.” 16 NMAC 5.17.12

A “consulting dentist’ engaged in collaborative practice must maintain an active clinical general dentistry or public health practice within the State and within reasonable referral distance from the collaborative dental hygiene practice as determined by the Board…” 16 NMAC 5.17.12

3. Other Mid-Level Dental providers

Dental assistants may provide “any basic supportive dental procedure if the procedure is performed under the supervision of a licensee,” presumably both dentists and dental hygienists. Dental assistants may “place and expose radiographs, apply pit and fissure sealant rubber cup coronal polishing, and apply topical fluoride, under the indirect supervision.” 16 NMAC 5.39.9

4. May a physician provide any of the services that are defined as dental or dental hygienist services?

“Regularly licensed physicians or surgeons are not prohibited from extracting teeth or treating any disease coming within the province of the practice of medicine…” N.M. Stat. Ann. § 61-5A-5.

5. May a nurse provide any of the services that are defined as dental or dental hygienist services?

Not mentioned in the statute
6. SELECTED OTHER ELEMENTS OF STATE PRACTICE LAWS

Who serves on the state dental practice board?

“Five dentists, two dental-hygienists, and two public members” serve on the nine-member New Mexico Board of dental health care. N.M. Stat. Ann. § 61-5A-8. Dental hygienist on the board shall also be members of the dental hygienist committee and shall be elected annually to sit on the board.

“Five dental hygienists, one dentist, and one public member” serve on the seven-member New Mexico dental hygienist committee. The committee shall have the power to “regulate the examination and licensure of dental hygienists, regulate the practice of dental hygiene, grant, deny, review, suspend, and revoke licenses and certificates to practice dental hygiene…and establish continuing education or continued competency requirements for dental hygienists.” N.M. Stat. Ann. § 61-5A-10.

There are five dental hygienist districts created for the purpose of selecting members of the Board and the committee.

Is unlicensed dental or dental hygienist practice prohibited specifically?


NORTH CAROLINA

Summary:

Dental practice is defined broadly to include anyone who attempts to or claims to “diagnose, treat, operate, or prescribe for any disease, disorder, pain deformity, injury, deficiency, defect, or other physical condition of the human teeth, gums, alveolar process, jaws…and/or adjacent structures of the oral cavity.” Anyone other than a licensed dentist is prohibited from practicing dentistry in the state. Exceptions are made for dentists in hospitals, State or county health departments, health education centers, non-profit health care facilities serving low-income populations approved by the State Health Director, and State or county owned nursing homes. In addition, dentists discharged from the military, dental school faculty, and dental students or interns practicing in “Board approved settings” are also exempt from holding a valid license to practice. There is general exception for “any duly licensed physician or surgeon performing acts within the practice of his profession.” N.C. Gen. Stat. § 90-29 (c)(1)
A dental hygienists may provide “complete prophylaxis, application of preventive agents to oral structures, exposure and processing radiographs, preparation of diagnostic aids, application of medicaments…” N.C. Gen. Stat. § 90-221 Dental hygienists must be graduates of a Board-accredited school, be licensed, and “may practice only under the supervision of one or more licensed dentists.” N.C. Gen. Stat. § 90-233 (a) This applies to hygienists practicing in local health department or State government dental public health program. Supervision is defined as “acts deemed to be under supervision of a licensed dentists when performed in a locale where a licensed dentist is physically present during the performance of such acts and such acts are being performed pursuant to the dentist’s order, control and approval.” N.C. Gen. Stat. § 90-221 (f).

In addition, a dentist in a private practice may not employ more than two dental hygienists in clinical dental hygiene positions at the same time. N.C. Gen. Stat. § 90-233 (b)

1. DENTIST

What constitutes practicing dentistry?

“Any person who owns, manages, supervises, controls or conducts, either himself or by and through another person or other persons…” and attempts to “diagnose, treat, operate, or prescribe for any disease, disorder, pain deformity, injury, deficiency, defect, or other physical condition of the human teeth, gums, alveolar process, jaws…and/or adjacent structures of the oral cavity, remove stains, accretions or deposit from human teeth, extract a human tooth or teeth, performs any phase of any operation relative or incident to the replacement or restoration of all or a part of a human tooth…, correct malposition or malformation, administer an anesthetic of any kind in the treatment of dental or oral disease…, takes impression of human teeth, performs or engages in any of the clinical practices included in…dental schools or colleges” is deemed to be practicing dentistry. N.C. Gen. Stat. § 90-29

The statute generally prohibits anyone other than a licensed dentist from operating dental clinics, offices or other dental facilities. Anyone other than a licensed dentist is also prohibited from the practice of dentistry with the exceptions of dental hygienists and dental assistants practicing within their capacity, dental interns, temporary practice by a licensed dentist of another state, graduate of a accredited North Carolina dental school holding an intern permit when such person is not licensed to practice dentistry, and non-profit organizations. The Board may also issue a specialized instructor’s license to “a person who is not otherwise licensed to practice dentistry in the State, but whom the Board finds to be qualified by training or experience…” N.C. Gen. Stat. § 90-29.5

What constitutes practicing as a dental hygienist?

Practicing as a dental hygienists shall mean performing “complete prophylaxis, application of preventive agents to oral structures, exposure and processing
radiographs, preparation of diagnostic aids, application of medicaments, and written records of oral conditions for interpretation by the dentist..." N.C. Gen. Stat. § 90-221. Dental hygienists must be graduates of a Board accredited school of dental hygiene and must be licensed by the Board.

May a dental hygienist provide any services in settings other than a dental office?

A dental hygienist may practice in a local health department or State government dental public health program but under the direction of a duly licensed dentist employed by that program or by the Dental Health Section of the Department of Health and Human Services. N.C. Gen. Stat. § 90-233.

3. OTHER MID-LEVEL PROVIDERS

There are no provisions for licensing dental assistants.

4. MEDICINE

What constitutes the practice of medicine?

“Any person shall be regarded as practicing medicine or surgery...who shall diagnose or attempt to diagnose, treat, or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person.” N.C. Gen. Stat. § 90-18 (b)

May a physician provide any of the services that are defined as dental or dental hygienist services?

Dental practice provisions do apply to “any act by a duly licensed physician or surgeon performed in the practice of his profession.” . N.C. Gen. Stat. § 90-29 (C-1) Since the provision is extremely broad, and the definition for the scope of practice of medicine is equally unspecific, a physician may arguably provide preventive dental services in “Board approved” settings.

5. NURSING

May a nurse provide any of the services that are defined as dental or dental hygienist services?

No reference to nurses in statute.

6. SELECTED OTHER ELEMENTS OF STATE PRACTICE LAWS

Who serves on the state dental practice board?
The North Carolina State Board of Dental Examiners shall consist of six dentists who are licensed to practice dentistry, one dental hygienist who is licensed to practice dental hygiene, and one person shall be a citizen and resident of North Carolina who is not licensed to practice dentistry or dental hygiene. The dental hygienist and the consumer member cannot participate or vote in any matters of the Board which involves the issuance, renewal or revocation of the license to practice dentistry in the State.

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

A dentist may not employ a “person not licensed in this State to do or perform any act or service, or aid[ ] or abet[ ] or assist[ ]” any person to do or perform any act that constitutes the practice of dentistry or dental hygiene if the said person is not licensed. N.C. Gen. Stat. § 90-41 (a)(13)

NORTH DAKOTA

Summary:

The practice of dentistry includes “examination, diagnosis, treatment, repair, administration of local or general anesthetics, prescriptions, or surgery of or for any disease, disorder, deficiency, deformity, condition, lesion, injury, or pain of the human oral cavity, teeth, gingivae, and soft tissues…” N.D. Cent. Code, § 43-28-01

The statute makes qualified exemptions for physicians or surgeons and general exemptions for dental students, dental faculty, dentists in the US armed forces, the US Public Health Service, or the US Veteran’s Bureau, coast guard, or director of the dental division of the state department of health. N.D. Cent. Code, § 43-28-02

The practice of dental hygiene means the “removal of accumulated matter from natural and restored surfaces of the teeth and from restorations of the human mouth…under the direct, modified general, or general supervision of a licensed dentist.” N.D. Cent. Code, § 43-20-03

Dental assistants may render services delegated by a licensed dentist under his/her direct supervision. N.D. Cent. Code, § 43-20-12

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry includes the “examination, diagnosis, treatment, repair, administration of local or general anesthetics, prescriptions, or surgery of or for any disease, disorder, deficiency, deformity, condition, lesion, injury, or pain of the human oral cavity, teeth, gingivae, and soft tissues, and the diagnosis, surgical, and adjunctive treatment of the diseases, injuries, and defects of the upper and lower human jaw and associated structure.” N.D. Cent. Code, § 43-28-01
Dentists and dental hygienists are prohibited from practicing dentistry in North Dakota without a valid license. Any person practicing or offering to practice dentistry without having complied with the provisions of the statute will be guilty, upon conviction, of class A misdemeanor. N.D. Cent. Code, § 43-28-11.1

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene means the “removal of accumulated matter from natural and restored surfaces of the teeth and from restorations of 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 the teeth if such acts are performed under the direct, modified general, or general supervision of a licensed dentist.” N.D. Cent. Code, § 43-20-03

• “General Supervision may be utilized if: the patient has been examined by the dentist in 12 months prior to the examination by the hygienist; the patient is being treated at the primary location of the supervising dentist, a public health setting, a hospital, a long-term care facility, or an institutionalized setting.” N.D. Cent. Code, § 43-20-03

• Direct Supervision means that a dentist is physically present in the dental office, has diagnosed the condition to be treated, has authorized the procedure to be performed, and before dismissal of the patient, has approved the work to be performed by the hygienist.

• Indirect Supervision means that a dentist is physically present in the dental office, has diagnosed the condition to be treated, and has authorized the procedure to be performed.

In order to practice dental hygiene in North Dakota, hygienists must be licensed by the state board. To qualify for a license, applicants must: file an application with the board, graduate from an accredited high school, graduate from an accredited dental hygiene program which provides a minimum of two years of academic curriculum, and pass dental hygiene examinations administered by the Board. N.D. Cent. Code, § 43-20-02

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may render services delegated by a licensed dentist under his/her direct supervision. N.D. Cent. Code, § 43-20-12
4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The provisions of the [dental practice laws] do not apply to “legally qualified and licensed physicians, surgeons and other practitioners authorized by law, who perform any act defined herein as the practice of dentistry in emergency cases.” N.D. Cent. Code, § 43-28-02

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the dental board?

The state dental board consists of seven members appointed by the governor. Five of the members are dentists, one member is a dental hygienist, and one is a consumer member. Members are appointed to the Board for a five-year term. N.D. Cent. Code, § 43-28-03

Is facilitating unlicensed practice prohibited specifically?

It is unlawful and considered a class A misdemeanor for “any dentist to help or assist any unlicensed person to perform any act or operation which is defined…as the practice of dentistry.” N.D. Cent. Code, § 43-28-25

OHIO

Summary:

Any person is regarded as practicing dentistry who “is a manager, proprietor, operator…of a place for performing dental operations, who performs…dental operations of any kind, diagnoses or treats diseases or lesions of the human teeth or jaws, or associated structures…” ORC Ann. 4715.01

The statute makes general exemptions for physicians, dental students, dental faculty, dentists of other states countries conducting clinical demonstrations before duly authorized dental or medical society, dental surgeon of the US armed forces, Public Health Service, or Veteran’s Administration. ORC Ann. 4715.34
Dental hygienists must practice under the supervision, order, control, and full responsibility of a dentist. The practice of a dental hygienist includes “prophylactic, preventive, and other procedures that licensed dentists...assign to dental hygienists.” These also may include intraoral tasks. ORC Ann. 4715.22

Dental assistants may perform services only under the direct supervision of a dentist licensed under the provisions of this [statute]. ORC Ann. 4715.01

1. DENTIST

What constitutes practicing dentistry?

Any person is regarded as practicing dentistry who “is a manager, proprietor, operator, or conductor of a place for performing dental operations, who teaches clinical dentistry, who performs, or advertises to perform dental operations of any kind, who diagnoses or treats diseases or lesions of the human teeth or jaws, or associated structures or attempts to correct malpositions thereof, or who takes impressions of the human teeth or jaws, or who constructs, supplies, reproduces...prosthetic dentures...” ORC Ann. 4715.01

It is unlawful for any person to practice dentistry or dental hygiene without a current and valid license. ORC Ann. 4715.09 It is also unlawful for a dental corporation or business providing dental services to employ a person not licensed to practice dentistry. ORC Ann. 4715.19

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

Dental hygienists must practice under the supervision, order, control, and full responsibility of a dentist. The practice of a dental hygienist includes “prophylactic, preventive, and other procedures that licensed dentists...assign to dental hygienists.” These also may include intraoral tasks and performance of such tasks must by under the general supervision and full responsibility of a dentist. ORC Ann. 4715.22

Dental hygienists may practice in hospitals, dental office, public or private school, health care facility, dispensary, or public institution. A dental hygienist may not provide dental hygiene services to a patient when the supervising dentist is not physically present at the location where the dental hygienist is practicing, except for services provided at a health care facility, services provided under a physician, and services provided under a dental hygiene program. ORC Ann. 4715.22

“ A dental hygienist may provide, for not more than fifteen consecutive business days, dental hygiene services to a patient” without the direct or indirect supervision of a licensed dentist. The hygienist must fulfill the following requirements: has at least two years or minimum 3000 hours of experience in the practice of dental hygiene, has
successfully completed a course approved by the state dental board, complies with written protocols for emergencies the supervising dentist establishes, the supervising dentist has examined the patient not more than seven months prior to the dental hygienist providing services, the supervising dentist completed and evaluated a medical and dental history of the patient not more than one year prior to the date the dental hygienist provides services, and if the dental hygienist services are provided in the health care facility, they are under the supervision of a doctor of medicine and surgery or osteopathic medicine and surgery who holds a current certificate. ORC Ann. 4715.22(C)

In order to provide services without the direct or indirect supervision, the hygienist must be employed by a dentist or be under the general supervision of a dentist.

- **General supervision** means a dentist authorizes the procedure, but the need not dentist be present when the authorized procedures are being performed.

- **Direct supervision** means a dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedure, and remains in the dental office or treatment facility while the procedure is being performed, and before the dismissal of the patient, evaluates the work performed.

In order to practice dental hygiene in Ohio, dental hygienists must be licensed and registered by the state Board. To qualify for a license as a dental hygienist, applicants must: file an application, be at least 18 years of age and be US citizens or legal residents, graduate from an accredited dental hygiene program and pass dental hygiene examinations administered by the Board. ORC Ann. 4715.28

3. OTHER MID-LEVEL PROVIDERS

**Dental Assistants**

Dental assistants may perform services only under the direct supervision of a dentist licensed under the provisions of this [statute]. ORC Ann. 4715.01

The specific scope of services for dental assistants is undefined in the statute.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide dental or dental hygiene services. The provisions of the [statute] “do not apply to a legally qualified physician or surgeon unless he practices dentistry as a specialty” ORC Ann. 4715.34
5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

It is unlawful for any dentist or dental hygienist to employ or permit a person to practice dentistry or dental hygiene who is not licensed under the provisions of this [statute]. ORC Ann. 4715.19

Who is on the Board of Dentistry?

The State dental board consists of seven persons, five dentists who have been practicing dentistry for a minimum of five years immediately preceding the appointment, one dental hygienist actively engaged in the practice of dental hygiene for at least five years immediately preceding the appointment, and one member of the public at large who is not associated with or financially interested in the practice of dentistry. All members are appointed by the Governor, with the advice and consent of the senate, for a five year term. ORC Ann. 4715.02

OKLAHOMA

Summary:

A person who is engaged in “treating or professing to treat…any of the diseases or disorders or lesions of the oral cavity, teeth, gums, maxillary bones, and associate structures, removing human teeth, correcting or attempting to correct malposed teeth, treating deformities of the jaws and adjacent structures…” will be deemed to be practicing dentistry. 59 Okl. St. § 328.19

The statute makes general exemptions for physicians or surgeons, dental students, dental faculty, dentists in the US armed forces, Coast Guard, US Public Health Services, or the US Veteran’s Administration, and dentists of other states making clinical demonstrations before a regularly organized dental or medical society or group, rendering services as public services. 59 Okl. St. § 328.19

Dental hygienists may remove deposits, accretions, and stains exposed surfaces of human teeth…, give topical caries prevention treatment to the extracoronal surfaces of the teeth… under the direct supervision of a licensed dentist. 59 Okl. St. § 328.34

Dental hygienists may practice only in the office of a dentist, or in hospitals under the direct supervision of dentists; provided, Board of Education or any organized health service my employ registered dentists whose services shall be limited to the
examination of teeth and teaching of dental hygiene or as otherwise authorized by the Board of Governors.

Dental assistants may provide supportive services under the direct supervision of a licensed dentist. Specific scope of these services are not defined. 59 Okl. St. § 328.3

1. DENTIST

What constitutes practicing dentistry?

A person who is engaged in “treating or professing to treat…any of the diseases or disorders or lesions of the oral cavity, teeth, gums, maxillary bones, and associated structures, removing human teeth, repairing or filling cavities in human teeth, administering anesthetics, correcting or attempting to correct malposed teeth, treating deformities of the jaws and adjacent structures, offering or undertaking, by any means or methods, to remove stains, discoloration, or any physical condition connected with the human mouth, taking impressions of the human teeth or jaws…” will be deemed to be practicing dentistry. 59 Okl. St. § 328.219

The practice of dentistry, dental hygiene, or professional entities including dental corporations without a valid Oklahoma license, except for those exempted, is prohibited. 59 Okl. St. § 328.31

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

Dental hygienists may remove deposits, accretions, and stains exposed surfaces of human teeth, and directly beneath the margin of the gum, give topical caries prevention treatment to the extracoronal surfaces of the teeth, take x-rays pertaining to the field of dentistry and may perform other acts in accordance with the rules prescribed by the Board of Governors. 59 Okl. St. § 328.34

Dental hygienists may practice only in the office of a dentist, or in hospitals under the direct supervision of dentists; provided, Board of Education or any organized health service may employ registered dentists whose services shall be limited to the examination of teeth and teaching of dental hygiene or as otherwise authorized by the Board of Governors.

In order to practice dental hygiene in Oklahoma, hygienists must be licensed or by the state Board. To qualify for a license as a dental hygienist, applicants must: graduate from an accredited dental hygiene program and pass dental hygiene examinations administered by the Board. 59 Okl. St. § 328.35
3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants, “under the dentists supervision” may perform “treatment of patients in accordance with the State Dental Act; the dental assistant may assist the dentist with the patient, provided, this shall be done only under the direct supervision and control of the dentist and only in accordance with the educational requirements and rules promulgated by the Board.” 59 Okl. St. § 328.3

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

Nothing in the Dental Act shall be construed as to prevent “physicians or surgeons, who are licensed under the laws of [Oklahoma], from administering any kind of treatment coming within the province of medicine or surgery.  59 Okl. St. § 328.19

5. NURSING

Dental nurses may provide supportive services only under the “direct supervision” of a licensed dentist.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

It is unlawful for a dentist or dental hygienist to aiding or abetting an unlicensed person to practice dentistry or dental hygiene in [Oklahoma].  59 Okl. St. § 328.32

Who serves on the dental board?

The Board consist of eight dentist members, one dental hygienist member and two members of the general public. Each dentist member is elected by dentists residing in the eight geographical districts established by the Board. The dental hygienist member is elected by dental hygienists licensed, residing, and practicing in Oklahoma. 59 Okl. St. § 328.7
OREGON

Summary:

The practice of dentistry means “the healing art which is concerned with the examination, diagnosis, treatment planning treatment care and prevention of conditions within the human oral cavity and maxillofacial region and condition of adjacent or related tissues and structures. “The practice of dentistry includes, but is not limited to the cutting, altering, repairing, removing, replacing or repositioning of hard or soft tissues and other acts or procedures as determined by the board and included in the curricula of dental schools... ” ORS. § 679.010

The statute makes exemptions for physicians, dental students, dental faculty, and dentists of other states making clinical demonstrations before a regularly organized dental or medical society or group, dentists practicing in the discharge of their official duty in the US Government and any of its agencies, dentists employed in the public health agencies who are not engaged in the direct delivery of clinical dental services to patients, and persons qualified to perform services relating to general anesthesia. ORS. § 679.025

The practice of dental hygiene includes “rendering of educational, preventive and therapeutic dental services in general, but specifically, scaling, root planing, curettage and any related intraoral or extraoral procedure required in the performance of such services. ORS. § 679.010(4) Dental hygienists may work under the general supervision of a licensed dentist in a dentist’ office, in any public institution, health care facility and/or HMO. ORS. § 679.150

Dental assistants may provide supportive services under the direct or indirect supervision of a licensed dentist or dental hygienist. ORS. § 679.010

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry means “the healing art which is concerned with the examination, diagnosis, treatment planning treatment care and prevention of conditions within the human oral cavity and maxillofacial region and condition of adjacent or related tissues and structures. The practice of dentistry includes, but is not limited to the cutting, altering, repairing, removing, replacing or repositioning of hard or soft tissues and other acts or procedures as determined by the board and included in the curricula of dental schools... ” ORS. § 679.010

No person shall practice of dentistry or dental hygiene, or own a office, dental corporation or place where dental services are rendered without a valid Oregon license. ORS. § 679.020
2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene includes “rendering of educational, preventive and therapeutic dental services in general, but specifically, scaling, root planing, curettage and any related intraoral or extraoral procedure required in the performance of such services. ORS. § 679.010(4)

- **General supervision** means “supervision requiring that a dentist authorize the procedure, but not requiring that a dentist be present when the authorized procedures are being performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.”
- **Direct supervision** means “supervision requiring that a dentist diagnose the condition to be treated, authorize the procedure, and the dentist remain in the dental treatment room while the procedures are being performed.”
- **Indirect supervision** means “supervision requiring that a dentist authorize the procedure and the dentist be on the premise while the procedures are being performed.” ORS. § 679.010

Dental hygienists may work under the **general supervision** of a licensed dentist in a dentist’s office, in any public institution, health care facility and/or HMO.

Dental hygienists are authorized to work without supervision in places where limited access patients are located. Hygienist may render all services within the scope of their practice by the limited access permit, to patients or residents of the following facilities or programs: nursing homes, adult foster homes, residential care facilities, adult congregate living facilities, and mental health residential programs. ORS. § 679.205

However, dental hygienists may not provide the following services under a limited access permit: administration of local anesthesia, providing sealants, denture soft lines, temporary restorations and radiographs except under the **general supervision** of a licensed dentist. Dental hygienists also may not administer nitrous oxide except under the **indirect supervision** of a licensed dentist. ORS. § 679.205

In order to practice dental hygiene in Oregon, dental hygienists must be licensed by the state Board. To qualify for a license, applicants must: file an application with the board, be 18 years of age or older, graduate from an accredited dental hygiene program, and pass dental hygiene examinations administered by the Board. ORS. § 679.040

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may provide supportive services under the **direct or indirect supervision** of a licensed dentist or dental hygienist. ORS. § 679.010
4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide any of the services that are defined as dental or dental hygiene services. Exceptions are made for any “person licensed to practice medicine in the state of Oregon in the regular discharge of their duties.” ORS. § 679.025

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

It is unlawful for a person to “employ or use services of any unlicensed person, to practice dentistry or dental hygiene, except as permitted by the statute.” ORS. § 679.170

PENNSYLVANIA

Summary:

Any person who “diagnoses, treats, operates on, or prescribes for any disease, pain or injury, or regulates deformity of physical condition, of the human teeth, jaws, or associated structures, or conducts a physical evaluation, or administers anesthetic agents, or uses ionizing radiation in the course of dental practice…is engaged in the practice of dentistry. 63 P.S. § 121

The statute makes qualified exemptions for physicians in emergency cases. The statute generally exempts dental students, dental faculty, and dentists of other states and countries, for the limited purpose of consultation with respect to any case under treatment in [Pennsylvania], or demonstrating before duly authorized society, dentists practicing in the discharge of their official duty in the US armed forces, and dentists employed in the public health agencies. 63 P.S. § 121

A legally licensed dental hygienist may “perform educational, preventive, and therapeutic services and intra oral procedures…under the supervision of a licensed dentist…in office of a dentist or public or private institution such as schools, hospitals, orphanages, and sanitoria or State health cars.” 63 P.S. § 121
Expanded function dental assistants, who hold a current valid certification under the Pennsylvania Dental Practice statute may perform “reversible intra-oral procedures…under the direct supervision of a licensed dentist and under an assignment of duties by a dentist…” 63 P.S. § 121

1. DENTIST

What constitutes practicing dentistry?

Any person who “diagnoses, treats, operates on, or prescribes for any disease, pain or injury, or regulates deformity of physical condition, of the human teeth, jaws, or associated structures, or conducts a physical evaluation, or administers anesthetic agents, or uses ionizing radiation in the course of dental practice, or who fits, constructs, and inserts any artificial appliance, plate, or denture for the human teeth or jaws, or who holds himself or herself out as being able or legally authorized to do so is engaged in the practice of dentistry.” 63 P.S. § 121

It is unlawful for any person to practice dentistry, dental hygiene, or dental assisting without a valid license or (valid certificate, in the case of expanded function dental assistant), except for those exempted. 63 P.S. § 129 Persons violating this provision shall be guilty of misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine or to “suffer imprisonment.” 63 P.S. § 129

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

A legally licensed dental hygienist may “perform educational, preventive, and therapeutic services and intra oral procedures which hygienists have been educated to perform and which require their professional competence and skill…under the supervision of a licensed dentist…in office of a dentist or public or private institution such as schools, hospitals, orphanages, and santoria or State health cars.” 63 P.S. § 121

• General supervision means “a dentist authorizes the procedure, but the need not dentist be present when the authorized procedures are being performed.

• Direct supervision means “a dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedure, and remains in the dental office or treatment facility while the procedure is being performed, and before the dismissal of the patient, evaluates the work performed.

Dental hygienists may not be authorized to perform “diagno[sis], treatment planning and writing prescriptions for drugs…for restorative, prosthetic, or orthodontic appliances.” 63 P.S. § 121
In order to practice dental hygiene in Pennsylvania, dental hygienists must be licensed and registered by the state Board. To qualify for a license, applicants must: graduate from an accredited dental hygiene program and pass dental hygiene examinations administered by the Board. 63 P.S. § 121

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Expanded function dental assistants, who hold a current valid certification under the Pennsylvania Dental Practice statute may perform “reversible intra-oral procedures…under the direct supervision of a licensed dentist and under an assignment of duties by a dentist…” Such procedures include, but are not limited to “placing and removing rubber dams and matrices, placing and contouring amalgam and other restorative materials and other reversible procedures not designated by this act to be performed only by licensed dentists or dental hygienists.” 63 P.S. § 121

Expanded function dental assistants may not perform “complete or limited examination, diagnosis or treatment planning, surgical or cutting procedures of hard or soft tissue, prescribing drugs, medicaments or work authorizations, taking impressions…, final inspection…, performing pulp capping…, placement and intraoral adjustments of prosthetic appliances, and administration of local anesthesia.” 63 P.S. § 121

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide certain dental services in emergency cases. The statute does not prohibit “the extracting of teeth or relieving pain by a licensed physician or surgeon in emergencies, or the making of application for such purposes.” 63 P.S. § 121

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may refuse, revoke, or suspend the license of any dentist or dental hygienist who found to be “knowingly aiding, assisting, procuring or advising any unlicensed person to practice dentistry or dental hygiene or uncertified person for expanded
function of dental assisting contrary to this [statute] or regulations of the Board.” 63 P.S. § 13.1

Who is on the Board of Dentistry?

The State Board of Dentistry consists of Secretary of Health or his designee, the Director of the Bureau of Consumer Protection in the office of the Attorney General, or his designee, the Commissioner of Professional and Occupational Affairs and ten additional members (who are appointed by the Governor with the advice and consent of a majority of the members elected to the Senate). Two of these members are from the general public, seven members are licensed dentists engaged in the practice of dentistry in Pennsylvania for a minimum of ten years immediately preceding their appointment to the Board, and one member is a licensed dental hygienist engaged in the practice of dentistry for at least three years immediately preceding his/her appointment to the Board. All members appointed for a six year term. 63 P.S. § 121.1

RHODE ISLAND

Summary:

The practice of dentistry is defined as the “evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders, and/or conditions of the oral cavity, cranio-maxillofacial area and/or the adjacent and associated structures and their impact on the human body, provided by a dentist, within the scope of his/her education, training, and experience…” R.I. Gen. Laws §5-31.1-1

The statute makes general exemptions for physicians, dental students, dental hygiene students, dental faculty, dentists in the US armed forces, the public health agencies, and dentists of other states countries conducting clinical demonstrations before duly authorized dental or medical society. R.I. Gen. Laws §5-31.1-7

Licensed dental hygienist may provide services under the general supervision of a licensed and registered dentist in public institution or school authority and in the office of a licensed dentist. R.I. Gen. Laws §5-31.1-33 Services provided by dental hygienists are not defined specifically.

Dental assistants may perform “dental services, procedures, or duties in aid of a licensed and registered dentist under the authorization and supervision of a licensed and registered dentist.” R.I. Gen. Laws §5-31.1-31

1. DENTIST

What constitutes practicing dentistry?
The practice of dentistry is defined as the “evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders, and/or conditions of the oral cavity, cranio-maxillofacial area and/or the adjacent and associated structures and their impact on the human body, provided by a dentist, within the scope of his/her education, training, and experience, in accordance with the ethics of the profession and applicable by law.” R.I. Gen. Laws §5-31.1-1

Specifically, any person who "owns, leases, maintains, operates a dental business in any office…where dental operations are performed, who directly or indirectly, for profit, or otherwise…diagnoses…, treats…, prescribes for…any of the lesions, disease, disorders, or deficiencies of the human oral cavity, teeth, gums, maxilla or mandible, and/or adjacent associated structures, extracts human teeth, corrects malpositions…, takes impressions, places substitutes in mouth…, administers anesthesia…” is engaged in the practice of dentistry. R.I. Gen. Laws §5-31.1-1(III)

It is unlawful for any person to practice dentistry, dental hygiene, or own a place where dental services are rendered without a valid license. R.I. Gen. Laws §5-31.1-6 “Any person who violates this provision…shall upon conviction, be punished by fine…or by imprisonment.” R.I. Gen. Laws §5-31.1-24

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

Any person is said to be practicing dental hygiene whose “activities are confined to performing those services and procedures that the dental hygienist has been educated to perform.” Licensed dental hygienist may provide services under the general supervision of a licensed and registered dentist in public institution or school authority and in the office of a licensed dentist. R.I. Gen. Laws §5-31.1-33

- **General supervision** means a dentist authorizes procedures, but is not required to be present when the procedures are being performed.

- **Direct supervision** means a dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedure, remains in the dental office or treatment facility while the procedure is being performed, and before the dismissal of the patient, evaluates the work performed.

Dental hygienists may not be authorized to perform "diagnosis, treatment planning, surgical procedures on soft or hard tissues, prescribe medications, or administer injectibles and/or general anesthesia. R.I. Gen. Laws §5-31.1-33

In order to practice dental hygiene in Rhode Island, dental hygienists must be licensed and registered by the state Board. To qualify for a license as a dental hygienist,
applicants must: graduate from an accredited dental hygiene program and pass dental hygiene examinations administered by the Board. R.I. Gen. Laws §5-31.1-33

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may perform “dental services, procedures, or duties in aid of a unlicensed and registered dentist under the authorization and supervision of a licensed and registered dentist.” R.I. Gen. Laws §5-31.1-31

Dental assistants may not perform: “diagnosis and treatment planning, surgical procedures on hard or soft tissues, prescribe medication, or administer injectible and/or general anesthesia. Dental assistants may perform “dental services, procedures, or duties in aid of a licensed and registered dentist under the authorization and supervision of a licensed and registered dentist. R.I. Gen. Laws §5-31.1-31

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide dental or dental hygiene services. The practice of “physicians in the regular discharge of their duties” is exempt from the Dental Practice Laws. R.I. Gen. Laws §5-31.1-37(1)

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

It is unlawful for any dentist or dental hygienist to be knowingly aid or assist any unlicensed person to practice dentistry or dental hygiene. R.I. Gen. Laws §5-31.1-10

Who is on the Board of Dentistry?

The State Board of Dentistry consists of Secretary of Health or his designee, the Director of the Bureau of Consumer Protection in the office of the Attorney General, or his designee, the Commissioner of Professional and Occupational Affairs and ten additional members (who are appointed by the Governor with the advice and consent of a majority of the members elected to the Senate). Two of these members are from the
general public, seven members are licensed dentists engaged in the practice of dentistry in Pennsylvania for a minimum of ten years immediately preceding their appointment to the Board, and one member is a licensed dental hygienist engaged in the practice of dentistry for at least three years immediately preceding his/her appointment to the Board. All members appointed for a six year term. 63 P.S. § 121.1

SOUTH CAROLINA

Summary:

Dental practice is defined broadly to include "diagnosing and treating disease, lesions or conditions of the oral cavity and associated adjacent structures" or anything in the curriculum of an accredited dental college. There is an unqualified general exception for physicians, which appears to allow them to perform any "dental" procedure allowed by their medical licenses.

A dental hygienist may provide "preventive services" including specifically prophylaxis and scaling, application of sealants, application of topical fluoride, examining teeth (for diagnosis by the dentist) and other procedures delegated by a dentist under the general supervision of a dentist. In schools, dental hygienists may provide the aforementioned preventive services under the general supervision of a dentist, with written permission of the student’s parent or guardian. In hospitals, nursing homes, long term care facilities, rural and community clinics, or government health facilities hygienists may provide preventive services including screening, counseling, and fluoride and sealant applications under the general supervision of a dentist. Treatment may not occur in these settings unless medical emergency care in available in the facility.

General Supervision means “a licensed dentist or the South Carolina Department of Health and Environmental Control’s public health dentist has authorized the procedures to be performed but does not require that a dentist be present when the procedures are being performed.”

Dental hygienists may not provide any services in a dental office under the general supervision of a licensed dentist. All services performed by dental hygienists in a dentist’s office must be under direct supervision.

Direct Supervision means “a dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and before the dismissal of the patient, evaluates the performance of the hygienist or dental assistant. Such requirement does not mandate that the dentist be present at all times, but he or she must be on the premises and actually involved in the supervision and control.

Dentists and hygienists may also provide charitable care under restricted licenses.
Dental assistants (certified and expanded duty) may provide certain preventive care under direct supervision of a dentist, on the premises at the time the service is performed. Under "restricted volunteer licenses," dentists and hygienists may provide charity care in clinics.

1. DENTIST

What constitutes practicing dentistry? “A person is practicing dentistry who:....shall diagnose or treat or profess to diagnose or treat any diseases or lesions or conditions of the oral cavity and associated adjacent structures; or...do any practice included in the curricula of dental colleges accredited by the Commission on Dental Accreditation, or administer...drugs or therapy utilized in the treatment of dental or oral diseases...” S C Code Ann §40-15-70 (2)(b),(c)

Under a “restricted volunteer license,” a dentist may practice “in clinics prescribed by the board in regulation;” but may not treat any patients except those who are uninsured or ineligible for “financial assistance for dental treatment.” The volunteer dentist may not receive direct or indirect “remuneration” and must review all patient cases, every thirty days, with “a local licensed dentist...” S C Code Ann §40-15-177

2. DENTAL HYGIENIST

What constitutes practicing as a dental hygienist? “Any person is considered to be practicing dental hygiene who engages in those clinical procedures primarily concerned with the performance of preventive dental services not constituting the practice of dentistry, including removing all hard and soft deposits and stains from the surfaces of the human teeth, performing clinical examination of teeth and surrounding tissues for diagnosis by the dentist, and performing such other procedures, under the supervision of a licensed dentist, as may be delegated by regulations of the board...” S C Code Ann §40-15-80(A) In general a dental hygienist may provide oral prophylaxis, which includes “removal of any and/or all hard and soft deposits, accretions, toxins, and stain from any natural or restored surfaces of primary, transitional, and/or permanent teeth by scaling and polishing as a preventive measure...” S.C. Code Ann §40-15-85 A hygienist may also “perform other duties authorized by regulations” and all procedures allowed for mid-level dental practitioners. S C Code Ann §§40-15-110, 39-14.

May a dental hygienist provide any services in settings other than a dental office? Yes. “...In school settings [and also at facilities owned or operated by the federal, state or local government, and in nursing home facilities], a licensed dental hygienist may provide oral hygiene instruction and counseling, perform oral screenings, provide nutrition and dietary counseling, and apply topical fluoride under the general supervision of a dentist. Hygienists may also provide prophylaxis and apply sealants under two conditions. First, students must have written permission of their parents or guardians; and second, a dentist who "employ[s] or supervise[s]" the hygienist must have
examined the student or other patient and authorized the procedure[s] in advance. The authorization and examination must have been performed within the preceding 45 days. Also the services may not be authorized for "active patient[s]" of other dentists. S C Code Ann §§40-15-80(B),(D)

"...dental hygienists employed within the public health system may provide education and "reversible, noninvasive" "primary preventive care" and education. Primary preventive care is "promotion and protection of health to avoid occurrence of disease through community wide and individual measures or improvements in lifestyle. These services are to be performed under the "direction and control" of the State Director of Public Health Dentistry but he or she need not be present at the time care is provided. Before a sealant is placed, there must be an examination and diagnosis by a dentist but only if a dentist is "available." SC Code Ann §40-15-110(c)

Under a “restricted volunteer license,” a hygienist may practice “in clinics prescribed by the board in regulation;” but may not treat any patients except those who are uninsured or ineligible for “financial assistance for dental treatment.” In addition, the hygienist may not receive direct or indirect "remuneration" and he or she may practice “only under the direct supervision of a ...dentist.” S C Code Ann §40-15-177

3. OTHER MID-LEVEL DENTAL PRACTITIONERS

A certified dental assistant is not required to have “formal academic dental training” and may perform certain procedures, specified by regulation, under the “direct supervision of a dentist present on the premises...” These procedures include “[a]pply[ing] topical drugs as prescribed by the dentist and certain other procedures that are not primary preventive oral health care. S C. Code Regs 39-12.

"Certified dental assistants employed within the public health system may assist in public health program activities as authorized by the State director of Public Health Dentistry.” As with public health hygienists, the assistants are under “direction and control of the State Director of Public Health Dentistry” but this official does not have to be present. As with hygienists, the public health dental assistants may perform “other duties” permitted by regulations. S C Code Ann §40-15-110

An "expanded duty dental assistant" has either graduated from an accredited dental assisting program or completed two years of “continuous, full-time employment as a chairside dental assistant.” The expanded assistant may apply “pit and fissure sealant” as well as other non-preventive procedures and assistant procedures and must practice under “the direct supervision of a dentist present on the premises...” S.C. Code Regs 39-13.

"...Unlicensed personnel in a dental office may perform those tasks as authorized by the board and for which minimal training standards and qualifications are established by
regulation. All tasks permitted to be performed by other than licensed personnel must be under the direct supervision of a dentist present on the premises...” §40-15-110

‘...direct supervision’ means that the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and before dismissal of the patient, evaluates the performance of the dental auxiliary....[the dentist does not have to be] present at all times but he must be on the premises actually involved in supervision and control.” S C Code Ann §40-15-85.

CHECK: 99 ALR 2D 654 Practicing medicine, surgery, dentistry, optometry, podiatry, or other healing arts without license as a continuing or separate offense.

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygienist services? Yes. “Nothing in [the dental practice] chapter may be construed to prevent the practice of medicine by a licensed physician..."[or to prevent “ U.S. military, Veterans' Administration or Public Health dental or medical officers from performing their “official duties.”] S C Code Ann §40-15-110.

5. NURSING

6. SELECTED OTHER ELEMENTS OF STATE PRACTICE LAWS

Who serves on the state board of dentistry? One lay member and one dentist from the state at large, six dentists, one each from the state’s Congressional districts and one dental hygienist. The at large lay and dentist members are appointed by the governor; the Congressional district dentist members are recommended by the board for appointment by the governor, the hygienist is nominated by election, for appointment by the governor. S C Code Ann §40-15-20.

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically? Yes. A dentist or a hygienist may be disciplined for employing or allowing an “unlicensed or unregistered person to practice dentistry or dental hygiene...” S C Code Ann §40-15-190(A)(4). Also, a "person" who “aid[s] or abet[s] anyone to practice dentistry or hygiene “in violation” of the dental practice chapter is subject to fine of up to $1,000 or prison sentences of up to 2 years or both. “Each day a violation occurs is a separate offense.” S C Code Ann §40-15-212
SOUTH DAKOTA

Summary:

The practice of dentistry is broadly defined as the “healing art which is concerned with the examination, diagnosis, treatment, planning, and care of conditions within the human oral cavity and its adjacent tissues and structures…” S.D. Codified Laws § 36-6A-26

The statute does not specifically state exemptions for physicians or surgeons. The statute makes general exemptions for dental students, dental faculty, dentists licensed in another state making a clinical presentation sponsored by a dental society or association, dentists in the US armed forces, the US Public Health Service, or the US Veteran’s Bureau. S.D. Codified Laws § 36-6A-33

The statute also exempts those providing dental services for patients under the “auspices of a community-based primary health care delivery organization.” S.D. Codified Laws § 36-6A-32.1

The practice of dental hygiene means the rendering of “educational, preventive, and therapeutic dental services, as well as any related extra-oral procedures required in the practice of those services” under the general, direct, or indirect supervision of a dentist. S.D. Codified Laws § 36-6A-26

Dental assistants may “under the direct or indirect supervision of a dentist or dental hygienist, render assistance to a dentist, dental hygienist, or dental technician.” S.D. Codified Laws § 36-6A-26

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry is broadly defined as the “healing art which is concerned with the examination, diagnosis, treatment, planning, and care of conditions within the human oral cavity and its adjacent tissues and structures…, to operate for any disease, pain, deformity, deficiency, injury, or physical condition of the human tooth, teeth, alveolar process, gums, or jaw or adjacent or associated structure.” S.D. Codified Laws § 36-6A-26

In addition, any person who “is a manager, proprietor, operator or conductor of a place where dental operations are performed, extracts a human tooth or corrects or attempts to correct malpositions of human teeth or jaws, diagnoses, treats, or removes stains or accretions from the human teeth or jaws, takes impressions of human teeth…” will also be deemed to be engaged in the practice of dentistry. S.D. Codified Laws § 36-6A-32

Dentists and dental hygienists are prohibited from practicing dentistry in South Dakota without a valid license. Any person practicing or offering to practice dentistry without...
having complied with the provisions of the statute will be guilty, upon conviction, of class 1 misdemeanor. S.D. Codified Laws § 36-6A-28

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

A dental hygienist may provide “educational, preventive, and therapeutic dental services, as well as any related extra-oral procedures” under the supervision of dentist. S.D. Codified Laws § 36-6A-26

- **General Supervision:** “supervision of a dental hygienist requiring that a dentist authorize the procedures to be carried out, and that the patient to be treated is a patient of record of the supervising dentist and has had a complete evaluation within the previous six months of the delegation of procedures.” S.D. Codified Laws § 36-6A-26

- **Direct Supervision:** supervision of a dental hygienist or dental assistant requiring that a dentist diagnose the condition to be treated, authorize the procedure to be performed, remain in the dental office while the procedures are performed, and before dismissal of the patient, approve the work performed.

- **Indirect Supervision:** the supervision of a dental hygienist or dental assistant requiring that a dentist has diagnosed the condition to be treated, has authorized the procedure to be performed and is physically present in the dental office.

Dental hygienists may practice in the office of a licensed dentist, public institution, or school authority. A dental hygienist may provide only educational services without the supervision of a licensed dentist in a public institution or school authority. All preventive and therapeutic services must be performed under the general supervision of a licensed dentist. S.D. Codified Laws § 36-6A-40

In order to practice dental hygiene in South Dakota, the state board must license hygienists. To qualify for a license, applicants must: file an application with the board, graduate from an accredited high school, graduate from an accredited dental hygiene program which provides a minimum of two years of academic curriculum, and pass dental hygiene examinations administered by the board. S.D. Codified Laws § 36-6A-44

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may “under the direct or indirect supervision of a dentist or dental hygienist, render assistance to a dentist, dental hygienist, or dental technician.” S.D. Codified Laws § 36-6A-26
The board will establish minimum educational and training requirements to perform as a dental assistant. The board may also require, or substitute, clinical experience in addition to or, or in lieu of, educational and training requirements. S.D. Codified Laws § 36-6A-42

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The statute does not make specific references to physicians or surgeons.

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the dental board?

The state board of dentistry consists of seven members appointed by the governor. Five of the members are dentists engaged in active practice in South Dakota for at least five years immediately preceding their appointment. One member is a dental hygienist in active practice for at least five years preceding appointment and one is a lay person who is a resident of South Dakota for at least five years. Members are appointed to the Board for a five-year term. S.D. Codified Laws § 36-6A-1

Is facilitating unlicensed practice prohibited specifically?

It is unlawful for any dentist to employ, assist, or enable, an unlicensed person to practice dentistry, dental hygiene. S.D. Codified Laws § 36-6A-59

TENNESSEE

Summary:

Any person is deemed to be practicing dentistry who “diagnoses, prescribes for or treats any disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws, or associated structures and such diagnosis and treatment may include the use of a complete or limited physical evaluation of the patients by a board eligible or board certified oral surgeon…” Tenn. Code Ann. § 63-5-108

The statute makes broad general exemptions for physicians or surgeons, dental students, dental faculty, dentists from other states or countries at meetings of the
Tennessee Dental Association or Pan Tennessee Dental Association, dentists of other states who are called into Tennessee for consultative or operative purposes if the Board or its designee gives discretionary approval, registered nurse anesthetists, and dentists in the US armed forces, the US Public Health Service, or the US Veteran’s Bureau. Tenn. Code Ann. § 63-5-109

Licensed and registered dental hygienists are “specifically permitted to participate unsupervised in educational functions involving organized groups or health care institutions regarding preventive oral health care.” Dental hygienists are permitted to participate in health screenings and similar activities; provided that no remuneration is given by the organized group to any hygienist or the hygienist’s employer for participating in these activities. Tenn. Code Ann. § 63-5-115(c)

Dental assistants may practice only in the office of a licensed dentist under his/her direct supervision, except in authorized public health programs. Tenn. Code Ann. § 63-5-115

1. DENTIST

What constitutes practicing dentistry?

Any person is deemed to be practicing dentistry who “diagnoses, prescribes for or treats any disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws, or associated structures and such diagnosis and treatment may include the use of a complete or limited physical evaluation of the patient,” “who extracts human teeth, repairs or fills human teeth, corrects malformations of human teeth or of the jaws, perform any oral surgery, takes impression of human teeth or jaws…, furnishes or supplies…prosthetic dentures…, interprets radiographs, and administers anesthetics.” Tenn. Code Ann. § 63-5-108

It is unlawful for any person to practice dentistry, a dental specialty, or dental hygiene in Tennessee without a valid license or without being registered. Tenn. Code Ann. § 63-5-107 The Board may invoke monetary penalties for any individual practicing dentistry without a valid license. Tenn. Code Ann. § 63-5-116 Any person who violates licensure provisions of this statute in a second offense may be guilty of class A misdemeanor. Tenn. Code Ann. § 63-5-128

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

Licensed and registered dental hygienists are specifically permitted to participate unsupervised in educational functions involving organized groups or health care institutions regarding preventive oral health care. Dental hygienists are permitted to participate in health screenings and similar activities; provided that no remuneration is...
given by the organized group to any hygienist or the hygienist’s employer for participating in these activities. Tenn. Code Ann. § 63-5-115(c)

Dental hygienists providing services in health care institutions under the **general supervision** of a licensed dentist must submit a written protocol which must be approved in advance by the Board. Tenn. Code Ann. § 63-5-115(d)

- **Direct Supervision** means continuos presence of a supervising dentist within the physical confines of the dental office when licensed and registered dental hygienists or registered dental assistants perform lawfully assigned duties and functions.
- **General Supervision** means the dentist is not present in the dental office or treatment facility while the authorized procedures are being performed by the dental hygienist, but the dentist has personally authorized the procedures and evaluates the performance of the dental hygienist.

In order to practice dental hygiene in Tennessee, hygienists must be licensed and registered by the state Board. To qualify for a license, applicants must: file an application with the board, graduate from an accredited dental hygiene program that provides a minimum of two academic years of dental hygiene curriculum, and pass dental hygiene examinations administered by the Board. Tenn. Code Ann. § 63-5-109

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may only practice in the office of a licensed dentist under the **direct supervision** of a licensed and registered dentist, except in authorized public health programs. Tenn. Code Ann. § 63-5-115

Licensed and registered dental assistants are “specifically permitted to participate unsupervised in educational functions involving organized groups or health care institutions regarding preventive oral health care.” Tenn. Code Ann. § 63-5-115(c)

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide any of the services that are defined as dental or dental hygiene services. “The practice of their professions by physicians or surgeons licensed as such under the laws of [Tennessee], unless they practice dentistry as a specialty are exempt from the dental practice laws. Tenn. Code Ann. § 63-5-109(1)

5. NURSING
The statute also exempts “the giving by a registered nurse anesthetist of any anesthetic for a dental operation under the direct supervision of a licensed dentist.”  Tenn. Code Ann. § 63-5-109(7)

TEXAS

Summary:

A person who “performs diagnosis, treatment, operation, or prescription for a disease, lesion, pain, injury, deformity, deficiency, or physical condition, of the human teeth, alveolar process, gums, jaws, or adjacent structures…” is engaged in the practice of dentistry.  Tex. Occ. Code § 251.003

The statute makes general exemptions for physicians or surgeons, dental students, dental interns, dental hygiene students, dental residents, dental faculty, an individual licensed to practice dentistry in any other state who performs a clinical procedure only as a demonstration for professional and technical educational purposes, and dental health service corporations chartered under the Texas Non-Profit Corporation Act.  Tex. Occ. Code § 251.004

A person who “removes accumulated matter…, topically applies drugs to the surface tissues of the human mouth or the exposed surfaces of the human teeth…, and performs any other task or procedure prescribed by the board” under the general supervision of a dentist is engaged in the practice of dental hygiene.  Tex. Occ. Code § 262.002

Dentists may delegate to qualified dental assistants “any dental act” that is reasonable and within the scope of duties of a dental assistant under the direct supervision of a licensed dentist.  These acts are not specifically defined in the statute.  Tex. Occ. Code § 258.002

1. DENTIST

What constitutes practicing dentistry?

A person who “performs diagnosis, treatment, operation, or prescription for a disease, lesion, pain, injury, deformity, deficiency, or physical condition, of the human teeth, alveolar process, gums, jaws, or adjacent structures, removes stains or concretions from human teeth, provides surgical and adjunctive treatment for disease, pain, injury deficiency, deformity, or physical condition, of the human teeth, alveolar process, gums, jaws, prescribes, makes...an impression of any portion of the human mouth, teeth, gums, or jaws...owns, maintains, or operates an office or place of business in which the person engages in the practice of dentistry, administers anesthetics...” is engaged in the practice of dentistry.  Tex. Occ. Code § 251.003
The practice of dentistry, dental surgery, or dental hygiene or owning a dental corporation or a place where dental services are rendered without a valid license is prohibited. Tex. Occ. Code § 256.001

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

A person who “removes accumulated matter, tartar, deposits, accretions, or stains, other than enamel stains, from the natural and restored surface of exposed human teeth and restorations in the human mouth, smoothes roughened root surfaces; polishes exposed human teeth, restorations in the human mouth, or roughened root surfaces; topically applies drugs to the surface tissues of the human mouth or the exposed surfaces of the human teeth; makes dental x-rays; and performs any other task or procedure prescribed by the board” is engaged in the practice of dental hygiene. Tex. Occ. Code § 262.002

Dental hygienist may practice in a “dental office of a licensed dentist, in an alternate setting, including a nursing home or the patient’s home, school, hospital, state institution, public health clinic, or other institution that has been approved by the board…” under the general supervision of a licensed dentist. Tex. Occ. Code § 262.152

- General supervision means that “a dentist is not required to be on the premise when the dental hygienist performs a delegated act.” Tex. Occ. Code § 262.151(3d)

All delegated acts require that a dentist examine the patient at least 12 calendar months preceding the date of performance of the service, task, or procedure by the dental hygienist. Tex. Occ. Code § 262.151(2B)

Dental hygienists may not provide “comprehensive examination or diagnosis, treatment planning, surgical or cutting procedures on soft or hard tissues, prescriptions of drug, medication, or work authorization, taking of impression for final restoration…, making of an intraoral occlusal adjustment, direct pulp capping…, and the final placement and intraoral adjustment of a fixed or removable appliance.” Tex. Occ. Code § 258.001

In order to practice dental hygiene in Texas, hygienists must be licensed by the Texas Board of Dental Examiners. To qualify for a license, individuals must: be at least 18 years of age, graduate from an accredited high school, graduate from a dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation that provides at least a two academic years of curriculum, and pass dental hygiene examinations administered by the board. Tex. Occ. Code § 256.053

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants
Dentists may delegate to a qualified dental assistant “any dental act” that is reasonable and within the scope of duties of a dental assistant under the direct supervision of a licensed dentist. These acts are not specifically defined in the statute. Tex. Occ. Code § 258.002 The licensed delegating dentist assumes the full legal responsibility of any act delegated to the dental assistant and services performed by the dental assistant. Tex. Occ. Code § 258.004

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may presumably provide some of the services that are defined as dental or dental hygiene services. “A physician licensed in this state who does not represent that the person is practicing dentistry, including a physician who extracts teeth or applies pain relief in the regular practice of the physician’s profession” is exempt from the dental practice statute. Tex. Occ. Code § 251.003(4) Physicians are also generally exempt from providing dental hygiene services under this statute. The statute does not apply to “a physician authorized to practice medicine in this state.” Tex. Occ. Code § 262.003

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may suspend or revoke the license of any dentist who is found “employing, directly or indirectly, or permitting an unlicensed person to perform dental services on a person…” Tex. Occ. Code § 259.008

Who makes up the dental board?

The Dental Hygiene Advisory Committee advises the Board on all matters relating to dental hygiene. Tex. Occ. Code § 262.051

UTAH

Summary:

The practice of dentistry means “to examine evaluate, diagnose, treat, operate, or prescribe therapy for any disease, pain, injury, deficiency, deformity, or any other

The statute makes exemptions for dental students, dental faculty, and dentists of other states making clinical demonstrations before a regularly organized dental or medical society or group, and rendering services as public services. Utah Code Ann. § 58-69-306

The practice of dental hygiene means to “perform preliminary instrumental examination of patient’s teeth, expose dental radiographs, assess dental hygiene status and collaborate with the supervising dentist regarding dental hygiene treatment, remove deposits..., remove toxins..., take impressions..., under the general supervision of a dentist.” Utah Code Ann. § 58-69-102

Dental assistants may provide supportive services under the direct or indirect supervision of a licensed dentist. Utah Code Ann. § 58-69-102

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry means to “examine evaluate, diagnose, treat, operate, or prescribe therapy for any disease, pain, injury, deficiency, deformity, or any other condition of the human teeth, alveolar process, gums, or jaws, and adjacent hard and soft tissues and structures in the maxillofacial region, take appropriate history and physical consistent with the level of professional service to be provided and the available resources in the facility in which the services is to be provided, take impressions, supply artificial teeth..., correct malpositions of teeth, administer anesthetics, remove deposits, accumulations..., and supervise the practice of dental hygiene and/or dental assistants.” Utah Code Ann. § 58-69-102.

The practice of dentistry or dental hygiene without a valid Utah license, except for those exempted, is prohibited. Utah Code Ann. § 58-69-503

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene means to “perform preliminary instrumental examination of human teeth and gums, expose dental radiographs, assess dental hygiene status and collaborate with the supervising dentist regarding dental hygiene treatment, remove deposits accumulations, calculus, and concretions from the surfaces of human teeth, remove toxins and debris from subgingival surfaces, take impressions of teeth or jaws except for impressions or registrations to supply artificial teeth..., and provide dental
hygiene care in accordance with a dentist’s treatment plan for a patient under the general supervision of a dentist. Utah Code Ann. § 58-69-102(7a)

Dental hygienist may also administer anesthesia and nitrous oxide under the indirect supervision of a dentist. Utah Code Ann. § 58-69-102(7b)

Dental hygienist may direct a dental assistant when the supervising dentist is not on the premise.

- **General supervision** means “the supervising dentist is available for consultation regarding the work the supervising dentist has authorized, without regard as to whether the supervising dentist is located on the same premises as the person being supervised.

- **Direct supervision** means “the supervising dentist is present and available for face-to-face communication with the person being supervised when and where the professional services are being provided.”

- **Indirect supervision** means “the supervising dentist is present within the facility in which the person being supervised is providing services and is available to provide immediate face-to-face communication with the person being provided.” Utah Code Ann. § 58-69-102(2-5)

In order to practice dental hygiene in Utah, hygienists must be licensed or by the state Board. To qualify for a license, applicants must: file an application with the board, graduate from an accredited dental hygiene program, and pass dental hygiene examinations administered by the Board. Utah Code Ann. § 58-69-801

3. **OTHER MID-LEVEL PROVIDERS**

Dental Assistants

A dental assistant is an “unlicensed individual who engages in, directly or indirectly, supervised acts and duties as defined by division rule made in collaboration with the board.” Utah Code Ann. § 58-69-102

Dental assistants may provide supportive services under the direct or indirect supervision of a licensed dentist. Utah Code Ann. § 58-69-102

4. **MEDICINE**

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

There are no specific references to physicians or surgeons in the statute.

5. **NURSING**
The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

Not specifically prohibited in the statute.

Who serves on the dental board?

There is a Dentist and Dental Hygienists Licensing Board, consisting of six licensed dentists, two licensed dental hygienists, and one member of the general public.

Utah Code Ann. § 58-69-201

VERMONT

Summary:

A person shall be regarded as practicing dentistry who “undertakes, by any means or method…diagno[sis], treat[ment], for any lesions, diseases, disorders, for deficiencies of the human oral cavity, teeth, gums, maxilla, or mandible or adjacent associated structures...” 26 V.S.A. § 721

The statute makes broad general exemptions for physicians or surgeons, dental students, dental faculty, dentists in the US armed forces, the US Public Health Service, or the US Veteran’s Bureau. 26 V.S.A. § 721(b)

Dental hygienist may perform services in the office of any licensed dentist, and in public or private schools or public or private institution under the “general supervision” of a licensed dentist. 26 V.S.A. § 854 Dental hygienist may also administer anesthetics under the direct supervision of a licensed dentist. 26 V.S.A. § 854

Specific services for dental hygienists are not defined in the statute.

Dental assistants may practice in the office of a dentist, in public or private schools or public or private institutions under the supervision of a licensed dentist. The performance of intraoral tasks shall be under the direct supervision of a licensed dentist. 26 V.S.A. § 864(a)

1. DENTIST

What constitutes practicing dentistry?

A person shall be regarded as practicing dentistry who “owns, leases, maintains, or operates any dental business…, who undertakes, by any means or method, gratuitously or for a salary, fee, money, or other reward… granted directly or indirectly…to diagnose
or profess to diagnose, treat or profess to treat or to prescribe for...any lesions, diseases, disorders, for deficiencies of the human oral cavity, teeth, gums, maxilla, or mandible or adjacent associated structures, who extracts human teeth, corrects malpositions thereof or of the jaws...” 26 V.S.A. § 721

Dentists and dental hygienists are prohibited from practicing without a valid license. 26 V.S.A. § 725

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

A dental hygienist may “perform duties for which the hygienist has been qualified by successful completion of the normal curriculum offered by schools of dental hygiene accredited by the American Dental Association...” 26 V.S.A. § 854

Dental hygienist may perform services in the office of any licensed dentist, and in public or private schools or public or private institution under the “general supervision” of a licensed dentist. 26 V.S.A. § 854 Dental hygienist may also administer anesthetics under the direct supervision of a licensed dentist. 26 V.S.A. § 854

- **Direct Supervision** means that a dentist is physically present in the dental office, a dentist has diagnosed the condition to be treated, a dentist has authorized the procedure to be performed, and before dismissal of the patient, a dentist has approved the work to be performed by the hygienist.
- **General Supervision** means that a dentist has diagnosed and authorized the procedure to be performed; however, the dentist is not required to be present when the authorized procedures are being performed.

In order to practice dental hygiene in Vermont, hygienists must be licensed by the state Board. To qualify for a license as a dental hygienist, applicants must: file an application with the board, graduate from an accredited dental hygiene program, pass dental hygiene examinations administered by the Board, and be of good moral character. 26 V.S.A. § 851

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may “assist a dentist with dental duties directly relating to the care and treatment of patients” under the **direct supervision** of a dentist. 26 V.S.A. § 861

Dental assistants may practice in the office of a dentist, in public or private schools or public or private institutions under the **supervision** of a licensed dentist. The performance of intraoral tasks shall be under the **direct supervision** of a licensed dentist. 26 V.S.A. § 864(a)
Dental assistants may not perform the following tasks: diagnosis, treatment planning, and surgical procedures on soft and hard tissues within the oral cavity or any other intraoral procedures that contributes to or results in an irremediable alteration of the oral anatomy. 26 V.S.A. § 864(b)

Dental assistants must “fulfill minimum educational requirements, training experience and professional standards necessary to practice as a dental assistant as promulgated by the Board.” 26 V.S.A. § 862

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide any of the services that are defined as dental or dental hygiene services. Nothing in the statute shall prevent “regularly licensed physicians or surgeons from treating or prescribing for lesions, disease, disorders, or deficiencies of the human oral cavity, teeth, gums, maxilla, or mandible or adjacent associated structures, or from extracting human teeth, or administering anesthetics, or using or prescribing drugs or other remedies.” 26 V.S.A. § 721(b)

Further, the statute states that “nothing in this [statute] shall be construed to interfere with the rights and privileges of physicians and surgeons licensed under the laws of this state.” 26 V.S.A. § 724

5. NURSING

The statute makes no reference to physicians or surgeons.

VIRGINIA

Summary:

The practice of dentistry is defined as the “prevention, diagnosis, and treatment of diseases and restoration to health of the structure of the oral cavity, including teeth and surrounding and supporting structures.” Va. Code Ann. § 54.1-2700

The statute makes general exemptions for physicians or surgeons, dental students, dental faculty, dental interns, individuals licensed to practice dentistry in any other state while making a clinical demonstration before a dental society, dentists in the US armed forces, the US Public Health Service, and the Veteran’s Administration. Va. Code Ann. § 54.1-2701(1-3) The statute also makes qualified exceptions for nurse practitioners certified by the Board of Nursing and the Board of Medicine. Va. Code Ann. § 54.1-2700
Licensed dental hygienist may provide “educational, therapeutic, diagnostic or preventive services” under the “direction of a licensed dentist.” Va. Code Ann. § 54.1-2722

Dental assistants may perform “duties appropriate to the training and experience of the dental assistant” under the direct supervision of a licensed dentist.  18 VAC 60-20-230

3. DENTIST

What constitutes practicing dentistry?

The practice of dentistry is defined as the “prevention, diagnosis, and treatment of diseases and restoration to health of the structure of the oral cavity, including teeth and surrounding and supporting structures.” Va. Code Ann. § 54.1-2700

Any person shall be deemed to be practicing dentistry who “diagnoses, treats, or professes to diagnose or treat any of the diseases or lesions of the oral cavity, its contents or contiguous structures, or extracts teeth, corrects malpositions of the teeth or jaws, takes impressions for fabrication of appliances or dental prosthesis, and supplies or repairs artificial teeth as substitutes for natural teeth…” Va. Code Ann. § 54.1-2711

The Board may also permit the practice of dentistry by persons holding a restrictive volunteer license. A restrictive license permits “only the practice of dentistry in a public health or community free clinics approved by the Board.” Persons holding a restrictive license must be sponsored and supervised by a dentist in Virginia and may not receive remuneration directly or indirectly for providing dental services. Va. Code Ann. § 54.1-2712.1

The practice of dentistry or dental hygiene without a current valid license from the Board of Dentistry is prohibited in the state of Virginia. Va. Code Ann. § 54.1-2709

4. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene means “cleaning and polishing teeth and assisting the members of the dental profession in providing oral health care and oral health education to the public” under the “direction of a licensed dentist.” Va. Code Ann. § 54.1-2722

A dental hygienist may perform “scaling and root planing of natural and restored teeth using hand instruments..., performing an original or clinical examination of teeth and surrounding tissues including charting of carious lesions, periodontal pockets or other abnormal conditions for assisting the dentist in diagnosis, subgingival irrigation..., and other duties appropriate to the education of the dental hygienist...” 18 VAC 60-20-220

Dental hygienist may practice in a dental office of a licensed dentist, public school dental clinics, State health clinics, clinics in the Department of Mental Health, clinics in
the Mental Retardation and Substance Abuse Services, and public health or community free clinics. Va. Code Ann. § 54.1-2726

“Dental hygienists and assistants shall engage in their respective duties only while in the employment of a licensed dentist or governmental agency and under the direction and control of the employing dentist or the dentist in charge…” Further, “the dentist shall be present and evaluate the patient during the time the patient is in the facility.” 18 VAC 60-20-210 No dentist shall supervise more than two dental hygienists at one time. 18 VAC 60-20-200

The Board may also permit the practice of dental hygiene by persons holding a restrictive volunteer license. A restrictive license permits “only the practice of dentistry in a public health or community free clinics approved by the Board.” Persons holding a restrictive license must be sponsored and supervised by a dentist in Virginia and may not receive remuneration directly or indirectly for providing dental services. Va. Code Ann. § 54.1-2726.1

Dental hygienists shall not perform “final diagnosis and treatment planning, surgical or cutting procedures on soft or hard tissues, prescribe or parenterally administer drugs or medicaments, administer nitrous oxide…” 18 VAC 60-20-190

In order to practice dental hygiene in Virginia, hygienists must be licensed. To qualify for a license, individuals must: be at least 18 years of age, graduate from a dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation that provides at least a two years of academic curriculum, and pass dental hygiene examinations administered by the Board. Va. Code Ann. § 54.1-2722

5. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may perform “duties appropriate to the training and experience of the dental assistant” under the direct supervision of a licensed dentist. 18 VAC 60-20-230 Specific scope of services and areas of practice for dental assistants are not defined under the statute.

6. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may presumably provide any of the services that are defined as dental or dental hygiene services. The statute does not apply to “a licensed physician or surgeon unless he practices dentistry as a specialty.” Va. Code Ann. § 54.1-2700
7. NURSING

The statute also does not apply to “a nurse practitioner certified by the Board of Nursing and the Board of Medicine except that intraoral procedures shall be performed under the direct supervision of a licensed dentist.” Va. Code Ann. § 54.1-2700

8. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may suspend or revoke the license of any dentist for “employing or assisting persons whom he knew or had reason to believe were unlicensed to practice dentistry or dental hygiene.” Va. Code Ann. § 54.1-2706

Who serves on the dental board?

The Board of Dentistry consists of ten members. Seven are licensed dentists who have been engaged in the practice of dentistry in Virginia for at least three years immediately preceding their appointment. Two members are dental hygienists who have been engaged in the practice of dental hygiene in Virginia for at least three years immediately preceding their appointment. The remaining one member is a public member. All members are appointed to a four-year term. Va. Code Ann. § 54.1-2702

WASHINGTON

Summary:

A person who “represents himself as being able to diagnose, treat, remove stains and concretions from teeth, operate or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaw…engages in the practice of dentistry. Rev. Code Wash. § 18.32.020

The statute makes qualified exemptions for physicians or surgeons, dentists in the US armed forces, US federal services on federal reservations, US Public Health Service, Veteran’s Administration, dental students, dental interns, and individuals licensed to practice dentistry in any other state while making a clinical demonstration before a dental society or dental association. Rev. Code Wash. § 18.32.030

Dental Hygienist scope of practice – refer to previous summary.

Dental Assistant scope of practice – refer to previous summary.

1. DENTIST
What constitutes practicing dentistry?

A person who “represents himself as being able to diagnose, treat, remove stains and concretions from teeth, operate or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaw, offers or undertakes by any means or methods to diagnose, treat…for any disease pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaw, owns, maintains or operates an office for the practice of dentistry, performs oral and maxillofacial surgery…” engages in the practice of dentistry. Rev. Code Wash. § 18.32.020

The practice of dentistry or dental hygiene or the attempt to practice dentistry or dental hygiene without a valid license and current registration is prohibited in the state of Washington. Anyone who practices dentistry or dental hygiene without a valid license and current registration shall be guilty, upon conviction, of gross misdemeanor. Rev. Code Wash. § 18.32.390

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

Refer to previous summary.

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Refer to previous summary

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may presumably provide some of the services that are defined as dental or dental hygiene services in emergencies. “The rendering of dental relief in emergency cases in the practice of his or her profession by a physician or surgeon, licensed as such under the laws of this state, unless the physician or surgeon undertakes to reproduce lost parts of the human teeth in the mouth or to restore or to replace in the human mouth lost or missing teeth” is excepted from the operation of provisions of the [statute].

Rev. Code Wash. § 18.32.030(1)
5. NURSING

Registered nurses and advanced registered nurse practitioners may not perform “any removal of or addition to the hard or soft tissue of the oral cavity, any diagnosis or prescription for treatment of disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, or adjacent structures, any prophylaxis, taking of any impressions of the teeth or jaw, or any administration of general or injected local anesthetic of any nature….” without the supervision of a licensed dentist. Rev. Code Wash. § 18.32.030(9)

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

It is unlawful for any dentist to “employ or retain any unlicensed person” perform any act that constitutes as practicing dentistry, unless they are exempt from this [statute]. Rev. Code Wash. § 18.32.745

Who serves on the dental commission?

The Washington State Dental Quality Assurance Commission consists of 12 dentists appointed by the Governor who are engaged in the practice of dentistry for at least four years prior to their appointment. There are no dental hygienists on the commission. Rev. Code Wash. § 18.32.0355

WEST VIRGINIA

Summary:

Anyone shall be deemed to be practicing dentistry who shall “diagnose, treat, any of the diseases or malformations or lesions of the oral cavity, teeth, gums, or maxillary bones…” or “open an office for the practice of dentistry.” W. Va. Code § 30-4-2

The statute makes qualified exemptions for licensed physicians or surgeons when rendering dental relief in emergency cases. W. Va. Code § 30-4-2. The statute also generally exempts dental students, dental faculty, and dentists of other states making clinical demonstrations before a regularly organized dental or medical society or group, dentists in the US armed forces, the US Public Health Service, and the US Veteran’s Bureau. W. Va. Code § 30-4-2

A person shall be deemed to be practicing dental hygiene who “under the supervision of a licensed dentist, removes deposits, accretions and stains from the surface of the teeth, makes topical application of drugs to the exposed surfaces of the teeth, takes dental X-rays and instructs patients in the practice of dental hygiene procedures.” W. Va. Code § 30-4-3
Dental hygienists may practice in the office of a dentist, in schools, in state or public health clinic under the general supervision of a licensed dentist. W. Va. Code § 30-4-13

Dental assistants may provide certain intra-oral services in the office of any licensed dentist under the direct supervision of a licensed dentist. W. Va. Code § 30-4-15

1. DENTIST

What constitutes practicing dentistry?

A person shall be considered practicing dentistry who shall “diagnose or profess to diagnose, treat or profess to treat, any of the disease or malformations or lesions of the oral cavity, teeth, gums, or maxillary bones, or shall prepare to fill cavities in the human teeth, correct malpositions of teeth or jaws…, administer general or local anesthetics…, produce, reproduce, construct, repair,…any prosthetic appliance to be used in , upon, in connection…with the human jaw or associated structures…” W. Va. Code § 30-4-2

A dental corporation may practice dentistry only through an individual dentist or dentists duly licensed to practice dentistry in the state of West Virginia. W. Va. Code § 30-4-4c

Dentists, dental hygienists, and dental corporations are prohibited from practicing dentistry in West Virginia unless all hold a valid license or valid certificate from the board of dental examiners. Any person practicing or offering to practice dentistry without having complied with the provisions of the statute will be guilty of misdemeanor. W. Va. Code § 30-4-18

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

A person shall be deemed to be practicing dental hygiene who “under the supervision of a licensed dentist, removes deposits, accretions and stains from the surface of the teeth, makes topical application of drugs to the exposed surfaces of the teeth, takes dental X-rays and instructs patients in the practice of dental hygiene procedures.” W. Va. Code § 30-4-3

Dental hygienist may also perform certain intra-oral tasks under the direct supervision of a licensed dentist. Dental hygienists may not provide diagnosis, treatment planning and prescriptions, surgical procedures on hard or soft tissues within the oral cavity, or any other intraoral procedure that contributes or results in an irreparable alteration of the oral anatomy. W. Va. Code § 30-4-15

Dental hygienist may perform services in the office of any licensed dentist, industrial clinic, and school or state industrial clinic having a dental program, under the supervision of a licensed dentist. W. Va. Code § 30-4-13

In order to practice dental hygiene in West Virginia, hygienists must be licensed by the state Board. To qualify for a license, applicants must: file an application with the board,
be a high school graduate, graduate from an accredited dental hygiene program, pass
dental hygiene examinations administered by the board, be at least 18 years of age and
of good moral character.  W. Va. Code § 30-4-14

OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may provide certain intra-oral services in the office of any licensed
dentist under the direct supervision of a licensed dentist.  W. Va. Code § 30-4-15

Dental assistants may not provide diagnosis, treatment planning and prescriptions,
surgical procedures on hard or soft tissues within the oral cavity, or any other intraoral
procedure that contributes or results in an irremediable alteration of the oral anatomy.
W. Va. Code § 30-4-15

3. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene
services?

A physician may not provide any of the services that are defined as dental or dental
hygiene services except in emergency situations. The statute does not prohibit a
“licensed physician or surgeon in the practice of his profession when rendering dental
relief in emergency cases, unless he undertakes to reproduce or reproduces parts of
the human teeth, or to restore or replace lost or missing teeth in the human mouth.”  W.
Va. Code § 30-4-2(1)

4. NURSING

The statute makes no reference to nurses.

5. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may refuse to issue a license, or after issuance, revoke or suspend a license
of any individual who “employs directly or indirectly, or permits any unlicensed person to
perform operations of any kind or to treat lesions of the human teeth or jaws or correct
malimposed formations thereof.”  W. Va. Code § 30-4-7

Who serves on the dental board?
The West Virginia Board of Dental Examiners consists of six members appointed by the Governor, with the advice of the Senate. Five of the members are licensed dentists with five years of experience preceding their appointment. One member is a dental hygienist licensed in West Virginia for at least five years immediately preceding appointment. W. Va. Code § 30-4-4

West Virginia also has a Dentist Provider Medicaid Enhancement Board, consisting of three dentists, one lay person, and one non-voting secretarial member. W. Va. Code § 9-4c-3

WISCONSIN

Summary:

The practice of dentistry means the “examination, diagnosis, treatment planning or care of conditions within the human oral cavity or its adjacent tissues and structures” and includes “examining into the fact, condition or cause of dental health or dental disease (pain, injury, deformity, physical illness or departure from complete dental health) or applying principles or techniques of dental science in the diagnosis, treatment, prevention or prescription for any lesions, dental diseases, disorders, deficiencies of the human oral cavity…” Wis. Stat. § 447.01(8)

The statute makes general exemptions for physicians dental students, dental hygiene students, dental fellows, dental interns, dental residents, an individual licensed to practice dentistry in any other state while making a clinical demonstration before a dental society. Wis. Stat. § 447.03

The practice of dental hygiene is the “performance of educational, preventive or therapeutic dental services” which include, “deep scaling or root planing… conducting oral screenings…” under the supervision of a licensed dentist. Wis. Stat. § 447.01 Dental hygienist may provide services in local health department without the supervision of a licensed dentist, and for a non-profit dental care program serving primarily indigent, economically disadvantaged or migrant worker populations under the general supervision of a licensed dentist. Wis. Stat. § 447.06(2)

Dental assistants may perform “remediable procedures” under the direct supervision of a licensed dentist, and procedures must be evaluated by the dentist before the dismissal of the patient. Wis. Stat. § 447.065

1. DENTIST

What constitutes practicing dentistry?

The practice of dentistry means the “examination, diagnosis, treatment planning or care of conditions within the human oral cavity or its adjacent tissues and structures” and
includes “examining into the fact, condition or cause of dental health or dental disease (pain, injury, deformity, physical illness or departure from complete dental health) or applying principles or techniques of dental science in the diagnosis, treatment, prevention or prescription for any lesions, dental diseases, disorders, deficiencies of the human oral cavity, teeth, investing tissues, maxilla or mandible, or adjacent associated structures, extracting human teeth or correcting their malposition, directly or indirectly…furnishing prosthetic dentures, administering anesthetics…engaging in the practices…included in the curricula of dental schools, penetrating, piercing or severing the tissues within the human oral cavity or adjacent associated structures…, and developing treatment plan for dental patients…” Wis. Stat. § 447.01

The practice of dentistry or dental hygiene without a valid and current license is prohibited in the state of Wisconsin. Wis. Stat. § 447.03

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

The practice of dental hygiene is the “performance of educational, preventive or therapeutic dental services” which include, “removing supragingival or subgingival calcareous deposits, subgingival cement or extrinsic stains from a natural or restored surface of a fixed replacement for a human tooth, deep scaling or root planing, conditioning a human tooth surface, placing sealants, conducting a substantive medical or dental history interview or preliminary examination of a dental patient’s oral cavity or surrounding structures…, conducting oral screenings without the written prescription of a dentist, participating in the development of a dental patient’s dental hygiene treatment plan…” under the supervision of a licensed dentist. Wis. Stat. § 447.01

Dental hygienists may practice as an employee or as an independent contractor in a dental office, school board or a governing body of a private school, dental, in hospitals, a state or federal prison, county jail or other federal, state, county or municipal correctional facility, in a facility established to provide care for terminally ill patients, for a local health department, for a charitable institution, for a nonprofit home health agency, for a nonprofit dental care program serving primarily indigent, economically disadvantaged or migrant work populations. Hygienist may provide services under general supervision, provided that that a licensed dentist has “made the written or oral prescription” and “examined the patient at least once during the 12-month period immediately preceding the hygienist services. Wis. Stat. § 447.06(2)

Dental hygienists may not “diagnose a dental disease or ailment, determine any treatment or any regimen of any treatment outside the scope of dental hygiene, prescribe or order medication or perform any procedure that involves the intentional cutting of soft or hard tissue of the mouth by any means.” Wis. Stat. § 447.06(3)
In order to practice dental hygiene in Wisconsin, hygienists must be licensed by the Wisconsin Board of Dentistry. To qualify for a license as a dental hygienist, individual must: submit an application to the Department of Dentistry, be a graduate of an dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation that provides at least a two academic years of curriculum, and pass dental hygiene examinations administered by the examining board. Wis. Stat. § 447.03

3. OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may perform “remediable procedures” under the direct supervision of a licensed dentist, and procedures must be evaluated by the dentist before the dismissal of the patient. Dental hygienists are not required to be licensed in the state of Wisconsin. Wis. Stat. § 447.065

4. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

The statute does not apply to “a physician or surgeon licensed in [Wisconsin] who extracts teeth, or operates upon the palate or maxillary bones and investing tissues, or who administers anesthetics, either local or general.” Wis. Stat. § 447.03(h)

5. NURSING

The statute makes no reference to nurses.

6. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Is facilitating unlicensed dental or dental hygienist practice prohibited specifically?

The Board may suspend or revoke the license of any dentist who “employed, directly or indirectly, any unlicensed or uncertified person to perform any act requiring licensure or certification under this chapter.” Wis. Stat. § 447.07

WYOMING

Summary:

Any person shall be deemed to be practicing dentistry who “performs, or attempts, or advertises to perform…any dental operation or oral surgery or dental service of any kind
gratuitously or for a salary, fee, money or other remuneration paid,…who diagnoses…prescribes for…treats disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws, or adjacent structure.” Wyo. Stat. § 33-15-114

The statute makes general exemptions for physicians or surgeons, dental students, dental faculty, dentists in the US armed forces, the US Public Health Service, or the US Veteran’s Bureau. Wyo. Stat. § 33-15-115

A dental hygienist may “remove calcareous deposits, accretions and stains from the surface of the teeth,” and perform other preventive, educational and therapeutic services and extraoral procedures. Dental hygienist may perform services in the office of any licensed dentist, or in any public or private institution under the general or direct supervision of a licensed dentist. Wyo. Stat. § 33-15-115

Dental assistants may “render assistance to a dentist, dental hygienist” under the direct or indirect supervision of a dentist. Wyo. Stat. § 33-15-128

1. DENTIST

What constitutes practicing dentistry?

Any person shall be deemed to be practicing dentistry who “performs, or attempts, or advertises to perform…any dental operation or oral surgery or dental service of any kind gratuitously or for a salary, fee, money or other remuneration paid,…who is a manager, proprietor, operator or conductor of a place where dental operations, oral surgery or dental services are performed, who by any means or method furnishes…any prosthetic appliance…, who diagnoses…prescribes for…treats disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws, or adjacent structure, who extracts human teeth, or corrects malpositions of the teeth or jaw…” Wyo. Stat. § 33-15-114

Dentists and dental hygienists are prohibited from practicing dentistry in Wyoming without a valid license. Any person practicing or offering to practice dentistry without having complied with the provisions of the statute will be subject to monetary penalties. Wyo. Stat. § 33-15-115

2. Dental Hygienist

What constitutes practicing as a dental hygienist?

A dental hygienist may “remove calcareous deposits, accretions and stains from the surface of the teeth,” and perform other preventive, educational and therapeutic services. Dental hygienist may perform services in the office of any licensed dentist, or in any public or private institution under the general or direct supervision of a licensed dentist. Wyo. Stat. § 33-15-115
Direct Supervision means that a dentist is physically present in the dental office, a dentist has diagnosed the condition to be treated, a dentist has authorized the procedure to be performed, and before dismissal of the patient, a dentist has approved the work to be performed by the auxiliary.

General Supervision means that a has diagnosed and authorized the procedure to be performed; however, the dentist need not be present when the authorized procedures are being performed.

Indirect Supervision means that a dentist is physically present in the dental office, a dentist has diagnosed the condition to be treated, and the dentist has authorized the procedure to be performed. WCWR 024-034-002 §1

In order to practice dental hygiene in Wyoming, hygienists must be licensed or by the state Board. To qualify for a license as a dental hygienist, applicants must: file an application with the board, graduate from an accredited dental hygiene program, pass dental hygiene examinations administered by the Board, and be of good moral character. Wyo. Stat. § 33-15-115

OTHER MID-LEVEL PROVIDERS

Dental Assistants

Dental assistants may “render assistance to a dentist, dental hygienist” under the direct or indirect supervision of a dentist. Wyo. Stat. § 33-15-128

3. MEDICINE

What constitutes the practice of medicine?

May a physician provide any of the services that are defined as dental or dental hygiene services?

A physician may provide any of the services that are defined as dental or dental hygiene services. Nothing in the statute applies to a “legally qualified medical doctor.” Wyo. Stat. § 33-15-115

4. NURSING

The statute makes no reference to physicians or surgeons.

5. SELECTED OTHER ELEMENTS OF PRACTICE LAWS

Who serves on the dental board?
The Board consists of six members for a four year term, appointed by the governor with the advice and consent of the Senate. Five of the members are dentists and one member is a dental hygienist. Each member must be engaged in the active practice of dentistry in the state of Wyoming for at least five continuous years immediately preceding the appointment. Wyo. Stat. § 33-15-101
## APPENDIX B

### STATE DEFINITIONS OF MEDICINE AND DENTISTRY: SIX CASE STUDY STATES

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<th>STATE</th>
<th>DEFINITION OF MEDICINE</th>
<th>DEFINITION OF DENTISTRY</th>
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<td>Connecticut</td>
<td>No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person, nor practice surgery, until he has obtained such a license as provided in section 20-10, and then only in the kind or branch of practice stated in such license. Conn. Gen. Stat. § 20-9 (2001)</td>
<td>Any person who owns or carries on a dental practice or business, or who, by himself or by his servants or agents or by contract with others, performs any operation in or makes examination of, with intent of performing or causing to be performed any operation in, the mouth and surrounding and associated structures, or who describes himself by the word &quot;Dentist&quot; or letters &quot;D.D.S.&quot; or &quot;D.M.D.&quot;, or in other words, letters or title in connection with his name which in any way represents such person as engaged in the practice of dentistry, or who diagnoses or treats diseases or lesions of the mouth and surrounding and associated structures, replaces lost teeth by artificial ones, attempts to diagnose or correct malposition thereof, or who, directly or indirectly, by any means or method, furnishes, supplies, constructs, reproduces or repairs any prosthetic denture, bridge, appliance or any other structure to be worn in the human mouth, except upon the written direction of a licensed dentist, or who places such appliance or structure in the human mouth or attempts to adjust the same, or delivers the same to any person other than the dentist upon whose direction the work was performed, or who sells or distributes materials, except to a licensed dentist, dental laboratory or dental supply house, with instructions for an individual to construct, repair, reproduce or duplicate any prosthetic denture, bridge, appliance or any other structure to be worn in the human mouth, or who advertises to the public, by any method, to furnish, supply, construct, reproduce or repair any prosthetic denture, bridge, appliance or other structure to be worn in the human mouth, or gives estimates on the cost of treatment, or who advertises or permits it to be done by sign, card, circular, handbill or newspaper, or otherwise indicates that he, by contract with others or by himself, will perform any of such operations, shall be deemed as practicing dentistry or dental medicine within the meaning of this chapter. Conn. Gen. Stat. § 20-123 (2001).</td>
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<td>Iowa</td>
<td>For the purpose of this subtitle the following classes of persons shall be deemed to be engaged in the practice of medicine and surgery: 1. Persons who publicly profess to be physicians or surgeons or who publicly profess to assume the duties incident to the practice of medicine or surgery. 2. Persons who prescribe, or prescribe and furnish medicine for human ailments or treat the same by surgery. 3. Persons who act as representatives of any person in doing any of the things mentioned in this section. Iowa Code § 148.1 (2002)</td>
<td>For the purpose of this subtitle the following classes of persons shall be deemed to be engaged in the practice of dentistry: 1. Persons publicly professing to be dentists, dental surgeons, or skilled in the science of dentistry, or publicly professing to assume the duties incident to the practice of dentistry. 2. Persons who perform examination, diagnosis, treatment, and attempted correction by any medicine, appliance, surgery, or other appropriate method of any disease, condition, disorder, lesion, injury, deformity, or defect of the oral cavity and maxillofacial area, including teeth, gums, jaws, and associated structures and tissue, which methods by education, background experience, and expertise are common to the practice of dentistry. Iowa Code § 153.13 (2002)</td>
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<td>New Mexico</td>
<td>J. &quot;the practice of medicine&quot; consists of: (1) advertising, holding out to the public or representing in any manner that one is authorized to practice medicine in this state; (2) offering or undertaking to administer, dispense or prescribe any drug or medicine for the use of any other person, except as authorized pursuant to a professional or occupational licensing statute set forth in Chapter 61 NMSA 1978; (3) offering or undertaking to give or administer, dispense or prescribe any drug or medicine for the use of any other person, except as directed by a licensed physician; (4) offering or undertaking to perform any operation or procedure upon any person; (5) offering or undertaking to diagnose, correct or treat in any manner or by any means, methods, devices or instrumentalities any disease, illness, pain, wound, fracture, infirmity, deformity, defect or abnormal physical or mental condition of any person; (6) offering medical peer review, utilization review or diagnostic service of any kind that directly influences patient care, except as authorized pursuant to a professional or occupational licensing statute set forth in Chapter 61 NMSA 1978; or (7) acting as the representative or agent of any person in doing any of the things listed in Paragraphs (1) through (6) of this subsection. N.M. Stat. Ann. § 61-6-6 (2001)</td>
<td>As used in the Dental Health Care Act [61-5A-1 to 61-5A-29 NMSA 1978], &quot;practice of dentistry&quot; means: (1) the diagnosis, treatment, correction, change, relief, prevention, prescription of remedy, surgical operation and adjunctive treatment for any disease, pain, deformity, deficiency, injury, defect, lesion or physical condition involving both the functional and aesthetic aspects of the teeth, gingivae, jaws and adjacent hard and soft tissue of the oral and maxillofacial regions, including the prescription or administration of any drug, medicine, biologic, apparatus, brace, anesthetic or other therapeutic or diagnostic substance or technique by an individual or his agent or employee gratuitously or for any fee, reward, emolument or any other form of compensation whether direct or indirect; (2) representation of an ability or willingness to do any act mentioned in Paragraph (1) of this subsection; or (3) with specific reference to the teeth, gingivae, jaws or adjacent hard or soft tissues of the oral and maxillofacial region in living persons, to propose, agree or attempt to do or make an examination or give an estimate of cost with intent to, or undertaking to: (a) perform a physical evaluation of a patient in an office or in a hospital, clinic or other medical or dental facility prior to, incident to and appropriate to the performance of any dental services or oral or maxillofacial surgery; (b) perform surgery, an extraction or any other operation or to administer an anesthetic in connection therewith; (c) diagnose or treat any condition, disease, pain, deformity, deficiency, injury, lesion or other physical condition; (d) correct a malposition; (e) treat a fracture; (f) remove calcareous deposits; (g) replace missing anatomy with an artificial substitute; (h) construct, make, furnish, supply, reproduce, alter or repair an artificial substitute or restorative or corrective appliance or place an artificial substitute or restorative or corrective appliance in the mouth or attempt to adjust it; (i) give interpretations or readings of dental roentgenograms; or (j) do any other remedial, corrective or restorative work. N.M. Stat. Ann. § 61-5A-4 (2001)</td>
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**STATE | DEFINITION OF MEDICINE | DEFINITION OF DENTISTRY**

**North Carolina**

Any person shall be regarded as practicing medicine or surgery within the meaning of this Article who shall diagnose or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person. A person who resides in any state or foreign country and who, by use of any electronic or other mediums, performs any of the acts described in this subsection, including prescribing medication by use of the Internet or a toll-free telephone number, shall be regarded as practicing medicine or surgery and shall be subject to the provisions of this Article and appropriate regulation by the North Carolina Medical Board. N.C. Gen. Stat. § 90-18 (2001)

A person shall be deemed to be practicing dentistry in this State who does, undertakes or attempts to do, or claims the ability to do any one or more of the following acts or things which, for the purposes of this Article, constitute the practice of dentistry:

1. Diagnoses, treats, operates, or prescribes for any disease, disorder, pain, deformity, injury, deficiency, defect, or other physical condition of the human teeth, gums, alveolar process, jaws, maxilla, mandible, or adjacent tissues or structures of the oral cavity;
2. Removes stains, accretions or deposits from the human teeth;
3. Extracts a human tooth or teeth;
4. Performs any phase of any operation relative or incident to the replacement or restoration of all or a part of a human tooth or teeth with any artificial substance, material or device;
5. Corrects the malposition or malformation of the human teeth;
6. Administers an anesthetic of any kind in the treatment of dental or oral diseases or physical conditions, or in preparation for or incident to any operation within the oral cavity; provided, however, that this subsection shall not apply to a lawfully qualified nurse anesthetist who administers such anesthetic under the supervision and direction of a licensed dentist or physician;
7. Takes or makes an impression of the human teeth, gums or jaws;
8. Makes, builds, constructs, furnishes, processes, reproduces, repairs, adjusts, supplies or professionally places in the human mouth any prosthetic denture, bridge, appliance, corrective device, or other structure designed or constructed as a substitute for a natural human tooth or teeth or as an aid in the treatment of the malposition or malformation of a tooth or teeth, except to the extent the same may lawfully be performed in accordance with the provisions of G.S. 90-29.1 and 90-29.2;
9. Uses a Roentgen or X-ray machine or device for dental treatment or diagnostic purposes, or gives interpretations or readings of dental Roentgenograms or X rays;
10. Performs or engages in any of the clinical practices included in the curricula of recognized dental schools or colleges;
11. Owns, manages, supervises, controls or conducts, either himself or by and through another person or other persons, any enterprise wherein any one or more of the acts or practices set forth in subdivisions (1) through (10) above are done, attempted to be done, or represented to be done;
12. Uses, in connection with his name, any title or designation, such as "dentist," "dental surgeon," "doctor of dental surgery," "D.D.S.," "D.M.D.," or any other letters, words or descriptive matter which, in any manner, represents him as being a dentist able or qualified to do or perform any one or more of the acts or practices set forth in subdivisions (1) through (10) above;
13. Represents to the public, by any advertisement or announcement, by or through any media, the ability or qualification to do or perform any of the acts or practices set forth in subdivisions (1) through (10) above. N.C. Gen. Stat. § 90-29 (2001)
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<th>STATE</th>
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<td>South Carolina</td>
<td>Any person shall be regarded as practicing medicine within the meaning of this article who (a) shall as a business treat, operate on or prescribe for any physical ailment of another, (b) shall engage in any branch or specialty of the healing art or (c) shall diagnose, cure, relieve in any degree or profess or attempt to diagnose, cure or relieve any human disease, ailment, defect, abnormality or complaint, whether of physical or mental origin, by attendance or advice, by prescribing, using or furnishing any drug, appliance, manipulation, adjustment or method or by any therapeutic agent whatsoever. S.C. Code Ann. § 40-47-40 (2001).</td>
<td>A person is practicing dentistry who: uses the word “dentist”, “dental surgeon”, or the letters “D.D.S.”, “D.M.D.”, or other letters or titles in connection with his name which in any way represents him as engaging in the practice of dentistry or in the administration of any dental health program; or for a fee or other consideration: (a) shall profess or indicate in any manner that he can or will attempt to perform dental procedures in the oral cavity and associated adjacent structures; or (b) shall diagnose or treat or profess to diagnose or treat any diseases or lesions or conditions of the oral cavity and associated adjacent structures; or (c) shall extract teeth, correct malpositions of the teeth or jaws, or take impressions, or construct, supply, repair, reline, or duplicate artificial teeth as substitutes for natural teeth, or adjust such substitutes, or do any practice included in the curricula of dental colleges accredited by the Commission on Dental Accreditation, or administer or prescribe drugs or therapy utilized in the treatment of dental or oral diseases, or shall use X ray for dental treatment or dental diagnostic purposes, or shall administer anaesthetics, local or general, for dental procedures; or (d) shall teach or profess to teach any phase of dental practice or related procedures. S.C. Code Ann. § 40-15-70 (2001).</td>
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<td>Washington</td>
<td>A person is practicing medicine if he does one or more of the following: (1) Offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality; (2) Administers or prescribes drugs or medicinal preparations to be used by any other person; (3) Severs or penetrates the tissues of human beings; (4) Uses on cards, books, papers, signs or other written or printed means of giving information to the public, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human disease or conditions the designation &quot;doctor of medicine&quot;, &quot;physician&quot;, &quot;surgeon&quot;, &quot;m.d.&quot; or any combination thereof unless such designation additionally contains the description of another branch of the healing arts for which a person has a license: PROVIDED HOWEVER, That a person licensed under this chapter shall not engage in the practice of chiropractic as defined in RCW 18.25.005. Rev. Code Wash. (ARCW) § 18.71.011 (2002)</td>
<td>A person practices dentistry, within the meaning of this chapter, who (1) represents himself as being able to diagnose, treat, remove stains and concretions from teeth, operate or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaw, or (2) offers or undertakes by any means or methods to diagnose, treat, remove stains or concretions from teeth, operate or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same, or take impressions of the teeth or jaw, or (3) owns, maintains or operates an office for the practice of dentistry, or (4) engages in any of the practices included in the curricula of recognized and approved dental schools or colleges, or (5) professes to the public by any method to furnish, supply, construct, reproduce, or repair any prosthetic denture, bridge, appliance, or other structure to be worn in the human mouth. The fact that a person uses any dental degree, or designation, or any card, device, directory, poster, sign, or other media whereby he represents himself to be a dentist, shall be prima facie evidence that such person is engaged in the practice of dentistry. X-ray diagnosis as to the method of dental practice in which the diagnosis and examination is made of the normal and abnormal structures, parts or functions of the human teeth, the alveolar process, maxilla, mandible or soft tissues adjacent thereto, is hereby declared to be the practice of dentistry. Any person other than a regularly licensed physician or surgeon who makes any diagnosis or interpretation or explanation, or attempts to diagnose or to make any interpretation or explanation of the registered shadow or shadows of any part of the human teeth, alveolar process, maxilla, mandible or soft tissues adjacent thereto by the use of x-ray is declared to be engaged in the practice of dentistry, medicine or surgery. The practice of dentistry includes the performance of any dental or oral and maxillofacial surgery. &quot;Oral and maxillofacial surgery&quot; means the specialty of dentistry that includes the diagnosis and surgical and adjunctive treatment of diseases, injuries, and defects of the hard and soft tissues of the oral and maxillofacial region. Rev. Code Wash. (ARCW) § 18.32.020 (2002)</td>
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APPENDIX C
LEVEL OF SUPERVISION REQUIRED: DENTAL HYGIENISTS

PREVENTIVE ORAL HEALTH SERVICES PROVIDED BY DENTAL HYGIENISTS

**G:** General Supervision: Dentist not required to be on treatment premises while services are provided. However, dentist must authorize the procedure and be available for consultation.

**D:** Direct Supervision: Dentist is required to be on treatment premises while services are provided. Dentist must authorize the procedure and sign off on the services provided before patient dismissal.

**I:** Indirect Supervision: Dentist is required to be on treatment premises while services are provided. Dentist must authorize the procedure but need not sign off of the procedure before patient dismissal.

**N:** No supervision: Dental hygienists are permitted to provide services without supervision.

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<th>State</th>
<th>Complete Prophylaxis</th>
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1A California: Hygienists can practice under general supervision in dentists’ offices; hygienists may establish autonomous practices in underserved areas (additional licensing requirements apply)
1B Colorado: Registered hygienists may practice independently in all settings without the supervision of a dentist
2 Hawaii: Hygienists can practice under general supervision if employed by a public health clinic.
3 Indiana: Hygienists can provide prophylaxis and other preventive services without supervision to children up to grade 12 and in Dept. of Health Clinics
4 Louisiana: Hygienists can practice under general supervision if employed by a public health clinic.
5 Maryland: Hygienists can provide prophylaxis and preventive services in Dept. of Public Health clinics without supervision
6 South Carolina: Hygienists may provide preventive services under general supervision; however, general supervision is defined more narrowly. General supervision requires that a dentist “authorize” or pre-examine the patient receiving preventive services from the hygienists. The dentist is not required to be on the treatment premises while the hygienist provides services. In addition, hygienists working in a dentist’s office must provide services under the direct supervision of a licensed dentist.
7 Virginia: Hygienists must provide all services under direct supervision if practicing in a dentist’s office.
8 Washington: Hygienists may provide prophylaxis, scaling, and topical fluoride without supervision in hospitals, nursing homes, and public health clinics with a minimum of two years training.
### APPENDIX D
EXEMPTIONS TO DENTAL PRACTICE LAW

**KEY**

**G = General Exemptions:** Physicians or Nurses permitted to provide preventive oral health services.

**Q = Qualified Exemptions:** Physicians or Nurses permitted to provide oral health services (generally limited to extraction of teeth) only in emergencies and in certain institutional settings.

**N/A = Not Applicable:** Statute makes no reference to Physicians or Nurses providing any type of oral health service.

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APPENDIX E
SHORT INTERVIEW GUIDE: CASE STUDIES

With support from the Center for Disease Control and Prevention’s (CDC) Public Health Practice Program Office, we are examining the factors that contribute to the enactment of public health-oriented provisions in state dental practice laws; the extent to which such laws encourage the development of alternative models of delivering preventive oral health care services; and what factors contribute to the implementation of alternative models of preventive oral health care delivery. Below we show the broad areas of focus for our interview with you. Please don’t be concerned if you are unable to discuss every question. However, if you are not able to discuss most of these questions, please let us know, as we may need to reschedule the interview with one of your colleagues.

CONNECTICUT, NEW MEXICO, NORTH CAROLINA, WASHINGTON

What motivating factors spurred enactment of the public health-oriented provisions of the states’ dental practice laws?

- What alternative model of preventive oral health care delivery has the state opted to enact/allow? Why?
- Was the alternative model enabled by an explicit law/regulation, or is it allowed because the existing statues are vague?

What was the planning process for developing such provisions?

- What steps were involved in the planning process?
- Who was involved in developing the public-health oriented law and/or the alternative model?
- Were political/environmental issues addressed during the planning process?
- What was the public-health oriented law intended to achieve?
- Who were the intended service recipients?

To what extent and how are such provisions implicated in the development and implementation of the alternative model for delivering preventive oral health care?

- Was a law necessary to implement the alternative oral health care model? Could the alternative model be implemented without the law?
- What challenges were involved in implementing the public-health oriented dental practice law/alternative preventive oral health care delivery model?

Have such provisions encouraged a change in the way preventive oral health care is delivered to low-income children through the alternative oral health care model?

- Has the delivery of preventive oral health care services been altered as a result of the law? How so?

Are there interim outcomes that suggest that the provisions/alternative model improve access to, or utilization of preventive oral health care services by low-income children?
- Has there been a change in: 1) the number of oral health care sites; 2) number of providers; 3) number of children receiving preventive oral health care services; 4) number of preventive oral health care encounters as a result of this law/alternative oral health care model?
- What lessons were learned as a result of implementing the public-health oriented law and/or alternative oral health care model? What would you change if you had to do it again?
- What factors are required/would inhibit the law’s replication in another state?

**IOWA, SOUTH CAROLINA:**

What motivating factors spurred enactment of the public health-oriented provisions of the states’ dental practice laws?

- What alternative model of preventive oral health care delivery has the state opted to enact/allow? Why?
- Was the alternative model enabled by an explicit law/regulation, or is it allowed because the existing statues are vague?

What was the planning process for developing such provisions?

- What steps were involved in the planning process?
- Who was involved in developing the public-health oriented law and/or the alternative model?
- Were political/environmental issues addressed during the planning process?
- What was the public-health oriented law intended to achieve?
- Who were the intended service recipients?

**What factors lead to the defeat of attempts to implement the alternative model?**

- What factors lead to the defeat of the alternative preventive oral health care model?
- What were the issues surrounding the alternative model’s initiative’s defeat? (e.g., political, economic)
- Were there attempts to broker a deal that would permit the initiative’s success?
- What obstacles/players precluded a compromise which would allow the alternative model to proceed?
- Are there plans to revisit the alternative model and attempt to implement the implement the alternative model?
- What factors/circumstances would be required to implement the alternative model?
- How does the state intend to address low-income children’s access to and utilization of preventive oral health care services?

**What lessons were learned as a result of implementing the public-health oriented law and/or alternative oral health care model? What would you change if you had to do it again?**
APPENDIX F
CONNECTICUT CASE STUDY

Connecticut’s Alternative Model for Delivering Preventive Oral Health Care

Dental hygienists with at least two years of experience are permitted to work without a dentist’s supervision in public health facilities. In these settings dental hygienists must:
- refer patients for treatment needs outside the dental hygienists’ scope of practice; and
- coordinate the referral for treatment to dentists.
All other dental hygienists working in other settings work under general supervision.

Summary

It is too early to tell how effective Connecticut’s alternative model of preventive oral health care delivery will be. Although the alternative model has been permitted under state statute since 1997, dental hygienists practicing in public health settings have found that their practice has not been affected by the law or the alternative model. Despite the fact that the law permits dental hygienists to bill Medicaid directly for their services, dental hygienists report several challenges that have made this impossible. The Medicaid regulations were in the process of being redrafted at the time of our interviews. It is hoped that allowing dental hygienists to receive direct Medicaid reimbursements will encourage more dental hygienists to work in public health facilities and increase low-income children’s access to preventive care. The alternative model is problematic in that it focuses primarily on preventive care. Although the state’s alternative model requires participating dental hygienists to refer children with treatment needs to dentists, this is challenging because so few dentists participate in the state’s Medicaid program.

Methods

This case study involved an in-depth review of Connecticut’s alternative model of delivering preventive oral health care services to low-income and underserved children. Specifically, we examined the process by which Connecticut passed legislation allowing

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39 Public health facility is defined as a hospital, community health center, group home, school, rest home, health care facility for the handicapped, nursing home, residential care home, mental health facility, home health care agency, homemaker-home health aide agency, substance abuse treatment facility, infirmary operated by an educational institution, and an intermediate care facility for the mentally retarded.
40 Under general supervision, a dental hygienist performs authorized procedures with the knowledge of a licensed dentist, whether or not the dentist is on the premises when the work is being done.
for an alternative model; and whether the alternative model allowed for a change in the delivery system for preventive oral health care services.

In consultation with individuals at CDC, we opted to study Connecticut because it had: 1) enacted a statute which permitted/encouraged an alternative model, and 2) because the alternative model had been implemented. The following major research questions guided our discussions with informants:

- What motivating factors spurred enactment of the public health-oriented provisions in the states’ dental practice laws?
- What was the planning process for developing such provisions?
- To what extent and how are such provisions implicated in the development and implementation of alternative models for delivering preventive oral health care to low-income children?
- Have such provisions encouraged a change in the way preventive oral health care is delivered to low-income children through the alternative oral health care model?
- Are there interim outcomes that suggest that such provisions improve access to, or utilization of, preventive oral health care services by low-income children?
- What were the factors that lead to the defeat of attempts to adopt such provisions/implement the alternative model?

We conducted twelve interviews with a wide range of informants between March 21, 2001 and April 5, 2001. Interviews averaged 60 minutes in length. At the outset, we solicited the participation of representatives from the state public health dental office, state Medicaid dental office, state dental board and/or dental hygienist board, state dental association, state legislators who sponsored the legislation, state dental hygienist association or state pediatric physicians association, providers delivering services under the model, and advocates. Many of the individuals we contacted agreed to participate in the study, others referred us to colleagues who could better answer our questions, and some declined an interview. Since our informants were promised anonymity we will not release their names, nor their professional affiliations due to the highly politicized nature of the subject. A copy of the short interview guide can be found as Appendix A.

The Context

In 1996, of the nearly 3,000 licensed dentists in Connecticut approximately half reported that they considered themselves to be Medicaid providers; however, only 25 to 30 percent of those were active in the program, and nearly 80 percent of active dental providers were not accepting new Medicaid patients.41 These figures are likely overstated since state data have consistently shown that few of the state’s licensed dental providers see Medicaid patients. In March 2000, the Department of Public Health determined that fewer than 10 percent of the state’s licensed dentists were

active Medicaid providers. Two hundred fifty of the 3,000 licensed dentists provide the vast majority of care for more than 300,000 Medicaid recipients (those in both the fee-for-service and managed care programs).\(^{42}\)

Finding dental providers able and willing to see children is difficult since there are only approximately 80 pediatric dentists in Connecticut. When surveyed in 1996, more than 75 percent of pediatric dentists reported that they cared for children insured by Medicaid. However, most (70 percent) were not accepting new Medicaid patients.\(^{43}\)

There are approximately 3,000 dental hygienists licensed to practice in Connecticut,\(^{44}\) most of whom practice in private settings. Dental hygienist practicing in private settings do so under a dentist’s general supervision. This means that the hygienist performs authorized procedures with the knowledge of a licensed dentist, whether or not the dentist is on the premises when the work is being done.\(^{45}\)

A relatively smaller number of dental hygienists practice in public health settings such as school based health centers (SBHCs) and public dental health clinics. Dental hygienists in public health facilities are permitted to work without a dentist’s supervision.\(^{46}\) The Hartford SBHC has a particularly successful program that provides comprehensive oral health care services (both preventive and treatment services). It is estimated that between 65-70 percent of children in Hartford receive services through this program.\(^{47}\) There are 43 public dental clinic sites\(^{48}\) (more than 30 of which are located in the state’s largest cities) and SBHCs in 16 urban schools.

Data shows that while the number of children enrolled in HUSKY Part A\(^{49}\) has increased, the percentage of children and youth under 21 receiving preventive dental services has decreased (29 percent in 1997 to 24 percent in 1999). During fiscal year 1999, only 28 percent of eligible children received any type of dental services (preventive or treatment), and only 12 percent received dental treatment services.\(^{50}\) A study on children aged 3 to 19 who were continuously enrolled in HUSKY Part A for

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\(^{44}\) PA 00-197-sSB 942 An Act Concerning Access to Dental Care for Children, the Elderly, and other Underserved populations.

\(^{45}\) PA 00-197-sSB 942 An Act Concerning Access to Dental Care for Children, the Elderly, and other Underserved populations.

\(^{46}\) Children’s Health Council data extrapolations for State Legislator Nardello.


\(^{48}\) The state’s Medicaid managed care plan.

one-year indicates that utilization rates for both preventive and treatment services improved, however more than one half of the children did not receive any dental services during the year, and 59 percent did not receive preventive dental care.51

Connecticut’s low Medicaid reimbursement rates are the most common reason cited for low dentist participation in Medicaid. The state increased rates in 1993 for services delivered to children; however adult services are still paid at a prohibitively low level. When the state implemented its Medicaid managed care program in 1995, capitation was recognized as a significant barrier to enrolling dental providers. Managed care plans began reimbursing providers at prevailing Medicaid fee-for-service rates which are well below those in the private sector. Medicaid fees in Connecticut are less than the tenth percentile for fees charged by general dentists in New England and well below commercial rates in Connecticut.52 For example, the Department of Social Services (DSS) reimburses dentists who conduct a comprehensive oral examination at $13 for adults and $21.90 for children; in contrast, private insurers pay between $35 and $55 for the same service.53

A class action law suit may resolve some of the dental care access issues faced by Medicaid enrollees. The suit was filed in June 2000 by the non-profit Greater Hartford Legal Assistance, Inc. against the director of Connecticut’s DSS. The lawsuit, filed on behalf of an estimated 182,000 children and 51,000 adults, cites the Department’s failure to meet minimum standards of oral health care for Medicaid recipients and asks the court to order the correction of the alleged deficiencies.

Factors Motivating the Enactment of the Public Health-Oriented Provisions

Several factors contributed to the development and enactment of the public health-oriented provisions of Connecticut’s laws governing dental hygienists. These factors include: 1) incremental changes in the law over several years; 2) involvement of various state councils overseeing the Medicaid managed care program and children’s access to services; and 3) an individual state legislator (and dental hygienist) who was committed to increasing low-income children’s access to oral health care.

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53 The state’s Medicaid managed care plan.

Incremental Changes in the Law

Prior to the enactment of the current public health-oriented statute, there were two incremental changes in the law that permitted dental hygienists to practice in more loosely supervised settings. Several informants reported that these initial changes in the law were necessary to pave the way for the current statute which establishes the alternative oral health care delivery model. Without these initial changes it is unlikely that dental hygienists could have mustered the political and professional support necessary to enact the current law.

The first important change in the law occurred in 1992 when the state’s general assembly enacted a law that amended and updated the statutes on dental hygienists. The law addressed virtually all aspects of their work including scope of practice, places of work, educational and examination requirements for licensure, etc. The act allowed dental hygienists to work under the “general supervision” of a dentist as opposed to under a dentist’s “direct supervision.” In addition, the law changed the dental hygienist’s scope of practice to reflect more current methodology in dental hygiene. It permitted dental hygienists to use professional judgment in providing treatment planning and assessments. This was the first substantive change in dental hygienist scope of practice in 75 years.

Later, in 1994, a second law was passed that changed the regulation of dental hygienists by moving jurisdiction from the state Dental Commission to the Department of Public Health (DPH), and permitted DPH to regulate dental hygienists as an independent discipline. Initially dental hygienists had sought to obtain a separate board and commission similar to those of other professions like dentistry, which would have allowed dental hygienists to regulate themselves. Although DPH understood the dental hygienists’ desire for independence, the Department was not supportive of creating new boards and commissions. DPH suggested the compromise that allowed the dental hygienists to separate from the Dental Commission, be recognized as a distinct profession, and circumvent the need to create a new board or commission.

Involvement of State Councils

The current public health-oriented provisions were also made possible by the fact that several state councils were interested in the issue of low-income children’s access to dental services. The Managed Care Advisory Council (MCAC) oversees the state’s Medicaid managed care program and ensures that children receive quality care. Created by the state General Assembly, The Children’s Health Council’s (CHC) mission is to ensure that all children in Connecticut have access to health services. These

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54 PA 92-35—sHB 5443, An Act Concerning the Regulation of Dental Hygienists.
55 Working under the general direction of a dentist who is present while the dental hygienist performs her work.
56 PA 94-149—sHB 5719 An Act Concerning Dental Hygienists.
groups began to seriously look at children’s dental access issues in 1997. Hearings were held, testimony was given, and studies were conducted to gather data on the issue. Data from some of the studies showed that public health-oriented programs that included dental hygienists had higher utilization rates. These data lent support for the current statutes and the alternative model.

State Legislator’s Commitment to Increasing Oral Health Care Access

Perhaps the most important motivating factor to passage of the current public health-oriented provision was the involvement of a state legislator and dental hygienist committed to increasing low income children’s access to oral health care. This legislator has had more than 30 years of experience as a dental hygienist working in both private practice and public health settings. Prior to her ascent to public office, she recognized the vast differences between privately insured children and those who were uninsured or enrolled in Medicaid. Low income children had disproportionately higher amounts of dental decay and their rates of utilization was lower. This disparity impacted her deeply as a practitioner, especially because dental caries are so preventable. In response, she set out to change the oral health care delivery system to increase children’s access. In 1986, she began writing letters to state agencies suggesting that dental hygienists could be better utilized to deliver preventive services to children. Unsatisfied with the responses she received, over the next several years she became politically active in the state’s Dental Hygienist Association. During her tenure as the Association’s legislative chair, the two laws described earlier were passed. She became interested in the legislative process and was asked to run for political office. She was elected to the state legislature in her second run for office.


The state legislator believed that multiple points of entry were required to get more children into the dental health care system. Her knowledge of the successful school-based health center model in Hartford convinced her that using dental hygienists in non-traditional settings would be ideal to increase children’s access to oral health care services. The Hartford model provided multiple points of entry, was cost effective, and demonstrated higher utilization rates than any other part of the state. The state legislator sought to pursue enactment in legislation that would allow for more programs using dental hygienists.

There are two models of utilizing dental hygienists. The first involves a dental hygienist who conducts an initial assessment and provides on-site preventive services. The second uses dental hygienists as case managers who coordinate children’s care from providers in the community. Both models are considered cost-effective because they allow dentists to focus on providing treatment services; and use less expensive dental hygienists to spend the extra time and attention often needed by low-income and

57 It should be noted that the Hartford model includes both dentists and hygienists and provides a comprehensive set of services.
underserved populations. In addition these models lend themselves easily to implementation in non-traditional settings.

Seeking to create a model that incorporated both methods of using dental hygienists, the state legislator sponsored a bill that would allow dental hygienists to practice unsupervised in public health settings. In 1996 she proposed enactment of the legislation that encouraged this model.

The dental community initially reacted with a great deal of opposition to the bill. The Dental Association was adamantly opposed to the legislation because they viewed it as a poor model of oral health care delivery. They believed (and still do) that the legislation creates a two-tiered system of care by disassociating the preventive oral health care needs of low-income children from those who can afford to see a dentist. In other words, under the system, poor children only have access to a system of preventive care without formal links to resources or facilities that can take care of their treatment needs. Children with private insurance, or the means to pay fee-for-service can obtain comprehensive services. Instead, the state Dental Association supports the notion of integrated oral health care teams to address patients’ comprehensive needs.

Dental hygienists believed instead that organized dentistry was concerned more with turf issues. Furthermore, they believed that dentists were concerned that the law would encourage dental hygienists to set up their own independent practices in the private sector.

Early in the process, there were contentious meetings between representatives of the dentists, dental hygienists and the state legislator to work out thorny issues. As a compromise, in 1997, an initial bill was passed that established an 18-month pilot study which would expire on September 30, 1999. This pilot program was intended to increase access to preventive dental care, particularly among children and the elderly enrolled in Medicaid or who are uninsured or underinsured. The program allowed dental hygienists with two years of experience to work without dental supervision in various public health facilities. Dental hygienists working in such settings were required to: 1) report the results of the assessment to the patient and appropriate staff of the facility; 2) refer any patient needing care outside the hygienist's scope of practice; and 3) coordinate the referral process to access available community resources. In addition, DPH was charged with reporting to the legislature by January 1, 1999 whether the pilot project had an effect on access to preventive dental care, and whether at least 35 percent of the state’s licensed dentists were accepting Medicaid patients. If the level was not reached, DPH was required to make recommendations as to whether the pilot project should continue.

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58 PA 97—SB 627 An Act Concerning Access to Preventive Dental Care. Three other initiatives were proposed at the same time in a consolidated bill: 1) increase Medicaid dental fees; 2) allocate money for special granted projects; and 3) increase research funds. Only the law permitting dental hygienists to work unsupervised in public health facilities was passed.
Dental hygienists believed that although dentists were not seeing Medicaid patients, they were trying to keep the dental hygienists from seeing them as well. Dental hygienists were concerned that the number of dentists participating in Medicaid would decline further, thus making the need for this alternative model more pressing. The state legislator hoped that the language of the pilot program would encourage more dentists to participate in the Medicaid program. At the inception of the pilot program, 29.4 percent of the state’s licensed dentists (775 of 2,637) were accepting Medicaid.59

By the end of the 18-month period, the number of dentists participating in the Medicaid program had decreased to 27.8 percent (741 of 2,669)60. As required DPH conducted a survey on the state’s safety net facilities (e.g., convalescent homes, SBHCs, and community health centers [CHCs]). These facilities were asked whether they had hired or anticipated hiring a dental hygienist as a result of the pilot program, and if the hygienist that the agency currently hired was working unsupervised. The survey found that in most cases, hygienists working in such settings were not unsupervised since the sites also staffed a dentist. In addition, very few safety net facilities reported they would hire dental hygienists as a result of the law. DPH reported that it could not be determined whether the pilot program had significantly affected access to dental care since there was a lack of baseline data.

A new law effective October 1, 1999 was enacted which repealed the pilot program and permanently allowed dental hygienists with at least two years experience to work in public health facilities without a dentist’s supervision.61 In this version, dental hygienists working in these settings were only required to: 1) refer for treatment any patient with needs outside the dental hygienist’s scope of practice; and 2) coordinate referral for treatment to dentists.

The state Dental Association offered no formal opposition to the final law, although they remain opposed to the model. In their view, the law does not encourage the development of integrated oral health care teams. The fact that dentists’ Medicaid participation had declined made it difficult for the state’s Dental Association to argue against the law, as did the dental hygienists’ considerable lobbying clout. Representatives of the dental association report that they were not given the opportunity to be involved in drafting the language of the final bill or to offer their opinion.

The Impact of the Public Health-Oriented Provisions on the Alternative Model

The alternative model is enabled through the public-health oriented law. Previous to the enactment of the law, dental hygienists in public health facilities were required to work under the general supervision of a dentist. This means that dental hygienists performed authorized procedures with the knowledge of a licensed dentist,

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59 Department of Public Health data.
60 Department of Public Health data.
61 PA 99—197 An Act Concerning Access to Dental Care for Children, the Elderly and Other Underserved Populations.
whether or not the dentist was on the premises when the work was being done. Under the current law, dental hygienists working in such settings work without a dentist’s supervision. All other dental hygienists working in non-public health facilities still work under general supervision.

However, dental hygienists working in public health facilities reported that the law has made very little difference in the way they practice. The scope of services they provide has not changed. In addition, dental hygienists who worked in SBHCs and other public health settings before the law was passed reported that they previously experienced considerable latitude under general supervision. For example, many dental hygienists working in public health settings, like SBHCs, reported that previously, they worked under a “dentist of record,” a supervising dentist who agreed to oversee their work, consult on cases, potentially provide treatment services when needed, and allow the facility to use his/her Medicaid provider number for billing purposes. In most cases, the dentist of record provided administrative services and very little clinical care at the facility. Many dentists of record have their own practice and are on-call to the dental hygienist when needed. Dental hygienists working in public health facilities such as SBHCs, are not autonomous or unsupervised; but their dentist of record does not typically impact their work on a regular basis. Such arrangements adhere to the law because dental hygienists work under the knowledge of a dentist who is liable for their work (whether or not he/she is on the premises).

The Impact on the Delivery of Preventive Oral Health Care Services

Thus far there has been no impact on the delivery of preventive oral health care services resulting from the law or the alternative model. Despite the fact that the law permits dental hygienists to work without the supervision of a dentist, hygienists in public health facilities have found that they must rely on a collaborating/supervising dentist to facilitate Medicaid reimbursement. Therefore, as of yet the alternative model has not been implemented, and there has been no change for dental hygienists working in public health facilities.

Reimbursement Issues

Nearly all our informants reported that reimbursement issues remain the biggest barrier to fully implementing the alternative model.62 Informants reported that although the alternative model has been permitted since 1997, no viable funding mechanism has been established to allow dental hygienists to bill for the services they delivered to children enrolled in Medicaid.

Medicaid provider numbers

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62 At the time of our interviews, we were told that the state and various stakeholders were in the process of redrafting new Medicaid regulations that would allow dental hygienists to obtain direct reimbursement.
The first barrier to obtaining reimbursement is dental hygienists’ reported inability to obtain provider billing numbers from the Medicaid department. Dental hygienists intimately involved in trying to implement the alternative model report that no dental hygienist has ever been given a Medicaid provider number by the Department of Social Services (DSS) despite repeated requests. One dental hygienist reported that she was told by DSS staff that dental hygienists will never be issued provider numbers. Another dental hygienist who directs a dental clinic attempted to secure a provider number from DSS so she could bill for the clinical services she provides. She was asked whether there was a dentist on site who would assume responsibility for clinical operations. She was told that she could not be a Medicaid provider outside of the clinic, and that any provider number she received would only be recognized at the clinic, and that DSS would not recognize dental hygienists as Title IXX (Medicaid) providers.

Dental hygienists’ inability to acquire provider numbers significantly inhibits their ability to practice unsupervised in public health facilities that do not also employ dentists. Without their own provider numbers, dental hygienists practicing in public health facilities are required to use a dentist’s provider number to bill for their services, thus potentially inviting the dentist’s supervision and oversight. Other dental hygienists working in public health facilities without collaborating dentists must rely on grant funds to pay their salaries because they are unable to bill Medicaid directly for their services. This raises important questions regarding why children enrolled in Medicaid are obtaining services funded by grant funds that should be used to cover care delivered to uninsured or underinsured children.

State officials explained that there has been great confusion surrounding Medicaid reimbursement. There are two Medicaid funding streams to be considered: 1) managed care; and 2) fee-for-service (FFS). Under the Medicaid managed care system, dental hygienists must be credentialed by each individual managed care organization (MCO) with which they participate. Once credentialed, dental hygienists receive provider numbers and can bill for services. Managed care organizations have been very eager to add dental hygienists to their provider network. This is because DSS allows enrollment in each MCO based on a county provider capacity ratio. DSS freezes Medicaid enrollment in any MCO that doesn’t meet the established ratio. Since MCOs can count dental hygienists as _ providers, including dental hygienists in their provider network helps MCOs meet the dental provider capacity ratio.

State informants contend that the alternative model has been fully implemented under the Medicaid managed care system, because MCOs have allowed dental hygienists to go through the credentialing and licensing process required to be network providers. Dental hygienists insist that this is incorrect. They do agree that MCOs are eager to include dental hygienists in their provider panels, but state that obtaining a credential is challenging because the MCOs have repeatedly lost dental hygienists’ paper work. One dental hygienist who directs a dental clinic and has completed the credentialing process was given a provider number by the MCO; however, the plan has stipulated that the provider number is for the clinic and not for her individually. She still must use a dentist’s provider number to process bills.
State officials reported that the reimbursement process for FFS Medicaid is still being implemented. At the time of our informant interviews, the department was developing regulations that would allow dental hygienists to be reimbursed for their services. Under the FFS Medicaid system, dental hygienists are only required to be credentialed by one agent. Reimbursement flows through EDS, Medicaid's fiscal agent. Dental hygienists working in public health facilities, with at least two years of clinical experience, and who are properly credentialed by EDS may obtain a provider number and be reimbursed. Dental hygienists may acquire their own Medicaid provider numbers even if they never intend to bill Medicaid.

However, according to State officials, dental hygienists may only use their provider numbers to directly bill under certain circumstances. Only dental hygienists who have contracted with a facility and have explicitly stated in their contract that they will be permitted to directly bill Medicaid can receive direct reimbursement. Dental hygienists who are salaried or contracted employees of public health facilities may not bill Medicaid directly for the services they provide. Dental hygienists working in these settings must bill Medicaid through the employing agency's provider number. Medicaid seems to have a more narrow interpretation of "public health facilities" than that outlined in the law. For example, Medicaid officials stated that dental hygienists could only practice unsupervised in certain public health settings (e.g., nursing facilities, ICFMR, group homes, schools, CHCs, and hospital outpatient departments) that have no existing dental clinic on site. In other words, facilities that previously provided services through a dental clinic are excluded.

State informants provided this set of examples: "If a nursing home has a dental chair and the dental hygienist goes there with her own equipment to perform cleanings, she can bill Medicaid directly using her provider number and Medicaid will pay her directly. Although the nursing home has a dental chair, it is not consistent with Medicaid's definition of an outpatient clinic. Even if the dental hygienist is salaried or contracted by the nursing home, the nursing home is not a dental clinic, which means that the hygienist may bill directly. (This situation applies to any situation where the site is NOT a licensed dental clinic.) If a hygienist is a staff person in a public health facility, she cannot bill Medicaid for services that she provides as a staff person; however, that same dental hygienist could go to a nursing home (that does not have a licensed dental facility) in the evening to do cleanings and use her personal provider number for billing. If a hygienist is a contracted individual with an SBHC, she may or may not be able to bill Medicaid depending on her contract stipulations."

According to dental hygienist informants, no dental hygienist has a contract with a public health facility that will allow her to bill Medicaid (independent of the agency) for services. Dental hygienist informants contend that the restrictions imposed by DSS are artificial since their reading of the law permits dental hygienists to obtain reimbursement for services they deliver to Medicaid enrollees. Specifically section 17B-262-699-Subsection A of the Medicaid regulation states that, "The provider (public dental hygienist) may sign claims and bill directly and shall submit claims to the Department according to the procedures set forth (in section of the Medicaid regulations that refer to..."
the sites where dental hygienists may practice unsupervised) and the billing instructions specific to the public health dental hygienist." Informants stated that if the restrictions imposed by DSS stand, it is hard to see how the law will be fully implemented or how dental hygienists' practice in public health facilities would be different since the passage of the law. In addition, it is unclear why dentists may use their own Medicaid provider number at the public health facility and their private practices while dental hygienists may not.

State informants reported that most dental hygienists have their own provider numbers and others are in the process of getting one. They report that Medicaid's provider relations department has created a type and specialty for public health dental hygienists. Furthermore, state officials stated that all hygienists should have a provider number. Since Medicaid regulations state that provider numbers are not tied to the hygienist's place of employment, it is especially important for dental hygienists under contractual arrangements to have provider numbers. They point out that dental hygienists who are under contractual arrangements prohibiting them from directly billing must adhere to their contract stipulations, regardless of Medicaid policy that may allow them to bill. The contractual arrangement is between the dental hygienist and the organization; Medicaid is not a party to the agreement and cannot supersede the contract. The contract has to clearly stipulate that the dental hygienist may bill directly for her services in order for Medicaid to reimburse the hygienist directly.

Reimbursement levels

Dental hygienists who do obtain reimbursement for services delivered in public health facilities will receive 90 percent of the rate paid to dentists for procedure codes that fall under the dental hygienist's scope of work. Since dentists are reimbursed at 30 percent of the usual and customary rate (UCR), dental hygienists will be receiving small sums for their services. Rates paid for children are higher than those for adults. For example, one informant reported that her clinic receives $55 for an assessment and prophylaxis on a child versus $23 for an adult. Another reported that her clinic receives between $21-$24 for a child prophylaxis (depending on whether the child is enrolled in FFS or managed care) and between $19.50 and $24 for an adult.

Several dental hygienists remarked that the low reimbursement levels have an adverse impact on the implementation of the model because they do not encourage the development of independent preventive dental clinics. One dental hygienist remarked that because start-up costs for a new dental clinic would be too expensive, and reimbursements too low, it is likely that very few dental hygienists would strike out on their own. It is likely that dental hygienists choosing to provide public oral health care services would do so only in existing settings. Another dental hygienist remarked that

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63 As we stated earlier no dental hygienist reported obtaining a provider number from DSS, or knowing any who have.
64 Preventive cleaning, polishing, and other measures to prevent disease.
65 These rates are reimbursed under a dentist's Medicaid provider number; dental hygienists will receive 90 percent of the amount.
because Medicaid reimbursement rates are currently so low, no dental hygienist would be able to support herself solely serving the Medicaid population. If dental hygienists are forced to see private pay patients to sustain their practices, they will defeat their public health-oriented purpose.

Assessment Codes

Sometime during the process of implementing the alternative model, it became clear that a new code would need to be established to differentiate an assessment completed by a dental hygienist from an examination conducted by a dentist. Dental hygienists are not permitted to provide exams (only assessments), and dentists are limited in the number of exams that can be reimbursed in a year. Dentists were concerned that if a dental hygienist was paid for an assessment using the exam code, the dentist to whom the child was referred for treatment could not be paid for the exam necessary to plan a treatment regimen.

Difficulty Linking Patients to Treatment Services

Dental hygienists working in public health settings (pre and post the law and alternative model) have found that it is very difficult to identify dentists willing to treat children who are uninsured or enrolled in Medicaid. Few dentists are willing to see Medicaid children in need of treatment, and many have very long waiting times for an appointment. Dental hygienists reported that dentists in their communities have waiting times for non-emergency appointments from 4 to 8 months long. Many reported that when faced with a child with emergent needs they can find a dentist willing to see an uninsured or Medicaid enrolled child, but only after considerable effort.

Although the alternative model requires that dental hygienists refer patients with treatment needs and coordinate referrals for treatment, the law does not encourage dentists’ participation in Medicaid or their ability and willingness to care for the uninsured. In addition, the law does not stipulate what a dental hygienist’s referral network should look like, or how many dentists it should include. Some dental hygienists hope that the legislation and alternative model will put pressure on dentists to step up and agree to treat children. Thus far, however, this has not been the case. The law and the alternative model focus on only half the equation (the prevention side) and only minimally address the treatment side.

Interim Outcomes

Currently the law and the alternative model have not significantly changed the way that dental hygienists practice in public health facilities in Connecticut. Dental hygienists performed the same functions before the law was enacted (e.g. treatment planning, prophylaxis, and care coordination). Prior to the law, dental hygienists worked under the general supervision of a dentist; however, many “dentists of record” were minimally involved in the dental hygienists’ daily clinical activities, although they did
maintain knowledge of and liability for the dental hygienists’ work. The law has the potential to change reimbursement streams for dental hygienists by allowing them to receive direct payments for services they provide independent of an agency or a supervising dentist. However, thus far, no dental hygienists have benefited from this new reimbursement mechanism, and instead have been forced to maintain their ties to a dentist of record for billing purposes. In some cases, billing under a dentist’s provider number encourages the old models of general supervision or in some cases, indirect supervision of dental hygienists. Furthermore, it discourages the creation of new access points (e.g., preventive dental clinics, SBHCs, etc.) since any dental hygienist interested in establishing a public health-oriented preventive practice will have to collaborate with a dentist to ensure she can bill for her services.

Although the law has been in place for several years, it may be too soon to tell how effective the law and the alternative model will be in increasing low-income children’s access to preventive health care services. The new Medicaid regulations may have a positive impact. Work still needs to be done on developing more reliable referral networks to ensure children have access to needed treatment services.

Lessons Learned

Our findings suggest that the following points are essential to developing and implementing a law and alternative model such as Connecticut’s:

- Incremental changes in law that permit dental hygienists to practice in more loosely supervised settings;
- Strong dental hygienist advocacy in the state legislature;
- Unbiased, solid data to clearly state the problem of children’s lack of access to oral health care services which engendered support for the new law and alternative model;
- Early in the process defining reimbursement mechanisms for dental hygienists under the alternative model;
- Building-in a referral mechanism to ensure that while children gain access to preventive services, their treatment needs are addressed as well.
Iowa’s Alternative Model for Delivering Preventive Oral Health Care

Iowa developed a medical model which permits physicians and their delegated auxiliaries to provide preventive oral health services to children. The services include:

- Application of the fluoride varnish provided in conjunction with EPSDT examination (which includes a limited oral screening). Varnish is recommended to applied at least twice a year;
- Physicians are expected to make an effort to refer patients or facilitate referral for comprehensive dental care

Summary

Iowa’s medical model of preventive oral health care delivery has not been successfully implemented for several reasons. 1) Considerable opposition from the Dental association to proceed with any training; 2) physicians uncertainty over reactions from dentists 3) the state has not aided in providing outreach or training for the model; and 4) lack of urgent need for the alternative model (relative to other states). The Iowa Administrative Rule created to allow limited oral screenings and applications of topical fluoride varnishes by physicians was effective on January 1, 2001. As of July 18, 2001, the Medicaid claims system showed that no claims have been filed by physicians for fluoride varnish applications.

Methods

This case study involved an in-depth review of Iowa’s alternative model of delivering preventive oral health care services to low-income and underserved children. Specifically we examined the Dental Practice laws and the process by which Iowa passed legislation allowing for an alternative model; and whether the alternative model allowed for a change in the delivery system for preventive oral health care services.

In consultation with individuals at CDC, we opted to study Iowa because the state 1) instituted an initiative that expanded upon the already-existing medical scope of practice laws to permit/encourage an alternative model; and 2) because the alternative model
had not been implemented. The following major research questions guided our discussions with informants:

- What motivating factors spurred enactment of the public health-oriented provisions in the states’ dental practice laws?
- What was the planning process for developing such provisions?
- What factors lead to the defeat of attempts to implement the alternative model?

We conducted seven interviews with a wide range of informants between July 23, 2001 and July 31, 2001. Interviews averaged 60 minutes in length. At the outset, we solicited the participation of representatives from the state public health dental office, state Medicaid dental office, state dental board and/or dental hygienist board, state dental association, state legislators who sponsored the legislation, state dental hygienist association or state pediatric physicians association, providers delivering services under the model, and advocates. Many of the individuals we contacted agreed to participate in the study, others referred us to colleagues who could better answer our questions, and some declined an interview. Since our informants were promised anonymity we will not release their names, nor their professional affiliations due to the highly politicized nature of the subject. A copy of the short interview guide can be found as Appendix A.

The Context

There are 1,865 dentists licensed to practice in Iowa, this number includes retired dentists or dentists living outside the state who still maintain their Iowa license. Of the 1,865 licensed dentists in Iowa, approximately 95 percent are Medicaid providers; however only 76 percent of them provided dental services to Medicaid recipients from July 1, 2000 to June 30, 2001. That means that 1,355 out of the 1,778 enrolled dentists provided services to Medicaid recipients in that time period. A total of 96,578 Medicaid recipients received dental services in that time period (31 percent of total Medicaid eligibles). More than half of the patients receiving dental services were children under age 21.

Access to dental care is not as severe a problem in Iowa as it is in other states. Nonetheless, many Iowans face significant dental access issues. Some counties have far worse problems than others. Informants reported that counties such as Dubuque, Ames, and Sioux City have particular problems with poor dentist Medicaid participation. In some parts of the state there are no pediatric dentists at all (55 counties were designated dental HPSA’s health professional shortage areas). Access seems to be related more to a workforce shortage overall than anything else.

The state’s Medicaid managed care program, HAWK-I, has focused on increasing children’s access to dental services. According to the Hawk-I evaluation report, the unmet need for all dental care services dropped from 30 to 10 percent. The study further showed that children enrolled in Hawk-I for a year were significantly more likely to have a regular source of dental care and less likely to delay receiving dental
An increase in Medicaid dental fees instituted in 2000 may lead to even greater access.

**HOW THE MODEL WORKS**

Under Iowa Medicaid rules, licensed physicians and auxiliaries under his/her supervision may apply fluoride varnish on children 0-3 and bill Medicaid for the service under a separate medical code for fluoride varnish application.

The varnish is applied when the child comes in for their periodic EPSDT exams, however, this does not mean that the varnish will be applied at every EPSDT visit. The physician or auxiliary screens the child’s teeth to assess for risk factors for caries; check for visible plaque; lesions and review history of decay. If any of the above criteria are present, the child receives the fluoride varnish application. The teeth are “toothbrush cleaned” and the varnish is then applied. Fluoride varnish application is recommended at least twice per year.

The physician billing under the new code receives payment directly from Medicaid under the fee-for-service arrangement. The physician may only be reimbursed for this service three times a year.

**Factors Motivating the Enactment of the Public Health-Oriented Provisions**

Iowa did not enact a new law to allow physicians or their auxiliaries to provide preventive oral health services to low-income children. Rather, this alternative model of preventive oral health care delivery was permitted on a voluntary basis under the state’s already existing dental and medical scope of practice laws.

A group of physicians in Storey County were concerned about children’s lack of access to oral health care. In particular, one physician who had attended an oral health care conference became interested in preventive oral health care. He was concerned that there was a large group of underserved, high-risk children in the country who could benefit from preventive oral healthcare, namely fluoride varnishes. Thereafter, he began to consider what role primary care physicians could play in the application of fluoride varnish. Another pediatrician in Scott County was also interested in preventive oral health care. He strongly advocated pediatrician’s involvement in oral health.

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66 Summary of HAWK-I Survey Results of previously uninsured children.

67 Since the medical practice act states “licensed physicians and surgeons or licensed osteopaths and surgeons who extract teeth or treat diseases of the oral cavity, gums, teeth, or maxillary bones as an incident to the general practice of their profession”, physicians have a qualified exemption to the dental practice act which states: “Fluoride varnish may only be applied by a licensed dentist, licensed dental hygienist, licensed physician or other health professional functioning within their scope of practice or licensure as provided under Iowa Medicaid rules” Iowa Dental Practice Act, Section 153.14 (2)
Another motivating factor was the EPSDT program. Nationwide, this program requires that children be referred to a dentist by age three; however, states have the option of requiring earlier dental referrals. The Department of Pediatric Dentistry (DPD) at the University of Iowa receives funding from a Maternal and Child Health grant and has always promoted early dental visits. Iowa adopted mandatory referrals for Medicaid children at age one consistent with the DPD’s view on early dental visits. Five years ago, the MCH program in an effort to promote early referrals to the dentist by age one, found that physicians were not in compliance withEPSDT requirements which specify that physicians refer children to dentists. MCH discovered that the compliance rate of the EPSDT periodicity schedule was very low, and threatened to withhold federal funding if rates were not increased to 80 percent.

The University of Iowa’s efforts to increase physicians compliance included sending out EPSDT newsletters devoted completely to oral health, screening and referrals. This opened up dialogue with pediatricians who reported that they could not obtain dental appointments for their patients. In some parts of the state, physicians reported that dentists were not taking new Medicaid patients and in general, not children at age one. Physicians in Storey County tried, however unsuccessfully to coax dentists to agree to see their patients. Physicians asked to meet with the Storey County Dental Society and asked the dentists directly if they would see Medicaid children. The dentists voted and decided that they wouldn’t. In particular, the Iowa Chapter of the Academy of Pediatrics had become increasingly frustrated with their inability to find dentists to see children in need of dental care.


Since no public health-oriented provisions were developed or enacted into law, the planning process for developing and implementing the alternative model is discussed.

Approaching DHS

The alternative model began to take shape in the Summer of 2000 when the Iowa Chapter of the Academy of Pediatrics approached the Medicaid advisory committee at the Department of Human Services (DHS) with their idea for providing preventive dental care. The physicians petitioned DHS to create an exception to Medicaid rule/policy and create a waiver to allow physicians to bill for and receive Medicaid reimbursement for the application of fluoride varnish to children 0-3 years of age. The Chapter indicated that children at high risk for early childhood caries lacked access to dental health care and that getting children to see dentists was problematic. The premise was also that children 0-3 would most likely have first point of contact with a physician rather than a dentist. Moreover, the physicians indicated that the proposed service was well within their scope of practice. The request for policy exception and waiver was granted and a draft of the proposed Medicaid rule was created.
Proposed Medicaid Rule

The proposed Medicaid rule allowing physician payment for topical fluoride varnish application was put through an administrative rules process that allowed for public comment. The Medicaid agency knew that this would be a sensitive and publicly charged issue particularly among organized dentistry. Thus, the Medicaid agency allowed for a commentary period that began July 12, 2000. Several compromises were made as a result of this public process which modified the original rules to some extent. Even before this process began and prior to the exception, Iowa Dental Association (IDA) was able to build into rules a series of measures that would provide some oversight on what physicians were permitted to do under the alternative model. Included in the measures was an anticipatory guidance to the parent or guardian of the child instructing them: 1) that the services about to be provided by the non-dental provider was not comprehensive oral health care; and that 2) the patient should obtain dental care from a dentist on a permanent basis for regular oral health care as quickly as possible.

Comments were received from several groups, organizations and individuals. This included dentists, physicians, dental hygienists and the IDA. Medicaid received nineteen comments, to which they responded. Comments were made on the fluoride application itself, disputes over whether a cleaning was needed prior to fluoride application, clarification on the age of children receiving the service, wording for the rule (i.e., dental screening vs. limited oral evaluations), training, referrals to dentists, and reimbursement issues.

Public Comments and Changes to the New Medicaid Rule

Many people were concerned about the application of fluoride. In general, concerns were over who would apply the fluoride and the potential complications that could arise if the services were delegated to physician’s auxiliaries (e.g., nurses, physician assistants). The type of fluoride, strength of application and frequency of application were all questioned too. Comments requested that the rule be clear on the use of the terms “fluoride application” and “fluoride treatment”. It was noted that the term “fluoride treatment” could imply other types of fluoride treatments such as fluoride rinses and topical fluoride gel application, both of which are not appropriate for small children and the latter cannot be easily or safely provided without proper dental equipment. DHS recognized the comment and as a result, the rule was changed to use the term “application of FDA-approved topical fluoride varnish”. DHS also specified that reimbursement for the fluoride application would be allowed up to three times per year in conjunction with EPSDT screenings. This however does not mean that a child would receive a fluoride application with every EPSDT visit.

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68 State officials reported that prior to changing their administrative rules, Iowa law already allowed physicians apply fluoride varnish. However, DHS decided to change their administrative rules to allow physicians to receive Medicaid reimbursement for services delivered to children, as such, public comment was allowed.

69 “EPSDT Periodicity Schedule for physical exams by the medical practitioner are required at the following intervals: every 3 months for ages 6-18 months; annually for ages 2-6; annually thereafter.”
The original petition submitted by the Academy addressed children 0-3 years of age, however the rule made no mention of this age and so clarification was requested. When the age limit was not included in the rule, concern arose over physicians seeing patients of all ages. The Department changed the rule to reflect the upper age limit that was in the original petition.

Commentors also challenged the effectiveness of the fluoride application without a cleaning. They argued that a prophylaxis (cleaning) was needed prior to fluoride varnish application in order for the fluoride to be effective. They also argued that a fluoride application could not be billed alone without a prophylaxis being performed on the same day. Both of these comments were dismissed since current scientific literature does not support these claims, and the topical fluoride application by a physician would be a separate code from dental codes.

Several compromises had to be made during the rules process to allow reimbursement for the alternative model. Among the compromises were those related to reimbursement and wording of the new rules. Some interested parties who commented on the rules noted that the terms “dental screening” and “limited oral evaluation” (e.g. “examination”) could not be used interchangeably and outlined the differences to DHS. They pointed out that the petition originally proposed that physicians would perform an “oral exam” rather than a “screening”. According to The American Dental Association (ADA), an oral exam denotes a more complicated and comprehensive procedure as opposed to an oral screening. Some who commented on the rules suggested that the wording on this specific issue be made clear so as not to portray the “oral screening” as comprehensive dental care which should be provided by a dentist. The result was the use of the term “limited oral screening” instead of “limited oral evaluations.”

The Dental Association also wanted to make sure that physicians could not “double dip.” The original petition requested reimbursement for the dental screening in addition to the fluoride varnish application, however the Dental Association argued that physicians were already being reimbursed for dental screenings through the EPSDT program. DHS was persuaded and limited reimbursement to only cover the fluoride varnish application. Physicians receive the same rate for the fluoride varnish as dentists.

Training

There was much concern over the need for professional training. Some who commented on the rules argued that physicians, their nurses and/or assistants were not trained in dentistry and that as such, children may be receiving inappropriate oral health by unqualified providers. Dental providers wanted assurance that physicians knew how to properly apply topical fluoride varnish and they wanted physicians participating in the alternative model to provide all services (e.g. limited oral screening, topical fluoride varnish application) without delegating them to auxiliaries. The Department defended
its posture by stating that physicians were “medically qualified” to provide the services outlined by the proposed rule and could delegate the screening or the application of the fluoride to an auxiliary (e.g. nurse practitioner or physician assistant) under the physician’s supervision recognizing that the physician accepts responsibility for what the auxiliaries do. The Department did not deny that physicians and their staff needed training on applying the fluoride varnish. Training materials in the form of videos were made available through the University of Iowa College of Dentistry. However, training was not part of the rules but physicians were encouraged to seek out appropriate training.

While the rule change was in process, the Dental Health Bureau and the Department of Public Health worked with the University of Iowa’s College of Dentistry to develop protocols for the application of the fluoride varnish. The University of Iowa College of Dentistry also offered training on the protocols as part of a continuing education course for physicians. This came about in response to requests from physicians for oral health education and fluoride varnish application training. The course offered a hands-on instruction on how to apply the fluoride varnish, infant oral health, examination and risk assessment. Three physicians and eight auxiliary staff from Storey and Scott Counties attended the session. Only one session of the course was conducted and not well attended.

**Revised Medicaid Rule Amendment**

The amendment was adopted on October 11, 2000 and became effective in January 1, 2001. IDA agreed to the rules after they were satisfied that their concerns had been considered. The final rule:

- Allows physicians or their auxiliaries to apply topical fluoride varnish to children 0-3 years of age in conjunction with EPSDT exams;

- Includes the oral screening (counting teeth and assessing risk factors for dental caries) as part of the EPSDT screening examination.

- Required Medicaid to create a separate billing code to reimburse fluoride varnish applications at same rate as dentists. The separate code W2203, used by physicians is an add on code to the EPSDT code. The rate for physicians is the same as the rate of dentists. The amount was $14.00 previous to July 1, 2001. Currently it is 3% less, making it $13.58 per fluoride application.

- Requires that physicians inform parents/legal guardians that the fluoride varnish application is not meant as a substitute for comprehensive dental care and the family should seek regular dental care. Physicians providing the service are expected to make every reasonable effort to refer or facilitate referral for these children for comprehensive dental care from a dental professional. The services rendered under the alternative model would follow
Factors Leading to the Defeat of Attempts to Implement the Alternative Model

Several factors have impeded the implementation of the alternative model. Those factors include: 1) informal opposition from organized dentistry; 2) physicians’ uncertainty over dentists’ reaction; 3) lack of state support for outreach and education about the model; and 4) no urgent need to implement the model statewide. One informant reported that the model has not been implemented because certain managed care organizations (MCOs) refuse to pay physicians even though Medicaid has authorized the payment. Other MCOs will only reimburse for Medicaid enrollees but not commercial enrollees.

Opposition from Organized Dentistry

Although the Iowa Dental Association (IDA) supported the goals set forth by the Academy of Pediatrics for early dental screening, the IDA was not in full agreement with the final rules. Although they had an impact on changing some of the rules, many of their concerns were not addressed. In addition, dentists have also been effective in discouraging further training sessions for physicians. Reportedly, dentists expressed their dismay that the dental school was providing the training. Since then there has been little to no priority put on conducting the training course.

Dentists’ informal opposition to the model has made it difficult to get the program implemented. Without appropriate training, physicians cannot provide fluoride varnishes. Furthermore, the college of Dentistry does not want to overstep the position of the Dental Association, which in part funds programs of the College of Dentistry. Currently, there is no group, organization or state office responsible for the statewide initiative to provide formal training for the alternative model. Currently, one dentist at the dental school provides training by request.

Reportedly, the dental community is reluctant to support the alternative model because they fear that the varnish will be misapplied. Informants also expressed concern that if successful with fluoride varnish, physicians will want to begin providing other dental services. Physicians disagree, saying that the intent of the law was not to eventually allow physicians to apply sealants or do restorative work since such services would go beyond physicians’ area of interest.

Physician Uncertainty over Reactions from Dentists

Physicians are concerned over potential opposition from dentists. Their fear is that participating in the alternative model will make dentists less likely to accept their referrals, however informants reported that the IDA has not stood in the way of
physicians since the ruling went into effect. The Academy of Pediatrics published a newsletter to inform physicians of children’s oral health care needs and the development of the alternative model. The Academy has made many efforts to convince physicians to participate in the alternative model however they believe that participation will only increase if the Dental Association supports the model.

**Lack of State-Funded Outreach or Training for the Model**

State officials reported that it was unlikely that the state would offer money to help facilitate outreach and training as a result of the state’s severe budget deficit. In the future, the Department of Public Health may partner with the University of Iowa to conduct outreach and training for the model; however it is hard to tell if this will happen given the state’s budgetary constraints.

The Iowa Chapter of the Academy of Pediatrics wants to ensure that medical providers are properly trained to apply fluoride varnish and is working on the problem. The Academy is considering having a community training to demonstrate the topical fluoride varnish procedure to physicians. In addition, the Academy would like to go into each community to talk about oral children’s oral health care needs and the benefits of fluoride varnish in children at high risk for developing early childhood caries.

**No Urgent Need for the Alternative Model**

Despite the good intentions of the Academy of Pediatrics and other well-intentioned physicians, the model has not gotten the attention they expected. Many physicians have not heard that they can do this procedure in their offices and be reimbursed by Medicaid. With no state initiative or outreach to get the word out, the alternative model may die out. The attendance at the training held at the University of Iowa indicated that the push for the alternative model was coming only from two counties, Scott and Storey County. In addition, physicians in those two counties seemed to have the greatest trouble finding dentists to see their patients. Therefore interest in the model was basically isolated to a few counties where the need was greater and only physicians in those areas had demonstrated interest in the alternative model. Were it not for the two pediatricians in Scott and Storey County, the alternative model would not exist. The special interest they have in oral health care access for children has been the only force keeping the initiative alive. Medicaid did not anticipate great use of the model by physicians. The need for the model no longer exists in one of the counties since the pediatricians were able to recruit a young pediatric dentist to that county. This pediatric dentist reportedly now has a practice with 50 percent Medicaid patients.

Applying Iowa does not have a severe statewide oral health crisis. Despite the fact that much of the state has been designated dental HPSAs, it seems that when there is a need, a physician can rely on a dentist to see a child on Medicaid. All our informants reported that only Storey and Scott counties have dire access needs. An informal referral network has been developed but is dependent on the area of the state.
The University of Iowa has created a referral guide outlining which dentists are willing to see either Medicaid children, very young children (0-3), or children with special health care needs. This resource directory helps facilitate physicians referrals to local dentists.

Due to all of the above factors related to the model not being implemented, informants anticipate that it will be several years before the model is operational.

**Lessons Learned**

Our findings suggest that the following points are essential to implementing an alternative model such as Iowa’s:

- Strong State funding for outreach and most importantly, for training;
- Great need for preventive oral health care, especially among children on Medicaid;
- Support from the dental community for physicians to provide services under the alternative model;
- Ensure that most providers will participate in the model and provide sufficient communication with the medical community to let them know what is going on.
APPENDIX H
NORTH CAROLINA CASE STUDY

North Carolina’s Alternative Model for Delivering Preventive Oral Health Care

Dental Practice Laws provide an exception that allows any duly licensed physician or surgeon to provide dental services so long as such services are delivered within the practice of the physician’s profession. Licensed physicians or the designated clinical provider functioning under standing orders may provide initial and periodic oral screening, patient education and the application of fluoride varnish in physician’s offices; health department clinics; Federally Qualified Health Centers (FQHC); rural health clinics; and other appropriate clinic settings.

Summary

The alternative model of oral health care delivery is a culmination of many different efforts undertaken by the state and other concerned individuals to improve oral health care access for low-income children. Overall, the development and implementation of the model has been an effective collaborative process. Some form of the alternative model (pilot project) has been in existence since 1999; however, physicians have always been permitted to provide oral health care services under their scope of practice. Medicaid spearheaded the statewide initiative and facilitated statewide implementation of the model through adequate reimbursement mechanisms. Although it is too early to tell how effective the model will be, it has been accepted by physicians who are eager to receive training on the application of fluoride varnish. Widespread implementation has yet to occur because of the difficulties involved with mass statewide training; however, there is significant statewide activity that is facilitating progress toward widespread implementation. It is hoped that physicians will be able to develop referral networks with local dentists so that children in need of dental care can be referred to a dentist and children aging out of the alternative model70 will be able to continue preventive care and receive treatment from a dentist. Many physicians currently providing services under the model have reported difficulties with referring children with treatment needs to a dentist.

Methods

This case study involved an in-depth review of North Carolina’s alternative model of delivering preventive oral health care services to very young, low income and underserved children. Specifically we examined the process by which North Carolina

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70 Age eligibility for the alternative model is 0-3 years of age.
passed legislation and rules and regulations allowing for an alternative model; and whether the alternative model allowed for a change in the delivery system for preventive oral health care services.

In consultation with individuals at CDC, we opted to study North Carolina because it has 1) statutes which permitted/encouraged an alternative model, and 2) because the alternative model had been implemented. The following major research questions guided our discussions with informants:

- What motivating factors spurred enactment of the public health-oriented provisions in the states’ dental practice laws?
- What was the planning process for developing such provisions?
- To what extent and how are such provisions implicated in the development and implementation of alternative models for delivering preventive oral health care to low-income children?
- Have such provisions encouraged a change in the way preventive oral health care is delivered to low-income children through the alternative oral health care model?
- Are there interim outcomes that suggest that such provisions improve access to, or utilization of, preventive oral health care services for low-income children?
- What were the factors that led to the defeat of attempts to adopt such provisions/implement the alternative model?

We conducted 13 interviews with a wide range of informants between June 4 2001 and June 20, 2001. Interviews ranged 60 minutes in length. We solicited the participation of representatives from the state public health dental office, state Medicaid dental office, state dental board and/or dental hygienist board, state dental association, state legislators who sponsored the legislation, state dental hygienist association or state pediatric physicians association, providers delivering services under the model, and advocates. Many of the individuals we contacted agreed to participate in the study, others referred us to colleagues who could better answer our questions, and some declined an interview. Since our informants were promised anonymity, we will not release their names, nor their professional affiliations due to the highly politicized nature of the subject. A copy of the short interview guide can be found as Appendix A.

The Context

In 1999 North Carolina ranked 45th in the nation in the number of dentists per 100,000 residents (38 dentists per 100,000 residents compared to a national average of 62).71 Of the 3,037 dentists in the state, eighty-one percent practice general dentistry; there are only 47 actively practicing pediatric dentists. Most practitioners cluster in the state’s urban areas (the Triangle72, Charlotte, and the area around Greensboro). Sixty-four counties, most of them rural, have lost dentists over the past 10 years.73 There are

72 Raleigh, Durham, Chapel Hill
73 As reported by the Sheps Center for Health Services Research at UNC.
four counties with no dentists at all, and 36 counties where there are no dentists currently offering services to Medicaid recipients. Seventy-nine percent of North Carolina counties (n=79) qualify as nationally recognized dental professional shortage areas. The scarcity of dentists is compounded for people covered by Medicaid because only 16 percent of the state’s 3,037 dentists participate in the program. As a result, only 95,000 out of 665,000 children on Medicaid received preventive dental care in 1999.74

With an overall shortage of dentists, there are insufficient dentists to serve the insured population, let alone low-income Medicaid or uninsured populations.75 Oral health is the number one unmet healthcare need in North Carolina as reported by the public, directors of Head Start programs, administrators of long term care facilities, directors of local health departments and other social service agencies.76 Virtually all dental disease can be found in only about one third of children, most of whom qualify for Medicaid, yet only 12 percent of North Carolina’s Medicaid-enrolled children 1-5 years of age visited a dentist in 1998.77 The small number of pediatric dentists in the state further aggravates the oral health care access problem facing the state’s low-income children. Twenty five percent of children entering kindergarten each year have untreated dental decay. Some clinicians believe that providing fluoride varnish to very young children could help to reduce the incidence of dental disease among this population by approximately 40 percent.78

Historically, there has been a struggle to provide access to oral health care for beneficiaries of entitlement programs (specifically Medicaid) because of low reimbursement. Medicaid’s dental budget has never exceeded more than 2.5 percent of the overall Medicaid budget. Medicaid currently reimburses dentists 62 percent of the usual and customary rate (UCR) on 44 of the most utilized dental codes, and 40 percent UCR on all other dental codes. Over any given time period, such low reimbursement has contributed to lower than 30 percent Medicaid participation rate among state dentists. The state Senate recently passed a bill (Senate Bill 863 and 1005 section 21-98) to increase Medicaid dental rates to 80 UCR or 100 percent of the 80th percentile. This bill has received a great deal of criticism because it attaches stipulations to the increased reimbursement; participating dentists must prove that they are utilizing the system for care coordination.79

Legislative action has been taken to increase the state’s supply of dental professionals. House Bill 974 and Senate Bill 861 permits licensure eligibility for out-of-

75 North Carolina Institute of Medicine Task Force on Dental Care Access. Report to the North Carolina General Assembly and to the Secretary of the North Carolina Department of Health and Human Services.
76 North Carolina Department of Medical Assistance HCFA grant application “Innovative Management of Dental Decay for Young Children Enrolled in Medicaid and SCHIP.” July 31, 2000.
77 Ibid
78 Ibid
79 The NC General Assembly passed the budget on September 21, 2001 and included a $1 million appropriation for 2001-2002 fiscal year and $2 million for 2002-2003 fiscal year to be used to develop and implement a plan to improve access to dental services for Medicaid-eligible children and Medicaid-eligible adults. It does not specifically allocate the funds to increase Medicaid reimbursement rates and leaves it up to the Department to consider various options.
state dentists who have graduated from accredited dental schools and have successfully passed the national and state board examinations in their respective states. However, the bill’s proposal for dental hygienists states that [out of state] candidates must have successfully completed board approved dental hygiene training. This section of the bill has received major criticism from North Carolina dental hygienists because it does not require that out-of-state dental hygienists graduate from an accredited dental hygiene school.80

Some observers have suggested expanding the dental hygienists’ autonomy as a method to increase access. However, the state’s 3,623 licensed, registered dental hygienists are prohibited from practicing without a licensed dentist present (direct supervision).81 In addition to shortages in dental professionals, geographical; cultural; and language diversity has also contributed to North Carolina’s access problem.

In comparison to the short supply of dentists, there are about 20,000 physicians in the state; 2,038 are family practitioners and 1,142 are pediatrics. Historically, practice guidelines have given the medical profession almost total responsibility for the prevention and early detection of oral diseases in children younger than 3 years of age.82 The American Academy of Pediatric Dentistry and the American Dental Association now recommend that the first dental visit occur around age one.83 However, the supply of dentists, specifically pediatric dentists impedes adherence to recommendation.

How the Alternative Oral Health Care Model Works

Physicians and/or the designated clinical provider functioning under standing orders deliver a package of services (initial and periodic oral screening, patient education and the application of fluoride varnish) to Medicaid enrolled children ages 0-3 years old. Physicians bill Medicaid directly and are reimbursed at a bundled rate ($43 for the initial assessment and $35 for follow-up visits); however, reimbursement is contingent upon providers offering patients all three components of the service package. Up to six fluoride applications are allowed over a 3-year period; physicians may bill the initial code once and the subsequent code as many times as Medicaid allows. Physicians are expected to develop referral networks with local dental providers and refer patients in need of treatment services.

80 In a vital role, hygienists need academic credentials. The News and Observer. April 28, 2001
Factors That Spurred the Development of the Alternative Model

Several factors contributed to the development and enactment of the alternative model. These factors include: 1) prior knowledge of a similar model operating in another state; 2) a simultaneous alternative model operating in the state; 3) the involvement of several key individuals and agencies concerned with improving oral health care access; 4) grant funding; 5) significant research findings that documented oral health care needs among low-income populations; and 6) provider interest.

Prior Knowledge of a Similar Model

Prior to the development of the current alternative model, state officials in North Carolina were made aware of a similar model operating in Washington State. Informants reported that Washington State’s model was the impetus for North Carolina’s model, specifically, the Medicaid reimbursement structure. Both states’ practice laws are similar in that physicians are excluded from the state’s dental practice laws and are permitted to provide all services that fall under their scope of practice. However, prior to a change allowing Medicaid reimbursement, there was no reimbursement mechanism available to physicians who chose to do so. Informants reported that they used materials from Washington State to demonstrate that this type of service delivery method was indeed viable. However, North Carolina differs from Washington State in provider acceptance level, reimbursable services and program structure. North Carolina is the first state to operate a statewide initiative (i.e. the alternative model) that is federally funded and has a built-in evaluation component. The Washington State Medicaid agency was very instrumental in helping North Carolina’s Medicaid Department emulate the model using physicians to provide preventive oral health care services.

Simultaneous Project in the State

A similar initiative, Smart Smiles operated shortly before simultaneously with North Carolina’s alternative model. The Smart Smiles program is a spin-off of the state’s Smart Start program (a state public/private partnership that targets the preschool (ages 0-5 years old) population); however, Smart Smiles focuses on oral health care in the Appalachian region of the state. Pursuant to the extensive oral health needs of Appalachian children, Smart Smiles applied for and was awarded a two-year grant from the Appalachian Regional Consortium. Grant funds were used to develop and implement a method to address children’s oral health care needs as well as their lack of access to dental care. After much deliberation the Smart Smiles program implemented a fluoride varnish program in 9 counties of the state (Appalachian regional chain) where dental decay among Appalachian children was most rampant. Although the program initially intended to use dental hygienists as service providers, opposition from local dentists caused the program to choose physicians instead, hence a medical model of
delivery. The program used grant funds to provide the varnish; however, physicians were required to donate the service.84

The Smart Smiles program began in 1998 and was in operation for a short time before discussion and collaboration with the North Carolina Division of Medical Assistance began.85 In fact, the full delivery package that was to be provided by physicians operating in the Smart Smiles program (and ensuing statewide alternative model) was not developed until the Medicaid agency became involved. In addition to providing Smart Smiles with program development assistance, the Medicaid agency provided reimbursement to physicians participating in the Smart Smiles program; however, services provided to non-Medicaid enrollees continued to be either donated by physicians or paid for by Smart Smiles grant funds.

Once physician reimbursement codes and the delivery package were developed, the state Medicaid agency began an 18-month pilot project called “Into the Mouths of Babes” that utilized the same model as the Smart Smiles program. The Medicaid agency used some of the information from the Smart Smiles program (e.g. informational handouts, training manual, etc.); however, the information was tailored for Medicaid providers and clientele. Although both projects/programs served as testing phases for the current statewide alternative model, the projects differ in that Smart Smiles emphasizes the application of fluoride varnish and outreach, while the Medicaid project (and ensuing state alternative model) focuses on the provision of a three-component package that includes fluoride varnish, oral assessments and patient education. Many informants reported that the projects feed-off of and benefit one another.

Involvement of Several Key Individuals and Organizations Concerned with Improving Oral Health Care Access

The current model was also made possible by the fact that several influential individuals and organizations were interested and willing to collaborate on the issue of low-income children’s access to dental services. These individuals and organizations lent credibility to the model and facilitated its development. The initiative is a result of collaboration among the Division of Medical Assistance (Medicaid), Division of Public Health, University of North Carolina (UNC) School of Dentistry, UNC School of Public Health, North Carolina Academy of Family Physicians, and the North Carolina Pediatric Society. Each organization provided key elements to the model.

The person primarily responsible for identifying fluoride varnish as a viable preventive tool in very young children was a pediatric dentist and former dean of the UNC School of Dentistry. He was very interested in the application of fluoride varnish to young children. His involvement in the program gave it credibility and garnered provider acceptance and participation. Although he originally targeted the dental community as

84 The program initially experienced low participation among providers, which increased after Medicaid reimbursement became available.
85 Discussion with Medicaid began in July 1999 at which time Smart Smiles modified the practitioner’s training presentation and service delivery package to comply with Medicaid stipulations.
primary providers of the varnish, it was suggested that pediatrician participation would enhance the availability of the service among hard to reach populations.

Most notable among the organizations involved in the development of the model is the North Carolina Division of Medical Assistance. All informants reported that the statewide model would not have been possible without the involvement of the Medicaid agency. The Agency took the lead on the development and implementation of the model by developing physician-delivered oral health reimbursement codes, setting comparable rates, and developing the service package. Medicaid is also responsible for expanding the "Into the Mouths of Babes" pilot project into a statewide initiative. In addition, the Medicaid agency is the grantee for many of the oral health care grants that have been awarded to the state. The responsibilities of the other collaborating partners include the North Carolina Academy of Family Physicians, which is responsible for training, and UNC provided much of the research findings to justify the model and the benefits of fluoride varnish.

The availability of federal grant funding added further incentive to develop and implement the alternative model. The only state funds used to operate the model are in the form of Medicaid reimbursement (which comes from the medical budget, not the dental budget). All other aspects (i.e. training and evaluation) are paid for by grant funding. The fact that the program received federal funds elevated its visibility statewide and added to its credibility.

The Division of Medical Assistance along with collaborating organizations was awarded grants from the Health Care Financing Administration (HCFA), Health Resources Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). In total, the state received $345,000 in grant funds intended for the development and evaluation of medical interventions for early childhood caries. A $2 million grant from HCFA was awarded to the collaboration as well as a $2.5 million grant from the National Institutes of Health (NIH) to evaluate the cost effectiveness of fluoride varnish applications on children in the Smart Smiles project. Informants reported that a total of five million dollars combined were received in grant funds from the Appalachian Regional Commission, NIH, HCFA, HRSA and CDC all intended to address oral health care needs of children.

The "Into the Mouths of Babes" 18-month pilot project was essentially the state's response to a federal RFP (request for proposals) that sought innovative ideas to reduce early childhood caries. Although the alternative model had already been developed and reimbursement for services available through Medicaid, the state required medical personnel to be trained but had no funds to provide training to physicians wishing to provide oral health care services. The grant awarded to the state allowed them to buy training materials and hire a dental hygienist to provide the training; prior to grant funding training was donated by the retired pediatric dentist who originally stimulated the interest in fluoride varnish and voluntarily provided pilot trainings.
The purpose of the grant was to develop a method to evaluate the training aspect of the model. The grant instituted a study portion of the project that included CME and training of 120 medical practices (3 cohorts of 40 practices) that have been identified as seeing a large number of Medicaid children. Three training curriculums are being tested as part of the HCFA training evaluation grant. The first curriculum is a conventional CME, the second combines conventional CME with learning collaboratives where participants participate in conference calls to discuss implementation efforts and the third curriculum contains both components as well as a dental hygienist who conducts on site visits to physician offices. Medical practices are being recruited to implement the model and are assigned to one of the three training groups called Access I, II and III. The three groups will be evaluated to determine the most effective method of training. This grant broadened the scope of the original “Into the Mouths of Babes” project that eventually expanded into a statewide initiative (i.e. the alternative model).

**Documented Oral Health Care Needs Among Low-Income Populations**

The North Carolina General Assembly charged the state Department of Health and Human Services (DHHS) to evaluate and recommend strategies to increase the level of participation of dentists in the Medicaid dental program and to improve the Medicaid program’s provision of preventive services to Medicaid patients. Specifically, the Department was directed to develop strategies for: 1) assisting dentists in increasing the number of their Medicaid patients; 2) increasing Medicaid patients’ access to quality dental services; 3) informing dental professionals on how to better integrate Medicaid patients into their practices; and 4) expanding the capacity of local health departments and community health centers to provide properly diagnosed and supervised preventive dental services such as sealant, fluoride, and basic hygiene treatments.\(^8^6\)

DHHS asked the North Carolina Institute of Medicine (IOM) to undertake the study; the IOM convened a task force of prominent state dentists, dental professionals, public health practitioners, physicians and other interested citizens. Their ensuing report documented the vast unmet oral health needs of the Medicaid population and helped to pave the way for subsequent action to address those needs. The task force made several recommendations to the General Assembly that included increasing Medicaid reimbursement to 80 percent UCR (Recommendation #1); and suggesting that the Division of Medical Assistance develop a new service package and payment method to cover early caries screenings, education, and the administration of varnish provided by physicians and physician extenders to children between the ages of 9 and 36 months (Recommendation #18).\(^8^7\)

**Provider Interest**

Informants reported that North Carolina has a very child friendly, public health/policy environment. The fact that physicians were eager to participate in any

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\(^8^6\) North Carolina Institute of Medicine Task Force on Dental Care Access. Report to the North Carolina General Assembly and to the Secretary of the North Carolina Department of Health and Human Services.  
\(^8^7\) Ibid
intervention that would improve the health of children encouraged the development of the alternative model. Several informants reported that pediatricians were asking for this type of model even before its inception. One informant believed that pediatricians' interest in and acceptance of this alternative oral health model is akin to their participation in other public health initiatives (e.g., vaccinations). Prior to the alternative model there was a significant increase in the number of Medicaid children served in private pediatric practices, which is attributed to the inception of the state’s Medicaid managed care program. North Carolina began providing funding for universal vaccines in 1994 (now ranked 6th in the nation for immunization rates) and most immunizations were done by the private sector. Informants reported that the private sector has been very responsive to public health initiatives (e.g. SCHIP).

Pediatricians were inclined to do something about children’s oral health care access. A national survey revealed that 74 percent of pediatricians expressed a willingness to apply fluoride varnish in their practices. It was very likely that physicians would participate once reimbursement was available for physician-delivered preventive oral health care services. In summary, this particular alternative model was chosen because physicians, (specifically pediatricians) are in contact with young children more frequently than dentists are, and because physicians showed great interest in the alternative model even from its beginning stages.

No Legislative Action Needed

No legislative process was required to implement the model. Physicians may provide oral health care services because both the dental practice and medical practice laws are broad enough to allow it. Dental Practice Laws provide an exception that allows any duly licensed physician or surgeon to provide dental services so long as such services are delivered within the practice of the physician’s profession.

Planning and Implementation of the Alternative Oral Health Care Model

North Carolina’s Department of Medical Assistance believes that the best way to improve children’s oral health care is to prevent disease. This belief led to Medicaid’s

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89 Dental practice is defined broadly to include anyone who attempts to or claims to “diagnose, treat, operate, or prescribe for any disease, disorder, pain deformity, injury, deficiency, defect, or other physical condition of the human teeth, gums, alveolar process, jaws… and/or adjacent structures of the oral cavity.” Dental practice provisions do apply to “any act by a duly licensed physician or surgeon performed in the practice of his profession.” N.C. Gen. Stat. § 90-29 (C-1) Since the provision is extremely broad, and the definition for the scope of practice of medicine is equally unspecific, a physician may arguably provide preventive dental services in “Board approved” settings. The scope of practice of medicine is as follows: “Any person shall be regarded as practicing medicine or surgery…who shall diagnose or attempt to diagnose, treat, or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person.” N.C. Gen. Stat. § 90-18 (b)
support of the alternative model of oral health care delivery that allows medical personnel to provide oral assessments, patient education, and fluoride varnish to children 0-3 years of age. While providers may provide services to children of any age and at any income per their scope of practice law, Medicaid only reimburses for services provided to children in the specified age group. It is important to note that many of the events described in this section occurred simultaneously rather than consecutively.

Planning

Since the state’s alternative model really began as a pilot project (“Into the Mouths of Babes”), the planning process for the pilot is essentially the planning process for the overall statewide model. The “Into the Mouths of Babes” project was an initiative to target dental screening and the application of fluoride varnish by pediatricians and family practice physicians. The genesis and establishment of the Smart Smiles project (discussed in the previous section) provided a conceptual framework and important experiences for the “Into the Mouths of Babes” project.

The six collaborating organizations (Division of Medical Assistance (Medicaid), Division of Public Health, University of North Carolina (UNC) School of Dentistry, UNC School of Public Health, North Carolina Academy of Family Physicians, and the North Carolina Pediatric Society) had equal input in designing and implementing the pilot project/alternative model (what they would do, when, how, what population, and what type training would be provided). Project partners believed that a medically delivered oral health preventive package could be conveniently added onto a clinical provider's existing services for young children (e.g. for immunizations and well child check ups).

The group went before the state Dental Board, Medical Board and Nursing Board to talk about the state’s practice laws in relation to the development of the alternative model. The Dental Board was not opposed to clinicians applying fluoride varnish. The state Medical Board interpreted the state practice law as allowing physicians to do basically anything they wanted to do under their medical scope of practice. Although the state Dental Board was notified of the project, the dental community (state Dental Board and the Dental Society) did not have much involvement in the development of the project. Project partners desired to include the Dental Board in the planning and implementation process in order to get their input and acclimate the dental community to the impending change in preventive oral health care provision.

Project partners also met with the former president of the Dental Society and the new member of the Board of Dental Examiners because both lived near the pilot sites. A group consisting of a dental hygienist; a public health dentist; and a public health professional supervised the pilot sites. These three individuals met with the Dental Societies in the counties where the pilot would operate. The Societies were briefed on the project and their involvement and input was sought. Overall, both the Dental Society and the North Carolina Academy of Pediatric Dentists supported the project.
The state Nursing Board questioned the model the most and needed a great deal of reassurance that oral health care services could be legally provided by nurses. The biggest issue was with public health nurses working in public health departments where there was not always a physician on site. Project partners developed standing orders that registered nurses and licensed practical nurses would follow; these orders can be modified by the physician to fit their particular service area. The orders dictated that the health department’s collaborating physician sign-off on orders, thereby, permitting the nurse to provide services. However, the process was modified for services delivered in private office settings; all project partners agreed that physicians in these settings should provide the initial oral assessment but may delegate other services (patient education and application of fluoride varnish) to anyone in the office. The program rules require that a licensed professional provide the service and project partners anticipated that nurses and physicians would provide the bulk of services.

Several months after discussions with the state practice boards, the state Medicaid agency developed the service delivery package as well as separate payment codes for physician delivered oral health care services (W8002 and W8003). Separate billing codes prevent double billing for dental screening performed by a dentists and physicians. Medicaid reimburses physicians $43 for the initial assessment (W8002) and $35 for follow up visits (W8003). Providers must offer patients a 3-component package of services: an initial oral assessment, patient education and the application of fluoride varnish. The package is recommended for all Medicaid eligible recipients from the time teeth erupt to 36 months of age; up to six applications are allowed over a 3-year period. Physicians may bill the initial code once and the subsequent code as many times as Medicaid allows; Medicaid pays a bundled rate for all three components.

Although periodic oral screening is recommended every 4 to 6 months after the initial oral screening and reimbursement is provided, Medicaid allows flexibility in billing in addition to simplified billing procedures. Medicaid realized the difficulty physicians would have scheduling services on a stringent periodic basis and relaxed billing requirements to allow providers to deliver all the components package within a longer billable period. Most providers have found it easier to fit a fluoride varnish application into a patient’s routine well child or sick child visit rather than bring a child in periodically solely for the varnish. Although there must be [at least] a 3-month period between fluoride applications, providers have a 4 to 6 month window of opportunity in which to bill Medicaid. This flexibility allows providers to piggyback oral health services onto other medical services.

Implementation

The “Into the Mouths of Babes” 18-month pilot project began in December 1999 in several counties of the state and quickly preceded to the current statewide alternative model. The Medicaid agency chose to roll the model out statewide during the infancy stages of the pilot project; the pilot expanded to a statewide initiative April 2001.

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Although the alternative model had the potential to initiate turf battles between dentists and physicians, informants reported that dentists acquiesced to the model after the program (specifically its limitations, eligibility, and allowable services) was fully explained. The bulk of opposition to the model is from individual dentists rather than from the state Dental Board or Dental Society. Some informants reported that opposition might have been greater if sealants or the use of dental hygienists were included in the alternative model. While a few dentists do not like the fact that physicians are providing preventive oral health care services, most dentists do not provide fluoride varnish to their patients and most do not serve this [young] population anyway. Reportedly, some dentists’ hesitancy toward the model was related to the lack of proven efficacy of fluoride varnish on this age group; however, overall, opposition to the model has not been an issue.

Training

Medicaid stipulated that all providers must receive training before being allowed to receive Medicaid reimbursement. Training was originally provided free of charge by a retired pediatric dentist; however, the massive amount of training required by physicians necessitated changes. Currently, a dental hygienist at the Academy of Family Physicians provides the training. Normally one person from a physician’s office attends the training and then trains his/her coworkers. The North Carolina Division of Public Health Oral Health Section, Division of Medical Assistance, UNC School of Dentistry, UNC School of Public Health, NC Pediatric Society, and the dental hygienist employed by the Academy of Family Physicians designed the curriculum for both the pilot project and statewide rollout. Physicians who wish to provide oral services may contact the Academy for Family Physicians for training; registration forms are required along with a $15 fee. Training sessions have been approved by the American Medical Association for 1.5 continuing education units.

As mentioned earlier, grants awarded to the state provided training funds for the model. One grant instituted a study portion of the project that included CME and training of 120 medical practices. Medical practices that are recruited to implement the model are assigned to three training groups called Access I, II, and III. The three groups will be evaluated to determine the most effective method of training. Some informants believe that, although a priority, the focus on training the study sites has slowed the overall, statewide training process and subsequent statewide roll out of the model. Others contend that the statewide roll-out should have waited until the study was completed to learn which methods of implementation work best.

91 In May 2000 the North Carolina Denatal Society passed a resolution in support of the preventive package provided by physicians.
92 It is estimated that fewer than 10 percent of private dental practices in NC use fluoride varnish; however, they use another type of (gel) fluoride treatment. Informants report that dentists may not be providing fluoride varnish because they don’t know about the product or that it is a Medicaid reimbursable service.
93 Training is funded by the HCFA/HRSA/CDC training evaluation grant.
94 “Innovative Management of Dental Decay for Young Children Enrolled in Medicaid and SCHIP”
Impact on the Delivery of Oral Healthcare Services

Prior to the pilot project, children had only received topical fluoride treatment through a dental office. Although physicians could legally provide the service, they were not trained to do so, nor was there a source of reimbursement to provide incentive to deliver the service. At the time of our interviews, 192 medical practices had been trained to provide oral health care services. The initial training provided by the retired pediatric dentist provided training to 60 practices in a 6-8 month period; 40 percent of these practices adopted the procedures in various increments. None of our informants could report on the actual number of physicians currently providing oral health care services; however, all reported that the medical community has fully embraced the model. Each physician office has structured the services to fit its particular method of operation. Most physicians use a combination/team approach in how they are providing oral health services by incorporating varnish applications into normal medical office type visits. While some physicians have delegated services to other providers in their office, other physicians are providing services themselves.

Interim Outcomes

Medicaid statistics indicate that over 5,000 children have received initial oral assessments from a physician or physician extender and over 500 have received follow-up care. These statistics do not take into account non-Medicaid children served through the Smart Smiles program. Smart Smiles physicians have provided 2,000 fluoride varnish applications since December 1999 (1,700 initial visits and 300 follow up visits). Medicaid estimates that it has spent close to $300,000 in provider reimbursement for the two codes (W8002 and W8003) and processed 8,000 claims.

It is estimated that close to 170,000 children could eventually qualify for the service under Medicaid. Health officials want to encourage physicians to apply the varnish because physicians have been far more willing than dentists to treat Medicaid patients. For example, nearly one in three North Carolina children had been eligible for Medicaid in 1998; yet, about 9 in 10 private dental practices did not make children on Medicaid a regular part of their practice during that period.95

It is apparent that although children are receiving initial care, there is a significant drop-off in the number that return for follow-up. Informants reported that this is of great concern since the efficacy of fluoride varnish is increased through repeated applications. Concerns over comprehensive care were also reported. While the alternative model addresses the preventive side of oral health care, it does not address treatment. It is hoped that physicians providing oral heath services under the alternative model will be able to establish a referral mechanism with area dentists. It is important that physicians communicate regularly with area dentists so that a referral mechanism exists for children with dental treatment needs, and so that those dentists will be receptive to treating children once they have aged-out of the alternative model.

Physicians have expressed concern about an inadequate dental referral network and some expressed concern about providing the preventive dental package, given the difficulty in referring young patients. There has been concern over the location of dentists willing to accept referrals; while many physicians call local providers to ask for assistance with referrals, many physicians reported that they must refer families to dentists that are located a significant distance from the patient’s home. Informants reported that most dentists view physicians as peers and are willing to accept referrals from them; however, this varies by county. Informants reported that some physicians had relationships with dentists prior to the alternative model while some physicians are currently in the process of developing relationships. Although the supply of dentists may prohibit the formation of a formal referral network for treatment services, the legislature believes that increased Medicaid dental reimbursement may encourage the development of informal networks.

All informants reported that it is too early to determine the effectiveness of the alternative model, which has only been available statewide since April 2001 (4 months prior to our interview).

Lessons Learned

Our findings suggested that the following points are essential to developing and implementing an alternative model such as North Carolina’s:

- Have a comprehensive mix of people on board from the developing stages. Include people and organizations that are influential and well respected in their particular fields.

- Adequate reimbursement is crucial to provider participation. No matter how well intentioned or altruistic a provider may be, they must be properly compensated for their services, especially if they are expected to incorporate new services in their already busy schedules.

- The Medicaid agency’s involvement is essential to the successful development and implementation of a model intended to address low-income populations. All informants applauded the Medicaid agency for its actions throughout the development and implementation of the alternative model.

- It is necessary to have unbiased, solid data to clearly state the problem of children’s lack of access to oral health care services. Such data justifies the need for the alternative model.

- Launching a model that is more narrow in scope and attempts to address preventive oral health care needs more incrementally (0-3 population) may be a

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96 Although none of the physicians we spoke with reported any frustration over an inadequate network, many have reported their frustrations to informants (i.e. project training staff) that we interviewed for this report.
more successful approach; the initiative is not seen as threatening to dentists or as competition. Few dentists are able/willing to see such young children.

- Fully test the program before expanding. Many informants reported concern over the fact that the state decided to roll the model out statewide before the pilot project had been fully completed. Informants reason that any kinks in the model could be worked-out in the pilot stage and a perfected model rolled out statewide.

- Make preventive oral health care services easy to incorporate into a regular office visit to ensure that physicians are not overwhelmed.

- Use of physicians (peers of dentists) may be more non-threatening than attempting to use other providers such as dental hygienists.
APPENDIX I
NEW MEXICO CASE STUDY

New Mexico’s Alternative Model for Delivering Preventive Oral Health Care

Dental hygienists may work under a new category of certification called “Collaborative Practice” wherein dental hygienists provide educational, assessment, preventive, clinical and other therapeutic services in a cooperative working relationship with one or more consulting dentists. Although dental hygienists work under a signed collaborative agreement with a dentist, they work without general supervision. Dental hygienists are permitted to own their own practice under this model; they are not limited to practicing in public health settings. It is not independent practice since a dental hygienist may not practice independent of a dentist.

Summary

It is too early to tell how effective New Mexico’s alternative model of preventive oral health care delivery will be. Although the alternative model has been permitted under state statute since April 2000\(^97\), the model has not been widely implemented (at the time of our interviews, only one dental hygienist was working under the Collaborative Practice Act (CPA)). The primary barriers to implementing this model are: 1) the fact that dental hygienists are not permitted to bill Medicaid directly for their services; and 2) dental hygienists face significant opposition from dentists who discourage the CPA model, and may not agree to sign collaborative agreements. This opposition makes it difficult for dental hygienists to practice under these settings. Furthermore, the rules and regulations governing the CPA allow for wide variation in how each collaborative practice protocol between a dental hygienist and dentist will be developed. This variation may result in some dental hygienists who find that they are more limited in the types of services they are permitted to provide under a CPA than other dental hygienists. Although this model attempts to address both preventive and treatment services, for the time being it is likely to be difficult to find dentists willing to participate in collaborative practice agreements. In addition, the limited number of dentists participating in the state’s Medicaid program make it difficult to ensure children’s access to needed treatment services.

\(^97\) The bill was passed January 1999, signed into law April 1999, effective July 1999 and enacted April 2000.
Methods

This case study involved an in-depth review of New Mexico’s alternative model of delivering preventive oral health care services to low-income and underserved children. Specifically we examined the process by which New Mexico passed legislation and rules and regulations allowing for an alternative model; and whether the alternative model allowed for a change in the delivery system for preventive oral health care services.

In consultation with individuals at CDC, we opted to study New Mexico because it had: 1) enacted a statute which permitted/encouraged an alternative model, and 2) because the alternative model had been implemented. The following major research questions guided our discussions with informants:

- What motivating factors spurred enactment of the public health-oriented provisions in the states’ dental practice laws?
- What was the planning process for developing such provisions?
- To what extent and how are such provisions implicated in the development and implementation of alternative models for delivering preventive oral health care to low-income children?
- Have such provisions encouraged a change in the way preventive oral health care is delivered to low-income children through the alternative oral health care model?
- Are there interim outcomes that suggest that such provisions improve access to, or utilization of, preventive oral health care services by low-income children?
- What were the factors that lead to the defeat of attempts to adopt such provisions/implement the alternative model?

We conducted twelve interviews with a wide range of informants between April 17 - 24, 2001. Interviews averaged 60 minutes in length. At the outset, we solicited the participation of representatives from the state public health dental office, state Medicaid dental office, state dental board and/or dental hygienist committee, state dental association, state legislators who sponsored the legislation, state dental hygienist association or state pediatric physicians association, providers delivering services under the model, and advocates. Many of the individuals we contacted agreed to participate in the study, others referred us to colleagues who could better answer our questions, and some declined an interview. Since our informants were promised anonymity we will not release their names, nor their professional affiliations due to the highly politicized nature of the subject. A copy of the short interview guide can be found as Appendix A.
The Context

Provider Supply

New Mexico has a statewide shortage of oral health professionals and ranks 48th in national ratings of dentist-to-population ratios. In 1999 there were 750 licensed dentists in New Mexico. Statewide there are 43 dentists per 100,000 population; the targeted ratio is 1:2,000. Only six counties meet the targeted ratio; two counties have no dental services and the remaining twenty five fall below the 1:2,000 ratio. As such, most of the state’s counties are considered Health Professional Shortage Areas (HPSA). There are 668 dental hygienists licensed and residing in New Mexico (39 per 100,000 population). Three-fourths of the state’s dentists employ at least one dental hygienist in their practices, a quarter of those employ more than one full time hygienist.

New Mexico’s dental resources are not distributed evenly throughout the state. For example, most dentists (62 percent) are located in urban areas and serve 57 percent of the population. Conversely, 38 percent of dentists in rural areas care for 43 percent of the population.

The shortage of dentists is due in part to the fact that there is no dental school in New Mexico. State residents interested in pursuing a dental career must train at out-of-state dental schools. Most dental students use the Western Interstate Commission on Higher Education (WICHE) as a mechanism to attend school. Through WICHE, dental students pay the equivalent of in-state tuition at dental schools outside New Mexico and the state pays a negotiated amount to the dental school. Of the 10 dental slots allotted for New Mexico residents in 1999, only four were accepted. In return for WICHE assistance, students must practice in New Mexico for a time proportionate to their years in the program or make monetary repayment.

The University of New Mexico has the only certified public oral health care professional education program in a public post-secondary institution. UNM offers both a 3 year associates degree and a baccalaureate degree in dental hygiene. There is no existing 2-year associate’s degree program in the state. However, several two-year accredited dental hygienist degree programs are under development at community colleges in underserved areas of the state. This initiative was initiated by the state’s Dental Association to address a reported shortage of dental hygienists.

Access

Many New Mexicans do not receive needed oral health care services. Data reveal that only 54 percent of children under 18 received a dental exam or service in

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Only 11 percent of second and third grade children in Albuquerque received dental sealants through the school program in 1998. Among adults, 61 percent needed dental services and 17 percent of those were unable to obtain dental services some of the time or not at all. Of those, more than half (56 percent) cited inability to pay as the primary reason for not being able to obtain services.

**Medicaid Participation**

Despite the fact that Medicaid enrollees in New Mexico have a broad dental package, only 34 percent of the state’s dentists provide any type of services to Medicaid patients. Of those New Mexico dentists with Medicaid licenses, only 46 percent participate in the state’s Medicaid managed care program. In fiscal year, only 16 percent of Medicaid children aged 0-20 received at least one dental visit. In the same year only 18 percent of all Medicaid eligibles had at least one dental visit.

New Mexico’s low Medicaid reimbursement rates are the most common reason cited for low dentist participation in Medicaid. The state did increase rates effective October 1, 1999 to 85 percent of the American Dental Association standards. Dental providers also report that administrative burden (slow or inadequate reimbursement and excessive paperwork) is another reason for their non-participation in Medicaid. Dentists also complain about issues commonly experienced with the Medicaid population (missed appointments, not valuing services provided, bringing all their children to the office, giving babies sugared drinks in bottles, etc).

**Safety-Net Providers**

Safety-net providers are often the only source of oral health care for underserved populations; however such resources are limited. There are 31 Department of Health and community health center sites with dental clinics; 20 Indian Health Service sites; and 2 other dental clinics in New Mexico. Between fiscal years 1995 and 1999, community health centers with dental sites provided a total of nearly 99,000 dentist and hygienist visits. Community clinics have a proportionally higher percentage of Medicaid patients than any other provider type in the state. For example, although community clinics represent only 9 percent of the dentists statewide, 92 percent of

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those accept Medicaid; versus those dentists in solo practice (74 percent) of whom 26 percent accept Medicaid.\textsuperscript{106}

**HOW THE MODEL WORKS**

Under New Mexico’s model a collaborative practice dental hygienist is permitted to own her own practice and provide preventive oral health care services. The dental hygienist must enter into a cooperative working relationship with a consulting dentist, and sign a formal collaborative practice agreement.

- A collaborative practice dental hygienist: provides educational, assessment, preventive, clinical and other therapeutic services to patients without general supervision. Other services can be provided only under a dentist’s prescription. A collaborative dental hygienist must refer each patient for a dental exam every 12 months, as well as those patients with further dental needs. All records and x-rays must be forwarded to the consulting dentist within 14 days. The collaborative practice dental hygienist may have more than one consulting dentist.

- The consulting dentist: serves as a dentist of record for the collaborative practice dental hygienist’s patients; provides consultation and verbal and/or written prescriptions to the collaborative practice dental hygienist for procedures requiring a diagnosis; written diagnosis and treatment recommendations must be sent to the collaborative dental hygienist within 30 days. A dentist can consult with no more than three collaborative practice dental hygienists.

**Factors Motivating the Enactment of the Public Health-Oriented Provisions**

Several factors contributed to the development and enactment of the public health-oriented provisions of New Mexico’s laws governing dental hygienists. These factors include: 1) incremental changes in the law over several years; and 2) the commission of two studies by the legislature to study the state’s health professions resources and the barriers to primary oral health care access.

Incremental Changes in the Law

Prior to the enactment of the current public health-oriented statute, there were two incremental changes in the law that permitted dental hygienists to practice in more loosely supervised settings. Several informants reported that these initial changes in the law were necessary to pave the way for the current statue which establishes the alternative oral health care delivery model. Without these initial changes it is unlikely that dental hygienists could have mustered the political and professional support necessary to enact the current law.

The first important change in the law occurred in 1986 when the state legislature enacted a law that permitted dental hygienists to practice under the general supervision of a dentist. General supervision is defined to mean “the authorization by a dentist of the procedures to be used by a dental hygienist, dental assistant or dental student and the execution of the procedures in accordance with a dentist’s diagnosis and treatment plan and in facilities as designated by rule of the board.” Under general supervision, a dentist need not be present when a dental hygienist is performing her work. Dental hygienists working in school-based health centers, community health centers (CHCs), nursing homes and other public settings worked under general supervision. However, dentists were required to authorize certain services. Prior to this amendment in the law, dental hygienists practiced under “indirect supervision” which means that a dentist was required to be present in the treatment facility while authorized treatments were performed.

Later, in 1994, another law was passed that changed the regulation of dental hygienists’ by establishing a Dental Hygienist Committee on the state’s Dental Board. This change allowed dental hygienists a measure of self-regulation. Prior to the change, the Dental Board, made up of 5 dentists, 1 hygienists, and 1 public member, was responsible for regulating dental hygienists. As a result of the 1994 change in law, the Dental Hygienist Committee made up of 5 dental hygienists, 1 dentist, and 1 public member is now the sole body with the authority to propose changes to the rules promulgated pursuant to the Dental Health Care Act (i.e. dental hygienist practice act). Any changes must be ratified by the whole Dental Board; however, the Board does not have the authority to amend any of the proposed changes. Furthermore, the Board must ratify the committee’s recommendations unless the Board can establish that a proposal is: 1) beyond the jurisdiction of the committee; 2) has an undue financial impact upon the board; or 3) not supported by the record.

Studies Commissioned by the State Legislature

The current public health-oriented provisions were also made possible by the fact that the state legislature commissioned two studies that examined the state’s health professions resources, and oral health care access barriers. The studies were carried out by the state’s Health Policy Commission (HPC). The first study, known as House Joint Memorial (HJM)17 was commissioned in 1997 to study barriers to recruitment and retention of health care professionals in New Mexico and to make recommendations to
address problems. Health care professionals of all types (including dentists) were surveyed in 1998. While work for HJM 17 was underway, the legislature requested another study, Senate Joint Memorial (SJM) 21, to analyze barriers to primary oral health care access and make recommendations. The same technical work group that worked on HJM 17 also worked on SJM 21 since they were familiar with the issues, and because so much of the data overlapped. The technical work group included representatives from the Department of Health, Human Services Department (the entity that administers Medicaid), state Dental Association, state dental hygienist associations, the University of New Mexico Division of Dental Hygiene, state Primary Care Association, the Medicaid managed care dental contractor, Doral Dental, and Albuquerque Public Schools.


After collecting and analyzing the data, and hearing testimony from stakeholders and advocates, the task force debated which recommendations to make to the legislature. This was a challenging process since many of the stakeholders on the task force held varying opinions on how much autonomy dental hygienists should be given. For example, dental hygienists pushed for unsupervised practice, and objected to stipulations requiring that a dentist examine a patient before a dental hygienist could provide services. They cited the state’s successful sealant program as an example, and a study that showed that less than 11 percent of school aged children would receive a sealant if a dentist was required to see a child before dental hygienist’s could apply one. Dentists, on the other hand expressed concerned about allowing dental hygienists to practice independently, and sought to ensure that dental hygienists were not permitted to diagnose or provide treatment to patients.

The HPC Task Force held several meetings and took votes before submitting recommendations to the legislature. The last vote was held on a Saturday, the dentist representative to the task force was not in attendance, and the final vote was taken without his final input. The Task Force voted to submit a recommendation which allowed dental hygienists to work in “collaborative practice” with dentists. A second recommendation was also passed which allowed dentists licensed in other states to practice in New Mexico without taking a practical exam (licensing by credential). Recommendations were submitted to the Interim Legislative Committee which accepted the recommendations and asked the HPC to draft the legislation.

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107 One of the primary problems noted in the task force was that a child had to seen by a dentists prior to the dental hygienists applying sealants. If a child was absent on the day that the dentist did exams for sealants, the child would not receive sealants. Because of this requirement children were not receiving sealants.

108 A great deal of discussion was held prior to the final meeting; therefore, it is likely that the his input was voiced in previous meetings and incorporated into the recommendations.

109 The New Mexico State Legislature alternately meets for either 30 days or 60 days a year, the Interim Committee reviews, studies issues and makes recommendations to the full legislature for action during sessions.
Under the Collaborative Practice model, dental hygienists may provide educational, assessment, preventive, clinical and other therapeutic services in a cooperative working relationship with one or more consulting dentists, but without general supervision. Dental hygienists are permitted to own their own practice under this model; they are not limited to practicing in public health settings. It is not independent practice since a dental hygienist may not practice independent of a dentist, and must collaborate instead.

Drafting the Law

Pursuant to the legislator’s request, HPC (i.e. Legislative Council Service) took primary responsibility for drafting the language of the law and negotiated the terms with various stakeholders. The dental hygienist Collaborative Practice Act (CPA) was modeled after the nurse practitioner model. In fact the legislative language from the state’s nurse practitioner law was used to draft the Collaborative Practice Act. Nurse practitioners in New Mexico practice independently of a physician, but consult with physicians to whom they refer patients when necessary. There is no supervisory relationship between a physician and a nurse practitioner. This was the intended model of the dental hygienist CPA. According to those involved in shaping the law’s language, the intent of the law was to allow dental hygienists to practice quasi-independently, but require them to have agreements with one or more consulting dentists to whom they could refer patients for treatment. Drafters of the law did not expect that collaborative practice dental hygienists would be subject to any supervision by their consulting dentists.

Negotiations on the law’s language were intense. Dentists reiterated their concerns about dental hygienists’ unsupervised practice. Informants reported that dentists feel a sense of ownership over their patients, and did not want their patients seen by dental hygienists without their involvement. Secondarily, dentists were concerned that people would not get yearly dental exams and evaluations if a dental hygienist was providing preventive services independently. Dental hygienists countered that any patient seen by a dental hygienist who had an abscess (or any other problem requiring treatment) would be referred to a dentist. In response, many dentists asserted that they would not accept any patients referred by a collaborative dental hygienist.

Dentists also sought to consign dental hygienist collaborative practice only to rural areas of the state. However, the law’s language was intentionally written without restrictions to apply to the entire state, as the drafters had no intention of limiting collaborative practice. Although HPC Task Force members admit that the need for dental care is more acute in rural areas, they believe that restricting collaborative practice (or any other service delivery) creates a two-tiered system of care. In addition, such action would represent restraint of trade and would not have been politically feasible.

Dental hygienists also wanted the law to allow for the creation of “dental practitioners,” masters-level hygienists who can provide care and administer anesthesia.
without supervision. This idea was rejected since it was staunchly opposed by the dental association; and HPC Task Force members favored more incremental steps towards increasing dental hygienists’ responsibility.

The law did not address reimbursement issues for dental hygienists working under the collaborative practice act. HPC task force members did not anticipate that it would be problematic for dental hygienists to obtain reimbursement. Furthermore, task force members felt that they had accomplished their goal of drafting language that created an avenue by which New Mexicans could access preventive oral health care.

Observers noted that overall, the language of the law is intentionally vague. Drafters did not intend to make collaborative practice overly restrictive in law since that could have invited further restrictions in rules and regulations as well. Furthermore, drafters suggested that if the law’s language had been more specific, it may not have been passed.

The legislature passed the Collaborative Practice Act in January 1999, it was signed by the governor in April 1999, and became effective July 1999. One informant stated that the law was passed because it was modeled after the nurse practitioner legislation, which is widely accepted and familiar to the legislature. Another informant stated that the legislature passed the law because it narrowly defined what dental hygienists can do. In the end the state dental association did not publicly oppose the law. Several observers noted that the state’s dental association understood that it could not stop the law from passing. Instead the dental association threatened to hold up the law’s implementation via a lawsuit; however, this did not come to pass.

Establishing the Rules and Regulations

A set of rules and regulations had to be developed by the state Dental Board and Dental Hygienists Committee together (i.e Super Board) before the law could be fully enacted. This was a contentious and drawn-out process; the final rules and regulations were not developed until April 2000. Board members opposed to dental hygienist collaborative practice opted simply to not develop the rules and regulations. Some informants reported that the dentists on the Dental Board thought the initiative would just “go away” if no rules or regulations were developed.

In October 1999, the Super Board directed a subcommittee to develop rules for the CPA. The dental members submitted a list of rules eight pages long, while the dental hygienists submitted rules that took up only one and a half pages. A smaller group was formed to integrate the members rules; however the integration was unsuccessful and progress stalled.

Months later, the bill’s sponsor requested an update on what had been done to implement the law. He was told that nothing had been done because the rules had not been developed. Outraged the legislator, who is also on the state’s finance committee,
told the Dental Board that if the rules and regulations were not developed by March 2000, the legislature would only appropriate $1.00 for the Board’s operating budget for the next fiscal year. The Board was motivated by the potential cut in funding.

The Super Board and attorneys familiar with the intent of the law drew-up the rules for collaborative practice in one very long meeting. Community members were also present at the meeting and offered their input. Over the course of the day, many compromises were made. For example, some dentists wanted to stipulated that no collaborative practice dental hygienist could operate within 45 miles of a dental office, and/or that collaborative practice dental hygienists could only practice in rural areas. These proposals were vetoed since the law’s language does not restrict collaborative practice to any area in the state. Dentists also wanted to place restrictions on who could be a consulting dentist; they were also opposed to the rule allowing dental hygienists to own their own practices. Dental hygienists gave in on their desire to be permitted to administer local anesthesia.

After the rules were developed, the Dental Board held a hearing, made some changes to the rules and held a vote. According to informants, the Board’s public members were split on several issues, and the final rules were passed. One board member (a dentist) was not present, the vote was 6 for and 4 against with the Chair abstaining. Since then the rules and regulations have been amended twice (e.g., easier application process, clarifying the protocol for dentist/dental hygienist agreements).

The rules that were passed closely regulate dental hygienists and do not allow for independent practice. One informant characterized the final rules like this: “the rules … make the relationship of the dental hygienists to the dentists more like the relationship that exists between physician assistants and physicians, rather than that of a nurse practitioner to a physician.” Some of the challenges resulting from the rules and regulations is described below. A full list of the rules and regulations pertaining to collaborative practice is included in Appendix B.

The Impact of the Public Health-Oriented Provisions on the Alternative Model

The alternative model is enabled through the public-health oriented law. Prior to the law, dental hygienists were required to work under the general supervision of a dentist. Under the current law, dental hygienists working under the collaborative practice act can own their own practice and provide preventive oral health care services without a dentist’s supervision. Collaborative practice dental hygienists must have a cooperative working relationship with a consulting dentist and work under a written protocol. All other dental hygienists (non-collaborative practice) still work under general supervision.
The Impact on the Delivery of Preventive Oral Health Care Services

Thus far the law and/or the alternative model have made almost no impact on the delivery of preventive oral health care services. At the time of our interviews only one dental hygienist was working under the collaborative practice act.110 All our informants cited two major stumbling blocks to fully implementing the collaborative practice model: 1) Few dentists are willing to enter into consulting agreements with collaborative practice dental hygienists; and 2) Despite the fact that the law permits collaborative dental hygienists to work without the supervision of a dentist, hygienists must rely on a consulting dentist to facilitate Medicaid reimbursement. Such reliance on the consulting dentist invites a dimension of supervision not intended by the legislation’s drafters, legislative sponsor, or the language of the law. We also found that developing a collaborative practice protocol can be challenging despite the existence of rules that govern it.

Finding a Consulting Dentist

Finding a dentist willing to consult with a collaborative practice dental hygienist is an enormous challenge. Many New Mexico dentists do not currently trust dental hygienists enough to consult with them, and assume liability for their actions. Observers reported it will take time for that trust to develop, and that dental hygienists will need to prove themselves in a non-threatening, non-competitive environment.

One informant remarked that it will likely be easier for dental hygienists to find dentists willing to collaborate in urban areas such as Albuquerque. In contrast, dentists in smaller communities have been reluctant to consult with collaborative dental hygienists because they are under pressure from their peers. Another observer remarked that dentists’ participation would increase if dentists viewed collaborative practice agreements as a way to make extra money and expand their patient base at no cost.

The one existing collaborative practice dental hygienist has contracts with three dentists in Albuquerque. She consults primarily with one dentist, with whom she shares an office and pays one-third of the rent and utilities. The other two dentists with whom she’s contracted have not yet sent her any patients. They have contracted with her to provide treatment services to Medicaid recipients who are in need of a second cleaning in a year (which is not covered by Medicaid). These patients will receive their first Medicaid-covered cleaning and treatment from the dentists, and be referred to her for any additional cleanings on a fee-for-service basis. She has not found many dentists willing to serve in a consulting capacity, or aware of the model’s existence.

110 As of November 2002, there are 15 dental hygienists working under the Collaborative Practice Act.
Reimbursement Issues

Nearly all our informants reported that reimbursement issues remain a significant barrier to fully implementing the alternative model. Although the alternative model has been permitted since April 2000, no viable funding mechanism has been established to allow dental hygienists to bill for the services they deliver to children enrolled in Medicaid or commercial insurance.

Medicaid provider numbers

The first barrier to obtaining reimbursement is dental hygienists’ inability to obtain provider billing numbers from the Medicaid department. There is nothing in state law that prohibits collaborative practice dental hygienists from billing Medicaid (or private insurance) directly; however, there is no language that explicitly requires that they be paid directly either.

Dental hygienists’ inability to acquire provider numbers significantly inhibits their ability to practice under the collaborative practice act. Without their own provider numbers, collaborative practice dental hygienists are required to use a dentist’s provider number to bill for their services, thus potentially inviting the dentist’s supervision and oversight.

Reportedly, the one collaborative dental hygienist has faced significant reimbursement challenges. She must rely on her consulting dentist to submit her bills. On some occasions, the dentist has refused to submit billing on her behalf until after he has seen the patient on referral, which significantly delays her reimbursement. The dental hygienist is not aware for which services the dentist has billed, or when the bills were submitted. She is not given a copy of the invoices he sends to Medicaid or private commercial insurers.

Medicaid Perspective: A state official reported that the Medicaid agency is considering whether to allow dental hygienists to directly bill for their services. However, the agency is hesitant because of patient safety concerns. Although the official admitted that reimbursement is not actually related to patient safety; direct reimbursement is a reward for providing services safely. It is only a matter of time before dental hygienists demonstrate that they can safely serve patients under a collaborative practice agreement, then they will be awarded direct reimbursement. The official did not anticipate that dental hygienists and dentists would be reimbursed at different rates once reimbursement is granted.

The same state official reported that dental hygienists in New Mexico have misinterpreted the law. They are incorrect in thinking that they are permitted to operate independent practices and bill Medicaid directly. According to the official, interested groups have differing opinions of the scope of the collaborative practice law. In the official’s opinion, the law is about access and manpower and providing services to underserved areas of the state. “The crux of the collaborative practice act is that a body
[a dental hygienist] be sent from a central place to a remote place to provide those services that a hygienist would be able to legally provide, that’s it, it has nothing to do with billing directly at all for it to work… Collaborative practice allows dental hygienists to operate in a building that’s farther away from the supervising dentists. General supervision implies that the dental hygienist is going to practice in a certain region, collaborative practice allows them to practice anywhere in the state of New Mexico. Independent practice allows hygienists to open their own practices, collaborative practice does not. If dental hygienists were truly permitted to work independently, there would be no question about issuing them Medicaid provider numbers but right now, the way that the collaborative practice works is that the dental hygienist has an umbilical cord to the dentists. Which is why Medicaid is wondering how/why they would give distinct provider numbers to dental hygienists. If the hygienist is still attached to the dentist, what difference does having their own provider number make?"

**Appeals to Allow Direct Reimbursement:**

Steps are being taken to address the issue of direct reimbursement. At the time of our interviews we learned that two state legislators had sent letters to the state Medicaid agency urging a policy change. The Super Board was in the process of writing letters to commercial insurance companies to inform them of the collaborative practice laws so they would be aware of dental hygienists’ new abilities. The Super Board hopes that commercial insurers will augment their policies to allow collaborative practice dental hygienists to bill directly for their services. Informants are also considering a last resort request that sympathetic legislators pass a law requiring commercial insurance companies to pay dental hygienists directly (as was done in California). Informants expect that the letters from the legislature will prompt the Medicaid agency to change its policy and permit direct reimbursement.

**Assessment Codes**

Sometime during the implementation process, it became clear that a new procedure code was needed to differentiate an assessment completed by a dental hygienist from an examination conducted by a dentist. Dental hygienists are not permitted to provide exams (which are provided by dentists); however they can not be paid for the assessments they do provide since no procedure code exists. Informants suggested that the American Dental Association will need to devise a code to identify an assessment by a dental hygienist.

One informant reported that the state is considering creating an “assessment” code for dental hygienists, but it would pay a lower rate than an “examination.” However, there is some concern that insurance companies will not want to pay both for an assessment done by a dental hygienist and a second examination by a dentist. Reportedly, dentists are concerned that they will not be paid for an exam after a dental hygienist has provided an assessment.

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111 In fact, under the Collaborative Practice Act, dental hygienists are permitted to own their own practices. State of New Mexico Board of Dental Health Care Rule 16.5.17.12C.
Collaborative Practice Protocol

The Dental Board’s rules and regulations provide some guidelines for developing collaborative practice protocols between consulting dentists and dental hygienists. However, these guidelines notwithstanding, designing a protocol can be challenging. Specifically the rules state “all protocols will include but are not limited to: review of health history charting of existing teeth and restorations, periodontal charting as necessary, and notations of potential pathology.” According to a patients’ age, dental hygienists are permitted to provide a range of services that include x-rays or other radiographs, prophylaxis-scaling, and topical fluoride treatment. All other procedures not listed require a prescription from the consulting dentist. Depending on the dentist, some may permit a dental hygienist to perform more services based on her professional judgment so long as those services are within the dental hygienist’s scope of work. For example, a consulting dentist could allow a collaborative dental hygienist to perform sealants without a prescription. This approval would be explicitly outlined in the collaborative practice agreement.

The collaborative practice dental hygienist in Albuquerque believed that her consulting dentist would give her wide latitude. She worked with her consulting dentist for several years in a private practice. They decided to leave their former practice and open their own private practices, sharing a building and the cost of rent and utilities. They discussed their practice arrangement and how supervision would work. She was responsible for drafting the collaborative practice protocol which the consulting dentist signed. At the start, the dentist was in complete accord with her and agreed to allow her to provide services to children, teens, and adults. Once she began providing services, she quickly learned that he would not permit her to provide sealants, nor would he provide a prescription for the service. Soon she learned that he was providing the sealants himself and obtaining the reimbursement. She believes that he is unwilling to relinquish control and permit her to provide services according to her professional judgment. The reimbursement problems described earlier are another indication of his refusal to allow her to run her own practice. In hindsight she has learned that the collaborative practice protocol was too vague since it does not explicitly state that she is permitted to provide sealants. In addition, the agreement did not describe how billing would be processed, or how and when she would receive her reimbursement.

Several dental hygienists reported the need to work with a consulting dentist who trusts the collaborative dental hygienist and will not be too restrictive. While dental hygienists may not chose to contract with a dentist who is restrictive, the fact that so few dentists are willing to consult in a collaborative agreement may make it difficult to find one willing to be more lenient. Dental hygienists report that it is essential to clearly define which services the collaborative dental hygienist is permitted to provide in the protocol.

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112 State of New Mexico Board of Dental Health Care Rule 16.5.17.13.
Interim Outcomes

Currently the law and the alternative model have not significantly changed the way that dental hygienists practice in New Mexico. Dental hygienists performed the same functions before the law was enacted (e.g. educational, assessment, preventive, clinical and other therapeutic services). The law has the potential to change reimbursement streams for dental hygienists by allowing them to receive direct payments for services they provide under collaborative practice. However, thus far, dental hygienists are not permitted to receive direct reimbursement, and instead are forced to use a dentist’s provider number for billing purposes. In some cases, billing under a dentist’s provider number may encourage the old models of general supervision or in some cases, indirect supervision of dental hygienists. Furthermore, it discourages the creation of new access points (e.g., additional collaborative practice dental hygienists) since any dental hygienist interested in establishing a collaborative practice will have to rely on a dentist to bill for services.

Although the law has been in place for more than a year, it is too soon to tell how effective the law and the alternative model will be in increasing low-income children’s access to preventive health care services. More dentists will have to agree to consult with dental hygienists in collaborative practice; and a reimbursement mechanism will need to be created before it the model’s effectiveness can be determined.

The collaborative practice model establishes a referral mechanism to ensure that patients who need treatment services have access to care. However, the law does not encourage dentists’ participation in the model, in the Medicaid program, or their ability and willingness to care for the uninsured.

Lessons Learned

Our findings suggest that the following points are essential to developing and implementing a law and alternative model such as New Mexico’s:

- Incremental changes in law that permit dental hygienists to practice in more loosely supervised settings;
- Early in the process defining reimbursement mechanisms for dental hygienists under the alternative model;
- It is essential to clearly define which services the collaborative dental hygienist is permitted to provide in the collaborative practice protocol.
South Carolina’s Alternative Model for Delivering Preventive Oral Health Care

Licensed dental hygienists may apply topical fluoride, apply sealants and provide oral prophylaxis under general supervision in certain public health settings. In these settings dental hygienists may provide oral hygiene instruction and counseling, perform oral screenings and provide nutrition and dietary counseling without a dentist’s prior authorization. Dental hygienists are expected to work closely with a dentist who will authorize treatment and provide treatment services outside the hygienists’ scope of practice. General supervision is not applicable to the practice of dental hygiene in a private dental office. The law is not intended to establish independent practice.

Summary

The alternative model has yet to be widely or fully implemented throughout the state; therefore, it is impossible to determine its effectiveness. Essentially, the alternative model has been permitted under state statute since 1988; however, its implementation (then and now) has been prohibited due to the lack of a state supervisory agency, rules, and definitions to regulate it. The majority of dental hygienists working in public settings have not been affected by the law or the alternative model; only one dental hygienist in the state has attempted to operate under the alternative model. The state has experienced a significant amount of difficulty implementing the alternative model primarily because of the vagueness of the law’s language, which many believe may lead to possible misinterpretation and misuse. The language of the law and the current reimbursement structure requires dental hygienists to maintain a supervisory relationship with a dentist, in spite of the liberties provided by the alternative model’s general supervision provision. Dental hygienists may not bill Medicaid directly nor may they provide treatment services without prior authorization from a dentist. While dental hygienists may provide preventive services, they are required by law to refer children with treatment needs to a dentist. This has been challenging because of the strained relationship that currently exists among many local providers and the dental hygienist attempting to operate under the alternative model.

Methods

This case study involved an in-depth review of South Carolina’s alternative model of delivering preventive oral health care services to low income and underserved populations.
children. Although the alternative model permits dental hygienists to also provide preventive services in settings other than schools (e.g. nursing homes), for the purposes of our study we have focused only on the alternative model as it relates to low-income children. Specifically we examined the process by which South Carolina passed legislation and rules and regulations allowing for an alternative model; and whether the alternative model allowed for a change in the delivery system for preventive oral health care services.

In consultation with individuals at CDC, we opted to study South Carolina because it has: 1) enacted a statute which permitted/encouraged an alternative model; and 2) because we understood that the alternative model had not been implemented. However after beginning our research we learned that it has indeed been implemented. The following major research questions guided our discussions with informants:

- What motivating factors spurred enactment of the public health-oriented provisions in the states’ dental practice laws?
- What was the planning process for developing such provisions?
- To what extent and how are such provisions implicated in the development and implementation of alternative models for delivering preventive oral health care to low-income children?
- Have such provisions encouraged a change in the way preventive oral health care is delivered to low-income children through the alternative oral health care model?
- Are there interim outcomes that suggest that such provisions improve access to, or utilization of, preventive oral health care services for low-income children?
- What were the factors that led to the defeat of attempts to adopt such provisions/implement the alternative model?

We conducted nine interviews with a wide range of informants between July 7, 2001 and July 11, 2001. Interviews ranged 60 minutes in length. We solicited the participation of representatives from the state public health dental office, state Medicaid dental office, state dental board and/or dental hygienist board, state dental association, state legislators who sponsored the legislation, state dental hygienist association or state pediatric physicians association, providers delivering services under the model, and advocates. Many of the individuals we contacted agreed to participate in the study, others referred us to colleagues who could better answer our questions, and some declined an interview. Since our informants were promised anonymity, we will not release their names, nor their professional affiliations due to the highly politicized nature of the subject. A copy of the short interview guide can be found as Appendix A.

The Context

The state is currently facing a shortage of dental health care professionals, which has resulted in access problems for the state’s 407,000 Medicaid eligible children who require dental education and professional care. In response, there are several initiatives in the state directed toward increasing oral health care access for low-income children. In particular, there is a program in Allendale County called Smiles for a
Lifetime; this program provides dental services 4 days a week during the school year. The dental clinic is managed by a nurse and dental services are provided by dentists paid by the state. Communicare, a private, non-profit charitable organization also provides charitable/low cost dental care. Communicare began as a pharmacy assistance program before expanding to provide oral health care services through volunteer dental providers.

A third notable program is a school based program is the Carol Drum Project that operates in Spartanburg. The Carol Drum Project is a screening and referral program for kindergarten, second and seventh graders; the project provides care for indigent children through a referral base of 30 local dentists. ‘Seals on Wheels’, an outreach/training program for the state’s dental school operates in Charleston. ‘Seals on Wheels’ is a sealant program for first graders and is sponsored by Medical University of South Carolina and Trident Public Health District; services are provided by dental students on a dental van. Another notable program that provides dental care to South Carolina’s low income children is called the Children’s Dental Clinic. This program has operated in Richland County since 1959 through a collaboration among many local providers including the Richland County Family Service Center, United Way and Palmetto Health Lines. This program is the largest operating volunteer program in the state; in Year 2000 150 dentists and dental hygienists provided $300,000 worth of oral health care to 2,000 children. All of these programs increase access to oral health care in their respective areas of the state. Each use a collaborative approach to provide comprehensive care to low-income children.

Dentists

Increases in Medicaid dental reimbursement are also intended to increase oral health care access. Dental rates were increased in January 2000 from 48 percent to the 75th percentile of usual and customary rates (UCR). The increase resulted in increased Medicaid participation; the number of dentists participating in the Medicaid program increased from 674 to 903 (as of August 2001). These dentists provided services to an additional 46,000 unduplicated Medicaid children within the first 12 months of the rate increase. South Carolina has a total of 1,800 licensed dentists (1,600 practicing); 1,250 general dentists and 50 pediatric dentists. Pediatric dentist provide services to the state’s one million children under age 18. Access to care has also increased due to sporadic programs sponsored by the state’s nine technical schools and newly established dental clinics powered by dental school residents.

Dental Hygienists

There are over 1,800 registered dental hygienists in South Carolina\(^{114}\), less than 20 percent of which belong to one of the state’s two Dental Hygienists Associations: The Committed Dental Hygienists Association and the South Carolina Dental Hygienists Association. These two Associations espouse vastly different beliefs. While the

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\(^{114}\) Data from the Office of Research and Statistics indicates that there are 1,400 non-federal, practicing dental hygienists.
Committed Dental Hygienists Association promotes a team concept of dentistry (dental hygienists cannot work without dentists and vice versa), the South Carolina Dental Hygienists Association promotes self-governance\textsuperscript{115} and independent practice. The membership volume of each Association is unknown.

In general, dental hygienists are perceived as a valuable addition to the state’s pool of providers and do a good job of providing care. Only dental hygienists practicing in public health settings are permitted to operate under general supervision, all other dental hygienists practice under direct supervision. General supervision is defined as a licensed dentist or a state Department of Health and Environmental Control’s (DHEC) public health dentist, has authorized the procedures to be performed but does not require that a dentist be present when the procedures are performed. The term direct supervision means that a dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedures to be performed and before the dismissal of the patient, evaluates the performance of the auxiliary. Such a requirement does not mandate that a dentist be present at all times, but he or she must be on the premises and actually involved in supervision and control.\textsuperscript{116}

\textbf{How The Alternative Model Works}

Ideally the model is envisioned to work as follows:

Dental hygienists working independently or under contract provide services (dental screenings, oral prophylaxis and sealants) to children in school settings. The dental hygienist first gains the support of local dentists for the purposes of developing a referral network for children with treatment needs that are outside of the dental hygienist’s scope of practice. The original concept for the program is to increase oral health care access to children by coordinating with area dentists.

Once a referral network is developed, the dental hygienist(s) obtains approval from the school to screen the children. Dental hygienists may perform screenings without a dentist’s prior authorization. During the screening process dental hygienists may find that some children have immediate treatment needs and must be referred to a dentist. Children who do not have immediate treatment needs are eligible to receive oral prophylaxis and sealants. After screening the children dental hygienists obtain parental permission to provide oral prophylaxis and sealants. Once permission is obtained the dental hygienist returns to the school accompanied by a dentist who will examine and diagnose the children and authorize the dental hygienist to provide services. The dentist will also refer children with immediate treatment needs to a local dentist or the accompanying dentist will provide treatment on site (the volume of children screened will likely prohibit the dentist from providing treatment on site).

\textsuperscript{115} Dental hygienists are currently governed by the State Dental Board, which consists primarily of dentists.
\textsuperscript{116} South Carolina 1876 Code, Section 2, Section 40-15-85.
Factors That Spurred the Development of the Alternative Model

Several factors contributed to the development and enactment of the alternative model. These factors include: 1) a pre-existing law that allowed dental hygienists to work under general supervision in public settings; 2) significant research findings that documented oral health needs among low-income populations and showcased the use of dental hygienists to increase access; and 3) the involvement of two practice Associations (Dental and Dental Hygienists) concerned with improving oral health care access.

Pre-Existing Law

Prior to the current legislation that allows dental hygienists to work under general supervision in certain public settings there was an existing law, passed in 1988 that provided the same liberties. The 1988 law allowed dental hygienists practicing under general supervision to provide oral health screenings, education and apply fluoride varnish; however, the application of sealants and oral prophylaxis required a pre-examination and written authorization from a licensed dentist who was either the employer or supervising dentist of the dental hygienist. The pre-examination and written authorization had to occur no more than 45 days prior to treatment by the dental hygienist. Treatment was prohibited for children who were active patients of another dentist (i.e. children who had a dentist of record). The law also stipulated that only low-income children could be served under the law; however this stipulation was removed in 1993 because it created a double standard of care.

There were several problems with the law. Under the law, public health dental hygienists were to be regulated by the Public Health Department’s Office of Public Health Dentistry; however, this component of the Public Health Department was closed in 1991, shortly after the law was passed. Therefore, the law was changed to allow for general supervision under the auspices of a dentist or a state public health dentist. Informants reported that implementation of the law was impeded because a definition of general supervision was never developed by the state Dental Board who is responsible for developing rules and regulations to regulate dental related laws. General supervision was not defined until new dental hygienist legislation was developed in year 2000.117

Informants reported that the [1988] law resulted in very little activity by dental hygienists in school settings. A survey conducted in 1993 by the South Carolina Dental Association revealed that dental hygienists providing services in nursing homes were either sent to the home by a dentist or were providing services in tandem with a dentist (much like they would in a private office setting). Informants reported that the only major effort by dental hygienists to provide services in school settings under general supervision was the basic definition of general supervision as opposed to direct supervision.

117 The 1988 law provided a definition of what could be performed; however, there was no stated definition of general supervision. The outline was a basic definition of general supervision as opposed to direct supervision.
supervision occurred between 1988 and 1989 in one school district of the state, which yielded mixed results. Some believe that this demonstrates that there has been no effort on the part of dental hygienists (since the original law was passed in 1988) to provide preventive oral health care in school settings.

In any event, the original law paved the way for current legislation. In fact, the current law is essentially an amendment of the 1988 law (rather than a new law in itself) and does not provide dental hygienists any new liberties. The fact that this law was already in existence facilitated the compromises that occurred in the development of the current legislation. The dental community was more willing to permit passage of new legislation, which they believed was fairly similar to the old law.

**Documented Oral Health Care Needs Among Low-Income Populations and the Benefits of Expanded Dental Hygienists Practice**

Prior to introducing new legislation one dental hygienist gathered research intended to document the vast unmet oral health care needs among low-income populations. She also gathered research that indicated safe practices and showcased how other states have used dental hygienists to increase oral health care access. Informants reported that historically dentists have used many arguments to oppose the expansion of dental hygienists’ practice, including portraying dental hygienists as incompetent and increased autonomous practice as unsafe. Research conducted by the dental hygienist revealed which arguments were valid and which were simply dentists’ opinion. However, some informants reported that dentists’ opinion carries some influence with the legislature.

Literature packets containing her research findings were distributed throughout the state and resulted in a coalition-building endeavor that included 25 different organizations including the Rural Health Association, South Carolina Academy of Pediatricians, Nurses Association and the Bureau of Aging. Her research was presented in state senate hearings and used to gather support for an alternative model that utilized dental hygienists to deliver services.

**Involvement of Associations Concerned With Improving Oral Health Care Access**

The concern of both the state Dental Association and the Dental Hygienists Association with improving low-income children’s access to care created an environment conducive to the development of the alternative model.

The state Dental Association has worked closely with the state Department of Health and Human Services, Department of Education, Department of Health and Environmental Control, Department of Social Services and a state legislator to design programs to increase access to oral health care. In addition, the Dental Association currently acts as an advisor to the state Department of Social Services. Informants report that the Dental Association has also worked to streamline the Medicaid program
to facilitate greater dental participation. The state Dental Association views dental hygienists as valuable providers of care and believe that they provide good care. This belief, along with the desire to increase access for children motivated the Dental Association to participate in crafting legislation to allow for the alternative model.

With the support of the entire South Carolina Dental Hygienists Association, one particular member of the SCDHA pushed for new legislation to expand the practice of dental hygienists. The Association believed that expanded practice would increase access. The dental hygienist’s concern over the significant amount of unmet oral health needs among low-income children spurred proposals to expand dental hygienists’ practice, hence the modification of old legislation to create the current alternative model.

The proposed legislation was modified through compromise with the state Dental Association. The state Dental Association and Dental Hygienists Association came together to develop new legislation that resulted in South Carolina’s alternative model of preventive oral health care delivery.


In the Spring of 1998 the South Carolina Dental Hygienist Association sought to: 1) create a dental hygienists governing board separate from the state Dental Board which currently governs both dentists and dental hygienists; and 2) increase the number of dental hygienists on the existing state Dental Board. Informants reported that although dental hygienists only held one seat on the Board, they still held a fair amount of political power. The SC Dental Hygienist Association also sought to make general supervision standard practice for dental hygienists operating in both private and public settings.

Before any legislation was proposed, a great deal of research had been conducted to justify the need for increasing low-income population’s access to oral health care and indicated the use of dental hygienists to facilitate it. These research findings were widely distributed and used to gain support for new dental hygienists legislation. In collaboration with the state Dental Association, one member from the State Dental Hygienists Association drafted and introduced legislation that would expand the autonomy of dental hygienists. The initial draft of the legislation called for general supervision across the board and an independent dental hygienists board. These two provisions would not only expand the practice of all dental hygienists but the provisions would also allow for their self-governance. Informants reported that the initial legislation was drafted and introduced by only one person, not the entire SC Dental

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118 The proposed legislation was written by the Association’s President and two legislative chairs.
119 At the time there was only one dental hygienist seat on the state Dental Board. Currently the Board is comprised of nine members: 6 dentists elected from each of the state’s congressional districts, one at large dentist who is appointed by the governor, one lay member and one dental hygienists who is elected by state dental hygienists.
Informants also reported that the general population of dental hygienists and dental hygienists' supporters were not in favor of the original bill.

The group solicited the opinion of the Committed Dental Hygienist Association [the rival association] by asking them what was good, bad and indifferent about the proposed legislation, how it would effect consumers, schools, etc.; and how the law could potentially be misused and abused. The Committed Dental Hygienists believed that the original bill proposed by the Dental Hygienists Association had the potential for abuse. In fact, a number of dental hygienists across the state opposed general supervision because of the responsibility it entails. Informants reported that total general supervision was very similar to independent practice, to which state dentists were adamantly opposed. Informants also reported that dentists insisted that the new legislation explicitly state that it is not intended to establish independent practice.

In order to reach a compromise, the Dental Association offered its support in drafting new legislation that would be supported by the general population of the dental community. Since a dental hygienists general supervision law already existed, a meeting was held among the Dental Association, Dental Hygienists Association and state legislators to discuss what modifications could be made to this law. Informants reported that the Dental Association cooperated with the Dental Hygienists Association because dentists wanted to support any legislation that would create access to care for additional numbers of children.

Many meetings were held among the state legislator, SC Dental Association and the SC Dental Hygienists Association to discuss what was best for the state’s children. After extensive discussion and compromise, new legislation co-drafted by both Associations was sent to the state’s House subcommittee and then to the full committee. The state legislature commented that this effort represented the first time that both Associations (Dental and Dental Hygienists) agreed on anything. The new legislation was passed during the state’s 2000 legislative session.

The new law is actually a modification of the 1988 law, the old law was modified to give a new definition of general supervision and removed the 45 day window in which dental hygienists can performed authorized treatment. Although the new law explicitly struck the requirement for pre-examination by a dentist prior to a dental hygienist providing treatment services; the law still requires dental hygienists in public health settings to receive authorization from a dentist before providing treatment. Informants describe the planning process for the law as peaceful, primarily because of the preexisting 1988 law. Informants reported that the new law was perceived by the dental community as simply a realignment and not a big deal.

**Implementation**

The current problems with the alternative model are a result of efforts to implement it. Soon after the legislation was passed a dental hygienist who wanted to

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120 This is contradictory as some informants reported that 3 members from SCDH wrote the original bill.
begin providing services under the model initiated efforts to do so. She met with the state Department of Health and Environmental Control (DHEC) to find out if the state intended to reopen the Office of Public Health Dentistry, which would supervise dental hygienists operating under the model. DHEC indicated that the state did not intend to reopen this office; in effect, this meant that there would be no service delivery mechanism (i.e. Public Health Dentistry) under which to implement the model.\(^{121}\) Since the state would not be involved with delivering preventive services under the new law, the dental hygienist began to look for alternative ways of implementation. It is important to note that during this time DHEC was in the process of hiring a dental coordinator under contract from the federal dental corps. This position was filled and the S.C. Dental Hygienists Association was invited to participate in the selection process before the alternative model of implementation was publicly discussed.

Meetings were held between the dental hygienist and the state Department of Health and Human Services (DHHS) to figure out how the law could be implemented. The hygienist expressed a willingness to hire other dental hygienists and dentists; and buy the equipment to start her own company. Several other meetings were held between the Dental Hygienists Association, DHHS and the state Dental Association to discuss implementation of the law; however, nothing was accomplished at the meeting and repeated meetings between the groups were unproductive.

Informants reported that DHHS was very supportive of the dental hygienist's intentions to start a private company to implement the model; DHHS issued a letter stating that it would make dental hygienists Medicaid providers and reimburse them directly.\(^{122}\) Informants reported that the state Dental Association was vehemently opposed to these plans and threatened to sue the state. The Dental Association also threatened to get an injunction to stop the dental hygienist from opening her company;\(^{123}\) however, in spite of opposition, the company was started. Because dental hygienists cannot bill Medicaid directly, all services must be billed through a collaborating dentist. A dentist from a state Medical University agreed to participate in the dental hygienist’s company but later declined due to opposition from peers. Another dentist agreed to participate and agreed to facilitate billing through his Medicaid provider number. This company is the only evidence of activity under the new law. However, informants reported that the company is currently being investigated to determine if it is operating illegally, since technically, the state has not officially implemented the law.

\(^{121}\) DHEC reported that it has placed preventive oral health through school based programs as a priority on its health care agenda. At the time of this meeting, DHEC had just hired recently hired a public health dentist and was not ready to resume dental health care services through that office. However, they did express that due to current budget constraints it was unlikely that the Public Health Department would [in the future] provide as much direct service as it had in the past.

\(^{122}\) This statement was not corroborated and we found no evidence of this letter

\(^{123}\) The injunction was mentioned because under federal regulations, dental hygienists are not recognized as CMS providers and cannot be paid directly by DHHS.
Interpretation Versus Intent

As noted earlier, the state Dental Board is responsible for creating rules and regulations for the law, it is also responsible for enforcing those rules. Although the Board’s involvement in the law’s development was minimal, their involvement is crucial to the law’s implementation. The law cannot be implemented until the Board develops rules for it and they are currently in the process of doing so. Since the regulations are the Board’s interpretation of the law, the Board must first clarify the intent of the law. Informants reported that the language of the law is vague and has the potential to be misinterpreted. The primary misunderstanding with the law is in the interpretation of the term “authorization”.

The new law’s removal of the word “pre-examination” and inclusion of the word “authorization” has been a serious point of contention among those attempting to implement it. Some contend that the Dental Board is trying to reinsert a pre-examination requirement into the law through regulation and interpretation. The law states that a dentist must authorize all treatment provided by a dental hygienists; however, there are different definitions of authorization. Informants reported that discussions held during the planning phase of the law included a discussion on the term ‘authorization’. Many believe that a general supervision law that requires authorization by a dentist ultimately requires that a dentist physically see and examine a patient before the dental hygienist may provide treatment. Others believe that this is a misinterpretation of the law and reason that if every child were having an exam there would be no need for the alternative model. The exam that some are alluding to is not a traditional exam but more like a flashlight screening of the child’s mouth. Although not as intensive, it requires that a dentist actually see the child before a dental hygienist provides an oral prophylaxis or sealant. In other words, a dentist cannot give blanket or remote authorization (e.g. authorize treatment for the whole 3rd grade from his/her office in another city). In hindsight, many informants report that the language of the law, specifically the word authorization, should have been more explicit and not left up to individual interpretation.124

The Implemented Model

Currently, the implementation of the law statewide has stalled; however, one dental hygienist has undertaken efforts to implement it on her own. She has started her own company that employs 14 dental hygienists, 4 dentists, 2 dental assistants and 6 administrative staff. Services provided by the program include screenings (provided free of charge), cleanings, sealants and fluorides. Dental hygienists perform the services and bill third party insurance companies or Medicaid through the company’s

124 In July 2001 the State Dental Board issued an emergency regulation that clarifies the word “authorization” to mean that a dentist must perform a clinical examination of the patient and determine the need for any specific treatment, and issue a work order for the procedure to be performed by the dental hygienists under general supervision. This regulation does not apply to dental students or dental hygienists contracted with DHEC. The State Dental Board and Dental Association are currently facing a lawsuit challenging the emergency regulation.
The dental hygienist who owns the company administers the subsequent payment. The program works as follows:

### Program Operation

The program forges relationships in schools by speaking with the superintendent and school board president in each county they wish to operate in. Dental hygienists accompany a dentist into the schools to do flashlight screenings and document obvious dental concerns (flashlight screenings by dental hygienists are not a point of contention since school nurses in South Carolina were already providing dental screenings prior to the law). After screenings are done, authorization forms are printed out for all the children that are screened. The Dental Board requires that the program get an authorization for each child screened. Each form includes the child’s name, the dentist name and license number, the hygienist’s name, address and license number and the collaborating dentists signature.125

Dental hygienists distribute and collect consent forms. Each form explains what the dental hygienists are permitted to do in the school setting and how the hygienist can help arrange transportation to a dentist if the child is in need of restorative services (the hygienist will try to work out transportation through the Department of Social Services or deliver services through the program’s mobile dental van). Original copies of consent forms are kept by the dental hygienist at the school and copies are sent home to the child’s parents.

Forms are sent home with the children to notify parents that their children have received services and to alert the parents of the dental hygienists’ findings. The forms clearly state that the dental hygienist’s screening is not intended to replace routine services provided by the child’s regular dentist. The form includes a section that asks the parent if the child has a dentist of record, if the parent knows of a dentist they would like their child to see or if they would like assistance with making an appointment with a dentist in the community. Transportation assistance is also offered. The form explains that the child’s insurance will be billed for services provided by the program. If the child does not have Medicaid or private insurance and needs help in paying for services they may contact the program office via a 1-800 number. Parents may also call the office to see if the child qualifies for the state Children’s Health Insurance Program (SCHIP), a payment plan is set up for those who do not qualify for CHIP or Medicaid (e.g. $1 per month). By law, the program must bill self-pay patients the Medicaid rate but has the option of writing the charge off if it is apparent that the parent cannot afford to pay.126

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125 The organization hires dental hygienists that live in each school district that is served by the program. The dental hygienists are familiar with the children, parents, teachers and area dentists that will accept Medicaid).

126 By law, the organization must make a reasonable effort to collect payment.
Referral Networks and Dentists of Record

The program we have just described has a limited referral network, which varies by county. Counties that have dentists to treat Medicaid children are receiving an increased amount of referrals as a result of the program. Some dentists have been receptive to receiving referrals from the program; however, others refuse to make appointments for children that have been treated by the dental hygienists who work for this private organization. Under the 1988 law patients of record could not be treated by public health dental hygienists; however, this is not the case under the current law. It appears that some individual local dentists are refusing to see patients once they have been seen by this private organization. This refusal is not mandated by law.

Informants reported that the current method of implementation is problematic because the program does not adequately identifying children who already receive services from a dentist in the community. Informants reported that neglecting to do this creates animosity from area dentists toward the program and creates problems for those who are administering the Medicaid program. The private organization provides oral prophylaxis and sealants to children who are already in the (Medicaid) system as patients of other dentists, which causes Medicaid payment for services to become complicated. Medicaid pays for two cleanings per year (every 6 months). Because of these limited benefits the following scenario may occur: a child may receive services at his/her dentist of record who bills Medicaid, then the private organization provides services to the child at school and bills Medicaid. The child may return to his/her dentist of record for services but the dentist will be denied payment (for the cleaning) from Medicaid because the child has either been seen within the 6 month period or has used up his/her Medicaid benefits for the year. When both the private organization and the dentist of record are providing services, the Medicaid agency must decide whom to pay; ultimately, someone will be denied.127

The state Department of Health and Human Services (which administers Medicaid) must develop a payment policy to determine who gets paid for services. Informants reported that the state Dental Association intends to support whatever policy DHHS develops. Informants suggested that there is a possibility that children may be penalized if DHHS decides to directly reimburse dental hygienists. They reason that dental hygienists that are directly reimbursed for services (without a dentist involved in the program) will not be in the position to provide comprehensive care in the long run. Although informants report that DHHS has been supportive of the private organization’s services, many believe that children served by the organization are put at a disadvantage. Informants reason that once the private organization provides services to the child, the organization must assume full responsibility for the child’s oral health care; however, it is impossible for the organization to provide comprehensive care or a continuous source of care because the program is mobile. Every informant reported

127 Currently, Medicaid edits by provider; this modification of the law occurred in 2000 when Medicaid reimbursement was increased. Under this law the proposed scenario is not entirely accurate because the law essentially allows both providers to be paid regardless of the time frame in which the child received treatment. Informants reported that the modification is currently under review.
that the services provided by the private organization are definitely needed and beneficial; however, many expressed concern over the lack of coordination with the dentists in each community that the organization serves.

Many believe that the private organization is profit driven; however the types of services that it provides are not huge moneymakers. Although profit is not their primary focus, the organization hopes to eventually attain self-sufficiency. The organization currently operates in 16 counties and poised to start in 8 more.

Informants reported that part of the state’s problem with the law and its implementation is primarily due to the process. Informants believe that the state should have waited to get the assistance and opinion of a public health dentist before developing the law. Informants state that the model should be a partnership between the state and the private sector to deliver the services. The current implementation of the law is not a partnership but a private business. Informants also report that proper funding is needed to make the law a reality. However, since the state is going through a 15 percent budget cut, additional money is unlikely.

**Impact on the Delivery of Oral Healthcare Services**

The alternative model has not had any significant impact on the way that oral health care is delivered. Only one dental hygienist has chosen to implement the model through a private organization. Although 14 dental hygienists are employed by the organization, this represents a very small portion of the state’s dental hygienists. Informants reported that dental hygienists that have chosen to work with the private organization have been blackballed by the dental community.

**Interim Outcomes**

The private organization that has implemented the model has provided screenings to 12,763 children since January 2001. The program provided services (cleanings, prophylaxis, and fluoride) to 3,500 children in that same time period; 1772 children received sealants. As stated earlier, all informants reported that this program is beneficial and has the potential to increase access for children. The state is finding that although there is significant need among Medicaid children, parents are not getting children to dental appointments and providing dental services at schools eliminates this barrier to care.

The organization operates all over the state, even in areas where access to care is sufficient. Informants believe that it should not operate in areas where there are sufficient providers; however, proponents of the program contend that the program must operate in areas where there is a patient mix of both insured and uninsured children in order for the program to be viable. The amount of uninsured children served by the

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128 33% had obvious problems, 14 percent had urgent care needs, 19 percent had “as soon as possible”.
organization varies by county; however, the volume of children served indicates that the program has been of benefit.

Informants agree that children can be served under the present law work but the present method of operation will become unsuccessful if collaboration with local dentists does not occur. The current program is operating in a vacuum and is not connected to any system of care.

Lessons Learned

Our findings suggested that the following points are essential to developing and implementing an alternative model such as South Carolina’s:

- The language of the law should be more black and white in its requirements (e.g. defining authorization, required paperwork, etc.). Informants reported that the language of the law is unclear, which has caused a lot of problems and confusion; so much so that some involved in its development now regret its passage.

- Communication is key. Several informants reported that the currently implemented program would be more successful if it operated more in collaboration with local providers. This collaboration would not only ease existing animosity but would provide for more comprehensive and continuous care for children.

- Public/Private partnerships may ease the tension and make the model easier to implement. Some informants reported that the current implemented program is an attempt to institute a public program in the private sector. The model may have been easier to implement if it were a collaboration/equal partnership with the state. Currently, South Carolina does not have the infrastructure to support the alternative model because there is no one in the individual districts to coordinate various activities.129

- A soft, slow approach may facilitate program success. Because all informants reported that the current program has great potential for increasing access, some of the problems with the program may be due to personality conflicts rather than the program itself.

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129 The state is currently developing several public/private partnerships to increase access. It has also initiated a new program called ‘First Smiles’ in which preventive oral health care services (oral health assessments, parent education and the application of fluoride varnish) are provided by medical personnel.
APPENDIX K
WASHINGTON CASE STUDY

Washington’s Alternative Model for Delivering Preventive Oral Health Care

Washington instituted a medical model which permits physicians, registered nurses, licensed practical nurses, and physician assistants to provide preventive oral health services to children 0-18 years of age, developmentally disabled adults, people over 65 years of age, and people with xerostomia. These services include:

- The application of fluoride varnish;
- Oral health exams; and
- Coordinating referral for treatment to dentists.

Summary

The effectiveness of Washington’s alternative model for delivering preventive oral health care is unknown. Although the alternative model is permitted under the state’s existing scope of practice laws, physicians, nurses, and physician assistants have not utilized the new model to a large degree. In fact, only a few pilot projects have been implemented in Washington that test this new delivery of care system. Despite the fact that the alternative model permits physicians and nurse practitioners to bill Medicaid directly for providing preventive oral health care services and to receive reimbursement rates equal to that of dentists, these providers are not seeking payment, thus indicating the relative absence of such services. Although Washington’s attempt to implement the alternative model has not recently run into problems that other states are experiencing, (e.g., turf issues and low Medicaid reimbursement rates) poor communication and outreach to medical providers about this new initiative have proven to be the state’s greatest hurdles. By providing more training and education to physicians, nurses, and physician assistants about their ability to provide preventive oral health services to low-income children, more of these providers will be encouraged to participate in the new model, and low-income children’s access to preventive care will be increased.

Methods

This case study involved an in-depth review of Washington’s alternative model of delivering preventive oral health care services to low-income and underserved children.
Although the alternative model permits physicians, nurses, and physician assistants to also provide preventive oral health services to developmentally disabled adults, adults over the age of 65, and persons with xerostomia, for purposes of this study we have focused only on the alternative model as it relates to low-income children. Specifically, we examined: 1) the process and extent to which Washington passed new legislation allowing for an alternative model; and 2) whether the alternative model allowed for a change in the delivery system for preventive oral health care services.

In consultation with individuals at CDC, we opted to study Washington because the state had instituted an initiative that expanded upon the already-existing medical scope of practice laws to permit/encourage an alternative model, and because this alternative model had been implemented. The following major research questions guided our discussions with informants:

- What motivating factors spurred enactment of the public health-oriented provisions in the states’ dental practice laws?
- What was the planning process for developing such provisions?
- To what extent and how are such provisions implicated in the development and implementation of alternative models for delivering preventive oral health care to low-income children?
- Have such provisions encouraged a change in the way preventive oral health care is delivered to low-income children through the alternative oral health care model?
- Are there interim outcomes that suggest that such provisions improve access to, or utilization of, preventive oral health care services for low-income children?
- What were the factors that led to the defeat of attempts to adopt such provisions/implement the alternative model?

We conducted eleven interviews with a wide range of informants between June 22, 2001 and July 13, 2001. Interviews averaged 60 minutes in length. We solicited the participation of representatives from the state public health dental office, state Medicaid dental office, state dental board and/or dental hygienist board, state dental association, state legislators who sponsored the legislation, state dental hygienist association or state pediatric physicians association, providers delivering services under the model, and advocates. Many of the individuals we contacted agreed to participate in the study, others referred us to colleagues who could better answer our questions, and some declined an interview. Since our informants were promised anonymity, we will not release their names, nor their professional affiliations due to the highly politicized nature of the subject. A copy of the short interview guide can be found as Appendix A.

Xerostomia—or the feeling of a dry mouth affects thousands of people, particularly the elderly and is associated with hypofunction of the salivary glands. Xerostomia is not a trivial compliant; it exerts serious negative effects on the patient's quality of life, affecting dietary habits, nutritional status, speech, taste, tolerance to dental prosthesis, psychological well being and oral health, particularly the susceptibility to dental caries and opportunistic infection.
The Context

Unlike many of the states in this study, Washington has a high supply of dentists. There are approximately 4,000 licensed dentists in the state. However, most of these dentists practice in private settings, a large number perform cosmetic dentistry, and approximately 110 newly practicing dentists serve in suburban areas. In addition, a significant number of Washington’s dentists are over the age of 55, and retirement of these dentists is a major concern. One informant reported that there are currently 200 dentists in Washington over the age of 70 who are about to retire.

Although Washington’s supply of dentists ranks above the national average, the state also has a low number of dentists participating in Medicaid\textsuperscript{131}. In addition, many dentists do not practice pediatric dentistry, and those that do have a full panel of private pay patients. In 2000, only 1,700 claims for pediatric dental services were filed with the state’s Medicaid agency.

Finding dental providers in Washington who are able and willing to serve children is difficult. One informant reported that finding a dentist to treat one or two Medicaid children is possible, however finding a dentist who will open up a practice and serve between 2,000 to 4,000 Medicaid children in need of oral health services is very difficult. This is major problem since 14 percent of children in Washington have unmet oral health needs. This is almost 50 percent higher than the national rate.\textsuperscript{132} Data indicate that among those children age one to three who are technically eligible for medical assistance through at least one of three state medical assistance programs, only one in five ever saw a dentist.\textsuperscript{133} In addition, the average caseload per Medicaid dentist doubled from 1993 to 1999.\textsuperscript{134}

Parts of Washington’s 23 counties have been designated federal Dental Health Professional Shortage Areas.\textsuperscript{135} Though mostly in rural areas, Washington’s dental access problems are found throughout the state. Serving these areas are safety-net providers, such as community health centers (with dental chairs), which provide oral health services to about 30 percent of Washington’s Medicaid enrollees. Indian tribal health centers are beginning to also serve this population.

Washington’s low Medicaid reimbursement rate was one reason cited for low dentist participation in Medicaid. In 1995, the state increased rates for services delivered to children. The current Medicaid fee-for-service (FFS) rate for dental services

\textsuperscript{131} Washington’s state Medicaid agency, the Medical Assistance Administration (MAA), recently reported that there are 3,869 Medicaid enrolled dentists. However, this number also reflects providers in neighboring states, such as Oregon. Provider Enrollment Summary. Medical Assistance Administration (MAA). July 31, 2001.
\textsuperscript{133} Low-income children may receive medical assistance through: 1) Medicaid, run by Washington’s Medical Assistance Administration; 2) Basic Health Plus, which allows low-income children whose parents are enrolled in Basic Health to receive full-scope Medicaid benefits; or 3) SCHIP, Washington’s State Children’s Health Insurance Plan.
is $18.18. However, other problems were cited as barriers to increasing dentists’ participation, including stigma attached with the Medicaid population and poor communication between the Medicaid agency and dentists. To combat these problems, the state awarded $5 million dollars to over 50 communities for projects aimed at enhancing access and raising dentists’ awareness of the oral health care needs of low-income populations.

There are approximately 13,898 physicians and 1,268 physician assistants (PA’s) licensed and actively practicing in Washington\textsuperscript{136}. While PA’s are allowed to apply fluoride varnish to children’s teeth, they must do so under the supervision of a physician. The same is true for Washington’s registered nurses and licensed practical nurses. There are 3,148 licensed and actively practicing nurse practitioners and 3,740 licensed and actively practicing registered nurses in the state.\textsuperscript{137} Though they are allowed to bill Medicaid directly like physicians, nurse practitioners who apply topical fluoride varnish to Medicaid children must do under the direction and supervision of either a physician or dentist.\textsuperscript{138} Though the alternative model permits all of these medical professionals to apply preventive oral health services, our informants provided the most information on physicians and nurse practitioners.

There are currently 24,246 enrolled physicians and 2,4000 enrolled nurse practitioners in Washington’s Medicaid program. These numbers, however, include enrollment of providers from neighboring states, such as Oregon. The data also suggest that there is an exceptionally high enrollment rate of out-of-state physicians.\textsuperscript{139}

Under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program, physicians have always been allowed to provide some oral health services, namely oral health exams. Physicians may bill for these services three times per year at no specific intervals. Until the development of the medical model, however, physicians were not permitted nor reimbursed by Medicaid for providing any additional preventive oral health service, such as the application of topical fluoride varnish. The state of Washington recognized that, in order to ensure continuity of care and because physicians expressed an interest to learn how to provide more comprehensive oral health services, physicians should be permitted to provide and be reimbursed for applying fluoride varnish to children’s teeth. Dentists originally thought that physicians would infringe upon dentists’ ability to collect Medicaid reimbursement; however, dentists have as much flexibility in billing as physicians.

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Factors Motivating the Enactment of the Public Health-Oriented Provisions

Washington did not enact a new law to allow physicians, nurses, and physician assistants to provide preventive oral health services to low-income children. Rather, this alternative model of preventive oral health care delivery was permitted on a voluntary basis under the state’s already existing dental, medical, and nursing scope of practice laws. A series of events and number of interagency agreements contributed to the
development and implementation of this model. However, it should be made clear that no new public health-oriented provision was enacted for the alternative model.

There are several factors that motivated the development of the alternative model that allow physicians, nurses, and physician assistants to apply fluoride varnish to children 0-18 years of age. These factors include: 1) lack of access to dental services for low-income children; and 2) key stakeholders' interest and commitment to increasing oral health care access.

Lack of access to oral health services for low-income children

Prior to 1994, the inability of low-income children to access preventive early intervention oral health services was a significant problem in Washington. At this time, dental providers were seeing a very limited number of Medicaid clients, despite the number of dentists enrolled in the Medicaid program. Several informants reported that concern over this lack of access was a motivating factor for allowing medical providers, such as physicians, nurses, and physician assistants to provide limited oral health services to children. As discussed below, many key stakeholders knowledgeable about this problem came together to form a coalition which was responsible for developing and implementing the voluntary medical model.

Involvement of Key Stakeholders

A second motivating factor for the development of the alternative model was the involvement and interest of many key stakeholders, including state government officials, dental association members, dental providers, and advocates, in improving low-income children’s access to dental services. Beginning in 1994, these stakeholders openly and individually expressed concern over the lack of access to oral health services for Washington’s low-income children. One interested group, while investigating how to expand access to care through primary prevention, found that physicians, nurses, and physicians assistants, who were providing the bulk of care to this population, had been successful in other primary care prevention efforts, such as immunizations. This group suggested the idea of allowing physicians, as well as nurses and physician assistants, to provide preventive oral health services to low-income children.

Another informant told us that advocates were adamant that low Medicaid reimbursement rates were the primary barrier to children’s access to dental care. It was also reported that in 1994, the Washington legislature got involved in this issue, even threatening to mandate increased Medicaid participation of dentists, if more dental providers did not start to treat more low-income children.

Due to these concerns, the key stakeholders formed the Washington Oral Health Coalition. As discussed below, the Coalition began the planning process for two important developments in providing increased preventive oral health services for low-income and Medicaid-eligible children. The first development was the Access to Baby and Child Dentistry Programs (ABCD), which began in 1995 in Spokane, Washington as
an initiative to motivate local community support and funding for training dentists to provide oral health services to Medicaid-children. The second development, which is the focus of this study, was the alternative model to allow physicians, nurses, and physician assistants to provide preventive oral health services to low-income children.


Since no public health-oriented provisions were developed nor enacted into law, the planning process for developing and implementing the alternative model is discussed.

In 1994, a meeting was held in Seattle with state policymakers, advocates, dental providers, and dental association members to discuss improving access to oral health care for low-income children. After learning about the severity of Washington's access problems, several of the meeting's attendees decided to form the Washington Oral Health Coalition, which was subsequently responsible for developing two important initiatives to combat the state's oral health access problems. The first initiative was the ABCD program, which began as a pilot project in Spokane and is now active in seven additional counties. The planning process for ABCD began soon after the 1994 meeting. A Spokane ABCD steering committee was formed and an interagency agreement was signed by the Coalition members, the state Medicaid agency, the state university, and the local Spokane dental society. This agreement stipulated that the dental society members were to be the dental providers in Spokane, that they would receive enhanced Medicaid fees, and that the state university would provide training and education. The ABCD program trains dentists to provide preventive and restorative dental care for Medicaid-eligible children. The program is based upon the premise that starting dental visits early will yield positive behaviors by both parents and children, thereby helping to control the caries process and reduce the need for costly future restorative work. The ABCD program has recently expanded to include training for physicians interested in applying fluoride varnish to children's teeth. This new program, known as the ABCDE program, will begin in Spokane in fall 2001.

The second initiative promoted by the Coalition was the voluntary medical model, which permits physicians, nurses, and physician assistants to apply topical fluoride varnish to low-income children. The idea of this medical model initially came from a state university faculty member who spoke about it at the Seattle meeting and who had developed a model curriculum for training these providers. The alternative model was supported not only by the Coalition, but it had also gained support by the state Medicaid agency. In 1994, Medicaid sent a letter of understanding to the Medical Quality Assurance Commission that stated that physicians, nurses, and physician assistants could apply topical fluoride treatments to children's teeth and that physicians and nurse practitioners could be reimbursed by Medicaid at the same rate as dentists. The Commission issued a determinative statement that instructed the Coalition to ensure that the alternative model was permitted or fell within the dental scope of practice laws, as well as the medical and nursing scope of practice laws. The Commission provided no further guidance or input into the alternative medical model.
Although initially the model had immediate support by Medicaid, there was some initial opposition, both by the state practice boards and state dental associations. At first, the state dental association expressed opposition to the model but backed away from actively opposing it after recognizing that it was so strongly supported by many stakeholders and that the association would lose the battle. Washington’s political climate was ripe for change, so the idea of the alternative model was viewed by many as the answer to meeting the oral health needs of the state’s poor children.

Dentists consented to the idea of the model once they understood that it would have no economical effect on them and that the model could serve as a partnership to enhance children’s health. In addition, dentists who were interested in or who were already treating low-income children could participate through the ABCD program, which not only trained them but which provided them the opportunity to receive greater reimbursement rates through participation in the program. ABCD-participating dentists currently receive between $3 and $4 above the Medicaid FFS rate of $18.18 per service. It should be noted that in 1995, one year after the Seattle meeting, Medicaid increased its dental fees to 75% USR, thus alleviating some stress and opposition from the states’ dentists.

The Impact of the Public Health-Oriented Provisions on the Alternative Model

After the letter of understanding was exchanged between Medicaid and the Medical Quality Assurance Commission, the state implemented the first pilot program that utilized the alternative model. In 1997, in Harborview, Washington, five nurse practitioners from a very large primary care child and teen clinic began applying fluoride varnish. State university staff provided the training for this program and monitored activities at the project site for several months. Beginning in 1997, Medicaid started to receive its first billings from these medical providers for fluoride varnish services provided to children. As permitted by the alternative model, the nurse practitioners were reimbursed at the same rate as dentists, approximately $18.18 per service.¹⁴¹

One important barrier to the new model, however, was that the medical providers had little or no formal training to provide the fluoride varnish. So, the state Medicaid agency entered into an interagency agreement with the state university for training of this new alternative model. Under this agreement, university staff, specifically a dental hygienist employed by the university, and two Medicaid staff members began to provide training to medical providers about the application of fluoride varnish. This current model of training is on a clinic-by-clinic basis, as requested by the clinic or physician.

In addition to the Harborview pilot project, there were a few additional areas throughout the state, specifically one in southwest Washington, where providers where

¹⁴¹ Prior to the alternative medical model, physicians, nurse practitioners, and physician assistants were not only not allowed to apply fluoride varnish to low-income children’s teeth, they were also not reimbursed by the Medicaid agency for this service. Under EPSDT, however, physicians had always been allowed to provide and be reimbursed for dental exams.
operating under the alternative model. There is no data to indicate the activity of this model.

The Impact on the Delivery of Preventive Oral Health Care Services

Thus far, there has been little impact on the delivery of preventive oral health care services resulting from the alternative model. Despite the fact that the alternative medical model is allowed under the existing scope of practice laws, very few if any medical providers are seeking reimbursement for providing topical fluoride varnish to low-income children. Although this does not indicate complete absence of these services, and in fact many signal other problems, such as billing problems, informants could not provide data that indicate how many physicians, nurses, or physician assistants have provided preventive oral health services under the new model. Therefore, findings indicate that the alternative model has been implemented on a very limited basis, mostly in pilot projects.

Other alternative models

Other initiatives and specifically other alternative models for the delivery of preventive oral health services to low-income children have been implemented in the past few years by the state of Washington. These models have been implemented on a bigger scale and may have impacted the delivery of preventive oral health care services to this population.

These initiatives include: a) the ABCD project, which trains dentists to provide services to low-income children, and which will eventually also train physicians to provide topical fluoride varnish; and 2) the implementation of an alternative model allowing dental hygienists to work independently to provide preventive oral health services in public health clinics and school-based health centers. Although the extent to which this model is implemented has not been investigated, it was a subject of discussion in many of our interviews.

Outreach

Nearly all our informants reported that the lack of outreach to medical providers about the alternative model serves as an important barrier to the full implementation of the model. The state of Washington has no formal campaign or outreach mechanism to educate medical providers about their ability to provide and be reimbursed for applying topical fluoride varnish to low-income children’s teeth. As reported by one official, it is not even clear if information about the new model has even been mentioned in the state Medicaid newsletter, which is sent periodically to licensed medical professionals in Washington. Outreach activities also have not been adopted by any of the professional associations or advocate organizations. Informants indicated that information about the medical model is passed word-of-mouth and thus, interest in the model has come on a very limited, person-by-person basis.
Training and Education

With no outreach to providers about the medical model, there has also been very little effort to provide training and education about how to treat children and how to apply topical fluoride varnish. This lack of training and education opportunities in Washington also serves as an additional barrier to the full implementation of the alternative medical model. As mentioned previously, state university staff under agreement with the state of Washington have provided some training and education services to physicians and nurse practitioners, either on an individual basis or in pilot projects. For the most part, however, the university staff have provided these services to ABCD-participating dentists. It is expected that in the fall, when the first ABCDE project begins in Spokane, that these services will be provided to interested physicians, nurses, and physician assistants.

Interim Outcomes

Currently the alternative medical model has not significantly changed the delivery of preventive oral health services to low-income and underserved children. There are no data to indicate whether and to what extent physicians, nurses, and physician assistants are providing topical fluoride varnish to children under this medical model. Prior to the voluntary alternative model, physicians were permitted to give oral health exams to children under EPSDT. However, application of fluoride varnish and subsequent treatment services had only been allowed by licensed dentists, many of whom, though Medicaid participating dentists, were not providing many services to low-income children. The alternative model was developed, in part, to fill the gaps in access for this population, by allowing medical providers, who were more willing and able to serve Medicaid-eligible families, to provide basic dental health services. In addition, the model has the potential to improve the referral process to dentists when more extensive treatment services are needed.

Although the alternative medical model has been in place for several years, it may be too soon to tell how effective it will be in increasing low-income children’s access to preventive health care services. The ABCDE pilot project that will begin this fall in Spokane may have the most potential. It will be the first test of the medical model in a well-established program that provides outreach, training, and education to providers about providing oral health services to low-income children. However, no findings will ever be established until data on this project and future pilot projects are collected and analyzed to measure if and how preventive oral health services are being provided to low-income and Medicaid-eligible children.
Lessons Learned

Our findings suggest that several elements are essential to developing and implementing an alternative medical model such as Washington’s model. Though not yet fully implemented, the success of this model depends on the following:

- Interest and support from various stakeholders, including state and local officials, dental and medical providers, dental and medical associations, and advocates, for improving access to preventive oral health services for low-income children;

- State and local financial support and resources for training, education, and outreach to physicians, nurses, and physician assistants about the medical model. This support is also needed in communities outside of Spokane to encourage the implementation of ABCDE and similar programs;

- Unbiased, solid data to clearly state the problem of children’s lack of access to oral health care services and to identify gaps in coverage of these services;

- Good working relationships between state and local health care delivery system representatives for facilitating open communication and information about the medical model;

- Either support from the state legislature for making the medical model mandatory, rather than voluntary, or extra incentives to medical providers for agreeing to adopt the medical model.