STATE OF IOWA

IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

Revised Agenda (1/18/13)
New information in red

Revised Agenda (1/30/13)
New information in red

IOWA DENTAL BOARD

AGENDA

January 31 – February 1, 2013

Location: Iowa Dental Board, 400 SW 8th St., Suite D, Des Moines, Iowa

Board Members: *Michael J. Rovner, D.D.S., Board Chair; Lynn D. Curry, D.D.S., Board Vice Chair; Steve Bradley, D.D.S., Board Secretary; Steven Fuller, D.D.S.; Matthew McCullough, D.D.S.; Mary Kelly, R.D.H.; Nancy Slach, R.D.H.; Diane Meier, Public Member; Lori Elmitt, Public Member*

THURSDAY, JANUARY 31, 2013

Committee Meetings:

9:00 a.m.	**EXECUTIVE COMMITTEE** *(Rovner, Curry, Bradley, Kelly)*	**Closed Session**	
9:30 a.m.	**LICENSURE/REGISTRATION COMMITTEE** *(Rovner, Meier McCullough)*	**Closed Session**	
10:00 a.m.	**BUDGET REVIEW COMMITTEE** *(Curry, Fuller, McCullough)*	**Closed Session**	
10:30 a.m.	**DENTAL HYGIENE COMMITTEE** *(See Separate Committee Agenda)*	**Open Session**	*Kelly, Slach, Bradley*

Board Meeting:

11:30 a.m.	**OPEN SESSION**	**Open Session**	*Full Board*
	I. CALL MEETING TO ORDER – ROLL CALL		*Mike Rovner*
	II. 1ST OPPORTUNITY FOR PUBLIC COMMENT		*Mike Rovner*
	III. APPROVAL OF OPEN SESSION MINUTES		*Mike Rovner*
	a. October 25-26, 2012 Quarterly Meeting New material added 1/18/13		
	IV. REPORTS		
	a. EXECUTIVE DIRECTOR'S REPORT		*Melanie Johnson*
	b. LEGAL REPORT		*Theresa Weeg*
	1. Update re: Review of Statutory Authority of Dental		

Hygiene Committee and Dental Board

2. Update re: Executive Order 80
3. Subsequent Examinations & RDH Under a Public Health Supervision Agreement
4. Update re: Dental Licensure Examinations & Use of Patients in Exams
5. Report re: Patient Referral Rules & Marketing Promotions (e.g., Groupon, free iPads, gift cards)
6. Other

c. ANESTHESIA CREDENTIALS COMMITTEE REPORT *Lynn Curry*

1. Recommendations re: Moderate Sedation Permit Applications *(See Separate Committee Agenda)*
   New material added 1/18/13
2. Recommendations re: General Anesthesia Permit Applications *(See Separate Committee Agenda)*
3. Other Committee Recommendations, If Any
   New material added 1/18/13

d. CONTINUING EDUCATION ADVISORY COMMITTEE REPORT *Lynn Curry*

1. Recommendations re: Continuing Education Course Applications *(See Separate Committee Agenda)*
   New material added 1/18/13
2. Recommendations re: Continuing Education Sponsor Applications *(See Separate Committee Agenda)* New material added 1/18/13
3. Other Committee Recommendations, If Any
   New material added 1/18/13

e. BUDGET REVIEW COMMITTEE REPORT *Lynn Curry*

1. Review of Quarterly IDB Financial Report
   New material added 1/18/13
2. Annual Fee Review Recommendation
3. Other Committee Recommendations, if any

f. EXECUTIVE COMMITTEE REPORT *Mike Rovner*

g. LICENSURE/REGISTRATION COMMITTEE REPORT *Mike Rovner*

1. Actions Taken by Committee on Applications
2. Pending Licensure/Registration Applications, If Any – Will Be Discussed Under Agenda Item VIII (2)
3. Other Committee Recommendations, If Any

h. DENTAL HYGIENE COMMITTEE REPORT *Mary Kelly*

1. Pending Dental Hygiene Applications, If Any – Will Be Discussed Under Agenda Item VIII (2)
2. Report RE: Actions Taken at Dental Hygiene Committee Meeting
3. Committee Recommendations, If Any

i. DENTAL ASSISTANT REGISTRATION COMMITTEE REPORT *Mike Rovner*

j. EXAMINATIONS REPORT

1. CRDTS (Central Regional Dental Testing Service) - *Dental Steering Committee Report* *Steve Bradley*
2. CRDTS - *Dental Hygiene Examination Review Committee Report* *Mary Kelly*
3. CRDTS - *Dental Examination Review Committee Report* *Steve Bradley*

k. AD HOC EXPANDED FUNCTIONS COMMITTEE REPORT *Mike Kanellis*

l. IOWA PRACTITIONERS REVIEW COMMITTEE REPORT

1. Quarterly IPRC report New material added 1/18/13 *Brian Sedars*

V. ADMINISTRATIVE RULES *Melanie Johnson*

a. FINAL ADOPTION

1. Adoption of final amendments to Chpt. 10, "General Requirements," Rule 650—10.5 – Amending the definition of "public health setting" to include day care settings (NOIA, ARC 0471C, 11/28/12 IAB)
2. Adoption of final amendments to Chpt. 11, "Licensure to Practice Dentistry or Dental Hygiene," and Chpt. 15, "Fees" (NOIA, ARC 0473C , 11/28/12 IAB)
3. Adoption of final amendments to Chpt. 35, "Iowa Practitioner Review Committee" (NOIA, ARC 0472C, 11/28/12 IAB)

b. NOTICE OF INTENDED ACTION

1. Possible amendments re: how long dental assistant examinations are valid before re-testing required; amendment re: non-registered out-of-state dental assistants (New agenda item added 1/18/13)
2. Possible amendments re: volunteer application and removal of fee (New agenda item added 1/18/13)

c. FOR DISCUSSION - none-

d. RULE WAIVERS - none-

e. PETITIONS FOR RULE MAKING - none-

VI. LEGISLATIVE UPDATE

a. Board of Medicine Proposal: Require Review of Iowa Prescription Monitoring Program Database Prior to Prescribing Controlled Substances (New material added 1/18/13) *Melanie Johnson*

Please Note: At the discretion of the Board Chair, agenda items may be taken out of order to accommodate scheduling requests of Board members, presenters or attendees or to facilitate meeting efficiency.

12:30 p.m. **- WORKING LUNCH -**

1:00 p.m. **VII. PRESENTATION: PUBLIC HEALTH SUPERVISION**

VIII. OTHER BUSINESS *Mike Rovner*

a. Review of 11/21/12 Letter from American Academy of Dental Sleep Medicine; and 9/5/12 Letter from American Academy of Sleep Medicine re: Scope of Practice

b. Update re: Dental Asst. Trainees and Trainee Status Expiration Date Extensions *Melanie Johnson*
(New material added 1/18/13)

IX. APPLICATIONS FOR LICENSURE /REGISTRATION & OTHER REQUESTS * *Mike Rovner*

a. Ratification of Actions Taken by Executive Director on Applications Since Last Meeting *Melanie Johnson*

b. Pending Licensure/Registration Applications*

1. April Strong – Application for Dental Assistant Registration and Radiography Qualification *Recommendation from Licensure/Registration Committee*
(New material added 1/18/13)
2. Jessica M. Koster, D.H. - Application for Dental Hygiene License (New material added 1/18/13) *Recommendation from Dental Hygiene Committee*
3. Tracy A. Lawler – Application for Dental Assistant Registration and Reinstatement of Radiography Qualification (New material added 1/30/13) *Recommendation from Licensure/Registration Committee*

X. 2nd OPPORTUNITY FOR PUBLIC COMMENT *Mike Rovner*

XI. ACTION, IF ANY, ON CLOSED SESSION ITEMS

1. Licensure/Registration Applications
2. Statement of Charges
3. Combined Statement of Charges, Settlement Agreement and Final Order
4. Settlement Agreements
5. Final Hearing Decisions
6. Final Action on Non-Public Cases Left Open
7. Final Action on Non-Public Cases Closed
8. Other Closed Session Items

- **BOARD RECESS UNTIL FRIDAY MORNING @ 9:00 A.M.**
- **OR ADJOURN MEETING, IF WORK COMPLETED**

FRIDAY, FEBRUARY 1, 2013

Please Note: At the discretion of the Board Chair, agenda items may be taken out of order to accommodate scheduling requests of Board members, presenters or attendees or to facilitate meeting efficiency.

9:00 a.m.	**XII. BOARD RECONVENES**	**Closed**	*Mike Rovner*
	XIII. DISCIPLINARY HEARINGS**		
9:00 a.m.	**a.** In the Matter of Gene Mueller, D.D.S. (# 10-114, #10-115)	**TBD**	
10:00 a.m.	**b.** In the Matter of Irene Broyles, D.D.S. (#11-106)	**TBD**	
	XIV. CONTINUE WITH ANY CLOSED SESSION AGENDA ITEMS	**Closed**	
	XV. OPEN SESSION	**Open**	

a. ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS

1. Licensure/Registration Applications
2. Statement of Charges
3. Combined Statement of Charges, Settlement Agreement and Final Order
4. Settlement Agreements
5. Final Hearing Decisions
6. Final Action on Non-Public Cases Left Open
7. Final Action on Non-Public Cases Closed
8. Other Closed Session Items

b. OTHER OPEN SESSION ITEMS, IF ANY

XVI. ADJOURN

Next Meeting: May 9-10, 2013

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

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

**Pursuant to Iowa Code section 272C.6(1) a licensee may request that their disciplinary hearing be held in closed session.

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1/17/13 MJ edits to CB's 1/10/13 draft

IOWA DENTAL BOARD
MINUTES
October 25-26, 2012
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Board Members	**October 25, 2012**
Michael J. Rovner, D.D.S., Chairperson	Present
Lynn D. Curry, D.D.S., Vice Chairperson	Present
Steven P. Bradley, R.D.H., Secretary	Absent
Steven C. Fuller, D.D.S.	Present
Matthew J. McCullough, D.D.S.	Present
Mary C. Kelly, R.D.H.	Present
Nancy A. Slach, R.D.H.	Present
Diane Meier, Public Member	Present
Lori Elmitt, Public Member	Absent

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

Attorney General's Office
Theresa Weeg, Assistant Attorney General

Other Attendees
Jane Slach, R.D.A., Iowa Dental Assistants Association
Carol Van Aernam, Iowa Dental Hygienists' Association
Chelsea Larson, DMACC Dental Hygiene Student
Heather Kinger, DMACC Dental Hygiene Student
Jeannene Veenstra, R.D.A., Iowa Dental Assistant Association
Tracy Rodgers, R.D.H., Iowa Department of Public Health
Larry Carl, Iowa Dental Association
Lori Pelke, Midwest Dental
Stephen Thies, D.D.S., Iowa Academy of General Dentistry
Eileen Cacioppo, Iowa Dental Hygienists' Association

CALL TO ORDER FOR OCTOBER 25, 2012

Chairman Rovner called the open session meeting of the Iowa Dental Board to order at 11:39 a.m. on Thursday, October 25, 2012. A quorum was established with 7 members present.

Roll Call:

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Present		x		x	x	x	x	x	x
Absent	x		x						

PUBLIC COMMENT

Chairman Rovner allowed time for public comment.

Mr. Carl, Iowa Dental Association, on behalf of the Iowa Dental Foundation, wanted to thank the Board and all of the other organizations, who supported the 2012 Iowa Mission of Mercy (IMOM). The event provided dental care to over 1300 patients. The next IMOM event is scheduled for October 18-19, 2013. The Iowa Dental Association hopes to hold it in Des Moines in 2013; however, details have not been finalized to date.

APPROVAL OF MINUTES

- *July 12-13, 2012 Minutes*

❖ MOVED by FULLER, SECONDED by KELLY, to approve the minutes of the July 12-13, 2012 meeting, with a correction on page 11 to amend the reference from Medicare to Medicaid. Motion APPROVED unanimously.

- *April 24-25, 2012 Minutes – Correction*

Ms. Johnson reported that the correction was adding another citation to the Iowa Code as the basis of going into closed session. The added reference is to Iowa Code section Section 21.5(1) "c" - to discuss matters presently in litigation or where litigation is imminent.

❖ MOVED by FULLER, SECONDED by KELLY, to approve the corrections of the minutes of the April 24, 2012 meeting as submitted. Motion APPROVED unanimously.

REPORTS

EXECUTIVE DIRECTOR'S REPORT

Ms. Johnson reported that the Board's new website has been launched.

Ms. Johnson reported that the AMANDA project is currently scheduled to "go live" on June 1, 2013, based on the current status of the project.

Ms. Johnson provided an overview of the statistical data for this last renewal including dental licenses, faculty permits, and sedation permits. There are currently over 10,000 licenses, registrations, and permits. Ms. Johnson also provided an overview on complaints, IPRC and monitoring.

LEGAL REPORT

Ms. Weeg thanked the Board for the opportunity to attend the attorney's round table at the meeting of the American Association of Dental Boards (AADB). Ms. Weeg provided an overview of the meetings, which she attended.

Ms. Weeg reported that there was some discussion about D-PREP. Dr. Guy Shampaine provided the overview with some information that included some model cases. The program appears to be a very comprehensive, useful program in evaluating dentists for a number of alleged problems. The Iowa Dental Board, currently, uses the University of Illinois for competency cases. The initial D-PREP evaluation has been calibrated so that the evaluations are the same across the spectrum of cases. Remediation is completed at a site other than where the initial evaluation was completed. The program is expensive; however, it appears to be very useful. Ms. Weeg stated that most states continue to utilize continuing education as a way of dealing with competency cases.

Ms. Weeg also reported that corporate practice is becoming a much bigger issue across the nation. States with prohibitions against corporate practice are finding themselves in litigation more frequently. The negative issues with corporate dentistry are the same as any other type of complaint. The primary question is how to remedy these issues.

Ms. Weeg indicated that some states have attempted to shut down corporate practices. This also results in litigation. Meanwhile, other states have proposed ideas to address these concerns without prohibiting corporate practice. One state requires licensed dentists be on site at least 40% of the time. Another state requires dentists to sign their own insurance forms. While a third state requires documentation of who performed each procedure. A fourth state requires a licensed dentist perform the final portion of the treatment. These may, or may not, be good ideas; however, they are proposals for addressing the issue of corporate dentistry without action that results in litigation.

There was some discussion regarding GROUPON coupons and whether this violated fee-splitting agreements.

Ms. Weeg also indicated that there was some discussion about the Federal Trade Commission (FTC) case against the state of North Carolina regarding teeth whitening. The case is currently in the Circuit Court of Appeals awaiting a decision.

There was also some discussion related to human trafficking. Ms. Weeg noted that the JADA recently ran an article, which addressed this topic and its impact on dentistry, and how dentistry interacts with this issue.

Ms. Weeg reported that there was discussion about the use of PMPs. There was some discussion about what states are requiring the use of PMPs, what states are recommending their use, and what states are doing to gather information for their investigations.

Dr. Curry reported that in October 2012, the state of New York filed a federal lawsuit about Aspen Dental for operating illegally. Ms. Weeg indicated that this is an issue everywhere.

Ms. Kelly thanked the Board for attending the AADB as well.

Ms. Kelly reported that there was a report about a task force that was established to look at the use of portfolios and trying to establish a national template. A statement was made at the meeting that there was no bigger issue facing dentistry apart from dental therapists. Ms. Kelly stated that the ADA reported that there was some confusion on its proposal for portfolio examination. The ADA did not intend to be the testing agency. A sub-group made a request for proposal (RFP). Only one response was received and it was from a group within the ADA. The task force decided to see what the state of California does.

Ms. Kelly reported that the ADA will change the National Examination for dentists; the examination will become a one-part examination. The change will go into effect in 2017. There is a distribution list to provide updates to interested parties. The AADB stated that the executive director or other designated representative will receive emailed updates concerning changes to the National Examination.

The ADA is also looking for representatives to the Commission on Dental Accreditation (CODA). Resumes are being accepted.

The AADB also indicated that they also provide a written report to the agencies. Ms. Kelly feels that this would be beneficial to the Board members.

EXPANDED FUNCTIONS

Dr. Rovner moved this agenda item ahead in the schedule to accommodate Dr. Kanellis, with the University of Iowa College of Dentistry, was unable to stay for the entire meeting.

Dr. Rovner indicated that he would like to put together a task-force to further address the matter of expanded functions for dental hygienists and dental assistants. Dr. Rovner requested that the task force make recommendations to the Board by January 31, 2013, if possible. If not, Dr. Rover asked the task-force to report to the Board in January 2013 about its progress.

Dr. Rovner appointed Dr. Kannellis, as chairperson; Dr. Mary Mariana, IDA; Ms. Jane Slach, IDAA; Ms. Eileen Cacioppo, IDHA; Lori Elmitt, Board Member; Ms. Kelly, Board Member; Dr. Bradley, Board Member; Dr. North, former Board member; and Ms. Arjes, Board staff; to the task force*.

*Following the October 2012 Board meeting, the Board chairman decided that it would be best to have all Board staff serve as support to the Expanded Functions Task Force, rather than have a Board staff member serve on the Committee. Therefore, the Chair subsequently rescinded Ms. Arjes' appointment as a task force member.

Mr. Cope asked that the meetings be posted and noticed so that interested parties can attend. Dr. Rovner stated that this should not be a problem.

Ms. Cacioppo asked about who the voting members would be. Dr. Rovner replied by stating that he does not wish to make this a matter that polarizes the group. Dr. Rovner would defer to Dr. Kanellis to handle these decisions.

EXAMINATIONS – PORTFOLIO

Dr. Rovner reported that this is a matter that has been under discussion for some time. Dr. Rovner indicated that the Board does not wish to pursue this matter further at this time; and that while the current process is imperfect; it appears to meet the Board's current needs. Dr. Rovner stated that the Board will always welcome further information as provided.

COMMITTEES

ANESTHESIA CREDENTIALS COMMITTEE REPORT
Dr. Curry reported that Committee met on October 18, 2012 by teleconference. The Committee has six recommendations regarding applications for moderate sedation application. A list of the recommendations has been provided to the Board.

Dr. Curry provided an overview of the recommendations and indicated that some of the applications have been recommended with limitations. For example, the Anesthesia Credentials Committee has recommended that ketamine not be used as a moderate sedative.

- MOVED by KELLY, SECONDED by MCCULLOUGH, to approve the Committee's recommendations as submitted. Motion APPROVED unanimously.

CONTINUING EDUCATION ADVISORY COMMITTEE
Dr. Rovner asked Ms. Cacioppo what the basis was for denying the course about Invisalign, which was indicated on the list of Committee recommendations. Ms. Jane Slach reported that the course appeared to focus on marketing, as opposed to the use and application of the product.

Dr. Curry provided an overview of the Committee recommendations. Dr. Curry clarified that most of the course denials were based on course content, which focused on practice management or marketing techniques.

Dr. Curry reported on the request for reconsideration from Dr. Gene Fortman regarding the course, "Setting Your Team on Fire for Patient Care". The request for reconsideration did not provide sufficient information to justify a change in credit hours awarded. The Committee voted to stand by the original recommendation for partial credit. The original Committee recommendation was approved by Board in July 2012.

Dr. Curry provided an overview of the Committee's recommendation for sponsor applications.

Dr. Curry reported that the Committee tabled a decision on a Dental Assisting National Board course, until additional information could be reviewed.

- MOVED by KELLY, SECONDED by SLACH, to approve the Committee's recommendations for continuing education credit of the courses as submitted. Motion APPROVED unanimously.

- MOVED by KELLY, SECONDED by MEIER, to approve the Committee's recommendations for sponsor status as submitted. Motion APPROVED unanimously.

BUDGET REVIEW COMMITTEE REPORT

- *FY12 BUDGET REVIEW*

Dr. Curry reported that Budget Review Committee met earlier in the month and that the meeting was very useful. Dr. Curry indicated that there have been some changes in regards to budget reports and ways in which money is accounted for over the last several fiscal years. Dr. Curry reported that the format currently being utilized presents a clearer picture of how items are budgeted and accounted for.

Dr. Curry indicated that the Committee, among other things, reviewed a fee history, which proved to be very informative. Dr. Curry reported that there have been few fee increases in recent years; however, spending in some areas, especially in the area of information technology, have been increasing almost every year. Dr. Curry indicated that the Board may need to look at increasing fees in the future in order to cover these increased costs. Dr. Curry reported that the last fee increases were implemented in 2005.

Ms. Johnson reported that the Committee met for approximately three hours on Friday, October 19, 2012. Ms. Johnson reported that Board staff went over past, current, and proposed future budgets. Ms. Johnson indicated that the Committee will make recommendations concerning the spending plans as they deem appropriate. Any recommendations made by the Committee will be forwarded to the Board for review and final approval.

- ❖ MOVED by MCCULLOUGH, SECONDED by CURRY, to continue moving forward with the spending plans as previously approved by the Board. Motion APPROVED unanimously.

Board staff indicated that there are sufficient funds to cover budgeted expenses through June 30, 2012.

Dr. Rovner decided to table to the discussion of the annual fee review for a later date.

- *REIMBURSEMENT FOR AMERICAN ASSOCIATION OF DENTAL BOARDS (AADB) MEMBERSHIP DUES*

The Board received a request to have the Board cover the cost of individual membership to the AADB for current Board members.

Ms. Kelly provided a brief explanation on the fees owed if a member of the American Association of Dental Boards (AADB) or when a meeting of the AADB is attended. Dr. Rovner indicated that he was a member of the AADB for a short time; however, he later found that he did not benefit sufficiently to warrant continued membership.

It was noted that the key difference between members and non-members is that the registration fees for the mid-year meetings are approximately $200 higher for non-members. These fees apply only if attending an AADB meeting.

Ms. Kelly stated that, in her opinion, the decision to be a member of the AADB is a personal one.

Ms. Braness informed the Board members that the State of Iowa may consider the Board's payment of individual memberships as a form of income.

Dr. Rovner is inclined to leave the matter alone for now and not pursue reimbursement of membership dues.

- ❖ MOVED by MCCULLOUGH, SECONDED by KELLY, to deny the request for fee reimbursement. Motion APPROVED unanimously.

- *FEES*

Ms. Slach asked about the differences in late fees between the dental professions. Ms. Johnson stated that the Board previously tried to change this last year when the Board tried to implement fee changes. Ultimately, the Governor's office chose to deny the original request for fee increases. Ms. Braness reported that staff is aware of the disparity in late fees; however, the Board was not granted the authority to make any changes in this area.

EXECUTIVE COMMITTEE REPORT

LIST OF APPROVED PROVIDERS FOR EVALUATION

Dr. Rovner reported that after the last Board meeting the Executive Committee reviewed several requests to authorize a number of new organizations for use in clinical assessments. The members of the Executive Committee were asked to review and consider the addition of two providers to the Board's list of as prior-approved facilities for purposes of Board ordered evaluations. The Executive Committee reviewed and approved of including the following two facilities: Professionals Program, Elmhurst Memorial Healthcare (Elmhurst, IL) and Acumen Assessments, LLC (Lawrence, KS). The Committee requestsed that the Board ratify their action to authorize the inclusion of these two facilities to the Board' "List of Resources for Assessments and Evaluations."

Ms. Weeg provided an overview of why the courses were added. Ms. Weeg indicated that other boards with which she works have used these providers in the past. The Executive Committee has tentatively approved these providers. Ms. Johnson indicated that the Board should ratify these decisions.

- MOVED by MEIER, SECONDED by CURRY, to ratify the Committee's actions to add the evaluation sites as submitted. Motion APPROVED unanimously.

OTHER COMMITTEE RECOMMENDATIONS, IF ANY

Ms. Johnson reported that the Executive Committee voted to allow Ms. Johnson attend a CLE course for government attorneys, sponsored by the Attorney General's office, to be held on November 16, 2012 and be reimbursed for that cost ($30).

- MOVED by KELLY, SECONDED by CURRY, to approve the Committee's recommendation to reimburse Ms. Johnson's fee to attend the continuing legal education course sponsored by the AG's office.. Motion APPROVED unanimously.

LICENSURE/REGISTRATION COMMITTEE REPORT

ACTIONS TAKEN BY COMMITTEE ON APPLICATIONS

Dr. Rovner reported that the Board was provided with a listing of applications reviewed by the Licensure/Registration Committee for their information.

DENTAL HYGIENE COMMITTEE REPORT

Ms. Kelly reported that the Board received copies of the public health supervision agreements. The agreements have been scanned for electronic access. An initial review confirms that the initial requirement for examination prior to receiving continued services was 12 months.

FLOURIDE TREATMENT

Representatives of the Iowa Dental Hygiene Association will continue to meet with Ms. Weeg and the Board to discuss matters concerning the scope of practice and other legal interpretations.

ACTIONS TAKEN AT DENTAL HYGIENE COMMITTEE MEETING

Ms. Kelly reported that the Committee recommended approval of an application for license for Ms. Van Vliet.

DENTAL ASSISTANT REGISTRATION COMMITTEE REPORT

Dr. Rovner indicated that there was a request for approval of expanded functions courses. Staff referred him to information available online for courses, which have been prior-approved. Dr. Rovner noted, that of the nine expanded functions currently allowed by rule, only four of the expanded functions have course material accessible online for training. Dr. Rovner stated that he would like to see course information made readily available for the remaining expanded functions.

Ms. Cacioppo, Iowa Dental Hygienists' Association, noted that some of the expanded functions courses are also available through the community colleges online. Ms. Jane Slach stated that the Educators Council developed courses, which are available to the public. Ms. Jane Slach indicated that there is usually an in-person orientation and assessment. Following this, the dental assistants train under the supervision of a licensed dentist. Later, the dental assistant training in expanded functions will complete the required examinations prior to completing the course and receiving certification.

Dr. Rovner continued to question why there is not more course material available for the remainder of the expanded functions. Ms. Arjes stated that the expanded functions courses available for download from the Board's website were developed in conjunction with Minnesota. Ms. Kelly indicated that it could be a matter of who developed and sponsored the course, and whether they choose to make that information available for public use.

Ms. Braness stated that the more course information can be posted to the Board's website if it is made available to the Board.

Ms. Arjes reported that nitrous oxide monitoring courses probably could not be provided "in-house" and still meet the requirements for approval.

Dr. Rovner asked for clarification regarding the requirements for training in expanded functions. Since registration is not required in all states, the Board may want to look at revising the rule, IAC 650—20.15 regarding registration for non-DANB certified dental assistants. Currently, the rule requires DANB-certification or a minimum of two years of clinical experience as a *registered* dental assistant. Dental assistants, who have more than two years of clinical experience, but were not registered in another state must either wait two years after becoming registered in Iowa or another state, or submit a rule waiver for approval to start training sooner.

Ms. Weeg and Ms. Johnson suggested that the Board look at revising the rule.

- MOVED by ROVNER, SECONDED by KELLY, to draft language to revise the requirements for expanded functions training as established in Iowa Administrative Code 650—20.15.

PUBLIC HEALTH SETTING – DENTAL HYGIENE COMMITTEE

Ms. Kelly reported that the Dental Hygiene Committee voted to recommend the proposed changes to IAC 650—Chapter 10, concerning the definition of allowed settings under public health supervision agreements. This item was discussed further later in the meeting under Administrative Rules/Rule Waivers.

EXAMINATION REPORTS

CRDTS STEERING COMMITTEE

Dr. Rovner stated that there was no report since Dr. Bradley was absent from the meeting. Dr. Curry indicated that he intended to attend on Dr. Bradley's behalf; however, CRDTS informed Dr. Curry that he would be ineligible to vote.

CRDTS DENTAL HYGIENE EXAMINATION REVIEW COMMITTEE

Ms. Kelly reported that the Committee met in July 2012. Ms. Kelly reported that some states are limiting the amount of expanded functions per dentist. Ms. Kelly also provided an overview about the requirements.

Ms. Kelly reported that CRDTS has indicated a willingness to visit anytime the Board would need.

Ms. Kelly reported that CRDTS provided standard equipment for the examinations. Ms. Kelly also reported that the CRDTS is now using tablets for scoring the dental hygiene examinations.

Ms. Kelly reported that the dental and dental hygiene examination fees will be increasing. These fees are established and collected by CRDTS.

CRDTS DENTAL EXAMINATION REVIEW COMMITTEE
There was no report.

IOWA PRACTITIONER REVIEW COMMITTEE REPORT

Mr. Sedars provided the Board with updated statistics for the IPRC. There was one (1) self-report. There are currently 13 participants. There are no new contracts under review; and two (2) participants were discharged from the program.

ADMINISTRATIVE RULES/ RULES WAIVERS

FINAL ADOPTION

- *Amendments to Chpt. 20, "Dental Assistants"(ARC #0170C – Notice of Intended Action (NOIA)), Adoption of Final Rule Amendments*

Ms. Johnson reported that these rules are eligible for final adoption. The final rule amendments establish a process for starting dental assistant trainee status over. They also put limits on the number of times a dental assistant could reapply for trainee status prior to requiring a rule waiver. The rules would also remove the 7-day rule, and require an active trainee status to begin working. The changes pertaining to the 7-day rule would be delayed to May 1, 2013. The remainder of the rules would be effective January 2, 2013.

Dr. Curry asked for clarification about high school students in a work study program. It was clarified that dental radiography is not allowed for dental assistants under the age of 18 due to federal guidelines.

❖ MOVED by SLACH, SECONDED by ROVNER, to adopt the rules with a change to include a requirement for a high school diploma or equivalent. Motion APPROVED unanimously.

NOTICE OF INTENDED ACTION

- *Proposed Amendments to Chpt. 10, "General Requirements"*

Ms. Johnson reported that these are proposed amendments to change the definition of public health settings. This would start the rulemaking process. A public hearing would be scheduled if the Board decides to file a Notice of Intended Action.

❖ MOVED by KELLY, SECONDED by MCCULLOUGH, to file a Notice of Intended Action regarding the proposed amendments as drafted.

The discussion continued prior to a final vote being taken.

Mr. Carl, Iowa Dental Association, asked the Board wait moving forward on this proposal until a more thorough review of the Iowa Department of Public Health oversight and processes concerning public health supervision agreements can be completed.

Mr. Cope, Iowa Dental Hygienists' Association, would encourage the review by the Board; however, the Iowa Dental Hygienists' Association sees this proposal as a beneficial addition to the scope of practice under public health supervision. Mr. Cope stated that there is no current timetable in place for the proposed review to be completed. Mr. Cope would ask that the rulemaking process be allowed to move forward.

Dr. Curry reported having some concerns about the lack of consistency between the public health supervision agreements. Dr. Curry understands the desire to move away from original 12-month requirement regarding dental examinations prior to patients receiving continued services under public health supervision. However, in his review of some of the public health supervision agreements, it appears that most agreements have a requirement of 12-24 months. Some of the agreements vary drastically from the rest. Dr. Curry is concerned about the lack of parameters concerning these basic requirements. Dr. Curry would ask to table this matter until January 2013.

Ms. Slach and Ms. Kelly expressed their disagreement in regards to tabling this discussion. Ms. Slach and Ms. Kelly pointed to the current rules, which establish public health settings and services, which are allowed.

Mr. McCollum stated that he has a question about the time-frame regarding how long public health services can be provided and what specifically is allowed under a public health supervision agreement. Mr. McCollum referenced the current rules in Iowa Administrative Code 650—Chapter 10.5(3) regarding the types of services, which are allowed without an examination. Mr. McCollum would interpret the rule to prohibit therapeutic services, to include, but not limited to, prophylactic services and sealants, without an examination.

Ms. Johnson reported that the review of the agreements stemmed from a request made by the Dental Hygiene Committee members.

Ms. Weeg stated that this discussion was veering outside of the scope of the agenda item. Ms. Weeg reminded everyone that the discussion needs to be limited to the proposed change regarding the addition of day care centers.

Ms. Cacioppo, Iowa Dental Hygienists' Association and former Board member, stated that from a historical view point, the Board, previously, wanted to avoid cookie-cutter public health supervision agreements.

Mr. Carl, Iowa Dental Association, asked about the impact of Executive Order 80 on this rulemaking proposal. Mr. Cope, Iowa Dental Hygienists' Association, stated that his interpretation regarding the executive order is that it may not apply to all rulemaking proposals.

Ms. Weeg provided clarification regarding the open meetings laws. Any matters not on the current agenda need to be discussed at a later meeting.

Mr. Carl asked Ms. Weeg for clarification about Executive Order 80 on this matter. Ms. Weeg stated that she could not fully address that as she was not prepared to discuss it. Ms Weeg indicated, however, there was nothing in the Executive Order that would prohibit a vote on the request to file a Notice of Intended Action.

Ms. Slach asked that Ms. Johnson read the proposed language.

Dr. Curry again asked that the Board table this matter until the Board members can into this in a more thorough manner, including related topics or consequences of the change.

Ms. Kelly disagreed with the suggestion to table this discussion. Ms. Kelly referenced the prior discussions of this matter, the fact that notice of the discussion was provided on the meeting agenda and related materials.

Ms. Johnson read the proposed language, clarifying where the new language existed.

Ms. Meier pointed out that this simply starts the rulemaking process. The proposed changes are not being adopted at this time.

Mr. Carl, Iowa Dental Association, stated that there is a pattern that language published in a Notice of Intended Action needs to be defended. Mr. Carl's suggestion, while not necessarily in opposition to the proposal, would be that the Board delays the vote on this until a later date so that further discussion regarding the language may occur.

Mr. Cope, Iowa Dental Hygienist's Association, stated his interpretation that the Dental Hygiene Committee recommendations are defined in statute. Mr. Cope wanted it noted that the Board is interpreting this as a suggestion as opposed to a recommendation. Iowa Code requires Board approval of all Dental Hygiene Committee recommendations, whereas, the Board has discretion in accepting Dental Hygiene Committee suggestions.

- MOVED by KELLY, SECONDED by MCCULLOUGH, to file a Notice of Intended Action as drafted. Motion APPROVED, 4-3.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Yes					x	x	x		x
No		x		x				x	
Absent	x		x						

- *Proposed Amendments to Chpt. 11, "Licensure to Practice Dentistry or Dental Hygiene" and Chapter 15, "Fees"*

Ms. Johnson reported that the proposed amendments:

- Correct a cross-reference in the rules applicable to dental hygiene licensure by credentials;
- Streamline the initial registration process for dental assistants applying for registration within three months of the next renewal due date. Dental assistant applicants applying close to a renewal cycle will pay the application fee and the renewal fee at the same time. Their registration will be issued for a period of 24 months plus the amount of time remaining until the next renewal due date. This change will eliminate the need for applicants to submit two separate applications and fees within one three-month period. Similar rule amendments were adopted for the initial licensure and renewal for dentists and dental hygienists. The proposed amendments extend the same simplified process to dental assistant applicants.

❖ MOVED by ROVNER, SECONDED by FULLER, to file a Notice of Intended Action as drafted. Motion APPROVED unanimously.

- *Proposed Amendments to Chapter 35, "Iowa Practitioner Review Committee"*

Ms. Johnson reported that the first few changes related to Committee terms. The proposed amendments would rescind the current term limits. The proposed changes also address committee appointments and elections. Lastly, the proposed amendments would change the requirements for those would be allowed to participate in the IPRC.

❖ MOVED by FULLER, SECONDED by ROVNER, to file a Notice of Intended Action as drafted. Motion APPROVED unanimously.

FOR DISCUSSION

- *Plan for Review of IDB Rules & Rulemaking Internet Site*

Ms. Johnson reported that legislation passed last session (HF 2465) requires each agency to conduct an ongoing and comprehensive review of all of the agency's rules. The goal of the review is the identification and elimination of all rules of the agency that are outdated, redundant, or inconsistent or incompatible with statute or its own rules or those of other agencies. HF 2465 also requires each agency to make available to the public a "uniform, searchable, and user-friendly rules database, published on an internet site." Ms. Johnson reported that she learned that the Governor's office staff that they would be developing a 5 year plan for reviewing rules and establishing a uniform format for the website. Additional instructions would be released as soon as information becomes available. This was presented for informational purposes only at this time.

- *Executive Order #80 – Stakeholder Rulemaking Groups*

Ms. Johnson reported that an executive order was issued establishing certain requirements rulemaking. This was provided for informational purposes.

RULE WAIVERS

- *Dr. Shiza Khan – Petition to Waive Subrule 11.4(1) Relating to Graduates of Foreign Dental Schools*

Ms. Braness provided an overview of the waiver request. Dr. Khan is a foreign-trained dentist, who has completed residency training at ADA-accredited dental programs. Dr. Khan is asking the Board to accept his residency training as a sufficient basis on which to grant an Iowa dental license.

❖ MOVED by ROVNER, SECONDED by CURRY, to approve the request as submitted. Motion APPROVED unanimously.

Ms. Weeg suggested that the Board may want to look at amending this rule in the future to include general practice residencies as an acceptable form of education to supplement the foreign training given the number of similar rule waivers, which have been approved over the past few years.

- *Kelly Scott – Petition to Waive Subrule 22.4(3) Relating to Requiring Radiography Course within Two Years of Application*

Ms. Braness provided an overview of the waiver request. Ms. Scott is a graduate of an ADA-accredited dental assisting program; however, Ms. Scott completed training in dental radiography more than two years ago. Ms. Scott is asking that the Board approve her prior training as a basis for application for a qualification in dental radiography.

❖ MOVED by KELLY, SECONDED by ROVNER, to APPROVE the request as submitted. Motion APPROVED unanimously.

- *Desirea Austin – Petition to Waive Subrule 20.15 Relating to Requiring Registration for Two Years Prior to Eligibility for Expanded Functions Training*

- *Heidi Doughman – Petition to Waive Subrule 20.15 Relating to Requiring Registration for Two Years Prior to Eligibility for Expanded Functions Training*

Ms. Braness provided an overview of these requests. Ms. Austin and Ms. Doughman are dental assistants who worked outside of the state of Iowa as dental assistants for several years prior to moving to Iowa and becoming registered. Under the current rule, Ms. Austin's and Ms. Doughman's prior dental assistant experience does not count towards the requirement to train in expanded functions since they were not registered as dental assistants prior to moving to Iowa. Ms. Austin and Ms. Doughman are asking the Board to accept their prior dental assisting experience as a basis to start training in expanded functions.

- ❖ MOVED by MCCULLOUGH, SECONDED by KELLY, to APPROVE the waiver requests for Ms. Austin and Ms. Doughman as submitted. Motion APPROVED unanimously.

PETITION FOR RULEMAKING

- *Petition from the Iowa Dental Foundation – Fee for Temporary Volunteer Permit Applications*

Ms. Johnson reported that this request stemmed from the Iowa Mission of Mercy where requests were made to waive the application fees for temporary permits for volunteers. The request is that the fee be eliminated. The Budget Review Committee looked at this request, and determined that there would be little fiscal impact.

Dr. Curry provided an overview of the number of requests for temporary permits over the last several years. The Budget Review Committee has recommended elimination of the fee for volunteers. These volunteer services are critical and the Committee members would like to encourage participation.

Ms. Slach asked for clarification about the extent of the changes. The rulemaking request has also proposed changes to the application.

Mr. Rovner provided a history of the rules regarding the volunteer permits. Dr. Rovner feels that the benefits vastly outweigh the small fee that is currently required.

- ❖ MOVED by ROVNER, SECONDED by KELLY**,** to approve the petition for rulemaking. Motion APPROVED unanimously.

LEGISLATIVE UPDATE

There was no report.

OTHER BUSINESS

LETTER FROM AMERICAN ACADEMY OF SLEEP MEDICINE (RE: SCOPE OF PRACTICE)
Dr. Rovner provided an overview regarding this request. They would like the Board's position in terms of what is currently allowed under Iowa law. Dr. Rovner agrees with their position.

- MOVED by CURRY, SECONDED by MCCULLOUGH, to draft an informal letter advising the American Academy of Sleep Medicine that the Board does not disagree with the ruling, and cannot respond formally without a formal request for a declaratory ruling. Motion APPROVED unanimously.

REVIEW OF ADVERTISTEMENT – RE: DENTAL IMPLANTS
Dr. Rovner indicated that this item would be addressed in closed session.

REVIEW OF LIST OF DENTAL ASSISTANTS GRANTED EXTENSIONS
Ms. Johnson reported that the list provided to the Board was an update. There were no changes.

CLARIFICATION FOR INSURANCE PURPOSES – LICENSE EXPIRATION DATE & LAPSE DATE
Dr. Rovner reported that some insurance companies have denied payment to dentists due to confusion about the difference between expiration dates and lapse dates. MetLife is equating the expiration date with the lapse date.

Lori Pelke, Midwest Dental, said that they have also experienced this same problem. Ms. Pelke stated that it was her understanding that a practitioner can resubmit the claim electronically without having to completely start over. Dr. Fuller has had problems with this issue and has had some difficulty in getting responses.

Dr. Rovner would ask the Board to forward a letter addressing this matter further. Dr. Curry agreed.

Mr. Carl, Iowa Dental Association, asked if there is a prompt-payment statute in Iowa. Board staff was not certain. Mr. Carl would ask Board staff to look into issue prior to responding.

Several Board staff members indicated having interactions with licensees facing these same problems.

DENTAL HEALTH PROFESSIONALS & WORKFORCE DATA

Ms. Johnson reported that this is a project from Delta Dental asking if there was a way to share non-confidential data for workforce information. Dental Dental's foundation has offered to pay for this. Ms. Johnson recommended waiting until the database, AMANDA, is live first to ensure compatibility.

Ms. Arjes indicated that the Iowa Department of Public Health coordinates with the University of Iowa to address some of these needs.

Dr. Curry provided a brief overview of the Delta Dental Foundation and the services the Foundation provides.

Mr. McCollum asked to if Delta Dental is involved with the University of Iowa Dental Tracking System. Mr. McCollum indicated that the Iowa Dental Association has supported the Dental Tracking program in the past.

Ms. Cacioppo, Iowa Dental Hygienists' Association, stated that University of Iowa Dental Tracking System is in place for for dentists, doctors and pharmacists. They looked at doing it for nurse practitioners; however, funding was not available. Some graduate students have recently started looking into information regarding dental hygienists.

Ms. Kelly was not certain if Delta Dental had contacted the University of Iowa; however, she thought that Delta Dental was starting with the Iowa Dental Board. Ms. Kelly stated that they indicated that funding would be available if needed to update the data fields and data sources.

Dr. Curry indicated his support of this request.

Dr. Rovner asked Ms. Johnson to reply to Delta Dental and indicate our willingness to participate and look into the issue of funding.

QUESTION ABOUT FREE HEALTH CLINIC & PATIENTS OF RECORD

Dr. Rovner reported that the Board received a request for clarification as to when patients become "patients of record" in free clinic. There is a question as to what kind of care can be provided if the patients are not considered patients of record.

Ms. Kelly stated that this is very similar to programs, such as Iowa Mission of Mercy (IMOM). Ms. Kelly indicated that she was not sure about the recordkeeping requirements.

Mr. McCollum indicated that there is no difference in requirements between patients of records and patients not of record. The recordkeeping and care requirements are the same pursuant to Board rules.

Dr. Curry asked for clarification about treatment of patients like this. Dr. Rovner indicated that the patients are asked to sign a form clarifying that they are not considered patients of record. Ms. Weeg thinks it may be a good to add information about how these patients should address issues such as follow-up care, if needed.

Mr. McCollum asked who maintains the patient records for IMOM. Mr. Carl, Iowa Dental Association, indicated that the Iowa Dental Foundation maintains those records.

Mr. Fuller indicated that there are number of free clinics that are offering services throughout Iowa.

Ms. Meier pointed out that there is a slightly difference between IMOM and free clinics. Practitioners in free clinics may run into those patients around town; whereas that is less likely in the cases of practitioners volunteering at programs such as IMOM.

Dr. Rovner asked that staff draft a letter thanking Dr. Jones for his service and acknowledge that his proposal is acceptable with the inclusion of recommendations for follow-up as well as a reminder about recordkeeping requirements.

APPLICATIONS FOR LICENSURE/REGISTRATION & OTHER REQUESTS

RATIFICATION OF ACTIONS TAKEN BY EXECUTIVE DIRECTOR SINCE LAST MEETING ON APPLICATIONS

Ms. Johnson reported that the Board was provided a list of licenses, registrations, and permits issued since the last meeting.

- MOVED by KELLY, SECONDED by FULLER, to ratify the actions taken on licenses, registrations and permits. Motion APPROVED unanimously.

PENDING LICENSURE/REGISTRATION APPLICATIONS

- *Joan van Vliet, Dental Hygiene License by Credentials*

Ms. Kelly reported that Dental Hygiene Committee has recommended approval of Ms. van Vliet's application for dental hygiene license.

- MOVED by KELLY, SECONDED by CURRY, to accept the recommendation of the Dental Hygiene Committee regarding Ms. van Vliet's application for license. Motion APPROVED unanimously.

PUBLIC COMMENT

Chairman Rovner allowed time for public comment.

No comments were received

CLOSED SESSION

- MOVED by FULLER, SECONDED by KELLY, to go into closed session pursuant to Iowa Code Section 21.5(1)(d) to discuss and review complaints and investigative reports which are required by state law to be kept confidential.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Yes		x		x	x	x	x	x	x
No	x		x						

Motion APPROVED by ROLL CALL

- The Board went into closed session at 1:52 p.m.
- The Board took a brief recess at 1:53 p.m.
- The Board reconvened at 2:00 p.m.

- MOVED by KELLY, SECONDED by CURRY for the Board to go into open session Motion APPROVED unanimously.

OPEN SESSION

OPEN SESSION ACTION ON CLOSED SESSION AGENDA ITEMS

- *In the matter of Jacquelyn L. George, R.D.A. (#11-210)*

Dr. Fuller disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

- MOVED by KELLY, SECONDED by SLACH, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye		x			x	x	x	x	x
Nay									
Abstain				x					
Absent	x		x						

Motion APPROVED by ROLL CALL.

- *In the Matter of Jordan N. Crawford, D.D.S. (#12-031)*

Dr. Fuller disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by SLACH, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye		x			x	x	x	x	x
Nay									
Abstain				x					
Absent	x		x						

Motion APPROVED by ROLL CALL.

- *In the Matter of Andrea D. Harryman, D.A. (#12-014)*

Dr. Fuller disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by SLACH, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye		x			x	x	x	x	x
Nay									
Abstain				x					
Absent	x		x						

Motion APPROVED by ROLL CALL.

- *In the Matter of Tony D. Stuntz, D.D.S. (#11-220)*

Dr. Fuller disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by SLACH, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye		x			x	x	x	x	x
Nay									
Abstain				x					
Absent	x		x						

Motion APPROVED by ROLL CALL.

- *In the Matter of Angela R. Karr, D.A. (#11-221)*

Dr. Fuller disclosed a potential conflict of interest, left the room during the discussion and did not vote on this matter.

❖ MOVED by KELLY, SECONDED by SLACH, to approve the proposed Combined Statement of Charges, Settlement Agreement and Final Order regarding this matter.

Member	Bradley	Curry	Elmitt	Fuller	Kelly	McCullough	Meier	Rovner	Slach
Aye		x			x	x	x	x	x
Nay									
Abstain				x					
Absent	x		x						

Motion APPROVED by ROLL CALL.

- *In the Matter of Shea A. McCarte, D.A. (#11-001)*

❖ MOVED by KELLY, SECONDED by SLACH, to approve the proposed Settlement Agreement and Final Order regarding this matter. Motion APPROVED unanimously.

- *In the Matter of Masih Safabakhsh, D.D.S.(#09-211)(#10-059)(#10-101)(#11-031)(#11-127)(#11-142)(#12-068)*

❖ MOVED by KELLY, SECONDED by SLACH, to approve the proposed Settlement Agreement and Final Order regarding this matter. Motion APPROVED unanimously.

- *In the matter of Gene V. Mueller, D.D.S.(#10-115, #11-114)*

❖ MOVED by KELLY, SECONDED by SLACH, to approve the proposed Notice of Hearing and Statement of Charges regarding this matter and schedule a hearing date for February 1, 2013. Motion APPROVED unanimously.

- *In the matter of Irene M. Broyles, D.D.S.(#11-106)*

❖ MOVED by KELLY, SECONDED by SLACH, to approve the proposed Notice of Hearing and Statement of Charges regarding this matter and schedule a hearing date for February 1, 2013. Motion APPROVED unanimously.

FINAL ACTION ON NON-PUBLIC CASES LEFT OPEN AND NON-PUBLIC CASES CLOSED

❖ MOVED by CURRY, SECONDED by FULLER, to keep open and close the following non-public cases: Motion APPROVED unanimously.

OPEN CASES	**CLOSED CASES**
07-007	11-001
10-115	10-059
11-114	10-101
11-106	11-031
09-136	11-127
09-137	11-142
11-190	12-068
12-044	08-119
12-045	11-140
12-059	11-200
12-091	10-119
12-119	11-137
12-120	11-150
12-104	12-062
12-102	11-218

OPEN CASES	CLOSED CASES
12-126	11-219
12-124	11-210
12-134	12-031
12-052	12-015
12-098	12-014
12-111	11-220
12-099	11-221
12-121	12-049
12-122	12-050
12-123	12-124
12-067	12-128
12-090	12-135
12-087	12-132

NEXT MEETING OF THE BOARD

The next meeting of the Board is scheduled for January 30-February 1, 2013, in Des Moines, Iowa.

ADJOURNMENT

Chairman Rovner adjourned the meeting at 7:20 p.m. on October 25, 2012.

Respectfully submitted,

Melanie Johnson, J.D.
Executive Director

MJ/cb

THOMAS J. MILLER
ATTORNEY GENERAL

JULIE F. POTTORFF
DEPUTY ATTORNEY GENERAL

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MEMORANDUM

To: All State Agencies

From: Julie F. Pottorff, Deputy Attorney General JFP

Re: Executive Order No. 80

Date: November 2, 2012

Our office has received a number of questions from state agencies concerning Executive Order No. 80 and the formation of "stakeholder groups" on rule-making issues. After consultation with general counsel in the Governor's Office, we are providing this memorandum in order to clarify implementation of the executive order and insure that state agencies have a common understanding that comports with the intention of the Governor's Office. Toward this end, we offer the following explanation and observations.

The stakeholder groups are meant to provide a forum for citizen ideas for effective and efficient regulation by state government. This goal may be accomplished by creating less burdensome rules or by amending or repealing existing rules. The stakeholder groups should be viewed as a prelude to agency rule making, a forum for ideas that may ultimately lead an agency to develop more effective and efficient rules.

The Governor's Office intends the stakeholder groups to be created at the department level and not necessarily by the agencies that are legislatively vested with rule-making authority. Although Executive Order 80 uses the term "agency" throughout, this term is not used in the executive order in the same way the term is defined in the Iowa Administrative Procedure Act. *See* Iowa Code § 17A.2(1) ("'Agency' means each board, commission, department, officer or other administrative office or unit of the state.") (2011). This more narrow use of the term "agency" in the executive order has caused some understandable confusion.

By requiring each "agency" to create a stakeholder group if requested by the "head of the agency" or the Administrative Rules Coordinator, Executive Order 80 is intended to

authorize creation of a stakeholder group by a department, *see* Iowa Code § 7E.4(6) ("'Department' means a principal administrative agency within the executive branch of state government. . . .), if requested by the department head, *see* Iowa Code ¶ 7E.4(8) ("'Head of the department' means the elective officer, director, commissioner, or other official in charge of a department."), or the Administrative Rules Coordinator. In effect, department heads and the Administrative Rules Coordinator will be the contact points for citizens interested in formation of the stakeholder group. This means a stakeholder group may be initiated at the request of a department head even though rule-making authority is legislatively vested elsewhere in a board, commission or another agency. And it means an agency legislatively vested with rule-making authority cannot initiate a stakeholder group unless that agency is itself a department.[1]

Similarly, the Governor's Office intends the stakeholder groups to be appointed by the departments and not necessarily by the agencies legislatively vested with rule-making authority. Appointments to a stakeholder group are in the "sole discretion" of the departments. EO 80, ¶ 2. Executive Order 80 directs that one person "shall be appointed to represent the agency or board." EO 80, ¶ 2. This is intended to insure that the departments include a government representative who may be, but is not required to be, from the agency that is legislative vested with rule-making authority over the subject of the stakeholder group. The department, for example, may appoint someone from within the department itself, from a board or commission legislatively vested with rule-making authority, or from the full-time staff of either the department or the agency legislatively vested with rule-making authority.

Importantly, nothing in Executive Order 80 diminishes or alters the rule-making authority of any state agency. When a stakeholder group has completed its work, a recommendation will be forwarded to the agency legislatively vested with rule-making authority. EO 80, ¶ 5. On receipt of the recommendation of a stakeholder group, the agency legislatively vested with rule-making authority is free to decide whether or not to initiate a rule making pursuant to the Iowa Administrative Procedure Act. EO 80, ¶ 6.

In summary, agencies vested with rule-making authority that are not departments will not initiate and may not even participate in the stakeholder groups, but should consider the stakeholder groups as a source of ideas for rule making that will be presented to them for their consideration.

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[1] We realize that many boards and commissions have long used informal groups to receive input on rules that are in the process of rule making or to receive input on potential rules. Executive Order 80 does not disrupt these informal processes.

ACTION

REPORT TO THE IOWA DENTAL BOARD

DATE OF MEETING: January 31-February 1, 2013

RE: **Recommendations: Applications for Moderate Sedation Permit and Moderate Sedation Training Courses**

SUBMITTED BY: **Anesthesia Credentials Committee**

ACTION REQUESTED: Board Action on Committee Recommendation

COMMITTEE RECOMMENDATIONS

The Committee requests that the Board accept the following recommendations:

- *Zach Dannenbring, D.D.S. – Moderate Sedation Permit*
  - Committee recommends approval of a moderate sedation permit for patients 13 years of age or older, who are classified as ASA 1-2.

- *Christopher Vanderbeek, D.D.S. – Moderate Sedation Permit*
  - Committee recommends approval of a moderate sedation permit for patients 13 years of age or older, who are classified as ASA 1-2.

- *Bradley Jordan, D.D.S. – Moderate Sedation Permit*
  - The committee's recommendation will be presented at the January 2013 Board meeting as the Anesthesia Credentials Committee is not scheduled to meet until January 24, 2013.

- *UCLA School of Dentistry and Wendel Family Dental Centre – Moderate Sedation Course*
  - The committee's recommendation will be presented at the January 2013 Board meeting as the Anesthesia Credentials Committee is not scheduled to meet until January 24, 2013.

- *Duquesne University Mylan School of Pharmacy: IV Moderate Sedation for Dentistry – Moderate Sedation Course*
  - The committee's recommendation will be presented at the January 2013 Board meeting as the Anesthesia Credentials Committee is not scheduled to meet until January 24, 2013.

Proposed Motion:
I move that the Board accept the Committee's recommendation as indicated above.

REPORT TO THE IOWA DENTAL BOARD

ACTION

DATE OF MEETING: January 31-February 1, 2013
RE: **Recommendations: Course & Sponsor Requests**
SUBMITTED BY: **Continuing Education Advisory Committee**
ACTION REQUESTED: Board Action on Committee Recommendation

COMMITTEE RECOMMENDATIONS

The Committee requests that the Board accept the following recommendations:

CONTINUING EDUCATION COURSE REVIEW

- The Committee recommended course approval/denial as follows:
- ***DANB:*** *"Orthodontic Assistant"* (Committee recommends 4 hours of credit; requested 12 hours)
- ***Carl Sandburg Community College:*** *"Taking Control of Your Diabetes Know-How"* (Approved; hours requested not specifically stated)
- ***Central Iowa Dental Hygiene:*** *"Minimally Invasive Dentistry"* (1 hour)
- ***Central Iowa Dental Hygiene:*** *"Second-Year Dental Hygiene Students Presented Table Clinics"* (2 hours)
- ***Central Iowa Dental Hygiene:*** *"Education and Legislative Progression of Dental Hygiene in Minnesota"* (**DENIED Credit:** Requested 2 hours)
- ***Iowa Society of Oral & Maxillofacial Surgeons:*** *"Progressive Implant Dentistry Strategies for the Anterior & Posterior Maxilla"* (8 hours)
- ***BOT Connections:*** *"Strategic Planning/Leadership Training Weekend"* (**DENIED Credit**: Hours requested not specifically stated)
- ***Susan Rector, D.D.S.:*** *"Orthodontic Temporary Anchorage Devices"* (2 hours)
- ***Kiess Kraft Dental Lab:*** *"Dental Implant Innovation – Zimmer Trabecular Metal & Zimmer Tapered Screw-Vent Dental Implants"* (1.5 hours)
- ***Iowa Dental Assistants Association – SE District:*** *"Understanding the New High: A Look at New Drug Trends"* (2 hours)
- ***Southeast Iowa District Dental Society:*** *"Interdisciplinary Treatment Approaches to the Contemporary Dental Implant"* (3.5 hours)
- ***Iowa Dental Hygienists' Association:*** *"Forensic Dentistry: The Role of the Dental Professional"* (3 hours)

- ***Iowa Dental Hygienists' Association:*** *"The Role of the Dental Hygienist in Catastrophe/Bioterrorism Preparedness"* (3 hours)
- ***3M ESPE:*** *"3M Update on Dental Materials"* (1 hours)
- ***Iowa Western Community College:*** *"Ho, Ho, Ho! Here Come the Holidays!"* (Committee recommends 2 hours of credit; requested7 hours)
- ***Dental Prosthetic Services:*** *"Partnering with Your Lab: Speaking the Same Language Through Photography & Impressions"* (1 hour)
- ***Iowa Academy of General Dentistry:*** *"Fixed Prosthodontics"* (8 hours lecture; 16 hours participation)
- ***Dr. Takanari Miyamoto:*** *"CBCT Airway Assessment, Management & Strategies for Treatment"* (2 hours)
- ***Dr. Takanari Miyamoto:*** *"Computer-Guided Implant Dentistry Symposium – Dental Implants in the Digital Age"* (4 hours)

- ***Kiess Kraft Dental Lab:*** *"Guided Implant Surgeries: Virtual Treatment Planning for Dental Implants & Importance of CBCT Interpretation"* (2 hours)
- ***Kiess Kraft Dental Lab:*** *"Use of Oral Appliance for Snoring & Obstructive Sleep Apnea"* (2 hours)
- ***Oral Surgeons, P.C. Implant Institute:*** *"Management of Common Dental Office Medical Emergencies and CPR Review"* (Committee recommends approval for actual clock hours, not to exceed 2 hours; requested 1.5-2 hours)
- ***Oral Surgeons, P.C. Implant Institute:*** *"Implant Complications"* (Committee recommends approval for actual clock hours, not to exceed 2 hours; requested 1.5-2 hours)
- ***Johnson County Dental Society:*** *"Pain Management and Diagnosis"* (1 hours)
- ***Cancun Study Club****: Multiple Titles – See attached* (30 hours)
- ***DynaFlex*** *"How to Communicate and Connect with Staff & Patients"* (Committee recommends approval of 1 hour per previous recommendation; resubmitted to request 2 hours)
- ***Mercy Cedar Rapids, Hall-Perrine Cancer Center:*** *"2013 Spring Cancer Care Update for Dental Health Professionals"* (2 hours)
- ***Delta Dental Minnesota:*** *"Putting Oral Pathology to Work in Your Practice Every Day."* (7 hours)
- ***Biomet 3i, LLC:*** *"Dental Implant Surgery & Advanced Implant Bone Grafting"* (Approved with recommendation to send sponsor letter requesting that licensees complete more than 1 course in order to meet their continuing education hours; requested 48 hours)
- ***Spring Park Dental Implant Study Club:*** *"DIEM2: Solutions for Immediate Full Arch Rehabilitation in One Day"* (2.5 hours)

- ***Karin Southard, D.D.S.:*** *"Periodontal Considerations in Orthodontic Treatment & Implications Related to Bone Health & Use of Bisphosphonates"* (2 hours)
- ***Karin Southard, D.D.S.:*** *"Managing Patients with Missing Teeth (including Using Implants for Anchorage)"* (2 hours)
- ***Impact Dental Training, LLC:*** *"Soft Tissue Diode laser Non-Surgical Clinical Techniques" (8 hours)*

CONTINUING EDUCATION COURSE – RECONSIDERATION FOR CREDIT

- ***Suzanne Stock, D.D.S.:*** *"Topics in Human Head and Neck Anatomy"* (2 hours requested, *course denied credit 10/16/12)*

❖ The Committee voted to APPROVE the course 2 hours of credit after reviewing the submission of new material, which showed a benefit to the practice of dentistry.

CONTINUING EDUCATION SPONSOR APPLICATIONS

❖ The Committee recommended APPROVAL of the sponsors listed below.

- *Hawkeye Community College (Recertification Application)*
- *Fort Dodge Oral & Maxillofacial Surgery, P.C.*
- *Johnson County Dental Society*

❖ The Committee recommended to DENY the sponsor application listed below as they did not show that the coursework specifically addressed the practice of dentistry. The committee will review the course submitted for approval at a later date.

- *Compliance Training Partners (Reconsideration following submission of additional information)*

EXPANDED FUCNTIONS COURSE REVIEW

❖ The Committee reviewed two requests for expanded functions course approval.

- *Placement & Removal of Gingival Retraction*
- *Applying Cavity Liners and Bases, Desensitizing Agents and Bonding Systems*

The Committee chose to DEFER the review and decision of these courses to the Dental Assistant Registration Committee prior to referring the courses back to the Board for final approval. The committee indicated, informally, approval of credit upon final recommendation for approval by the Dental Assistant Registration Committee and the Board.

REQUEST FOR CONTINUING EDUCATION CREDT FOR VOLUNTEER WORK

❖ The Committee reviewed a request to grant continuing education credit for volunteer work.

The Committee recommended to DENY the request since volunteer work is very unlikely to teach new techniques or information to the participants. Requested a letter be forwarded including the definition of "continuing education" as defined in IAC 650—Chapter 25.

Proposed Motion:

I move that the Board accept the Committee's recommendation as indicated above.

Dental Board Financial Report (As of December 31, 2012)

Updated 8.31.12

	REVENUES	FY12 Estimated Budget	FY12 Actual as of 9.30.12	FY12 % Spent (Actual/Budget)	FY13 Estimated Budget Revised 10.12.12	FY13 Actual as of 12.31.12	FY13 % Spent (Actual/Budget)
	Prior FY Carryover of fees	147,910.69	147,910.69	100%	300,644.61	300,644.61	100%
204	Intra-State Transfers	95,520.00	-	0%	95,520.00	-	0%
401	Licensing Fees (new and renewal)(0521,0529,0530)	859,954.31	877,878.40	102%	767,797.39	688,085.00	90%
401	§8.2 reimbursement receipts (0512,0570,0578)	72,500.00	77,262.00	107%	72,500.00	39,887.00	55%
	Revenue Total	**1,175,885.00**	**1,103,051.09**	94%	**1,236,462.00**	**1,028,616.61**	83%
Class	**EXPENDITURES**						
101	Personnel	594,275.00	582,419.62	98%	624,044.00	289,695.98	46%
202	In-State Travel	9,865.00	9,861.71	100%	9,500.00	4,094.54	43%
203	State Vehicle Operation	2,500.00	2,323.04	93%	2,500.00	1,059.08	42%
204	State Vehicle Depreciation	-	-	0%	2,160.00	-	0%
205	Out-of-State Travel	4,000.00	3,965.43	99%	6,000.00	-	0%
301	Office Supplies	10,500.00	8,300.49	79%	8,000.00	5,315.09	66%
309	Printing and Binding	9,000.00	8,298.58	92%	10,000.00	7,009.76	70%
313	Postage	12,000.00	11,816.00	98%	9,500.00	4,123.19	43%
401	Communications	12,300.00	12,654.29	103%	12,250.00	3,572.66	29%
402	Rentals	44,674.00	44,628.37	100%	50,200.00	29,229.36	58%
405	Professional & Scientific Services	4,100.00	3,362.50	82%	4,000.00	580.12	15%
406	Outside Services	28,700.00	28,583.09	100%	13,750.00	10,549.21	77%
407	Intra-State Transfers	100.00	13.88	14%	2,500.00	315.87	13%
409	Outside Repairs	1,158.00	638.00	55%	1,000.00	-	0%
411	Attorney General Reimbursement	-	-	0%	-	-	0%
412	Auditor of State Reimburseement	-	-	0%	-	-	0%
414	Reimbursement to other Agencies	22,190.00	14,752.99	66%	21,000.00	10,010.18	48%
416	ITD Reimbursements	16,410.00	16,405.12	100%	23,310.00	6,180.37	27%
432	Gov Transfer Attorney General	21,000.00	19,139.33	91%	20,500.00	7,478.64	36%
433	Gov Transfer Auditor of State	2,000.00	490.73	25%	2,000.00	-	0%
434	Gov Transfer Other Agencies	900.00	808.89	90%	3,100.00	-	0%
501	Equipment/Non-Inventory	19,221.00	-	0%	17,000.00	-	0%
502	Office Equipment	2,000.00	918.00	46%	500.00	-	0%
503	Equipment/Non-Inventory	50.00	-	0%	50.00	-	0%
510	IT Equipment	174,666.00	32,516.42	19%	196,446.00	2,613.83	1%
601	Claims	-	-	0%	-	-	0%
602	Other Expenses & Obligations	102,746.00	-	0%	126,152.00	-	0%
701	Licenses	-	-	0%	-	-	0%
705	Refund	530.00	510.00	0%	-	-	0%
	Expenditure Total	**1,094,885.00**	**802,406.48**	73%	**1,165,462.00**	**381,827.88**	33%

RECAP	FY12 Budget	FY12 TO DATE	FY12 %	FY13 Budget	FY13 TO DATE	FY13 %
Total Revenue	**1,175,885.00**	**1,103,051.09**	94%	**1,236,462.00**	**1,028,616.61**	83%
Total Expenditures	**1,094,885.00**	**802,406.48**	73%	**1,165,462.00**	**381,827.88**	33%
Balance	**81,000.00**	**300,644.61**		**71,000.00**	**646,788.73**	
Approp Close Out &/or Appeal Boards		**-**			**-**	
Estimated Carry Forward to next Fiscal Year	**81,000.00**	**300,644.61**		**71,000.00**	**646,788.73**	

REPORT TO THE IOWA DENTAL BOARD

FYI ONLY

DATE OF MEETING: January 31-February 1, 2013
RE: **Quarterly Report on IPRC Activities**
SUBMITTED BY: Brian Sedars, Health Professions Investigator
ACTION REQUESTED: None.

The Iowa Practitioner Review Committee evaluates, assists, and monitors the recovery, rehabilitation, or maintenance of dentists, hygienists, or assistants who self-report impairments. As necessary, the Committee notifies the Board in the event of noncompliance with contract provisions.

The IPRC is both an advocate for the health of a practitioner and a means to protect the health and safety of the public.

The Board's administrative rules require the Committee to submit a quarterly report to the Board on the activities of the IPRC. Below is the quarterly report.

Iowa Dental Board

Iowa Practitioner Review Committee

Current Numbers (as of 1/17/13)	2013 Totals
Self Reports	2
Current Participants	7
Contracts under Review	2
Discharged Participants	1

REPORT TO THE IOWA DENTAL BOARD

POSSIBLE ACTION

DATE OF MEETING: January 31, 2013

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

SUBMITTED BY: Melanie Johnson, Executive Director

ACTION REQUESTED: Consideration of Final Rule Amendments

Amendment Eligible for Final Adoption

At the October 24, 2102 meeting the Board approved the filing of proposed rule amendments to Chapter 10. The amendments expand the definition of "public health settings" to include programs affiliated with the Early Childhood Iowa (ECI) initiative authorized by Iowa Code Chapter 256I and day care centers (excluding home-based day care centers). The proposed amendment is eligible for final adoption at this time should the Board decide to move forward with a final rule amendment.

Public Hearing Held, Written Comments Received

A public hearing was held on January 8, 2013 and written comments were accepted through that date. One person attended the public hearing. The Board office received a number of comments concerning these amendments (copies included with this Report). Comments were received from private practice dental hygienists, dental hygienists in public health settings, community college educators, a community health center director/dentist, a public health center president/CEO, licensed dentists, I-Smile coordinators, a dental hygiene student, Delta Dental of Iowa, the Iowa Dental Association, Iowa Association for the Education of Young Children, and Iowa Primary Care Association. All but one of the written comments submitted were in support of the proposed rule amendment.

IDA Raised Concerns and Requests Delay in Implementation

The Iowa Dental Association expressed concern that the Board "noticed the Rule Amendment without adequate consideration for patient safety and without considering the need for enhanced oversight of participants in a public health supervision arrangement." The IDA indicated that it is concerned that patient safety may be "unnecessarily compromised by expanding the number of settings in which dental hygienists are permitted to provide dental hygiene services under a public health supervision arrangement." They indicate that their concern is based on the fact that under a public health supervision agreement a dentist need not be physically present to supervise the services provided by a dental hygienist. IDA requested that the Board delay implementation of the rule amendment and "conduct a comprehensive review of the patient safety implications."

Comment RE: Changing "Day Care" to "Child Care"

During the comment period the Administrative Rules Code Editor raised a question about the usage of "day care" vs. "child care" in the proposed rule amendment. The Code Editor indicated that in the Iowa Code, "child care" is used almost universally, most notably in chapters 135, 237, 237A and 279. In the Iowa Administrative Code, "child care" is used, particularly in reference to child care centers

and in-home providers; see 441—Chapters 109, 110, also Chapters 118, 170. By contrast, “day care” occurs only a handful of times, mostly in reference to adult day services; see 441—Chapter 171 and Iowa Code chapter 231D. The Board may want to consider changing “day care” to “child care” if it elects to adopt final rule amendments.

The comments from the Iowa Association for the Education of Young Children also suggested changing “day care” to “child care.” The Association indicated that “child care” is “commonly accepted language used by the profession for the service of providing care to children.”

PHS Presentation at January 31, 2013 Board Meeting

At the January 31st Board meeting there will be a presentation about public health supervision (PHS). The presentation will include: reason for the original PHS rule, rulemaking history, role of the Iowa Department of Public Health, role of the Iowa Dental Board, and a Board member’s observations concerning the PHS agreements he reviewed. In addition, copies of the PHS agreements will be made available electronically to Board members prior to the meeting.

Attached for Review

- ARC 0471C, Published in 11/28/12 IAB - Notice of Intended Action, Chapter 10
- Comments Received Concerning ARC O471C

ARC 0471C

DENTAL BOARD[650]

Notice of Intended Action

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

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

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

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

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

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

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

This proposed amendment was approved at the October 25, 2012, meeting of the Dental Board.

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

This amendment is intended to implement Iowa Code section 153.33.

The following amendment is proposed.

Amend subrule 10.5(1) as follows:

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

NOIA Comments Rec'd

Search NOIA Comments Rec'd

From	Subject	Received
Date: Tuesday		
Barbara Merrill	Iowa Dental Board comments	Tue 1/8/2013 3:37 PM
Tori Squires	Input on Rule Making	Tue 1/8/2013 2:12 PM
Barbara Merrill	Iowa Dental Board rules	Tue 1/8/2013 1:47 PM
Venker, Daniel [DOC]	Letter of support for addition of daycare centers to dental PH supervison s...	Tue 1/8/2013 7:37 AM
Date: Monday		
Mike DeAnda	Support of adding Daycare Centers to the list of Public health Supervision ...	Mon 1/7/2013 4:29 PM
joyce602@mchsi.com	letter to support DH in day care centers	Mon 1/7/2013 3:25 PM
Suzanne Heckenlaible	Delta Dental of Iowa - Comment on Iowa Code section 153.33, subrule 10.5...	Mon 1/7/2013 2:15 PM
Dawn Doore	dental board decision letter	Mon 1/7/2013 2:01 PM
tena geis	[L2SPAM] public hearing testimony	Mon 1/7/2013 10:58 AM
Date: Sunday		
Susan R. Hyland	PH Supervision & Daycare Centers	Sun 1/6/2013 10:09 PM
Date: Last Week		
David Miller	letter of testimony for Jan. 8th IDB hearing	Fri 1/4/2013 9:22 PM
Mary Kay Brinkman	[L2SPAM] Public Comment on proposed rule change: Public Health Superv...	Thu 1/3/2013 4:11 PM
Mary Jo knowles	Public Health supervision	Thu 1/3/2013 9:01 AM
Miriam Burk	Including day care centers under public health supervision	Tue 1/1/2013 6:05 PM
Mary Ann White	Public Hearing on January 8, 2013, adding day care centers to list	Mon 12/31/2012 11:41 PM
Freed,Adam J.	ARC 0471C: Public Health Supervision	Mon 12/31/2012 9:37 AM
Terry Kemp	Public Health Supervision comments on day care settings	Sun 12/30/2012 7:36 PM
Date: Two Weeks Ago		
Reynolds, Julie C.	Jan 8 public hearing comments	Fri 12/28/2012 2:56 PM
bill vanzuiden	Day Cares	Fri 12/28/2012 10:13 AM
Megan W	Letter to the IDB	Fri 12/28/2012 9:57 AM
Bianca Carmona	Daycare Screenings	Thu 12/27/2012 9:59 AM
Linda Meyers		Wed 12/26/2012 4:57 PM
Sherry Steinbach	Day care Centers and Public health Supervision	Mon 12/24/2012 8:04 AM
Date: Three Weeks Ago		
Nancy Adrianse	Iowa code section 147.76 Public comment	Fri 12/21/2012 10:45 AM
Ken Jones	Public Health Supervision/Hygiene Preventive Care at Daycare Centers	Thu 12/20/2012 3:50 PM
Emily Boge	[L2SPAM] Iowa Dental Board Request	Tue 12/18/2012 8:31 PM
Mary Jo Ketelsen	FW: Hygienist Public Health Supervision	Tue 12/18/2012 3:29 PM
Sodawasser, Sara A	Preventive dental health in daycares	Tue 12/18/2012 12:38 PM
Piper, Renee	Day care	Tue 12/18/2012 10:24 AM
Carol Van Aernam	Day Care Centers	Mon 12/17/2012 6:11 PM
Carol Van Aernam	Day Care Centers	Mon 12/17/2012 6:07 PM
Date: Older		
Katie McBurney	Public Comment for Public Health Supervision Agreement	Thu 11/29/2012 9:48 AM

Johnson, Melanie [IDB]

From: Katie McBurney [kmcburney@marionph.org]
Sent: Thursday, November 29, 2012 9:48 AM
To: Johnson, Melanie [IDB]
Subject: Public Comment for Public Health Supervision Agreement

As a dental hygienist practicing under public health supervision agreement, I am asking you to consider allowing day care settings and ECI supported settings to be included in the public health supervision agreement. By providing non-invasive dental screenings, fluoride varnish and OHI, we are giving these children a better chance to being cavity free and finding a local dentist for a lifetime. The majority of these children cannot get to a pediatric dentist who will see them by age 1 and therefore parents are unaware of dental care needs and/or prevention needs for their child's oral health. Also, a high percentage of the children targeted cannot find a dentist who will except their low paying Medicaid insurance. As dental hygienists, we can refer them to the appropriate dentist, educate them, and work with the dental community to prevent decay and educate parents about the causes of decay before the age of 3 or 4. We know as dental professionals that prevention is key to oral health and also in reducing costs from Medicaid and dental treatment/surgery. Let's all work together to prevent Early Childhood Caries!

Thanks for your time,
Katie

Katie McBurney, RDH, I-Smile Coordinator
Marion County Public Health
2003 N. Lincoln St.
Knoxville IA 50138
Phone: 641-828-2238 ext. 226
Fax: 641-842-3442
I-Smile™ ~ Healthy Mouths for Healthy Kids
www.ismiledentalhome.iowa.gov

Promoting and Protecting the Health of Marion County

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Johnson, Melanie [IDB]

From: Carol Van Aernam [cvanaernam@aol.com]
Sent: Monday, December 17, 2012 6:07 PM
To: "melanie. johnson"@iowa.gov
Subject: Day Care Centers
Attachments: December 17 Ia Dental Board Letter.docx

Ms. Johnson,
Please find an attached letter in favor of adding Day Care Centers for the Public Hearing on January 8,2013.
Thank you.

Carol Van Aernam
cvanaernam@aol.com

December 17, 2012

Melanie Johnson

Executive Director Iowa Dental Board

400 SW 8th Street

Des Moines, IA 50309-4687

Dear Iowa Dental Board Members,

I urge you to add "Day Care Centers to the Public Health Supervision Agreement.

The Poverty Level for children living in Iowa has increased since 2000 by 50.5%. Nationally it has increased 33.3%. The Poverty Line was set at $ 22,314 in 2010 for a family of four. These families cannot afford dental care. In 2011 *over 79,000* Medicaid enrolled children ages 0-5 did not see a dentist. Dental Hygienists with a Public Health Supervision Agreement need to be able to see these children and provide preventive services. Adding Day Care Centers allows greater access to preventive services by Public Health Supervision Hygienists. Hygienist's refer these children to dentists and give preventive services that can save a life and prevent chronic infection for our children in Iowa.

Dentists and hygienists need to work together to serve those in Iowa who cannot help themselves.

Thank you.

Carol Van Aernam RDH, BA

411 West Madison Place

Indianola, Iowa 50125

Johnson, Melanie [IDB]

From: Carol Van Aernam [cvanaernam@aol.com]
Sent: Monday, December 17, 2012 6:11 PM
To: Johnson, Melanie [IDB]
Subject: Day Care Centers
Attachments: December 17 Ia Dental Board Letter.docx

Ms. Johnson,
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Thank you.

Carol Van Aernam
cvanaernam@aol.com

December 17, 2012

Melanie Johnson

Executive Director Iowa Dental Board

400 SW 8th Street

Des Moines, IA 50309-4687

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Dentists and hygienists need to work together to serve those in Iowa who cannot help themselves.

Thank you.

Carol Van Aernam RDH, BA

411 West Madison Place

Indianola, Iowa 50125

Johnson, Melanie [IDB]

From: Piper, Renee [Piper@iowacentral.edu]
Sent: Tuesday, December 18, 2012 10:23 AM
To: Johnson, Melanie [IDB]
Subject: Day care

As an educator and dental hygienist I see the unmet dental health needs in our communities of the children under 5years of age at every clinical session. The students provided the dft for the patients seen in the clinic in the last 15 weeks. The results are as follows: Dft - 4.8
Low social economic status, (including those families who rely on daycares), lack of education, increase in language barriers (Hispanic children-who are at greatest risk) the documented shortage of dental providers, dentists who do not accept XIX, or new patients regardless of ability to pay, restrictive practices for hygienists, (who have the knowledge and skills), are access to care problems Iowa children face.
Please allow dental hygienists who are more than adequately trained to provide the necessary skill sets for the prevention of dental disease in our communities. Stop the politics and let the hygienists continue to provide a safe and effective modality for the children in our state.
Dental Disease is 100% preventable.

- Barriers to regular dental care are lack of insurance, lack of dental health literacy, and few dental providers taking Medicaid.
- In 2011, 119,053 Medicaid enrolled children ages 0-12 did not see a dentist.
  - Ages 0-2: 55,540 Medicaid enrolled children did not see a dentist.
  - Ages 3-5: 24,143 Medicaid enrolled children did not see a dentist.
- In 2011 Medicaid Enrolled Children Receiving a Dental Service from Title V Contractors.
  - Children ages 0-2: 10509 received a dental service, 56485 did not.
  - Children ages 3-5: 11,903 received a dental service, 45, 779 did not.
- According to the Iowa Kids Count Report in 2011, 16.2% of Iowa Children live in poverty.
- Hygienists deliver essential Preventive Services, Education, and refer these individuals to dentists.
- Public health supervision of dental hygienists has allowed the state of Iowa to develop the I-Smile program significantly enhancing access to quality oral health care.
- According to the 2011 I-Smile report nearly 110,000 Iowa children between the ages of 0-12 received a dental service from a dentist in 2011, a 54% increase over 2005 numbers.
- The same report indicates that over 26,000 Iowa children, ages 0-12, received a dental service from a Title V contractor, a 231% increase since 2005.

SMILES MEAN THE SAME IN EVERY CULTURE *(AUTHOR UNKNOWN)*

Renee Piper, RDH, MA
Coordinator Dental Hygiene
Iowa Central Community College
One Triton Circle
Fort Dodge, Iowa 50501
515-574-1335

Johnson, Melanie [IDB]

From: Sodawasser, Sara A [SodawaSA@crstlukes.com]
Sent: Tuesday, December 18, 2012 12:38 PM
To: Johnson, Melanie [IDB]
Subject: Preventive dental health in daycares

Melanie,

It has been brought to my attention that day care settings have been removed from the IPH Supervision agreements. As a public health dental hygienist who has worked in the field, I will report to you that there are many day cares who have received our preventive services in the past, and who have greatly benefitted from them.

Many of the day cares served focus on the low income. Some don't. Either way, not only do the children receive preventive services, but parents are provided with educational information to help them understand the how/why's of oral health for their kids. These visits also help raise oral health awareness, and serve as a link to access to care for many children.

Please help support keeping the verbiage to include day care settings in the agreements, thank you.

Sara Sodawasser, RDH, BS
Public Health Dental Hygienist/Supervisor
St. Luke's Dental Health Center
855 A Ave. NE MOP LL1
Cedar Rapids, IA 52402
319-369-7056 direct line
319-369-7730 clinic line
319-369-7192 fax

Johnson, Melanie [IDB]

From: Mary Jo Ketelsen [mketelson@davchc.com]
Sent: Tuesday, December 18, 2012 3:28 PM
To: Johnson, Melanie [IDB]
Subject: FW: Hygienist Public Health Supervision

From: Mary Jo Ketelsen
Sent: Tuesday, December 18, 2012 3:24 PM
To: 'Melane.Johnson@iowa.gov'
Subject: Hygienist Public Health Supervision

Dear Iowa Dental Board,

Please consider that Day Care Centers would be an excellent place to educate children on the importance of oral health care, and an effective way for hygienist to reach all children in need.

The American Academy of Pediatric Dentistry recommends that children have their first dental exam by age one. There are very few Parents aware of this and its importance, and there are only a few Dentist willing to see patients at this young age. Hygienist are in a perfect position under Public Health Supervision to screen these children mouths for concerns, possibly apply fluoride varnish, deliver a story time education on healthy diet and the importance of brushing, and getting out some of the wonderful educational pamphlets we have available to the Parents.

We all know dental decay is a preventable disease, and with the fast pace live styles these parent's lead, they need to be reminded of healthy eating and caring for their children's mouths. Day Care Centers are just as an ideal setting as WIC and Head Start sites are for educating Parents through their children.

Please allow a licensed dental hygienist help close the gap to children not receiving dental care. I find it very rewarding currently working in a WIC centers, and Head Start Sites screening children's mouths and educating these parents the importance of care, and healthy eating. This important information needs to be addressed to all demographics of the population Day Care Centers need to be included for the well-being of all children.

Sincerely,

Mary Jo Ketelsen RDH

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Johnson, Melanie [IDB]

From: Emily Boge [ereinert@hotmail.com]
Sent: Tuesday, December 18, 2012 8:31 PM
To: Johnson, Melanie [IDB]
Subject: [L2SPAM] Iowa Dental Board Request

Importance: Low

Greetings Ms. Johnson and IDB,

My name is Emily, and I am a private practice dental hygienist from rural eastern Iowa. I practice in Manchester in a larger office group, and am an advocate for dental health and overall public health for our state. I ask that you please include daycare centers in the scope of the RDH Public Health Supervision Agreement. Although this decision does not effect the way I am choosing to practice at this time, it does effect the care that small children (such as my 5 and 7 year old sons) receive in an alternative setting.
Many of us have heard excuses parents and caregivers provide when choosing to forgo dental care for young children. We all agree this choice is deleterious long-term, but allowing hygienists to be present as health professionals in daycares can be part of the answer to bridging this educational gap. Daycare centers provide a unique opportunity for us to reach these small kids. I desire for each child to be exposed to as much preventive care instruction, and disease prevention, as possible. As all of us remember from early pediatric-focused dental coursework, dental caries is nearly 100% preventable with proper instruction. Please allow these hygienists to get into these centers to provide the care these children need to be healthy, productive Iowans later in life.

I do appreciate your time and talents.
Sincerely,
Emily Boge

Emily Boge, RDH, BS, MPAc
13151 Kramer Road
Farley, IA 52046

319.231.1193
ereinert@hotmail.com
toothfairyemily@hotmail.com

Johnson, Melanie [IDB]

From: Ken Jones [KJones@riverhillshealth.org]
Sent: Thursday, December 20, 2012 3:49 PM
To: Johnson, Melanie [IDB]
Cc: Denise Janssen; Rick Johnson; Ed Dye; ShiloHilger; Jason Phelps; Joseph Dougherty; elrbrown@aol.com; Nancy Adrianse
Subject: Public Health Supervision/Hygiene Preventive Care at Daycare Centers

Importance: High

Melanie,

I am in full support of giving Hygienists the ability to provide preventive services to young children at Daycare Centers in Iowa. I am the Dental Director at River Hills Community Health Center in Ottumwa Iowa. I can attest that outreach to children is critical to minimizing dental caries.

I have been involved in a partnership with the area Elementary Schools to provide dental screenings, fluoride varnish applications, and sealants. This program has made a substantial positive impact with these students. Many of them that we see in the school setting have never been to the Dentist before and many of them have follow-up needs. We collaborate with the I-Smile Coordinator in our area as well. She plays the important role of getting Care Coordination for these kids so that they can get their problems addressed.

We also have a partnership with the Head Start program to provide screenings, oral health education, and fluoride varnish to the pre-school children.

I am of the opinion that these programs/partnerships that involve a Hygienist and preventive care are wonderful. That is why I hope to see the Iowa Dental Board allow for Daycare Centers to be a point of access for these types of preventive services.

Thank you for your time! Happy Holidays!

Dr. Ken Jones
Dental Director/Dentist
River Hills Community Health Center
Ottumwa Iowa 52501
phone: 641-683-5773 ext 158

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Johnson, Melanie [IDB]

From: Nancy Adrianse [adriansen@iowapca.org]
Sent: Friday, December 21, 2012 10:45 AM
To: Johnson, Melanie [IDB]
Subject: Iowa code section 147.76 Public comment

Dec. 21, 2012

Iowa Dental Board Members,

Please carefully consider the inclusion of day care centers and programs affiliated with the Early Childhood Iowa initiative in the definition of public health settings for public health supervision of dental hygienists.

In an open mouth survey conducted by the IDPH in 2012, it was found that more children in Iowa are now eligible for Medicaid benefits. This would indicate that more families are falling into a low income situation. Low income is one of the risk factors for children having decayed teeth. Allowing dental hygienists to provide preventive dental services such as fluoride varnish in day care centers will allow more children to benefit from this decay preventing service and help to reduce the risk of decay. Along with providing these preventive service this provides the opportunity to increase the oral health literacy of these families. Not only is this a benefit to these children but this low cost service will save Iowa money. Repairing decayed teeth is much more expensive for the state and filled teeth are much more expensive to maintain over a life time.

The Iowa Dental Board does a good job protecting the oral health of Iowans and this inclusion will continue that good work.

Thank you for your carefully consideration of this amendment.

Nancy Adrianse
3210 SW 33rd Street
Des Moines, Iowa 50321

Johnson, Melanie [IDB]

From: Sherry Steinbach [sherrysteinbach@hotmail.com]
Sent: Monday, December 24, 2012 8:03 AM
To: Johnson, Melanie [IDB]
Subject: Day care Centers and Public health Supervision

Iowa Dental Board,
I am writing in regards to the hygienists role in day care services.
We start teaching our children at an early age to dress themselves, how to eat with spoons and forks, and not to touch something or do something that could cause injury. Why not start with teaching brushing as well as good eating habits.
Day Care settings are an excellent way to reach large numbers of children. Children need early education in the area of good oral hygiene. The child learn to trust someone looking into their mouths and do listen to simple brushing instructions.
An oral exam by a hygienist can help spot potential dental problems, possibly before the situation becomes a real dental emergency with a severe abscess and a frightened child that is in pain.
I recently started working for the I Smile program with Marion County Public Health. While talking with mothers with small children, I was amazed at the number of parents that do not help brush their children's teeth, don't brush at all and never look in side their mouths.
We need to use every opportunity to reach children and improve their oral health .
As a dental hygienists I believe every child should have a healthy mouth.
Please include day care centers under the hygienist's Public Health Supervision Agreement.

Sincerely,
Sherry Steinbach, RDH

Johnson, Melanie [IDB]

From: Linda Meyers [lmeyers@familyia.org]
Sent: Wednesday, December 26, 2012 4:57 PM
To: Johnson, Melanie [IDB]

Melanie and Members of the Iowa Board of Examiners,

I would like to express my support of the proposal to expand the public health sites that dental hygienists can offer preventive dental services to include daycare centers. As everyone is aware the under 3 year old child is a segment of the population that cannot easily access preventive dental care. We have seen a rise in Early Childhood caries over the past 10 years. We are seeing many more children being covered by preventive dental care by going to the children where they are such as schools, WIC Clinics and Head Start centers. It only makes sense to reach out to daycares where most of their clients are under 3 years old. I have been asked by day care centers to see their clients but have had to decline because their sites are not in my scope. Please consider this change so we can reach more children and realize full potential of what Public Health has to ofer.
Sincerely, Linda Meyers
--
Linda G. Meyers, RDH
I-Smile Coordinator for Pottawattamie and Mills Counties
Family Inc
3501 Harry Langdon Blvd, Suite 150
Council Bluffs, Iowa 51501
office: (712)256-9566
fax: (712)256-9916

Johnson, Melanie [IDB]

From: Bianca Carmona [bcarmona@davchc.com]
Sent: Thursday, December 27, 2012 9:57 AM
To: Johnson, Melanie [IDB]
Subject: Daycare Screenings

Good morning,

I am a hygienist working for Community Health Care. I also do screenings at WIC two days per week, and also do Head Start screenings twice per year. I have no doubt that you are aware of all of the same statistics that I am:

- Barriers to regular dental care are lack of insurance, lack of dental health literacy, and few dental providers taking Medicaid.
- In 2011, 119,053 Medicaid enrolled children ages 0-12 did not see a dentist.
  - Ages 0-2: 55,540 Medicaid enrolled children did not see a dentist.
  - Ages 3-5: 24,143 Medicaid enrolled children did not see a dentist.
- In 2011 Medicaid Enrolled Children Receiving a Dental Service from Title V Contractors.
  - Children ages 0-2: 10509 received a dental service, 56485 did not.
  - Children ages 3-5: 11,903 received a dental service, 45, 779 did not.
- According to the Iowa Kids Count Report in 2011, 16.2% of Iowa Children live in poverty.
- Hygienists deliver essential Preventive Services, Education, and refer these individuals to dentists.
- Public health supervision of dental hygienists has allowed the state of Iowa to develop the I-Smile program significantly enhancing access to quality oral health care.
- According to the 2011 I-Smile report nearly 110,000 Iowa children between the ages of 0-12 received a dental service from a dentist in 2011, a 54% increase over 2005 numbers.
- The same report indicates that over 26,000 Iowa children, ages 0-12, received a dental service from a Title V contractor, a 231% increase since 2005.

I wanted to share with you my personal opinion from an experienced stand point. I see several children in all of the environments that I'm working in. Several of the children that I have seen, I have seen in all three of these facilities, and they have had ongoing problems. I think that adding in day care facilities is **vital**, so that we can keep track of these, and see other children who are in need of care and not receiving it. If we see a child at WIC who has caries, we have documentation of that, and we are able to show the parent the areas of concern and document that. If we then see this child again in day care, again at WIC, in head start, this allows us to have several opportunities to instill the importance of regular dental care in the parent, and if they choose not to get care for the child, then it helps to establish documentation for possible cases of neglect.

It breaks my heart to see these children with blown out teeth that say "these ones hurt sometimes," or "we get Mountain Dew at home." We need as many opportunities to educate and inform parents as possible. We need every opportunity to document our findings, and be able to say, "I see that we have seen your child 3 times now, and have documented that he has complained of pain at all three visits, and the problem is getting worse," and use that opportunity to offer appointments, and to advise, if need be, that this kind of continued dental problem has been documented and can be considered abuse and neglect—and we are mandatory reporters. (I am not throwing those words around lightly or regularly, but in the past few places of employment—since 2009—I have had to advise this maybe 3 times. Sometimes making the parents aware of this, is enough to get them to get the child the necessary treatment. I hate to see these poor little angels suffering, and I'd hate to think that we would choose to miss an opportunity to be able to catch problems early, educate children and parents, and help those in need.

I hope that this email may be helpful in making a decision.

Thank you for your time.

Bianca Carmona, R.D.H.

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Johnson, Melanie [IDB]

From: Megan W [myvonne.ingew@gmail.com]
Sent: Friday, December 28, 2012 9:57 AM
To: Johnson, Melanie [IDB]
Subject: Letter to the IDB

Dear Iowa Dental Board,

My name is Megan Williams and I am a second year student in Iowa Central Community College's dental hygiene program. I am writing to you to express my concern about the decision made earlier this year to not expand dental hygiene Public Health Supervision Agreements to day care centers. This is a large missed opportunity to establish some basic education and preventative practices in these young children and their parents. So many of these children lack access to dental care due to not being insured, lack of the parents' dental health literacy, or due to the small number of dental providers that do take Medicaid. Any and all of these reasons are why large numbers of children are not being seen by a dental professional until there is already a high decay rate. By the time these children enter into the public school system, the should be seen have by a dental professional, regardless of their ability to pay. This is where the Public Health Supervised Dental Hygienist comes in. The state of Iowa has done great things in allowing this position. For example, the I-Smile program has significantly enhanced access to quality care. According to I-Smile's 2011 report there has been a 54% increase (since 2005) in the number of children ages 0-12 that have received a dental service from a dentist. Because not only are these public health supervised hygienists providing education and preventative services, they are referring these children to dentists.

There are over 1,500 childcare centers in the state of Iowa. Excluding daycare centers from the dental hygiene Public Health Supervision Agreement would just add another block to dental care for thousands of children. I hope the IDB takes another look at the progress being made in Iowa children's dental health due to the Public Health Supervision Agreement and changes their minds in regards to day care centers.

Thank you,

Megan Williams

Johnson, Melanie [IDB]

From: bill vanzuiden [wavanzui@yahoo.com]
Sent: Friday, December 28, 2012 10:13 AM
To: Johnson, Melanie [IDB]
Subject: Day Cares

To whom it may concern,

I am a dental hygienist with twenty-nine years in private practice and three years in public health with a public health supervision agreement. I have enjoyed my job in private practice but I can honestly say my work with children in public health far exceeds my other dental experience.

Recently I learned that day care centers are not included in the facilities we are allowed to provide dental care. I am not sure why exactly, but find it very surprising!! Parents who have children in daycare centers have them there obviously because they are working. In order to make dental appointments they are forced to take off valuable work time. Even though they may have private dental insurance that would cover these visits, many are not prioritizing early age dental visits. I believe there are several reasons for this which may include not knowing the ADA's recommendation for age of first visit, hours of dental office, and dentists not seeing children until age four or five.

Our children with state provided dental coverage(T19) actually have many more opportunities to receive a dental screening at a very early age. These children are seen in conjunction with the WIC program, at Head Start, preschools, and possibly other facilities. The number of children with public health coverage that are being seen and referred to private dental offices is incredible! Shouldn't we support those families that are helping fund these programs just as much.

By providing dental screenings in day cares we can educate parents on the importance of early dental intervention, helping them to prioritize their children's dental health. If issues are detected in these screenings we are not only increasing the dental health of the child but possibly the dental health of the entire family. Those families who may not have a dental home are provided with a list of dentists in their communities accepting new patients. This kind of referral system is guaranteed to increase business to the whole dental community. I see this as a win/win. Please allow dental hygienist to continue advancing our field and yours!!! Thank You for your consideration of this issue.

Sincerely,
Elizabeth

Vanzuiden R.D.H.

Johnson, Melanie [IDB]

From: Reynolds, Julie C. [ReynolJC@crstlukes.com]
Sent: Friday, December 28, 2012 2:56 PM
To: Johnson, Melanie [IDB]
Subject: Jan 8 public hearing comments

To whom it may concern at the Iowa Dental Board,

As a dentist in a public health clinic and a graduate student in dental public health, I understand the barriers that children face to accessing dental services in Iowa. Although children's access to dental care in Iowa far exceeds many other states, a subset of children continue to go year after year without utilizing the dental care system for reasons that are out of their control. The best way to change this is to maximize the number of locations at which children are exposed to the dental healthcare system, and do so as early in their childhood as possible.

Currently, young children are exposed to oral health personnel at locations such as Head Start preschools, WIC centers, schools, and federally qualified health centers (FQHCs). In many cases, these personnel are public health dental hygienists who are able to have a presence in institutions whose clients are dentally underserved. These institutions are typically places where other oral health professionals would not otherwise be located. Increasing the scope of settings where public health hygienists are able to work will improve access to dental care for children in Iowa. In this case, the setting happens to be day care centers. **Day care centers should therefore be included in the list of public health settings in which public health dental hygienists are able to perform their duties.** This action will increase the robustness of our state's oral healthcare system and have a positive impact on the oral health of Iowa's children.

Sincerely,

Julie C. Reynolds, DDS
Dentist, St. Luke's Dental Health Center
Cedar Rapids, IA

Graduate Student in Dental Public Health
University of Iowa College of Dentistry
Iowa City, IA

Johnson, Melanie [IDB]

From: Terry Kemp [kemp4@yousq.net]
Sent: Sunday, December 30, 2012 7:36 PM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision comments on day care settings
Attachments: IDB public health daycare supervision letter 12-31-12.docx

Please see the attached comments.

Thank you.

To: Iowa Dental Board

From: Patricia Kemp, RDH

I have been practicing dental hygiene in Iowa for 28 years. I have been in public health for the past thirteen years. I write in favor of allowing public health supervision of dental hygienists to include all settings with early childhood daycare, including home based.

General dental practices very rarely allow children under the age of three into their private practices. The families of very young children are mislead into believing the child does not require dental services. They are told the child does not need to be seen unless there is a problem. How deplorable to wait until a problem exists! The American Dental Association recommends a child have an initial dental exam six months after the first tooth erupts. Unfortunately, only a minority of children ever see a dentist prior to age three.

In my years providing services at the Women, Infant, Children (WIC) program, I can attest to the very real need for dental hygiene services for children under the age of three. Dental decay does exist in this age group. Often decay is rampant and requires dental care under general anesthesia, thus costing the taxpayers thousands of dollars per child. Prevention and education beginning at birth prevents decay and saves money.

Our ultimate goal is to have healthy children. It makes the most sense to serve families and the children where they are. Please allow public health supervision to include day care centers in all areas.

Thank you for your time and attention to this matter.

Sincerely,

Patricia Kemp, RDH
1865 Carter Road
Dubuque, IA 52001

563-556-1498

Johnson, Melanie [IDB]

From: Freed,Adam J. [afreed@brownwinick.com]
Sent: Monday, December 31, 2012 9:37 AM
To: Johnson, Melanie [IDB]
Cc: Cownie, Catherine C.
Subject: ARC 0471C: Public Health Supervision
Attachments: Letter to Melanie Johnson - Expanded Definition of Public Health Settings (12-31-12) (00442550).pdf

Melanie:

Please find attached the Iowa Dental Association's comments on the Dental Board's proposed rules to expand the definition of "public health settings." Please let us know if you have any questions. Thanks. Happy New Year!

Adam

A Firm Commitment to Business™

Adam J. Freed
Attorney
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Brown, Winick, Graves, Gross, Baskerville and Schoenebaum, P.L.C.
666 Grand Avenue, Suite 2000
Ruan Center, Des Moines, IA 50309-2510

December 31, 2012

direct phone: 515-242-2490
direct fax: 515-323-8590
email: cownie@brownwinick.com

VIA E-MAIL: Melanie.Johnson@iowa.gov

Melanie Johnson
Executive Director
Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines, Iowa 50309-4687

Re: ARC 0471C: Expanded Definition of "Public Health Settings"

Dear Ms. Johnson:

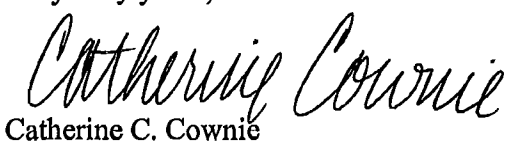
This firm serves as counsel to the Iowa Dental Association (the "Association"). It has come to the attention of the Association that the Iowa Dental Board (the "Board") recently noticed an amendment to Chapter 10 of the Board's rules to expand the definition of "public health settings" to include programs affiliated with the Early Childhood Iowa initiative and certain day care centers (the "Rule Amendment"). The Association is concerned that the Board noticed the Rule Amendment without adequate consideration for patient safety and without considering the need for enhanced oversight of participants in a public health supervision arrangement.

Section 10.5 of the Board's rules authorizes a dentist and a dental hygienist to enter into a written agreement under which the dentist provides public health supervision over the dental hygienist when the hygienist provides services in specified public health settings. The dentist need not be physically present to supervise the services provided by the hygienist; but the dentist must be available to provide communication and consultation with the dental hygienist. The hygienist must only provide dental hygiene services pursuant to age- and procedure-specific standing orders from the dentist.

Patient safety may be unnecessarily compromised by expanding the number of settings in which dental hygienists are permitted to provide dental hygiene services under a public health supervision arrangement. The top priority of the Board's rulemaking should be ensuring the highest level of patient safety. The lack of direct supervision by dentists in a public health supervision arrangement clearly compromises patient safety and may present a heightened risk of harmful errors.

One of the Association's top priorities is ensuring adequate access to high-quality dental care for all Iowans, regardless of their socioeconomic status. Access to dental care, however, should not be provided at the cost of compromised patient safety. Therefore, the Association hereby requests that the Board delay implementation of the Rule Amendment and conduct a comprehensive analysis of the patient safety implications of the overall public health supervision rule and the current proposed Amendment. If you have any questions regarding this issue, please do not hesitate to contact me.

Very truly yours,



Catherine C. Cownie

CCC:af

Johnson, Melanie [IDB]

From: Mary Ann White [merryannwhite@gmail.com]
Sent: Monday, December 31, 2012 11:41 PM
To: Johnson, Melanie [IDB]
Subject: Public Hearing on January 8, 2013, adding day care centers to list
Attachments: dental health supervision.docx; National Call To Action To Promote Oral Health.docx

Dear Ms. Johnson:

Attached, please read the information I feel strongly will help the Iowa Dental Board regarding the public hearing scheduled January 8, 2013 to hear testimony concerning adding day care centers to the list of settings where a dental hygienist could provide servies.

I have taken much time to state the truth as it relates to my personal experience. I admire the fact that I have been afforded the opportunity to provide this valuable information for you.

Respectfully,

Mary Ann White, RDH

December 31, 2012

Mary Ann White
1662 South Bluff Boulevard
Clinton, Iowa 52732
H. 563.243.7848
C. 563.219.1843
merryannwhite@gmail.com

SUBJECT: Adding day care centers to the list of settings where a dental hygienist provide preventive services

Dear Iowa Dental Board:
Thank you for taking time to evaluate the ramifications of providing **PREVENTIVE DENTAL SERVICES** to groups of **UNDERSERVED IOWA CHILDREN**, our future.

- By providing preventive and referral services to Iowa *day care children*, we are setting up a higher standard of care for our future generations.
- *Day care children* are direct result of the **WORKING CLASS PEOPLE**, children of those mothers and/or fathers who work at least 40 hours a week, who contribute to the income and tax base of Iowa, many of whom do not have dental insurance.
- When mothers/fathers work full time, what dentist is available when the parents are working Monday through Friday? Parents must take off work to take child to dentist. At this point, it would be to the advantage of the family to have the Registered Dental Hygienist provide as many preventive services as possible while parents are at work, then make best use of the parents time off work with the child if referral to a dentist is foreseen. I have been a single parent and know this to be true as a serious and genuine personal example.
- I currently possess two Iowa Public Health Care Agreements with two different dentists and am employed full time in a private general dental office. I choose to offer my services in this capacity to further improve the dental plight from the standard of care which was in effect in my previous generation. Dental health begins at birth.
- Dr. Satcher noted that major barriers to oral health include socioeconomic factors, such as lack of dental insurance or the inability to pay out of pocket, or problems of access that involve transportation and the need to take time off from work for health needs. While 44 million Americans lack medical insurance, about 108 million lack dental insurance. Only 60 percent of baby boomers receive dental insurance through their employers, and most older workers lose their dental insurance at retirement. (U. S. Department of Health and Human Services; Surgeon General, Vice Admiral Regina M. Benjamin, M.D., M.B.A., May 25, 2000).
- The hundreds of patients I have provided oral screenings for have been extraordinarily grateful.
- Enclosed please find a copy of the "U.S. Department of Health and Human Services. *National Call to Action to Promote Oral Health.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, Spring 2003." Within this document, you will find many highlighted areas which dental hygienists in the state of Iowa are required to be specifically trained to

carry out as set forth by the rules and regulations of the Iowa Dental Board. I personally have provided many volunteer hours of continuing education to many local hospitals, nursing homes and schools over, and most specifically *day care centers* to provide much needed and most commonly overlooked education to support the *day care teachers* who reach out to the community for my help annually (without interfering with the dentists in any technique). As uncovered in this report, there is an overwhelming-ever ending amount of work to be done, which could never be accomplished, as mentioned, without an organized mass state by state effort.

- I have been a dental hygienist for 17 years and have no desire to become a dentist. I never have. I also have many dental hygiene friends and I have never heard a word spoken which indicates the dental hygiene profession cares to interfere with the role of a dentist as it exists in the state of Iowa. I/we have great respect for the profession of dentistry, for which I would not have a job in the state of Iowa. It has never been nor ever will be the intention of myself or any dental hygienist I have ever met to negate or take away any referrals or take over any skills or monetary gain which a dentist perceives to be rightfully theirs as set forth by the Iowa Dental Board.
- Due to the overpopulation and difficulty of newer graduates in my particular area, I strongly consider the public health arena to be a valuable frontier for the young dental hygienists in the state of Iowa through proven outreach programs to day care, less chair time for the dentist and screening, education, sealant programs, fluoride programs, I-Smile programs and Title V contractors.

I am not directly involved in the state level, yet provide many hours of ground level volunteer hours of dental hygiene. I volunteer at the Gateway Free Dental Clinic, Clinton, Iowa. I greatly respect the two dentists who support me through this effort, one of whom provides free dental care to the underprivileged of our community. Without these remarkable state-wide organizations any many like it, and the continuing efforts of the hundreds of people that provide these services, the state of Iowa would be considered to be more negligent.

"If you give a man a fish you feed him for a day. If you teach a man to fish you feed him for a lifetime." Chinese Proverb. This is what dental hygienists love to do!

Respectfully,

Mary Ann White, RDH

National Call To Action To Promote Oral Health

A Public-Private Partnership

under the leadership of

The Office of the Surgeon General

Acknowledgements

We express our appreciation to the many voluntary and professional organizations, private and government agencies, foundations, and universities that contributed to the development of this document. We thank them for their existing and future efforts to improve the nation's health through promoting oral health and for their commitment to public-private partnerships.

Suggested Citation

U.S. Department of Health and Human Services. *National Call to Action to Promote Oral Health.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, Spring 2003.

Preface from the Surgeon General

The great and enduring strength of American democracy lies in its commitment to the care and well-being of its citizens. The nation's long-term investment in science and technology has paid off in ever-expanding ways to promote health and prevent disease. We can be proud that these advances have added years to the average life span and enhanced the quality of life. But an "average" is necessarily derived from all values along a continuum and it is here that we come to recognize gaps in health and well-being. Not all Americans are benefiting equally from improvements in health and health care. America's continued growth in diversity has resulted in a society with broad educational, cultural, language, and economic differences that hinder the ability of some individuals and groups from realizing the gains in health enjoyed by many. These health disparities were highlighted in the year 2000 Surgeon General's report: *Oral Health in America* where it was reported that no less than a "silent epidemic of oral diseases is affecting our most vulnerable citizens—poor children, the elderly, and many members of racial and ethnic minority groups." The report also highlighted the disabling oral and craniofacial aspects of birth defects.

The report was a wake-up call, raising a powerful voice against the silence. It called upon policymakers, community leaders, private industry, health professionals, the media, and the public to affirm that oral health is essential to general health and well-being and *to take action*. No one should suffer from oral diseases or conditions that can be effectively prevented and treated. No schoolchild should suffer the stigma of craniofacial birth defects nor be found unable to concentrate because of the pain of untreated oral infections. No rural inhabitant, no homebound adult, no inner city dweller should experience poor oral health because of barriers to access to care and shortages of resources and personnel.

Now that call to action has been taken up. Under a broad coalition of public and private organizations and individuals, orchestrated by the principals who led the development of the *National Call To Action To Promote Oral Health* has been generated. We applaud the efforts of these partners to heed the voices of their fellow Americans. At regional meetings across the country concerned citizens addressed the critical need to resolve inequities in oral health affecting their communities. More than that, ideas and programs were described to explain what groups at local, state or regional levels were doing or could do to resolve the issues.

Combining this store of knowledge and experience with private and public plans and programs already under way has enabled the partnership to extract the set of five principal actions and implementation strategies that constitute the *National Call To Action To Promote Oral Health*. These actions crystallize the necessary and sufficient tasks to be undertaken to assure that *all* Americans can achieve optimal oral health. It is abundantly clear that these are not tasks that can be accomplished by any

single agency, be it the Federal government, state health agencies, or private organizations. Rather, just as the actions have been developed through a process of collaboration and communication across public and private domains, their successful execution calls for partnerships that unite private and public groups focused on common goals. The seeds for such future collaborative efforts have already been sown by all those who participated in the development of this *Call To Action*. We appreciate their dedication and take it as our mutual responsibility to further partnership activities and monitor their impact on the health of the public. We are confident that sizable rewards in health and well-being can accrue for all Americans as these actions are implemented.

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Introduction

The *National Call To Action To Promote Oral Health* is addressed to professional organizations and individuals concerned with the health of their fellow Americans. It is an invitation to expand plans, activities, and programs designed to promote oral health and prevent disease, especially to reduce the health disparities that affect members of racial and ethnic groups, poor people, many who are geographically isolated, and others who are vulnerable because of special oral health care needs. The *National Call To Action To Promote Oral Health*, referred to as the *Call To Action*, reflects the work of a partnership of public and private organizations who have specified a vision, goals, and a series of actions to achieve the goals. It is their hope to inspire others to join in the effort, bringing their expertise and experience to enrich the partnership and thus accelerate a movement to enhance the oral and general health and well-being of all Americans.

Origins of the Call To Action

Oral Health in America: A Report of the Surgeon General alerted Americans to the importance of oral health in their daily lives[1]. The Report, issued in May 2000, provided state-of-the-science evidence on the growth and development of oral, dental and craniofacial tissues and organs; the diseases and conditions affecting them; and the integral relationship between oral health and general health, including recent reports of associations between chronic oral infections and diabetes, osteoporosis, heart

and lung conditions, and certain adverse pregnancy outcomes. The text further detailed how oral health is promoted, how oral diseases and conditions are prevented and managed, and what needs and opportunities exist to enhance oral health. Major findings and themes of the report are highlighted in Table 1.

Table 1: Major Findings and Themes from *Oral Health in America: A Report of the Surgeon General*

- Oral health is more than healthy teeth.
- Oral diseases and disorders in and of themselves affect health and well-being throughout life.
- The mouth reflects general health and well-being.
- Oral diseases and conditions are associated with other health problems.
- Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health as well.
- Safe and effective measures exist to prevent the most common dental diseases—dental caries and periodontal diseases.
- There are profound and consequential oral health disparities within the U.S. population.
- More information is needed to improve America's oral health and eliminate health disparities.
- Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth, and teeth.

Source: U.S. Department of Health and Human Services *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000: 10-11.

The Report's message was that oral health is essential to general health and well-being and can be achieved. However, a number of barriers hinder the ability of some Americans from attaining optimal oral health. The Surgeon General's Report concluded with a framework for action, calling for a national oral health plan to improve quality of life and eliminate oral health disparities.

The Rationale for Action

The rationale for action is based on data from the Surgeon General's Report (Table 2). These and other data on the economic, social, and personal burdens of oral diseases and disorders show that although the nation has made substantial improvements in oral health, more must be done.

Table 2. The Burden of Oral Diseases and Disorders

The Burden of Oral Diseases and Disorders

Oral diseases are progressive and cumulative and become more complex over time. They can affect our ability to eat, the foods we choose, how we look, and the way we communicate. These diseases can affect economic productivity and compromise our ability to work at home, at school, or on the job. Health disparities exist across population groups at all ages. Over one third of the U.S. population (100 million people) has no access to community water fluoridation. Over 108 million children and adults lack dental insurance, which is over 2.5 times the number who lacks medical insurance. The following are highlights of oral health data for children, adults, and the elderly. (Refer to the full report for details of these data and their sources).

Children

- Cleft lip/palate, one of the most common birth defects, is estimated to affect 1 out of 600 live births for whites, and 1 out of 1,850 live births for African Americans.
- Other birth defects such as hereditary ectodermal dysplasias, where all or most teeth are missing or misshapen, cause lifetime problems that can be devastating to children and adults.

- Dental caries (tooth decay) is the single most common chronic childhood disease – 5 times more common than asthma and 7 times more common than hay fever.
- Over 50 percent of 5- to 9-year-old children have at least one cavity or filling, and that proportion increases to 78 percent among 17-year-olds. Nevertheless, these figures represent improvements in the oral health of children compared to a generation gap.
- There are striking disparities in dental disease by income. Poor children suffer twice as much dental caries as their more affluent peers, and their disease is more likely to be untreated. These poor-nonpoor differences continue into adolescence. One out of four children in America is born into poverty, and children living below the poverty line (annual income of $17,000 for a single family of four) have more severe and untreated decay.
- Tobacco-related oral lesions are prevalent in adolescents who currently use smokeless (spit) tobacco.
- Unintentional injuries, many of which include head, mouth, and neck injuries, are common in children.
- Intentional injuries commonly affect the craniofacial tissues.
- Professional care is necessary for maintaining oral health, yet 25 percent of poor children have not seen a dentist before entering kindergarten.
- Medical insurance is a strong predictor of access to dental care. Uninsured children are 2.5 times less likely than insured children to receive dental care. Children from families without dental insurance are 3 times more likely to have dental needs than children with either public or private insurance. For each child without medical insurance, there are at least 2.6 children without dental insurance.
- Medicaid has not been able to fill the gap in providing dental care to poor children. Fewer than one in five Medicaid-covered children received a single dental visit in a recent year-long study period. Although new programs such as the State Children's Health Insurance Program (SCHIP) may increase the number of insured children, many will still be left without effective dental coverage.
- The social impact of oral diseases in children is substantial. More than 51 million school hours are lost each year to dental-related illness. Poor children suffer nearly 12 times more restricted-activity days than children from higher-income families. Pain and suffering due to untreated diseases can lead to problems in eating, speaking, and attending to learning.

Adults

- Most adults show signs of periodontal or gingival diseases. Severe periodontal disease (measured as 6 millimeters of periodontal attachment loss) affects about 14 percent of adults aged 45-54.
- Clinical symptoms of viral infections, such as herpes labialis (cold sores), and oral ulcers (canker sores) are common in adulthood affecting about 19 percent of adults 22 to 44 years of age.
- Chronic disabling diseases such as temporomandibular disorders, Sjögren's syndrome, diabetes, and osteoporosis affect millions of Americans and compromise oral health and functioning

- Pain is a common symptom of craniofacial disorders and is accompanied by interference with vital functions such a eating, swallowing, and speech. Twenty-two percent of adults reported some form of oral-facial pain in the past 6 months. Pain is a major component of trigeminal neuralgia, facial shingles (post-herptic neuralgia), temporomandibular disorders, fibromyalgia and Bell's palsy
- Population growth as well as diagnostics that are enabling earlier detection of cancer means that more patients than ever before are undergoing cancer treatments. More than 400,000 of these patients will develop oral complications annually.
- Immunocompromised patients, such as those with HIV infection and those undergoing organ transplantation, are at higher risk for oral problems such as candidiasis.
- Employed adults lose more than 164 million hours of work each year due to dental disease or dental visits
- For every adult 19 years or older with medical insurance, there are three without dental insurance.
- A little less than two thirds of adults report having visited a dentist in the past 12 moths. Those with income at or above the poverty level are twice as likely to report a dental visit in the past 12 months as those who are below the poverty line.

Older Adults

- Twenty-three percent of 65- to 74-year-olds have severe periodontal disease (measured as 6 millimeters of periodontal attachment loss). (Also, at all ages men are more likely than women to have more severe diseases, and at all ages people at the lowest socioeconomic levels have more severe periodontal disease.)
- About 30 percent of adults 65 years and older are edentulous, compared to 46 percent 20 years ago. These figures are higher for those living in poverty.
- Oral and pharyngeal cancers are diagnosed in about 30,000 Americans annually; 8,000 die from these diseases each year. These cancers are primarily diagnosed in the elderly. Prognosis is poor. The 5-year survival rate for white patients is 56 percent; for blacks, it is only 34 percent.
- Most older Americans take both prescription and over-the-counter drugs. In all probability, at least one of the medications used will have an oral side effect – usually dry mouth. The inhibition of salivary flow increases the risk for oral disease because saliva contains antimicrobial components as well as minerals that can help rebuild tooth enamel after attack by acid-producing, decay-causing bacteria. Individuals in long-term care facilities are prescribed an average of eight drugs.
- At any given time, 5 percent of Americans aged 65 and older (currently some 1.65 million people) are living in a long-term care facility where dental care is problematic.
- Many elderly individuals lose their dental insurance when they retire. The situation may be worse for older women, who generally have lower incomes and may never have had dental insurance. Medicaid funds dental care for the low-income and disabled elderly in some states, but reimbursements are low. Medicare is not designed to reimburse for routine dental care.

Source: U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000:2-3.

The nation's total bill for dental services was estimated by the Department of Health and Human Services' Centers for Medicare and Medicaid Services to be $70.1 billion in 2002; this figure underestimates the true cost because it does not take into account the indirect expenses of oral health problems, nor the cost of services by other health care providers. These other providers include specialists who treat people with craniofacial birth defects, such as cleft lip or palate, and children born with genetic diseases that result in malformed teeth, hair, skin, and nails, as happens in the ectodermal dysplasias. Patients with oral cancers, chronic pain conditions such as temporomandibular (jaw) disorders, autoimmune disease such as Sjögren's syndrome (which leads to the destruction of the salivary and tear glands) and victims of unintentional or intentional facial injury are examples of other groups of patients who may require costly and long-term oral and medical services. Beyond these expenses are the millions of school and work hours lost every year because of oral health problems.

Partnering for Progress

Aware that the Report had reinforced and stimulated a number of ongoing activities, but seeing a need to facilitate communication and coordination of the nation's efforts, the Office of the Surgeon General extended an open invitation to organizations to launch the development of the *Call To Action*. The resulting Partnership Network (Appendix 1) was charged to enumerate promising existing initiatives to enhance oral health, with an emphasis on those related to the Surgeon General's Report and to the *Healthy People 2010* oral objectives[2], and to expand these efforts by enlisting the expertise of individuals, health care providers, communities, and policymakers at all levels of society. Input was captured through convening listening sessions held in five cities and by using Internet websites. The listening sessions were much like town hall meetings, providing opportunities to present the issues and solutions and attracting participants with diverse points of view. The testimony proved to be extremely valuable in demonstrating the extent to which oral health concerns extend beyond the oral health community and in providing a wealth of ideas and activities for resolving the issues (Appendix 2). The text that follows expresses the vision, goals, and actions proposed for the *Call To Action*.

Vision and Goals

The Vision

of the *Call To Action* is

> To advance the general health and well-being of all Americans by creating critical partnerships at all levels of society to engage in programs to promote oral health and prevent disease.

The Goals

of the *Call To Action* reflect those of *Healthy People 2010*:

> To promote oral health.
>
> To improve quality of life.
>
> To eliminate oral health disparities.

As a force for change to enhance the nation's overall health and well-being, the *Call To Action* urges that oral health promotion, disease prevention, and oral health care have a presence in all health policy agendas set at local, state, and national levels. For this to happen, the public, health professionals, and policymakers must understand that oral health is essential to general health and well-being at every stage of life. In addition, the oral health community must be ready to act in efforts to address the nation's overall health agenda.

The Actions

Each of the five actions that follow should be read as a call for a response from the individuals and groups who are most concerned and in a position to act—whether as community leaders, volunteers, health care professionals, research investigators, policymakers, and other concerned parties, or as public and private agencies able to bring their organizational mandates and strengths to the issues. The groups and individuals responding need to work as partners, sharing ideas and coordinating activities to capitalize on joint resources and expertise to achieve common goals. The actions proposed reflect ideas and approaches outlined in the Surgeon General's Report and emphasized in public testimony during listening sessions. Note, however, that individual Network members may not necessarily concur with every assessment or conclusion in the text that follows.

The theme that emerged was that people care about their oral health, are able to articulate the problems they face, and can devise ingenious solutions to resolve them--often through creative partnerships. Ultimately, the measure of success for any of any of these actions will be the degree to which individuals and communities--the people of the nation itself--gain in overall health and well-being. To achieve those ends, the partners have proposed four guiding principles: Actions should be 1) culturally sensitive, 2) science based, 3) integrated into overall health and well-being efforts, and 4) routinely evaluated.

Action 1. Change Perceptions of Oral Health

For too long, the perception that oral health is in some way less important than and separate from general health has been deeply ingrained in American consciousness. Activities to overcome these attitudes and beliefs can start at the grassroots level, which can then lead to a coordinated national movement to increase oral health literacy, defined as the degree to which individuals have the capacity to obtain, process, and understand basic oral and craniofacial information and services needed to make appropriate health decisions. By raising Americans' level of awareness and understanding of oral health, people can make informed decisions and articulate their expectations of what they, their communities, and oral health professionals can contribute to improving health; health professionals and researchers can benefit from work with oral health partners; and policymakers can commit to including oral health in health policies. In this way, the prevention, early detection, and management of diseases of the dental, oral, and craniofacial tissues can become integrated in health care, community-based programs, and social services, and promote the general health and well-being of all Americans.

Implementation strategies to change perceptions are needed at local, state, regional, and national levels and for all population groups. All stakeholders should work together and use data in order to:

Change public perceptions

- Enhance oral health literacy.
- Develop messages that are culturally sensitive and linguistically competent.
- Enhance knowledge of the value of regular, professional oral health care.
- Increase the understanding of how the signs and symptoms of oral infections can indicate general health status and act as a marker for other diseases.

Change policymakers' perceptions

- Inform policymakers and administrators at local, state, and federal levels of the results of oral health research and programs and of the oral health status of their constituencies.
- Develop concise and relevant messages for policymakers.
- Document the health and quality-of-life outcomes that result from the inclusion (or exclusion) of oral health services in programs and reimbursement schedules.

Change health providers' perceptions

- Review and update health professional educational curricula and continuing education courses to include content on oral health and the association between oral health and general health.
- Train health care providers to conduct oral screenings as part of routine physical exams and make appropriate referrals
- Promote interdisciplinary training of medical, oral health, and allied health professional personnel in counseling patients about how to reduce risk factors common to oral and general health.
- Encourage oral health providers to refer patients to other health specialists as warranted by examinations and history. Similarly, encourage medical and surgical providers to refer patients for oral health care when medical or surgical treatments that may impact oral health are planned.

Action 2. Overcome Barriers by Replicating Effective Programs and Proven Efforts

Reduce disease and disability. While the effectiveness of preventive interventions such as community water fluoridation and school-based dental sealants applied to children at risk have been persuasively demonstrated, very few states have implemented both measures sufficiently to meet their health objectives. Private and public agencies have conducted pilot projects and demonstration programs to inform the public and health professionals on ways to reduce the burden of oral disease through education, behavior change, risk reduction, early diagnosis, and disease prevention management. Local efforts to engage and educate community leaders in activities to improve oral health have been developed. The designs and outcomes of those programs should be well documented, evaluated, and made available to others. *The Guide to Community Preventive Service*[3] *and The Guide to Clinical Preventive Services*[4] provide criteria and strong foundations for evaluating the scientific evidence and promoting effective interventions. Testimony at the listening sessions also identified programs and interventions that warrant consideration.

Having accurate data on disease and disabilities for a given population is critical. Program success depends on how well the program is designed and implemented to address the defined problems. While available data reveal variations within and among states and population groups in patterns of health and disease, there are many subpopulations for which data are limited or nonexistent.

Improve oral health care access. Health disparities are commonly associated with populations whose access to health care services is compromised by poverty, limited education or language skills, geographic isolation, age, gender, disability, or an existing medical condition. While Medicaid, State Children's Health Insurance Programs (SCHIP), and private organizations have expanded outreach efforts to identify and enroll eligible persons and simplify the enrollment process, they have not completely closed the gap. Adults lacking language skills or reading competence may not know that they or their children are eligible for dental (or medical) services. In addition, some 25 million Americans live in dental care shortage areas, as defined by Health Professional Shortage Area criteria.

Those who seek care may be faced with health practitioners who lack the training and cultural competence to communicate effectively in order to provide needed services. Programs that have overcome these barriers, including outreach efforts and community service activities conducted through dental schools and other health professional schools and residency programs, should be highlighted and replicated.

Compounding health disparity problems is the lack of adequate reimbursement for oral care services in both public and private programs. Private insurance coverage for dental care is increasing, but still lags behind medical insurance. Inadequate reimbursement has been reported for many Medicaid and SCHIP programs. Eligibility for Medicaid does not ensure enrollment, and enrollment does not ensure that individuals obtain needed care. Several states are demonstrating the potential for improving

children's oral health access by conducting outreach programs to the public and improving provider participation through operational changes These improvements include increasing dental reimbursement to competitive levels, eliminating bureaucratic administrative barriers, contracting out the management of dental benefit plans, and modeling commercial insurance programs to eliminate patient stigma associated with Medicaid.

The federal effort to address gaps in care through new funding for oral health services at Community Health Centers and Migrant Health Centers is also a positive step. Appendix 2 describes a number of approaches for improving oral health care access that were presented in testimony. No matter which approach is taken, a necessary first step is to establish close working relationships with the groups in question so that strategies tailored to their varying and continuing health needs can be developed.

Enhance health promotion and health literacy. Public policies and community interventions to make health care and information more accessible have been effective. So have been efforts to encourage healthier lifestyles and increase interventions for prevention or early detection of disease by changing the environment (the places where people work, play, learn, or live). Expansion of community-based health promotion and disease prevention programs, including increasing understanding of what individuals can do to enhance oral health, is essential if the needs of the public are to be met. Policies and programs concerning tobacco cessation, dietary choices, wearing protective gear for sports, and other lifestyle-related efforts not only will benefit oral health, but are natural ways to integrate oral health promotion with promotion of general health and well-being.

Many Americans don't know why oral health is important, they don't know all they can do to preserve their oral health, and may not recognize signs indicating that they are in trouble. Several oral health campaigns are raising awareness of why oral health is important and how to access care, such as a nationwide campaign by the American Dental Association emphasizing the importance of the early diagnosis of oral cancer. It is encouraging that messages like these are being communicated--through public service announcements, campaigns, and all the venues available in today's media-conscious culture. More needs to be done to increase the health literacy of the public.

Implementation strategies to overcome barriers in oral health disparities need to engage all groups, particularly those most vulnerable, in the development of oral health care programs that work to eliminate health disparities and aim to:

Identify and reduce disease and disability

- Implement science-based interventions appropriate for individuals and communities.
- Enhance oral health-related content in health professions school curricula, residencies, and continuing education programs, by incorporating new findings on diagnosis, treatment and prevention of oral diseases and disorders.
- Build and support epidemiologic and surveillance databases at national, state, and local levels to identify patterns of disease and populations at risk. Data are needed on oral health status, disease, and health services utilization and expenditures, sorted by demographic variables for various populations. Surveys should document baseline status, monitor progress, and measure health outcomes.
- Determine, at community or population levels, oral health care needs and system requirements, including appropriate reimbursement for services, facility and personnel needs, and mechanisms of referral.

- Encourage partnerships among research, provider, and educational communities in activities, such as organizing workshops and conferences, to develop ways to meet the education, research, and service needs of patients who need special care and their families.
- Refine protocols of care for special care populations based on the emerging science base.

Improve access to oral health care

- Promote and apply programs that have demonstrated effective improvement in access to care.
- Create an active and up-to-date database of these programs.
- Explore policy changes that can improve provider participation in public health insurance programs and enhance patient access to care.
- Remove barriers to the use of services by simplifying forms, letting individuals know when and how to obtain services, and providing transportation and child care as needed. Assist low-income patients in arranging and keeping oral health appointments.
- Facilitate health insurance benefits for diseases and disorders affecting craniofacial, oral, and dental tissues, including genetic diseases such as the ectodermal dysplasias, congenital anomalies such as clefting syndromes, autoimmune diseases such as Sjögren's syndrome, and chronic orofacial pain conditions such as temporomandibular disorders.
- Ensure an adequate number and distribution of culturally competent providers to meet the needs of individuals and groups, particularly in health-care shortage areas.
- Make optimal use of oral health and other health care providers in improving access to oral health care.
- Energize and empower the public to implement solutions to meet their oral health care needs.
- Develop integrated and comprehensive care programs that include oral health care and increase the number and types of settings in which oral health services are provided.
- Explore ways to sustain successful programs.
- Apply evaluation criteria to determine the effectiveness of access programs and develop modifications as necessary.

Enhance health promotion and health literacy

- Apply strategies to enhance the adoption and maintenance of proven community-based and clinical interventions, such as community water fluoridation and dental sealants application.
- Identify the knowledge, opinions, and practices of the public, health care providers, and policymakers with regard to oral diseases and oral health.
- Engage populations and community organizations in the development of health promotion and health literacy action plans.
- Publicize successful programs that promote oral health to facilitate their replication.
- Develop and support programs promoting general health that include activities supporting oral health (such as wearing oral facial protection, tobacco cessation, good nutrition).

Action 3. Build the Science Base and Accelerate Science Transfer

Advances in health depend on biomedical and behavioral research aimed at understanding the causes and pathological processes of diseases. This can lead to interventions that will improve prevention, diagnosis, and treatment. Too many people outside the oral health community are uninformed about, misinformed about, or simply not interested in oral health. Such lack of

understanding and indifference may explain why community water fluoridation and school-based dental sealant programs fall short of full implementation, even though the scientific evidence for their effectiveness has been known for some time and was reaffirmed with the release of *Oral Health in America.* These and other effective preventive and early detection programs should be expanded—especially to populations at risk.

Biomedical and behavioral research in the 21st century will provide the knowledge base for an ever-evolving health care practice. This scientific underpinning requires the support of the full range of research from basic studies to large-scale clinical trials. To achieve a balanced science portfolio it is essential to expand clinical studies, especially the study of complex oral diseases that involve the interactions of genetic, behavioral, and environmental factors Clinical trials are needed to test interventions to diagnose and manage oral infections, complications from systemic diseases and their treatment, congenital and acquired defects, and other conditions. Oral health research must also pursue research on chronic oral infections associated with heart and lung disease, diabetes, and premature low-birth-weight babies. Such research must be complemented by prevention and behavioral science research (including community-based approaches and ways to change risk behavior), health services research to explore how the structure and function of health care services affect health outcomes, and by population health and epidemiology research to understand potential associations among diseases and possible risk factors. Surveys are needed to establish baseline health data for America's many subpopulations as well as to monitor changing patterns of disease. No one can foresee the findings from genetic studies in the years ahead, but without question these advances will profoundly affect health, even indicating an individual's susceptibility to major diseases and disorders. Hybrid sciences of importance to oral health are also on the rise. For example, bioengineering studies are establishing the basis for repair and regeneration of the body's tissues and organs—including teeth, bones, and joints-- and ultimately full restoration of function Oral diagnostics, using saliva or oral tissue samples, will contribute to overall health surveillance and monitoring

If the public and their care providers are to benefit from research, efforts are needed to transfer new oral knowledge into improved means of diagnosis, treatment, and prevention. The public needs to be informed, accurately and often, of findings that affect their health. They need clear descriptions of the results from research and demonstration projects concerning lifestyle behaviors and disease prevention practices. At the same time, research is needed to determine the effect of oral health literacy on oral health. Communities and organizations must also be able to reap the benefits of scientific advances, which may contribute to changes in the reimbursement and delivery of services, as well as enhance knowledge of risk factors. Advances in science and technology also mean that life-long learning for practitioners is essential, as is open lines of communication among laboratory scientists, clinicians, and the academic faculties that design the curricula, write the textbooks, and teach the classes that prepare the next generation of health care providers.

Implementation strategies to build a balanced science base and accelerate science transfer should benefit all consumers, especially those in poorest oral health or at greatest risk. Specifically there is a need to:

Enhance applied research (clinical and population-based studies, demonstration projects, health services research) to improve oral health and prevent disease

- Expand intervention studies aimed at preventing and managing oral infections and complex diseases, including new approaches to prevent dental caries and periodontal diseases.
- Intensify population-based studies aimed at the prevention of oral cancer and oral-facial trauma.
- Conduct studies to elucidate potential underlying mechanisms and determine any causal associations between oral infections and systemic conditions. If associations are demonstrated, test interventions to prevent or lower risk of complications.
- Develop diagnostic markers for disease susceptibility and progression of oral diseases.

- Develop and test diagnostic codes for oral diseases that can be used in research and in practice.
- Investigate risk assessment approaches for individuals and communities, and translate them into optimal prevention, diagnosis, and treatment measures.
- Develop biologic measures of disease and health that can be used as outcome variables and applied in epidemiologic studies and clinical trials.
- Develop reliable and valid measures of patients' oral health outcomes for use in programs and in practice.
- Support research on the effectiveness of community-based and clinical interventions
- Facilitate collaborations among health professional schools, state health programs, patient groups, professional associations, private practitioners, industries, and communities to support the conduct of clinical and community-based research as well as accelerate science transfer

Accelerate the effective transfer of science into public health and private practice

- Promote effective disease prevention measures that are underutilized.
- Routinely transfer oral health research findings to health professional school curricula and continuing education programs and incorporate appropriate curricula from other health professions-- medical, nursing, pharmacy, and social work--into dental education.
- Communicate research findings to the public, clearly describing behaviors and actions that promote health and well-being.
- Explore ways to accelerate the transfer of research findings into delivery systems, including appropriate changes in reimbursement for care.
- Routinely evaluate the scientific evidence and update care recommendations.

Action 4. Increase Oral Health Workforce Diversity, Capacity, and Flexibility

Meet patient needs. The patient pool of any health care provider tends to mirror the provider's own racial and ethnic background[5] As such, the provider can play a catalytic role as a community spokesperson, addressing key health problems and service needs. While the number of women engaged in the health professions is increasing, the number of underrepresented racial and ethnic minorities is decreasing and remains limited. Specific racial and ethnic groups are underrepresented in the active dental profession compared to their representation in the general population: African Americans comprise 2.2 percent of active dentists versus 12 percent of the population, Hispanics comprise 2.8 percent of active dentists versus 10.7 percent of the population; Native Americans comprise 0.2 percent of active dentists versus 0.7 percent of the population The reasons are complex but certainly include the high cost of dental school education (upwards of $100,000 indebtedness for dentist graduates). Efforts to address these problems at all levels—from improving K-12 education in science and math to providing scholarships and loan forgiveness programs for college and pre-doctoral programs--are essential if a truly representative health workforce is to be achieved. Efforts require full community participation, mentorship, and creative outreach as well as building upon federal or state legislation and programs.

Enhance oral health workforce capacity. The lack of progress in supplying dental health professional shortage areas with needed professional personnel underscores the need for attention to the distribution of care providers, as well as the overall capacity of the collective workforce to meet the anticipated demand for oral health care as public understanding of its importance increases. Dental school recruitment programs that offer incentives to students who may want to return to practice in rural areas and inner cities are in a prime position to act. Through these programs schools increase the diversity of the oral health

workforce. To effect change in oral health workforce capacity, more training and recruitment efforts are needed. The lack of personnel with oral health expertise at all levels in public health programs remains a serious problem, as does the projected unmet oral health faculty and researcher needs. In public health programs, oral health professionals are needed to implement surveillance, assess needs, and target population-based preventive programs. Oral health professionals in state health agencies frequently promote integration of federal, state, and local strategies and serve as the linking agent for public-private collaborations. Currently, there is an acknowledged crisis in the ability to recruit faculty to dental schools and to attract clinicians into research careers. Dental school faculty and oral health researchers are needed to address the various scientific challenges and opportunities oral health presents, and to help transfer emerging knowledge to the next generation of health care providers. The lack of trained professionals ultimately results in a loss in the public's health. Efforts are underway to address these needs, but the rate of recruitment and retention is slow. Scholarships and loan forgiveness programs have made a difference, but more public investment in developing health workforce personnel is needed.

Enhance flexibility and develop local solutions. The movement of some states towards more flexible laws, including licensing experienced dentists by credentials is a positive one and today, 42 states currently permit this activity. The goal of moving society toward optimal use of its health professionals is especially important in a society that has become increasingly mobile, especially since the oral health workforce has projected shortages that are already evident in many rural locales. State practice act changes that would permit, for example, alternative models of delivery of needed care for underserved populations, such as low-income children or institutionalized persons, would allow a more flexible and efficient workforce. Further, all health care professionals, whether trained at privately or publicly supported medical, dental, or allied health professional schools, need to be enlisted in local efforts to eliminate health disparities in America. These activities could include participating in state-funded programs for reducing disparities, part-time service in community clinics or in health care shortage areas, assisting in community-based surveillance and health assessment activities, participating in school-based disease prevention efforts, and volunteering in health-promotion and disease-prevention efforts such as tobacco cessation programs.

Implementation strategies to increase diversity, capacity, and flexibility must be applied to all components of the workforce: research, education, and both private and public health administration and practice. Efforts are needed to:

Change the racial and ethnic composition of the workforce to meet patient and community needs

- Document the outcomes of existing efforts to diversify the workforce in practice, education, and research.
- Develop ways to expand and build upon successful recruitment and retention programs, and develop and test new programs that focus on individuals from underrepresented groups.
- Document the outcomes of existing efforts to recruit individuals into careers in oral health education, research, and public and private health practice.
- Create and support programs that inform and encourage individuals to pursue health and science career options in high school and during graduate years.

Ensure a sufficient workforce pool to meet health care needs

- Expand scholarships and loan repayment efforts at all levels.
- Specify and identify resources for conducting outreach and recruitment.
- Develop mentoring programs to ensure retention of individuals who have been successfully recruited into oral health careers.
- Facilitate collaborations among professional, government, academic, industry, community organizations, and other institutions that are addressing the needs of the oral health workforce.

- Provide training in communication skills and cultural competence to health care providers and students.

Secure an adequate and flexible workforce

- Assess the existing capacity and distribution of the oral health workforce.
- Study how to extend or expand workforce capacity and productivity to address oral health in health care shortage areas.
- Work to ensure oral health expertise is available to health departments and to federal, state, and local government programs.
- Determine the effects of flexible licensure policies and state practice acts on health care access and oral health outcomes.

Action 5. Increase Collaborations

The private sector and public sector each has unique characteristics and strengths. Linking the two can result in a creative synergy capitalizing on the talent and resources of each partner. In addition, efforts are needed within each sector to increase the capacity for program development, for building partnerships, and for leveraging programs. A sustained effort is needed right now to build the nation's oral health infrastructure to ensure that all sectors of society--the public, private practitioners, and federal and state government personnel--have sufficient knowledge, expertise, and resources to design, implement, and monitor oral health programs. Leadership for successfully directing and guiding public agency oral health units is essential. Further, incentives must be in place for partnerships to form and flourish.

Disease prevention and health promotion campaigns and programs that affect oral and general health--such as tobacco control, diet counseling, health education aimed at pregnant women and new mothers, and support for use of oral facial protection for sports—can benefit from collaborations among public health and health care practicing communities. Interdisciplinary care is needed to manage the general health-oral health interface. Achieving and maintaining oral health requires individual action, complemented by professional care and community-based activities. Many programs require the combined efforts of social service, education, and health care services at state and local levels. Most importantly, the public in the form of voluntary organizations, community groups, or as individuals, must be included in any partnership that addresses oral and general health.

Implementation strategies to enhance partnering are key to all strategies in the *Call To Action*. Successful partnering at all levels of society will require efforts to:

- Invite patient advocacy groups to lead efforts in partnering for programs directed towards their constituencies.
- Strengthen the networking capacity of individuals and communities to address their oral health needs.
- Build and nurture broad-based coalitions that incorporate views and expertise of all stakeholders and that are tailored to specific populations, conditions, or programs.
- Strengthen collaborations among dental, medical, and public health communities for research, education, care delivery, and policy development.
- Develop partnerships that are community-based, cross-disciplinary, and culturally sensitive.
- Work with the Partnership Network and other coalitions to address the four actions previously described: change perceptions, overcome barriers, build a balanced science base, and increase oral health workforce diversity, capacity, and flexibility.
- Evaluate and report on the progress and outcomes of partnership efforts.

- Promote examples of state-based coalitions for others to use as models.

The Need for Action Plans

with Monitoring and Evaluation Components

Activities proposed to advance any or all of the actions described above must incorporate schemes for planning and evaluation, coordination, and accountability. Because planning and evaluation are key elements in the design and implementation of any program, the need to create oral health action plans is emphasized.

Whether individuals are moved to act as volunteers in a community program, as members of a health voluntary or patient advocacy organization, employees in a private or public health agency, or health professionals at any level of research, education, or practice, the essential first step is to conduct a needs assessment and develop an oral health plan. Because the concept of integrating oral health with general health is intrinsic to the goals of this Call To Action, oral health plans should be developed with the intent of incorporating them into existing general health plans. *Healthy People 2010* objectives can be used to help guide needs assessment and to establish program goals and health indicators for outcome measures. At the state level many, but not all, states have already developed oral health plans; however, not all of these plans have been integrated into the state's general health plan and policies. While a detailed plan is necessary to guide collaboration on the many specific actions necessary for enhancing oral health, integration of key components into the state's general health plan will assure that oral health is included where appropriate in other state health initiatives.

At any level, formal plans with goals, implementation steps, strong evaluation components, and monitoring plans will facilitate setting realistic timelines, guidelines, and budgets. The oral health plan will serve as a blueprint, one that can be a tool for enlisting collaborators and partners and attracting funding sources to ensure sustainability. Building this plan into existing health programs will maximize the integration of oral health into general health programs—not only by incorporating the expertise of multidisciplinary professional teams, but also allowing the plan to benefit from economies of scale by adding on to existing facilities, utilizing existing data and management systems, and serving the public at locations already known to patients.

To facilitate establishing, monitoring and revising written plans and ensure their progress:

- Use the *Healthy People 2010* objectives to help establish program goals and guide the needs assessment and development of health indicators for outcome measures.
- Develop and nurture a consortium of stakeholders.
- Align plan priorities with the views and expertise of primary stakeholders
- Build upon existing plans within your organization, state, or local community or apply aspects of plans established at other locations to suit program needs.
- Ensure that cultural sensitivity is utilized in the design, development, implementation, and evaluation of plans.
- Emphasize the value of incorporating oral health into general health plans by educating the public, health professionals, and policymakers about oral health and its relation to general health and well-being.
- Integrate existing oral health plans into general health plans.
- Establish and maintain a strong surveillance and evaluation effort.
- Regularly report on progress to all stakeholders and policymakers.
- Commit resources to ensure that oral health programs and systems include staff with sufficient time, expertise, and information systems, and address oral health needs.

Next Steps

This *National Call To Action To Promote Oral Health* provides the basis for integrating efforts of current and future members of the Partnership Network to facilitate improvement of the nation's health through oral health activities The five actions outlined in this report require public-private partnerships at all levels of society and a commitment from those who are involved in health programs to contribute expertise and resources. The Partnership Network members will serve to foster communication and collaborations and will act as a forum to measure progress toward these actions in coordination with the *Healthy People 2010* initiative.

Appendix 1

Partnership Network Members (as of November 2001)

Academy of General Dentistry

American Academy of Pediatrics

American Academy of Pediatric Dentistry

American Association of Public Health Dentistry

American Association of Women Dentists

American College of Nurse-Midwives

American Dental Association

American Dental Hygienists' Association

American Dental Trade Association

American Dental Education Association

American Medical Association

American Public Health Association

American Society of Dentistry for Children

Association of Maternal and Child Health Programs

Association of Academic Health Centers

Association of Clinicians for the Underserved

Association of Maternal and Child Health Programs

Association of Schools of Public Health

Association of State and Territorial Health Officials

Association of State and Territorial Dental Directors

Bureau of Dental Health, New York State Health Department

Campbell Hoffman Foundation

Center for Child Health Research

Children's Defense Fund

Children's Dental Health Project

Colorado Department of Public Health and Environment Oral Health Program

Connecticut Health Foundation

Consumer Health Care Products Association

Delta Dental Plans Association

Delta Dental/Washington Dental Service

DENTSPLY InternationalFamilies USA

Family Voices (Federation for Children with Special Needs)

Friends of NIDCR

Colgate Palmolive Company

Grantmakers In Health

Henry Schein, Inc.

Hispanic Dental Association

Illinois Department of Public Health

International Association for Dental Research, American Association for Dental Research

Maryland Department of Health and Mental Hygiene

National Oral Health Policy Center

Minority Health Communications

National Association of Child Advocates

National Association of Children's Hospitals

National Association of Community Health Centers

National Association of County and City Health Officials

National Association of Local Boards of Health

National Association of State Medicaid Directors

National Maternal and Child Oral Health Resource Center

National Conference of State Legislatures

National Dental Association

National Foundation for Ectodermal Dysplasias

National Governors' Association

National Health Law Program

National Health Policy Forum

National Association of Urban-Based HMOs

New York State Department of Health

Oral Health America

Reforming States Group

Research America

Ronald McDonald House Charities

Special Olympics and Special Olympics University

The Children's National Medical Center

The Robert Wood Johnson Foundation

The Rotunda

Urban Institute Health Policy Center

Washington Dental Service Foundation

W.K. Kellogg Foundation

Women's and Children's Health Policy Center

Appendix 2
What People Said

The sections that follow are derived from the presentations of individuals and organizations at the five regional listening sessions held during winter and spring 2002 and from the written testimony received. The issues identified in the Surgeon General's Report were restated in terms of objectives and grouped into five objectives: 1. Change perceptions, 2. Overcome barriers, 3. Enhance research and its application, 4. Strengthen infrastructure, and 5. Expand partnerships. These objectives formed the basis for summarizing the testimony and for the Actions described in the text. By describing general approaches as well as some specific programs and projects underway, this appendix can serve as a resource to aid responses to the *Call To Action*. Some programs might lend themselves to replication at other sites; others may inspire new and ingenious plans, programs, and partnerships. As background, each of the five objectives is preceded by a text box quoting relevant portions of *Oral Health in America: A Report of the Surgeon General*.

While it was expected that many of those who testified came from segments of the oral health community, it was especially gratifying that many of the respondents spoke from other perspectives. They were community leaders, concerned citizens, representatives of health voluntary organizations, and other nonprofit organizations and foundations, and employees of public agencies at all levels of local, state, and federal government.

A Rich Repertoire...

The listening sessions exemplified the kind of democracy-in-action associated with town meetings in America. The people who attended reflected the racial and ethnic diversity of the community's population and demonstrated the degree of innovation and creativity Americans can achieve when committed to resolve critical health issues. Participants were ingenious in describing coalitions, partnerships, and funding opportunities involving all kinds of entities: a community church working with the local dental society, a state health agency cooperating with a private foundation and volunteer dental professionals, a dental insurance corporation subsidizing treatment costs to improve access to services for poor people, school nurses working with parents, dental hygienists, and local dentists to implement dental screening programs and referrals for care, and private philanthropies financing mobile vans to reach people in remote areas. Several organizations detailed how they had competed for small federal grants, which they used to plan and conduct pilot programs. Several dental schools described using private foundation grants to fund community outreach programs utilizing dental students. Clearly there is no one-size-fits-all remedy to the health problems that the nations' communities and populations experience.

...but an Uncertain Future

However, not every program was a demonstrable success. Indeed, more than one presenter expressed concern that their efforts were piecemeal and the future was cloudy: programs could last only as long as the resources and funding. In one case, a program that was built on the promise of partial support had to cease when state funding was cut back. Thus the listening sessions were also a declaration that more long-term strategies must be pursued and public awareness of the importance of oral health must grow. The commitment of communities to build the public-private partnerships by expending the social, political, and economic will at federal, state, and local levels can yield long-lasting health benefits for all community members.

Testimony Highlights

Objective 1: Change perceptions of the public, policymakers, and health providers regarding oral health and disease so that oral health becomes an accepted component of general health.

What the report said

The mouth is the major portal of entry to the body and is equipped with formidable mechanisms for sensing the environment and defending against toxins or invading pathogens. In the event that the integrity of the oral tissues is compromised, the mouth can

become a source of disease or pathological processes affecting other parts of the body

that can reveal signs of disease, drug use, domestic physical abuse, harmful habits or addiction such as smoking, and general health status. Imaging...may provide oral signs of skeletal changes such as those occurring with osteoporosis and musculoskeletal disorders, and may also reveal salivary, congenital, neoplastic, and developmental disorders. Oral-based diagnostics are increasingly being developed and used as a means to assess health and disease without the limitations and difficulties of obtaining blood and urine.

Oral diseases and disorders in and of themselves affect health and well-being across the life span. They include the common dental diseases, dental caries and the periodontal diseases, and other oral infections, such as cold sores and candidiasis, as well as birth defects occurring in infancy and chronic craniofacial pain conditions and oral cancers seen in later years....

Diseases and disorders that result in dental and craniofacial defects damage self-image, self-esteem, and well-being. Oral-facial pain and loss of sensori-motor functions limit food choices and the pleasures of eating, restrict social contact, and inhibit intimacy... .Patients with oral and pharyngeal cancers may experience loss of taste, loss of chewing ability, difficulty in speaking, pain, and the psychological stress and depression associated with disfigurement.

Oral complications of many systemic diseases also compromise the quality of life, Problems of speaking, chewing, taste, smell and swallowing are common in neurodegenerative conditions such as Parkinson's disease; oral complications of AIDS include pain, dry mouth, and Kaposi's sarcoma; cancer therapy can result in painful ulcers, mucositis, and rampant dental caries; periodontal disease is a complication of diabetes and osteoporosis. Prescription and non-prescription drugs often have the side effect of dry mouth.

Oral infections can be the source of systemic infections, especially in people with weakened immune systems, while oral signs and symptoms are often a significant feature of a general health problem, such as the autoimmune disease, Sjøgren's syndrome.

Most intriguing of all, are associations reported between chronic oral infections and serious health problems, such as diabetes, heart and lung disease, and adverse pregnancy outcomes. Investigators are actively engaged in research to confirm initial findings and discover the mechanisms involved.

Source: U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. pp.133, 283-284.

Addressing the Issue

The testimony reinforced the concept that oral health is secondary and separate from general health is one that is deeply ingrained in American consciousness and hence may be the pivotal and most difficult barrier to overcome. Cultural historians can point to a tradition in Europe and America in which dentistry was long associated with tooth extractions performed by itinerant surgeons who were reviled as charlatans, despised as sources of acute pain and suffering, and abundantly caricatured in art and literature. Something of this stigma associated with dentistry and its practitioners remains today, not only in terms of the way the profession is popularly depicted in filmsand comedy routines, but also in terms of its ranking in the hierarchy of health and medical specialties. The very fact that dental education was established separately from medical training, as was the practice of dentistry, may have unwittingly contributed to the stigma—and may also in part account for why a lack of perceived need remains one of the major reasons that many people do not seek regular dental care. Thus, efforts to achieve acceptance of the intrinsic importance of oral health and its interdependence with general health must be directed to medical practitioners and other health professionals and researchers, as well as to educators, policymakers, and the general public. This point was brought home to attendees at one regional meeting during which a woman testified that in all her years as a diabetic patient in

which her physicians referred her to specialists such as ophthalmologists and neurologists for potential diabetes complications, no one had ever once suggested that she see a dentist concerning her oral health status. At another hearing it was reported that medical residents in a prenatal clinic were interested to learn that women with moderately severe periodontal disease might be at risk for pre-term and low birth weight infants. Even with that knowledge, however, they would not act on any new findings such as these, without an official recommendation from the American College of Obstetricians and Gynecologists.

"No physician or other medical specialist I saw ever suggested I see a dentist."

-- a woman with diabetes

Associations between oral infections and systemic conditions continue to be reported, and if the results of studies prove a cause-effect relationship, their widespread communication may very well effect a significant change in the practices and programs of health professionals as well as policymakers and the general public. In the meantime, the various programs described at the listening sessions to explain the oral health-general health connection are helping to make a difference. In so doing, they also reveal to what extent otherwise well-educated Americans, even health care providers, are uninformed about the multiple defense, repair, and maintenance functions performed by oral tissues as gatekeepers to the body, the fine-tuned sensory-motor skills of orofacial nerves and muscles, and the necessary role of oral hygiene and nutrition in keeping oral tissues healthy.

Listening session participants gave a number of examples of public relations awareness campaigns conducted at local and state levels, the exemplary use of public service announcements, and even dental product infomercials on the Internet with educational content.

Model programs in which volunteer oral health professionals educate segments of the population at the places where they congregate -older Americans at senior centers, primary grade students in school, pregnant women seen in prenatal clinics- offer the possibility of stimulating high interest by tailoring the message to the specific oral health problems and appropriate interventions for the given audience. Programs that test training methods for nurses and physicians to conduct oral health evaluations, make appropriate dental referrals, and apply preventive interventions such as fluoride varnishes or dental sealants were seen as ways to integrate oral health services with medical care and pave the way for a time when such practices will be routinely accepted. An example of a well-thought-out awareness campaign was the Watch Your Mouth program in Washington state, which used radio and print advertisements to educate the public on the importance of oral health. The campaign also included an evaluation component allowing before-and-after statistical analyses of effectiveness.

With regard to educating policymakers, there is no question that the advocacy of members of consumer and health voluntary organizations (e.g., Sjögren's Syndrome, March of Dimes, The Temporomandibular Joint Association, National Foundation for Ectodermal Dysplasias) as well as oral health research and professional organizations, has done much to inform and raise the consciousness of these leaders and with positive effects. These advocates have used persuasive and well-documented arguments concerning the impact of oral health—and its lack—on the health, education, financing, and productivity of large segments of the constituencies the legislators represent. On the principle of strength through numbers, coalitions of such groups, especially partnering oral health patient organizations with medical disease organizations (e.g., heart, cancer, diabetes, arthritis) might achieve a greater impact, while underscoring that oral health and general health are inextricably linked.

Changing the Paradigm

Nonetheless, no matter how well meaning and constructive local, state, and regional efforts at changing perceptions have been, the best route to overcoming the cultural, historical, legal, and structural impediments to accepting oral health as essential to general health and well-being may be to create a broad awareness and education program that would be coordinated at the national level. This program could foster the necessary paradigm shift in perception. Such a program--supported by a broad

coalition of patient and consumer groups, private and public research and practitioner organizations--could achieve collectively what no one group has yet been able to achieve singly.

Objective 2: Remove known barriers between people and oral health services.

What the Report said:

This report presents data on access, utilization, financing, and reimbursement of oral health care; provides additional data on the extent of the barriers, and points to the need for public-private partnerships in seeking solutions. The data indicate that lack of dental insurance, private or public, is one of several impediments to obtaining oral health care and accounts in part for the generally poorer health of those who live at or near the poverty line, lack health insurance, or lose their insurance upon retirement. The level of reimbursement for services also has been reported to be a problem and a disincentive to the participation of providers in certain public programs.

Source: U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. p. 286.

Addressing the Issue

Concern about barriers to care was by far the issue that most engaged speakers at the *Call To Action* listening sessions, eliciting the widest range of proposals and programs. There was unanimous agreement that rates of reimbursement for oral health care under the Medicaid program are low and, as a result of many state budget shortfalls in recent years, will be subject to further cuts. These budgetary limitations have also affected State Children's Health Insurance Programs, in which dental care is only an option. States that have made concerted legislative efforts to raise Medicaid reimbursement rates to levels consistent with customary fees in the area have seen improvements in the number of poor patients served and providers willing to treat patients covered under Medicaid. Speakers also expressed hope that Medicare, which specifically excludes dental services other than in exceptional cases, such as when dental care is integral to treating a medical condition, could some day be expanded to cover oral health care for seniors.

"When did we allow dental care to become medically unnecessary in the first place?"

--An advocate for special care dentistry

While participants argued for coordinated and large-scale efforts at legislative and corporate reforms to extend coverage and improve oral heath care benefits for Americans who lack dental insurance or have extremely limited coverage, a number of speakers described programs and demonstration projects targeted to particular risk groups. Rather than wait for policy changes and insurance reforms, they saw the urgency to create innovative access and delivery programs to serve poor children, members of racial and ethnic minorities, the elderly, rural residents, or individuals with disabilities and other special care needs. A few examples of targeted programs that have been launched in recent years have been chosen from the listening sessions to illustrate their variety and are described below. Subject to evaluation of their overall effectiveness and cost, they might be adapted to other venues. In all cases, it was clear that it was the dedication and drive of a few key individuals determined to turn dreams into realities that enabled these programs to be implemented. Whether a school nurse or principal, a health agency official, dental hygienist, a clergyman, academic faculty member, practicing dentist or physician, a private foundation director, or a local community leader, these were people who sought out and obtained the trust, cooperation, commitment, and funding from multiple sources to get their programs going and keep them going.

A dental school-based program for children with special care needs. The College of Dental Medicine of the Medical University of South Carolina in Charleston developed a demonstration project that provided the screening and referral of children to a state-wide network of dentists willing and able to treat children with complex care needs. Administrators have used this

project to enrich the education of dental students through clinical rotations and an expanded special care curriculum and to increase the competencies of practicing dentists to serve special care patients through continued education courses. The project has also advanced research by collecting data on the oral health problems seen in special care patients and by correlating these problems with the underlying health problem. The project resulted in greatly increased services, the publication of a dental directory for parents, and an extension of special care seminars and courses for other health professionals and administrators.

"A hallmark of successful programs is community-level involvement"

--A community volunteer

SABER promotora model. Much of the appeal of this model is its grassroots origin in a Hispanic community in southern California. As the program director indicates, "The model is based on naturally occurring networks and linkages that exist in the Latino community." Promotoras are community health advocates who serve as role models for behavior change and work in traditional ways to provide culturally appropriate dental health education and information, while promoting the bonding of neighbors, friends, and family.

Meeting the needs of rural communities. "Rural communities are the canaries in the workforce coal mines," was the way one federal dentist described the ever-growing shortage of dental care providers in rural and frontier communities. These communities are also unlikely to have access to a fluoridated water supply and adequate transportation to larger cities and towns. What is impressive is how some communities have taken it upon themselves to meet the challenges. For example, three rural communities in New York State have each implemented a different approach to the provision of care: a mobile dental clinic, a primary care-based dental clinic at a critical access hospital, and a freestanding satellite dental clinic. These facilities reflect the commitment of partners that included community and consumer groups, foundations, dental associations, hospitals, government agencies, and the dental school of the State University of New York at Buffalo.

Care for institutionalized elderly. A nonprofit charitable organization, Apple Tree Minnesota, was first designed to serve indigent elderly living in institutions and has since been expanded to serve poor children. The program brings dental care to individuals through mobile dental vans that work out of stationary clinics as hubs. The program also conducts needs assessment to support a role in public policy development and advocacy and creates regional advisory councils to develop grassroots advocates. The program has been replicated in other states, but because funding for care comes from Medicaid there have been severe shortfalls, which must be made up by seeking other sources of revenue.

An Indian Health Service prenatal dental education program for Native American mothers. This Oklahoma program was designed to provide oral health care to expectant mothers and to advise them on ways to prevent early childhood dental caries by adopting appropriate feeding practices to their babies and teaching appropriate oral hygiene for newborns (as well as the mothers). The program has a strong evaluation component that includes follow-up interviews with participants. Such a program provides an opportunity for integrating oral health education and services in a hospital where women are already being seen in an obstetrics unit.

Private practitioners reach out. The Georgia Dental Association in partnership with the Georgia Medicaid agency were effective at the level of the legislature and governor in increasing the state's investment in oral health. In 2002 Georgia was the only state to receive an increase in Medicaid funding for dental care – a 3.5 percent increase in provider reimbursement rates. Georgia also successfully reduced administrative barriers, such as prior authorization requirements and burdensome provider applications. As a result, the number of dentists signing up to provide care to Medicaid patients continues to increase. Dentists themselves orchestrated a Medicaid promotional campaign called Take 5, encouraging each dentist to take on five new Medicaid patients.

Objective 3: Accelerate the building of the scientific and evidence base and accelerate the application of research findings to improve oral health.

What the Report Said

The science base for dental diseases is broad and provides a strong foundation for further improvements in prevention; for other craniofacial and oral conditions the base has not reached the same level of maturity...The nation's continued investment in research is critical for the provision of new knowledge about oral and general health and disease...However the next steps are more complicated. The challenge is to understand complex diseases caused by interaction of multiple genes with environment and behavioral variables—a description that applies to most oral diseases and disorders—and translate research findings into health care practices and healthy lifestyles. At present there is an overall need for behavioral and clinical research, clinical trials, health services research, and community-based demonstration research. Also, development of risk assessment procedures for individuals and communities and of diagnostic markers to indicate whether an individual is more or less susceptible to a given disease can provide a basis for formulating risk profiles and tailoring treatment and program options accordingly.

Source: U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. p.284-285.

Addressing the Issue

Support for continued research to advance oral health science, particularly in exploring the oral health-general health connection, was implicit in the testimony of many individuals addressing the *Call To Action*. Clearly, additional well-designed research studies that can explore the role of chronic oral infections as risk factors for adverse pregnancy outcomes, poorly controlled diabetes, heart and lung diseases, and the potential role of oral infections in other conditions are needed. The major private oral health research organization, the American Association for Dental Research (AADR), stated that it was committed to promoting the goals of the *Call To Action* and is encouraging its section members to follow up with symposia at annual meetings. Also, the research agenda of the American Dental Association sets out many of the profession's research needs and can be used as a blueprint for research studies.

Many who testified at the listening sessions concentrated on the need to put research into practice. They spoke as community leaders, care providers, directors of clinics and public health and health care financing agencies, and as representatives of dental schools, schools of dental hygiene, and dental societies. Participants expressed frustration that known ways of preventing oral disease and promoting oral health are still not being adopted by individuals and communities, often where the needs are greatest. Many noted that in the 21st century, over a third of Americans fail to enjoy the benefits of community water fluoridation—one of the most effective and inexpensive means of preventing dental caries. Similarly, the need to increase applications of dental sealants and topical fluorides were emphasized. In addition, the need for epidemiology and surveillance studies to determine the scope of oral health problems and project future service needs at local, state, and national levels was stressed. There was also a call for expanding health services research and the use of outcomes measures to determine the effectiveness and cost-effectiveness of various prevention and treatment modalities as well as ways of delivering oral care services. Calls for the adoption of a universal oral survey assessment form and for research to develop diagnostic markers and other measures of risk assessment were also strongly recommended as ways to facilitate surveillance and epidemiology studies as well as providing optimal tailor-made oral health care to patients.

Comments made at the listening sessions highlighted the need for further research on biomaterials and their health effects, as well as on the science transfer of proven dietary preventive measures. For example, there was some discussion of the use of xylitol and other cariostatic sugar substitutes to prevent dental

Objective 4: Ensure the adequacy of public and private health personnel and resources to meet the oral health needs of all Americans and enable the integration of oral health effectively with general health. The focus is on having a responsive, competent, diverse, and flexible workforce.

What the report said

The public health capacity for addressing oral health is dilute and not integrated with other public health programs ..Local, state, and federal resources are limited in the personnel, equipment, and facilities available to support oral health program. There is also a lack of available trained public health practitioners knowledgeable about oral health As a result, existing disease prevention programs are not being implemented in many communities, creating gaps in prevention and care that affect the nation's neediest populations...cutbacks in many state budgets have reduced staffing of state and territorial dental programs and curtailed oral health promotion and disease prevention programs.

There is a lack of racial and ethnic diversity in the oral health workforce. Efforts to recruit members of minority groups to positions in health education, research, and practice in numbers that at least match their representation in the general population not only would enrich the talent pool, but also might result in a more equitable geographic distribution of care providers.

A closer look at trends in the workforce discloses a worrisome shortfall in the numbers of men and women choosing careers in the education of oral health professionals and the conduct of oral health research.

Source: U.S. Department of Health and Human Services *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. p.286.

Addressing the Issue

If anything, testimony at the regional listening sessions affirmed that the oral health infrastructure has continued to deteriorate with additional shortfalls in personnel and budgets. Within the public sector, it is essential to have a strong federal oral health infrastructure that provides stability and support for state public oral health efforts. These state programs can then advise and provide technical assistance to community oral health programs The Centers for Medicare and Medicaid Services has appointed a dental officer in recognition of the importance of having an oral health expert who can stimulate effective and efficient programs at the state and local levels as they relate to Medicaid and the State Children's Health Insurance Program. But the shortfall of oral health expertise in other state and federal agencies—individuals who can stimulate, facilitate, and ensure strong public-private partnerships—is critical. At present, 12 out of 50 states and 7 territories lack a permanent full time dental director. A similar lack of dental public health expertise exists in state agencies managing multi-million dollar Medicaid programs and the State Children's Health Insurance Program. The only remedy to this problem is to employ enough staff to enable states to conduct essential public health activities. One spokesperson defined the "minimum staffing requirement" to include dental public health experts and a support staff of epidemiologists, dental hygienists, public health educators, and information resource managers. Their collective expertise is essential to conduct needs assessments, surveillance studies, maintain databases such as the National Oral Health Surveillance System, identify dental shortage areas and underserved populations, and develop, implement, and evaluate preventive programs and state oral health plans.

Many public health programs and activities rely for their performance on long-established partnerships with other public health agencies and with private sector dental practitioners. Indeed, public health dentists also frequently serve as faculty members of dental schools, teaching dental public health classes. But absent an authoritative oral health administrator within critical state health agencies--a central hub--the system falls apart and the public's health suffers.

Turning to the problems of personnel needs within the education, research, and practitioner community, there was widespread support for programs to expand recruitment, especially of racial and ethnic minority dental students, by easing dental school indebtedness through loan repayment programs, the quid pro quo variously being willingness to serve in dental shortage areas, treat underserved and Medicaid patients, or participate in federal oral health research activities. State practice act changes that would allow a more flexible and efficient workforce were recommended. Some listening session participants argued for greater autonomy in practice rules, emphasizing the educational and preventive services they could perform in non-traditional sites such as nursing homes and schools, if they were free to practice under general dentist supervision. Dental hygienists and non-dental health professionals offered alternative approaches to care delivery, providing examples of how they can contribute to meeting oral health needs at the local and state levels through screenings, patient education, and preventive care.

Objective 5: Expand public-private partnerships and build upon common goals to improve the oral health of those who suffer disproportionately from oral diseases.

What the Report Said

The collective and complementary talents of public health agencies, private industry, social service organizations, educators, health care providers, researchers, the media, community leaders, voluntary health organizations and consumer groups, and concerned citizens are vital if America is not just to reduce, but to eliminate, health disparities. This report highlights variations in oral and general health within and across *all* population groups. Increased public-private partnerships are needed to educate the public, to educate health professionals, to conduct research, and to provide health care services and programs. These partnerships can build and strengthen cross-disciplinary, culturally competent, community-based, and community-wide efforts and demonstration programs to expand initiatives for health promotion and disease prevention programs.

Source: U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. p.286.

Addressing the Issue

The establishment of the Partnership Network in the development of the *National Call To Action To Promote Oral Health* exemplifies how well this objective has been taken to heart. The partners will play a key role in disseminating the goals and objectives of the *Call To Action* and, as discussed in the final section, can propose how best to monitor and provide oversight in the implementation of the actions proposed.

In addition, abundant evidence from the listening sessions provides further examples of the creative public-private partnerships that are already being forged at all levels of community, state, and federal government. To facilitate partnership building, several sources can be mentioned that have been helpful in enabling groups to come together to develop oral health programs. For example, the Health Resources and Services Administration (HRSA) provided support for state dental health agencies to hold state summits, where interested private and public groups can come together to assess needs and opportunities. Other states have used technical assistance provided by the National Governors Association to convene problem-solving teams to develop state oral health plans.

Several states have received grants from the Centers for Disease Control and Prevention to improve basic oral health services, including support for program leadership, monitoring oral health risk factors, and developing and evaluating prevention programs. HRSA has a new cooperative agreement program where dental faculty train general pediatric and family medicine residents to provide basic components of oral health assessments to children from birth to five years who are medically or dentally underserved and at high risk for oral health problems. The National Institutes of Health also has a grant program targeted to health professional schools for enhancing faculty research skills and enriching curricula. Foundations such as the

Robert Wood Johnson, W. K. Kellogg, and The Pew Charitable Trust are among a number of private foundations concerned with health and health care in America that have supported health services research and demonstration projects. Grantmakers In Health has provided guidance to the broad array of foundations all across the nation by highlighting private and public sector initiatives to meet oral health challenges and suggesting additional strategies involving foundation participation.

Certainly the media can be enlisted in alerting the public to oral health concerns; they have been and can continue to be a lightning rod in many areas of health, especially in terms of populations at risk. Often their accounts name individuals and organizations that are actively engaged in the health issues in question. Among them are consumer groups and health voluntary organizations, which have played significant roles in raising awareness, expanding research, and improving care and treatment. Often these organizations have started as grassroots groups formed by a few individuals and families concerned with a health problem and have grown into effective national and international organizations.

The enthusiasm and commitment demonstrated by the scores of attendees at the regional listening sessions and from the many written submissions are testimony that a critical mass of Americans view oral health as a priority and need. They demonstrated and expressed the willingness and ability to be recruited to work as partners to achieve the vision and goals of the *National Call To Action To Promote Oral Health.*

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[1] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000:2-3. (http://www.nidcr.nih.gov/)

[2] U.S. Department of Health and Human Services. *Healthy People 2010.* 2nd ed. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000. (http://www.healthypeople.gov/)

[3] Interventions to Prevent Dental Caries, Oral and Pharyngeal Cancers, and Sports-related Craniofacial In- juries: Systematic Reviews of Evidence, Recommendations from the U.S. Task Force on Community Preventive Services, and Expert Commentary. *Am J Prev Med* 2002; 1-84; 23(1S)

[4] U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services*, 2nd Edition, Williams and Wilkins, Baltimore. 1996; 953p.

[5] Brown LJ, Lazar V. Minority dentists: why do we need them? Closing the gap. Washington Office of Minority Health, U.S. Department of Health and Human Services; 1999 Jul. p.6-7.

Johnson, Melanie [IDB]

From: Miriam Burk [burkmiriam@yahoo.com]
Sent: Tuesday, January 01, 2013 6:05 PM
To: Johnson, Melanie [IDB]
Subject: Including day care centers under public health supervision
Attachments: day care centers public health agreement.docx

Melanie,

I am sending a letter as an attachment to be included in the testimony on January 8th at the IDB public hearing. Thank you.

Miriam Burk, RDH

Miriam Burk, RDH
340 South Downey St
Walcott, IA 52773

January 1, 2013

Melanie Johnson
Executive Director Iowa Dental Board
400 SW 8th St
Des Moines, IA 50309-4687

Dear Melanie,

I understand that the IDB will be holding a public hearing on January 8th, 2013 to hear testimony about whether to add day care centers to the list of settings where a dental hygienist could provide services under Public Health Supervision. I am unable to attend this hearing on the 8th but plan to come to the IDB meeting on the 10th of January.

Public Health Supervision has been successful in building on Iowa's private practice dental profession along with public health providers to enhance access to quality oral health care. In 2011 however, 55,540 Medicaid enrolled children ages 0-2 did not see a dentist and 24,143 children ages 3-5 did not. My grandson is a Medicaid enrolled child that attends daycare while his mom (my daughter) is either at work or attending college classes. I know that there is still an access to care issue in Iowa. I have seen this personally whether it is an issue of transportation or the fact that one can not afford to miss college classes or work to take their child to the dentist. I feel it should be an easy decision for the IDB to include day care centers in the list of settings where dental hygienists can provide services under Public Health Supervision. To be honest, I am not quite sure why it hasn't been included already.

Thank you for taking the time to hear my opinion on this matter.

Sincerely,

Miriam Burk, RDH

Johnson, Melanie [IDB]

From: Mary Jo knowles [mzzz72@hotmail.com]
Sent: Thursday, January 03, 2013 9:01 AM
To: Johnson, Melanie [IDB]
Subject: Public Health supervision
Attachments: dental board.docx

I have attached a letter for support of the Public Health supervision to include the daycares.
Mary Jo Zern.

I am a dental hygienist that works at Community Health Center Dental Clinic in Southeast Iowa , which is a federally qualified health center . I also work as a dietitian at WIC clinics, where other dental hygienists do oral screening.

At the dental clinic we have seen many of the children that have been referred from the WIC , Head Start , and daycare centers from the dental hygienists in the I-Smile program. Many of the children do have Medicaid, but no other dental providers will accept this coverage. At the WIC clinic I see children from infants to age five. The infants do not always get off the bottle at age one. The sippy cup is used in bed or through the day with flavored milk, juice and fruit drinks. Many children drink bottled water without fluoride that also makes them at risk. It is very crucial from age 1-3 to be seen by a dental professional. With the benefit of education and fluoride varnish done by a dental hygienist at this age, all available opportunities including daycares are beneficial. The Public Health supervision of dental hygienist has increased access to dental health care. Prevention of dental caries is important to prevent dental treatment with extensive time at a dental office or hospital setting. Education, prevention and a referral to dentist at an early age is crucial.

From personal experience, I have seen many children with numerous dental needs. Not everyone goes to Head Start and WIC clinics. There will be more children at daycare centers that could be reached for dental care access.

Mary Jo Zern , RDH. RD.

Johnson, Melanie [IDB]

From: Mary Kay Brinkman [marykay.brinkman@q.com]
Sent: Thursday, January 03, 2013 4:11 PM
To: Johnson, Melanie [IDB]
Subject: [L2SPAM] Public Comment on proposed rule change: Public Health Supervision of Hygienists - adding ECI and daycare

Importance: Low

Hi Melanie,

I would like to submit my comments concerning the proposed amendment to the public health settings for dental hygienists practicing under public health supervision. I **strongly agree** with adding day care centers as a public health setting in which dental hygienists can provide oral health services under their public health supervision agreements. The key to reducing oral disease among Iowa children is to screen for problems early and educate both parents and caregivers about the importance of good oral health. Daycare centers are an ideal place to provide these services. I would advocate to include all *licensed* day care centers. Licensed daycare providers must take continuing education and the I-Smile Coordinators in Iowa have been working with the Child Care Resource Centers to include oral health education. Screening and providing fluoride varnish would be an excellent next step.

Amend subrule 10.5(1) as follows:

10.5(1) *Public health settings defined.* For the purposes of this rule, public health settings are

limited to schools; Head Start programs; programs affiliated with the early childhood Iowa (ECI)

initiative authorized by Iowa Code chapter 256I; day care centers (excluding home-based day care

centers); federally qualified health centers; public health dental vans; free clinics; nonprofit community

health centers; nursing facilities; and federal, state, or local public health programs.

Thank you for considering this important change.

Mary Kay Brinkman RDH, BS

3400 Melanie Dr.

Urbandale, IA 50322

515-278-9073

Johnson, Melanie [IDB]

From: David Miller [dnmiller@myomnitel.com]
Sent: Friday, January 04, 2013 9:21 PM
To: Johnson, Melanie [IDB]
Subject: letter of testimony for Jan. 8th IDB hearing
Attachments: Personal letter to IDB.docx

Hello Ms. Johnson,

Please include this letter with those submitted for the January Iowa Dental Board hearing regarding public health RDHs providing services in day care centers.

Thank you,

Nancy Miller, RDH, BS

Nancy G. Miller, RDH, BS
1898 Zinnia Avenue
Rockford, IA 50468
#641-749-2604
RDH License #895

January 3, 2013

Melanie Johnson, JD
Executive Director, Iowa Dental Board
400 SW 8th Street
Des Moines, IA 50309-4687

RE: Letter supporting RDHs providing services in day care centers under PH Supervision Agreements

Dear Ms. Johnson:

I am writing this letter for the upcoming January 8th hearing.
I support the inclusion of day care centers as a setting dental hygienists can provide services under the public health supervision agreements.

I am a dental hygienist who has practiced for thirty seven years, most of which has been in private practice. In 1980, I was very fortunate to have the opportunity to work for a year and a half in a public health setting in a well child clinic in Muscatine, Iowa. The children I screened either had decay or had the potential for decay. I was able to influence care-givers as well as the children. It was not unusual to see babies fed with bottles filled with Kool-aid or other sweetened beverages. It was an eye-opening experience for me to realize the lack of dental health knowledge amongst parents and care-givers.

This experience helped me understand the importance of the preventive role of dental hygienists in public health settings. Not only do hygienists provide necessary preventive services but they are the link for many children to receive needed dental care by a referring dentist. At the dental office where I am employed, we have a waiting list of Medicaid and low-income customers who will be accepted for treatment; only a limited number are allowed each month and only those already screened by the public health dental hygienist are included on this list. We still receive phone calls daily from Medicaid eligible customers desiring an appointment.

I feel that increasing the settings where dental hygienists can reach more dentally underserved populations will only help increase access to dental care for Iowa's children. Statistics showing the increased numbers of children served by hygienists and referred dentists can be seen by viewing the reports collected by public health agencies. These reports can be viewed on the Oral Health Bureau of the Iowa Department of Public Health website. On the website, there is a sentence that states the important role the dental hygienist has – "Preventive dental services are particularly important to reduce overall disease and, in turn, current and future treatment costs."

Thank you for serving on the Iowa Dental Board and for your role in protecting the citizens of Iowa.

Sincerely,

Nancy G. Miller

Johnson, Melanie [IDB]

From: Susan R. Hyland [klas-hyland@juno.com]
Sent: Sunday, January 06, 2013 10:08 PM
To: Johnson, Melanie [IDB]
Subject: PH Supervision & Daycare Centers

Ms. Johnson,
I support for Public Health Supervision & Adding Daycare Centers to PH Supervision Site List.
Access to dental care is a complex problem without a simple solution. Public Health Supervision for dental hygienists is an important part of the development of a solution.
The Delta Dental Foundation held an event on November 30, 2012: *Educate, Motivate, Activate: Access to Oral Health Care for Aging Iowans.* ***At the event, the Delta Dental of Iowa Foundation introduced their 2020 Strategic Plan.*** ** The presentations included Best Practices in Iowa and across the country to improve oral health access (focusing on the elderly, but showed programs and technology used to provide services in the community). Two concepts were presented by multiple speakers:*

- ***It is necessary to provide services where people Live, Work and Play.***
- ***The Models included Dental Hygienists working under public health supervision or other collaborative agreements allowed in their states.***

Most public health dental hygienists in Iowa are working for Title-5 public health agencies, Federally Qualified Community Health Centers and Non-profit Community Health Centers. These hygienists deliver essential Preventive Services, Education, and refer these individuals to dentists.
According to the 2011 I-Smile report nearly 110,000 Iowa children between the ages of 0-12 received a dental service from a dentist in 2011, a 54% increase over 2005 numbers.
The same report indicates that over 26,000 Iowa children, ages 0-12, received a dental service from a Title V contractor, a 231% increase since 2005.
Adding Daycare Centers to the list of PH Supervision Sites:
1. Many low-income families receive childcare assistance to attend daycare centers that participate in this assistance program.
2. Screenings at these centers provide an opportunity to encourage routine dental exams and identify children with suspected treatment needs while providing preventive services.
3. Many of the families qualify for Medicaid, but have trouble finding a provider for a couple of reasons: few providers accept new Medicaid patients and many providers will not see children until they are 3-5 years old.

As a dental hygienist and an Iowa citizen, I firmly believe that access to dental care especially preventive services must be increased. Efforts to limit PH Supervision are not in the best interest of the Iowa citizens we serve.

Susan R. Hyland, RDH, BSDH
Iowa Dental Hygienists' Association
Lutheran Women in Missions
Tap Dancing Dental Hygienist
klas-hyland@juno.com

Johnson, Melanie [IDB]

From: tena geis [tena.geis1@gmail.com]
Sent: Monday, January 07, 2013 10:58 AM
To: Johnson, Melanie [IDB]
Subject: [L2SPAM] public hearing testimony
Attachments: Iowa Dental Board public health supervision.docx

Importance: Low

Please find attached my support of the inclusion of day care centers to the Public Health Supervision Agreement, Thank you, Tena

January 7, 2013

Dear Iowa Dental Board:

I am writing in regards to the public hearing to be held tomorrow, January 8, 2013 regarding the inclusion of Day Care centers in the Iowa Dental Hygienist's Public Health Supervision Agreement.

I am in complete support of this proposal to include qualifying day care centers in this agreement. As a former Dental Hygiene Professor that taught Community Health and now in my position as Dental Program Director at a Federally Qualified Health Center, I am very familiar with the access to care issues faced by all ages in our state, especially the children.

Daily, in our clinic, we experience small children with great dental needs. We try to treat most of these children, but many times the child is too small or the decay too extreme to manage well in our clinic and they must be referred to a specialty practice. Any and all efforts to reduce this amount of decay experienced by these populations will result in great benefits to all. Education, risk identification, and facilitating finding available providers can result in earlier intervention and better outcomes.

Because many of this population deal with transportation issues, difficulties missing work and language barriers-to name just a few of the barriers, preventive services provided at the day care center will help to reduce some of the barriers these children face. Our dental hygienists are skilled and educated to professionally and competently provide these services.

I urge you to support this proposal to help improve the status of oral health in our youngest and most vulnerable population.

Tena Geis, RDH, MA

Ankeny, IA 50023

515-257-8695

Johnson, Melanie [IDB]

From: Dawn Doore [ddoore@yahoo.com]
Sent: Monday, January 07, 2013 2:01 PM
To: Johnson, Melanie [IDB]
Subject: dental board decision letter
Attachments: board letter.docx

Melanie,

I am a public health dental hygienist in Southeast Iowa. I have attached a letter which you may present to the dental board tomorrow. Sorry it took me so long but I wanted to make sure I had my thoughts together. I hope this will help get this change to the public supervision agreement sites changed. I would love to be able to see children in all kinds of settings. Hopefully this will be a stepping stone to more access to dental care in the state of Iowa.

Thank you for bring this to the board.

Dawn T. Doore, RDH

Dawn T. Doore, RDH
3223 Timberline Drive
Keokuk, IA 52632
319-795-2376

To the Iowa Dental Board Members,

I am writing this letter to encourage you to consider adding daycare centers to the public health supervision agreement sites. I have been working in the public health arena since 2005. I have seen many children who have had dental needs which parents were not aware they had. Daycare center are a great place to be able to reach many children. Most preschools in my service area have between 15 to 20 children where child care centers have 3 to 4 times that amount. Having a large amount of children in one place, I can easily send information about first dental visits, brushing and flossing, and early childhood caries. Most of the dentists in Lee and Van Buren counties will not see children until they are 3 or 4 which leaves this children unable to receive any dental services unless they want to travel over 45 minutes to get to a dentist who will see children at age 1. Being able to see these very young at their daycare center, I am able to guide these children to a dentist who will see them. Many of the children at daycare center have working parents who many not be able to get their children into the dentists or may not have dental insurance. By being able to see these children, they will get screening which children in Head Starts, WIC and preschools are receiving. Why should these children be left out because they are too young for preschools, no room at early Head Start, or not eligible for WIC. Please think of the children which we would be able to help if you add daycare center to the public health supervision agreement sites. I would hate to have a child who needs our services just because where they are during the day.

Looking at the information that I have gathered from the last 6 years, the number of children with ECC has been dropping because of the programs which the children have been able to participate in. I have always felt that if I see 50 children and only find one that needs treatment that it is all worth it. I always hate to see a child who is getting ready to go to kindergarten and they have a mouthful of decay because they had not had the opportunity to have a dental screening through a public health program. In the last 6 years, I have been able to see over 3700 children in Lee and Van Buren counties in the preschool and daycare settings. Many children had their first dental encounter at a preschool or daycare

center. They may have been scare but having their friends have their teeth looked at make them understand that it is not a bad thing. Many parents will comment that their child may not cooperate. The child wants to have their teeth looked at because it is in a non-threating place where they feel safe. Once a child has had a good experience then going into a dental office will not be scary for them because they have done it before at daycare or preschool.

Please consider adding daycare centers to the public health supervision agreement sites so we will be able to provide dental screening to as many children in the state of Iowa as we can. Wouldn't it be great if Iowa was the leader in reducing early childhood caries by seeing as many children as we can. Please think of the children which will greatly benefit from your decision.

Thank you for your consideration.

Dawn T. Doore, RDH
Public Health Hygienist working in Southeast Iowa

Johnson, Melanie [IDB]

From: Suzanne Heckenlaible [SHeckenlaible@deltadentalia.com]
Sent: Monday, January 07, 2013 2:14 PM
To: Johnson, Melanie [IDB]
Cc: Ed Schooley, D.D.S.; Beth Jones
Subject: Delta Dental of Iowa - Comment on Iowa Code section 153.33, subrule 10.5(1)
Attachments: IDB Rules Public Comment Letter 1-7-2013.pdf

Melanie –

Please find attached Delta Dental of Iowa comments to Iowa Code section 153.33, subrule 10.5(1). Please let me know if you have any questions, thanks.

Suzanne Heckenlaible
Vice President, Public Affairs
Delta Dental of Iowa
9000 Northpark Drive
Johnston, IA 50131
ph. 515-261-5559
fax: 888-558-9215
sheckenlaible@deltadentalia.com

DELTA DENTAL

www.deltadentalia.com

January 7, 2013

Ms. Melanie Johnson, Executive Director
Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines, IA 50309-4686

Dear Ms. Johnson:

We are writing to submit comment to Iowa Code section 153.33, subrule 10.5(1)

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

In 2012, The Delta Dental of Iowa Foundation announced new long term, strategic direction focuses on two visionary oral health 2020 goals, which include: every Iowa child age 0-12, living in a households with incomes below 300 percent of the federal poverty level, will be cavity-free; and every Iowa nursing home resident and homebound elderly person will have access to oral health care.

Increasing access to oral health care in a variety of settings that maintain quality of care is critical to achieve the Foundation's long term goals. Access to screenings and preventive care, such as dental sealants and fluoride varnish, are important to assure low-income children who are more at risk of tooth decay, have good oral health. By offering preventive care to children and seniors in various settings, we can broaden our reach to this underserved population with preventive services.

Delta Dental of Iowa and the Foundation are committed to supporting initiatives that support and improve the oral health of Iowans. Thank you.

Sincerely,

Suzanne Heckenlaible

Suzanne Heckenlaible
Vice President, Public Affairs
Delta Dental of Iowa

Ed Schooley DDS

Ed Schooley, D.D.S, M.H.A.
Dental Director
Delta Dental of Iowa

Delta Dental of Iowa
9000 Northpark Drive
Johnston, IA 50131

Telephone 515-261-5600
Toll Free 877-983-3582
Facsimile 515-261-5573

WE LOVE TO SEE *your* SMILE®

Johnson, Melanie [IDB]

From: joyce602@mchsi.com
Sent: Monday, January 07, 2013 3:25 PM
To: Johnson, Melanie [IDB]
Subject: letter to support DH in day care centers
Attachments: January 7 IDB.docx

Dear Melanie,

Please find attached letter of support for dental hygienists to visit day care centers utilizing the Public Health Supervision Agreement. Thank you for your time, I am sure you have been busy and have received many letters.

Sincerely yours,

Joyce Miller, DH

January 7, 2013

Executive Director Iowa Dental Board
400 SW 8th Street
Des Moines, IA 50309-4687

Dear Melanie Johnson,

I am writing to support dental hygienists providing preventive dental hygiene services utilizing the Public Health Supervision Agreement at day care centers.

Adding day care centers to the Public Health Supervision Agreement has merit because not all families understand the need for dental care and are unable to pay for dental treatment. The dental hygienists' visit may be the child's or the family's first contact with dental services or dental care. As part of the public health service, the dental hygienist provides care coordination which connects the family to a dentist, aids finding payment for these services, if necessary, and assists with additional needs that enable the family to receive care.

These are financially difficult times for both families and state agencies, but dental care is important. No dentist will ever disagree with the need for preventive dental care for children. It is important to introduce dental care early and educate parents and children to prevent decay. If young children receive preventive dental care, they will have better general health and be better dental patients in the future.

Starting prevention early avoids dental pain, decreases days missed from school which increases learning and reduces overall cost of dental care. Public health services provided by the dental hygienist, under the Public Health Supervision Agreement, are the first steps for children to receive dental treatment.

Sincerely yours,

Joyce Miller, RDH

Johnson, Melanie [IDB]

From: Mike DeAnda [mdeanda@dsmhealth.com]
Sent: Monday, January 07, 2013 4:29 PM
To: Johnson, Melanie [IDB]
Subject: Support of adding Daycare Centers to the list of Public health Supervision sites

Melanie,
I am writing you in support of adding Daycare Centers to the list of Public Health Supervision sites.
I am aware of how dental hygienists working under public health supervision can improve access to care. I am in the unique position of operating one of the largest public health dental clinics in Iowa and and largest school based oral health program (Smile Squad).
An overview of our program. We provide oral health education, screenings, and referrals to elementary school age children attending 36 elementary schools and screenings in 6 middle schools. Additionally, dental sealants and dental treatment services are provided in these same sites. Several years ago in conducting screenings of elementary school age children for dental sealants, we noticed that many children were already carious and not good candidates for dental sealants. We knew to be effective, we needed to reach children at an earlier age. This was the driving force to establish our Little Healthy Smiles Project, providing oral health education , screenings, referrals for treatment and fluoride varnish applications for children attending 52 headstart and pre-school programs in Polk County. Our target centers are low income sites- HeadStart and Early Childhood IA sites. Today we provide over 3200 screenings. This provides additional opportunities to identify pre-school age children in need of dental care and referral to a dentist for care. In our community, we can guarantee access to care in our clinic as we are also one of the largest dental Medicaid providers and also have a pediatric dentist on staff.
The short of all this is that our success in operating the Smile Squad is directly linked to our ability to use dental hygienists under Public Health Supervision and use our dentists to provide dental treatment services in our clinic and in our Mobile Dental Clinic. As dental access is an issue here in Iowa, we will look to dental hygienists to be a part of our efforts to address dental access in central Iowa.

As the administrator of a public dental health clinic, I believe that access to dental care, especially preventive services, is important. Efforts to limit Public Health Supervision are not in the best interest of children in Iowa. I strongly urge you to add Daycare Centers to the list of public health supervision sites.

Mike DeAnda
President/CEO
Des Moines Health Center, Inc.
1111 -9th Street, Suite 190
Des Moines, IA 50314
ph: 515.244.9136 x 107; fax 515.244.9153

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Johnson, Melanie [IDB]

From: Venker, Daniel [DOC]
Sent: Tuesday, January 08, 2013 7:37 AM
To: Johnson, Melanie [IDB]
Subject: Letter of support for addition of daycare centers to dental PH supervison sites
Attachments: Support for Public Health Supervision Daycare Centers.doc

Dear Melanie,

Can you please enter my letter into the record at today's board hearing regarding the matter of adding daycare centers to the list of public health supervision sites to the board rules? I'd appreciate it. I have students today interning at the correctional facility so I cannot attend the board meeting in person.

Thank you so much.

Dr. Daniel Venker

Support for Public Health Supervision & Adding Daycare Centers to PH Supervision Site List

Access to dental care is a complex problem without a simple solution. Public Health Supervision for dental hygienists is an important part of the development of a solution.

The Delta Dental Foundation held an event on November 30, 2012: **Educate, Motivate, Activate: Access to Oral Health Care for Aging Iowans**. At the event, the Delta Dental of Iowa Foundation introduced their 2020 Strategic Plan.* The presentations included Best Practices in Iowa and across the country to improve oral health access (focusing on the elderly, but showed programs and technology used to provide services in the community). Two concepts were presented by multiple speakers:

- It is necessary to provide services where people Live, Work and Play.
- The Models included Dental Hygienists working under public health supervision or other collaborative agreements allowed in their states.

Most public health dental hygienists in Iowa are working for Title-5 public health agencies, Federally Qualified Community Health Centers and Non-profit Community Health Centers. These hygienists deliver essential preventive services, education, and refer these individuals to dentists in the community.

Significant strides have been made in access to care for many children ages 0 to 12 since 2005. The I-Smiles program has been a major player in making this progress across the state of Iowa. Others I am sure have quoted statistics to you in their statements to you regarding this important strategy of adding day care centers to the list of public health supervision sites.

The importance of adding day care centers to the list of public health supervised sites is:

1. Many low-income families receive childcare assistance to attend daycare centers that participate in this assistance program.

2. Screenings at these centers provide an opportunity to encourage routine dental exams and identify children with suspected treatment needs while providing preventive services.

3. Many of the families qualify for Medicaid, but have trouble finding a provider for a couple of reasons: few providers accept new Medicaid patients and many providers will not see children until they are 3-5 years old.

As a licensed dentist and an Iowa citizen, I firmly believe that access to dental care, especially preventive services, must be increased.

Thank you. Daniel Venker, DDS, MS

701 Rose Avenue, Des Moines, IA. 50315.

*See second page

*The Delta Dental of Iowa Foundation's long-term, strategic direction focuses funding primarily to programs and investments that help support two new visionary oral health 2020 goals, which include:

1. Every Iowa child age 0-12, living in a household with an income below 300 percent of the federal poverty level, will be cavity-free.
2. Every Iowa nursing home resident and homebound elderly person will have access to oral health care.

As part of the new strategic direction, the Foundation will begin to shift funding to oral health projects supporting these new goals. To achieve the two visionary goals, the Foundation's future funding will focus on four critical areas:

- Oral health education and prevention
- Fluoridation
- Access to care for underserved children
- Access to care for the homebound elderly and nursing home residents.

Johnson, Melanie [IDB]

From: Barbara Merrill [bmerrill@iowaaeyc.org]
Sent: Tuesday, January 08, 2013 1:47 PM
To: Johnson, Melanie [IDB]
Subject: Iowa Dental Board rules
Attachments: oral health letter.doc

Ms. Johnson,
Please find attached written comments on the proposed rules.
Thank you,
Barb Merrill

Barb Merrill

Executive Director, Iowa Association for the Education of Young Children
Program Manager, T.E.A.C.H. Early Childhood® IOWA
5525 Meredith Drive Suite F, Des Moines, IA 50310
Visit our website www.iowaaeyc.org
(515) 331-8000 ext. 11; (800) 469-2392; fax (515) 331-8995

The Mission of Iowa AEYC is to ***serve*** and ***act*** on behalf of the early childhood profession.

It isn't a disgrace not to reach the stars, but it is a disgrace to have no stars to reach for.
Benjamin E. Mays

Iowa Association for the Education of Young Children

January 8, 2013

Melanie Johnson, Executive Director
Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687
Melanie.Johnson@iowa.gov

Dear Ms. Johnson:

On behalf of the Iowa Association for the Education of Young Children, I am writing to express our support for a proposed amendment to the Iowa Dental Board Rules (specifically subrule 10.5(1)) which expands the public health settings to include day cares and programs affiliated with Early Childhood Iowa.

We believe that access to oral health is a necessary prerequisite to educating young children and expanding the options for where oral health services can be accessed, especially by taking those services to where children are for major parts of the day, makes good sense. The program standards we promote for entities providing early childhood education already requires a comprehensive list of health and safety standards, including attention to the oral health of children. Specifically, it requires an agreement with a health professional who will address oral health needs of children in care. By expanding access to such professionals, we believe the proposed amendment will help our efforts to promote higher quality care and education settings for Iowa's young children.

Because we know that dental disease is the most common infectious disease among young children, expanding access to address this problem is of primary importance. Currently, dental hygienists have gone into preschools and other child care settings to provide dental care to all consenting children. Public health supervision has allowed thousands of Iowans to receive preventive dental care which they may not have otherwise been able to access. Last year, 76 dental hygienists provided more than 61,000 screenings through public health supervision (in addition to other services such as fluoride and sealant applications). The volume of preventive care provided through public health supervision each year indicates its importance.

Another recommendation we have would be to consider changing your verbiage from day care to child care. This is the commonly accepted language used by the profession for the service of providing care to children.

We urge the board to support this amendment in the interest of the overall health and well-being of children.

Sincerely,

Barbara Merrill
Executive Director
Iowa Association for the Education of Young Children

Phone: 515-331-8000
Fax: 515-331-8995
5525 Meredith Drive, Suite F
Des Moines, Iowa 50310
info@iowaaeyc.org
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www.iowaaeyc.org

Johnson, Melanie [IDB]

From: Tori Squires [tsquires@iowapca.org]
Sent: Tuesday, January 08, 2013 2:09 PM
To: Johnson, Melanie [IDB]
Subject: Input on Rule Making

Iowa Dental Board Members,

On behalf of the Iowa Primary Care Association, we thank you for the opportunity to provide input as you consider the amendment to rules which would expand the definition of public health settings to include programs affiliated with the Early Childhood Iowa initiative and day care centers.

The Early Childhood Iowa Initiative targets the needs of young low-income children and their families by developing strong community support systems. Allowing dental hygienists to access those day care centers and preschools that this initiative supports will allow those children attending these centers early access to preventive oral health care. Dental decay is the most chronic disease found in young low income children. Early access to preventive oral health services reduces a child's risk to having decay and provides an opportunity to educate parents on the importance of oral health care. In 2011, 56,458 Medicaid enrolled children did not receive any dental services. Including these day cares and preschools in the settings that dental hygienists can provide services will reduce those numbers.

The Iowa Primary Care Association's mission is to provide leadership by promoting, supporting and developing quality health care for underserved populations in Iowa. Allowing low-income children to access oral health preventive services in preschools and daycares will increase the number of children receiving preventive oral health services and increase the oral health literacy of their parents.

The Iowa Primary Care Association supports increased access to preventive services for all underserved individuals and supports the inclusion of daycare and preschool centers supported by the Early Childhood Initiative in the definition of public health settings for dental hygienists working under Public Health Supervision.

Thank you for your thoughtful consideration of this amendment.

The Iowa Primary Care Association

Tori Squires
Senior Program Director
Iowa Primary Care Association (Iowa PCA)
9943 Hickman Road, Suite 103
Urbandale, Iowa 50322
515-333-5012 (direct line)
515-244-9610 (main office)
www.iowapca.org

Johnson, Melanie [IDB]

From: Barbara Merrill [bmerrill@iowaaeyc.org]
Sent: Tuesday, January 08, 2013 3:31 PM
To: Johnson, Melanie [IDB]
Cc: Leann Andre; Susan Gray; mairy@gwaea.org; Rendon, Tom [ED]; rdcasto@mediacombb.net
Subject: Iowa Dental Board comments
Attachments: Letter to Iowa Dental Board.pdf

Ms. Johnson,

Please find attached the letter of support from our organization with comments regarding the proposed legislation regarding children's oral health.

Do not hesitate to contact me if you need more information.

Thank you,
Barbara Merrill

Barb Merrill

Executive Director, Iowa Association for the Education of Young Children
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January 8, 2013

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Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687
Melanie.Johnson@iowa.gov

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We believe that access to oral health is a necessary prerequisite to educating young children and expanding the options for where oral health services can be accessed, especially by taking those services to where children are for major parts of the day, makes good sense. The program standards we promote for entities providing early childhood education already requires a comprehensive list of health and safety standards, including attention to the oral health of children. Specifically, it requires an agreement with a health professional who will address oral health needs of children in care. By expanding access to such professionals, we believe the proposed amendment will help our efforts to promote higher quality care and education settings for Iowa's young children.

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Another recommendation we have would be to consider changing your verbiage from day care to child care. This is the commonly accepted language used by the profession for the service of providing care to children.

We urge the board to support this amendment in the interest of the overall health and well-being of children.

Sincerely,

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Thank you for your thoughtful consideration of this amendment.

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Tori Squires
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REPORT TO THE IOWA DENTAL BOARD

ACTION REQUIRED

DATE OF MEETING: January 31, 2013

RE: **Rules: Final Amendments to Chapter 11, "Licensure to Practice Dentistry or Dental Hygiene," and Chapter 15, "Fees"**

SUBMITTED BY: Melanie Johnson, Executive Director

ACTION REQUESTED: Approval to File Adopted & Filed Amendments

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Amendments Eligible for Final Adoption

At the October 24, 2102 meeting the Board approved the filing of proposed rule amendments to Chapter 11, "Licensure to Practice Dentistry or Dental Hygiene," and Chapter 15, "Fees." The proposed amendments are eligible for final adoption at this time. The final amendments are identical to the proposed amendments.

The final amendments:

- Correct a cross-reference in the rules applicable to dental hygiene licensure by credentials;
- Streamline the initial registration process for dental assistants applying for registration within three months of the next renewal due date. Dental assistant applicants applying close to a renewal cycle will pay the application fee and the renewal fee at the same time. Their registration will be issued for a period of 24 months plus the amount of time remaining until the next renewal due date. This change will eliminate the need for applicants to submit two separate applications and fees within one three-month period. Similar rule amendments were adopted for the initial licensure and renewal for dentists and dental hygienists. The proposed amendments extend the same simplified process to dental assistant applicants.

Public Hearing Held, No Written Comments Received

A public hearing was held on January 8, 2013 and written comments were accepted through that date. No comments were received and no one attended the public hearing.

Attached for Review

- ❖ Draft Adopted & Filed rule amendments
- ❖ Copy of the NOIA - ARC 0473C, published in the 11/28/12 IAB

DENTAL BOARD [650]

Adopted & Filed

Pursuant to the authority of Iowa Code section 147.76, the Dental Board hereby amends Chapter 11, “Licensure to Practice Dentistry or Dental Hygiene,” and Chapter 15, “Fees,” Iowa Administrative Code.

These amendments were published as Notice of Intended Action in the Iowa Administrative Bulletin on November 28, 2012 as ARC 0473C.

These amendments correct a cross reference in the rules applicable to dental hygiene licensure by credentials and streamline the initial registration process for dental assistants applying for registration within three months of the next renewal due date. Dental assistant applicants applying close to a renewal cycle will pay the application fee and the renewal fee at the same time. Their registrations will be issued for a period of 24 months plus the amount of time remaining until the next renewal due date. This change will eliminate the need for applicants to submit two separate applications and fees within one three-month period. Similar rule amendments were adopted for the initial licensure and renewal for dentists and dental hygienists. The proposed amendments extend the same simplified process to dental assistant applicants.

A public hearing was held on January 8, 2013 and written comments were accepted through that date. No comments were received and no one attended the public hearing. The final amendments are identical to the proposed amendments.

The Iowa Dental Board adopted these amendments on January 31, 2013.

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

These amendments will become effective on April 10, 2013.

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

The following amendments are adopted.

ITEM 1. Amend subparagraph **11.6(2)"e"(1)** as follows:

(1) Passed an examination approved by the board in accordance with Iowa Code section 147.34(1) and administered by a regional or national testing service. The clinical examinations approved by the board are specified in 650—subrule ~~12.1(5)~~ 12.3(5).

ITEM 2. Amend subrules 15.3(13) and 15.3(14) as follows:

15.3(13) *Dental assistant registration only application.* ~~The fee for an application for registration as a registered dental assistant is $40.~~

a. Application fee. The application fee for dental assistant registration is $40.

b. Initial registration period and renewal period. If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the registration application fee. A dental assistant registration shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a registrant shall pay the renewal fee as specified in 650—15.4(153).

15.3(14) *Combined application—dental assistant registration and qualification in radiography.* ~~The fee for a combined application for both registration as a registered dental assistant and radiography qualification is $60.~~

a. Application fee. The application fee for a combined application for both registration as a registered dental assistant and radiography qualification is $60.

b. Initial combined registration and radiography qualification period and renewal period. If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the combined registration/radiography qualification application fee. A dental assistant registration and radiography qualification shall not be issued for a period less than three months or longer than two years and three months. Thereafter, the applicant shall pay the renewal fee as specified in 650—15.4(153).

ARC 0473C

DENTAL BOARD[650]

Notice of Intended Action

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

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

Pursuant to the authority of Iowa Code section 147.76, the Dental Board hereby gives Notice of Intended Action to amend Chapter 11, "Licensure to Practice Dentistry or Dental Hygiene," and Chapter 15, "Fees," Iowa Administrative Code.

These proposed amendments correct a cross reference in the rules applicable to dental hygiene licensure by credentials and streamline the initial registration process for dental assistants applying for registration within three months of the next renewal due date. Dental assistant applicants applying close to a renewal cycle will pay the application fee and the renewal fee at the same time. Their registrations will be issued for a period of 24 months plus the amount of time remaining until the next renewal due date. This change will eliminate the need for applicants to submit two separate applications and fees within one three-month period. Similar rule amendments were adopted for the initial licensure and renewal for dentists and dental hygienists. The proposed amendments extend the same simplified process to dental assistant applicants.

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

A public hearing will be held on January 8, 2013, at 10 a.m. at the office of the Iowa Dental Board located at 400 SW 8th Street, Suite D, Des Moines, Iowa. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendments.

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

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

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

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

The following amendments are proposed.

ITEM 1. Amend subparagraph **11.6(2)"e"(1)** as follows:

(1) Passed an examination approved by the board in accordance with Iowa Code section 147.34(1) and administered by a regional or national testing service. The clinical examinations approved by the board are specified in 650—subrule ~~12.1(5)~~ 12.3(5).

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b. Initial combined registration and radiography qualification period and renewal period. If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the combined registration/radiography qualification application fee. A dental assistant registration and radiography qualification shall not be issued for a period less than three months or longer than two years and three months. Thereafter, the applicant shall pay the renewal fee as specified in 650—15.4(153).

REPORT TO THE IOWA DENTAL BOARD

ACTION REQUIRED

DATE OF MEETING:	January 31, 2013
RE:	**Rules: Final Amendments to Chapter 35, Iowa Practitioner Review Committee**
SUBMITTED BY:	Melanie Johnson, Executive Director
ACTION REQUESTED:	Approval to File Adopted & Filed Rule Amendments

---

Amendments Eligible for Final Adoption

At the October 24, 2102 meeting the Board approved the filing of proposed rule amendments to Chapter 35, Iowa Practitioner Review Committee. The proposed amendments are eligible for final adoption at this time. The final amendments are identical to the proposed amendments.

The final amendments:

- Rescind the 9 year term limit for membership on the Committee.
- Change the term period to match the term periods for other Board Committees (May 1st – April 30th)
- Change the date for electing a chair and vice chair from January 1st to the last meeting closest to April 30th; with terms starting May 1st .
- Clarify when the Board can refer a practitioner to IPRC.

Public Hearing Held, No Written Comments Received

A public hearing was held on January 8, 2013 and written comments were accepted through that date. No comments were received and no one attended the public hearing.

Attached for Review

- Draft Adopted & Filed rule amendments
- Copy of the NOIA - ARC 0472C, published in the 11/28/12 IAB

DENTAL BOARD [650]

Adopted and Filed

Pursuant to the authority of Iowa Code section 147.76, the Dental Board hereby adopts amendments to Chapter 35, "Iowa Practitioner Review Committee," Iowa Administrative Code.

These amendments were published as Notice of Intended Action in the Iowa Administrative Bulletin on November 28, 2012 as ARC 0472C.

These amendments remove term limits for membership on the Iowa Practitioner Review Committee; provide for terms which begin on May 1 and end on April 30; require an annual election of a chairperson and vice chairperson whose terms begin on May 1; and clarify that participation in the program occurs through either a practitioner's self-reporting or a referral from the Dental Board. The proposed amendments bring the Committee's practices in line with other committees of the Dental Board.

A public hearing was held on January 8, 2013 and written comments were accepted through that date. No comments were received and no one attended the public hearing. The final amendments are identical to the proposed amendments.

The Iowa Dental Board adopted these amendments on January 31, 2013.

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

These amendments will become effective on April 10, 2013.

These amendments are intended to implement Iowa Code sections 153.33.

The following amendments are adopted.

ITEM 1. Amend subrule 35.1(3) as follows:

35.1(3) *Composition of the committee.* The chairperson of the board shall appoint the members of the IPRC. Committee members, except the executive director, shall be appointed for three-year terms~~, for a maximum of three terms~~ which begin on May 1 and terminate on April 30. The committee shall elect a chairperson and vice chairperson annually at the last meeting ~~of each calendar year to begin serving a one-year term on January 1~~ closest to April 30. The chairperson and vice chairperson will serve one-year terms beginning on May 1. The membership of the IPRC may include, but is not limited to:

a. Executive director of the board or the director's designee from the board's staff;

b. One practitioner who has remained free of addiction for a period of no less than two years following successful completion of a board-approved recovery program, a board-ordered probation for drug or alcohol dependency, addiction, or abuse, or an IPRC contract;

c. One physician/counselor with expertise in substance abuse/addiction treatment programs;

d. One psychiatrist or one psychologist; and

e. One public member.

ITEM 2. Amend subrule 35.1(4) as follows:

35.1(4) *Eligibility.* To be eligible for participation in the IPP, a practitioner must self-report an impairment or suspected impairment directly to the office of the board or be referred by the board pursuant to rule 650—35.2(272C). A practitioner is deemed ineligible to participate in the program if the license committee or IPRC finds sufficient evidence of any of the following:

a. The practitioner is engaged in the unlawful diversion or distribution of controlled substances or illegal substances to a third person or for personal profit or gain;

b. At the time of the self-report, the practitioner is already under board order for an

impairment or any other violation of the laws and rules governing the practice of the profession;

c. The practitioner has caused harm or injury to a patient;

d. There is currently a board investigation of the practitioner that concerns serious matters related to the ability to practice with reasonable safety and skill or in accordance with the accepted standards of care;

e. The practitioner has been subject to a civil administrative or criminal sanction, or ordered to make reparations or remuneration by a government or regulatory authority of the United States, this or any other state or territory or a foreign nation for actions that the committee determines to be serious infractions of the laws, administrative rules, or professional ethics related to the practice of dentistry, dental hygiene, or dental assisting;

f. The practitioner provided inaccurate, misleading, or fraudulent information or failed to fully cooperate with the board or committee; or

g. There is currently a complaint before the board related to an impairment.

ARC 0472C

DENTAL BOARD[650]

Notice of Intended Action

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

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

Pursuant to the authority of Iowa Code section 147.76, the Dental Board hereby gives Notice of Intended Action to amend Chapter 35, "Iowa Practitioner Review Committee," Iowa Administrative Code.

These proposed amendments remove term limits for membership on the Iowa Practitioner Review Committee; provide for terms which begin on May 1 and end on April 30; require an annual election of a chairperson and vice chairperson whose terms begin on May 1; and clarify that participation in the program occurs through either a practitioner's self-reporting or a referral from the Dental Board. The proposed amendments bring the Committee's practices in line with other committees of the Dental Board.

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

A public hearing will be held on January 8, 2013, at 11 a.m. at the office of the Iowa Dental Board located at 400 SW 8th Street, Suite D, Des Moines, Iowa. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendments.

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

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

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

These amendments are intended to implement Iowa Code section 153.33.

The following amendments are proposed.

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d. One psychiatrist or one psychologist; and

e. One public member.

ITEM 2. Amend subrule 35.1(4) as follows:

35.1(4) *Eligibility*. To be eligible for participation in the IPP, a practitioner must self-report an impairment or suspected impairment directly to the office of the board or be referred by the board pursuant to rule 650—35.2(272C). A practitioner is deemed ineligible to participate in the program if the license committee or IPRC finds sufficient evidence of any of the following:

a. The practitioner is engaged in the unlawful diversion or distribution of controlled substances or illegal substances to a third person or for personal profit or gain;

b. At the time of the self-report, the practitioner is already under board order for an impairment or any other violation of the laws and rules governing the practice of the profession;

c. The practitioner has caused harm or injury to a patient;

d. There is currently a board investigation of the practitioner that concerns serious matters related to the ability to practice with reasonable safety and skill or in accordance with the accepted standards of care;

e. The practitioner has been subject to a civil administrative or criminal sanction, or ordered to make reparations or remuneration by a government or regulatory authority of the United States, this or any other state or territory or a foreign nation for actions that the committee determines to be serious infractions of the laws, administrative rules, or professional ethics related to the practice of dentistry, dental hygiene, or dental assisting;

f. The practitioner provided inaccurate, misleading, or fraudulent information or failed to fully cooperate with the board or committee; or

g. There is currently a complaint before the board related to an impairment.

Revised 1/18/13

REPORT TO THE IOWA DENTAL BOARD

For Review

DATE OF MEETING: January 31, 2013

RE: **Legislative Proposal by Board of Medicine – Require Review of Iowa Prescription Monitoring Program Prior to Prescribing Controlled Substances**

SUBMITTED BY: Melanie Johnson

ACTION REQUESTED: For review and consideration.

Background

The Iowa Board of Medicine and the Iowa Board of Pharmacy are supporting a legislative proposal to amend Iowa Code Chapter 124, Controlled Substances. The amendment would require pharmacists and prescribing practitioners to review the Iowa Prescription Monitoring Program (PMP) before writing prescriptions for controlled substances. Currently, pharmacists and prescribing practitioners are not required to review the database prior to prescribing controlled substances. The proposed amendment would affect dentists. The Board of Pharmacy manages the Iowa PMP.

Back ground information about the legislative proposal and the Iowa PMP is attached for your review. Representatives from the Board of Medicine and Board of Pharmacy will be available at the IDB January 31st meeting to answer any questions you may have about the proposed legislation and the Iowa PMP. They are interested in knowing if the Dental Board would join the Boards of Medicine and Pharmacy in support of this legislative change.

Attached for Review

- Iowa Board of Medicine Proposed Amendments to Iowa Code Chapter 124
  - Copy of legislation to amend Chpt. 124
- Iowa Board of Pharmacy Legislative Proposal
- Materials from the Iowa Board of Pharmacy about the Iowa Prescription Monitoring Program (PMP):
  - PMP PowerPoint Presentation
  - PMP User Guide (1/14/2013)

- Other Board of Medicine Legislative Proposals
  - Copy of legislative to amend Chpt. 148

PROPOSED AMENDMENTS TO CHAPTER 124

INTENT OF AMENDMENTS:

1. The Iowa Prescription Monitoring Program is a statewide database of prescriptions written for controlled substances The program has been in operation since 2009. Heretofore, pharmacists and prescribing practitioners were not required to review the database information before writing or filling prescriptions for controlled substances.

2. The proposed amendments requires pharmacist and prescribing practitioner to access patient information from the prescription monitoring program before prescribing or filling a prescription if the pharmacist or prescriber believes the patient is at risk of drug abuse or diversion.

3. The proposed amendments also allows a licensing board to adopt rules, such as providing guidance on determining risk factors, to implement this requirement.

4. The amendments retains the original law's immunity from liability for pharmacists and prescribers who act in good faith.

5. The prescribers affected by this law are physicians, physician assistants, certified registered nurse anesthetists, dentists, podiatrists.

6. The proposed amendments were approved by the Iowa Board of Medicine on November 16, 2012, and by the Iowa Board of Pharmacy on November 9.

PROPOSED AMENDMENTS: CHAPTER 124 – CONTROLLED SUBSTANCES

Iowa Code 124.553(6)

~~Nothing in this section shall require~~ A pharmacist or prescribing practitioner ~~to~~ shall obtain information about a patient from the program before prescribing or renewing a prescription for controlled substances or filling a prescription for controlled substances if the pharmacist or prescribing practitioner believes or have reason to believe that a patient is at risk of drug diversion, misuse or abuse of controlled substances. The licensing boards of the pharmacist and prescribing practitioner may adopt administrative rules to implement this requirement for their licensees. ~~A pharmacist or prescribing practitioner does not have a duty and shall not be held liable in damages to any person in any civil or derivative criminal or administrative action for injury, death, or loss to person or property on the basis that the pharmacist or prescribing practitioner did or did not seek or obtain or use information from the program. A pharmacist or prescribing practitioner acting reasonably and in good faith is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting or receiving or using information from the program.~~

NEW SUBSECTION: Iowa Code 124.553(7)

A pharmacist or prescribing practitioner acting reasonably and in good faith shall not be held liable in damages to any person in any civil or derivative criminal or administrative action for injury, death, or loss to person or property on the basis that the pharmacist or prescribing practitioner did or did not seek or obtain or use information from the program. A pharmacist or

prescribing practitioner acting reasonably and in good faith is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting or receiving or using information from the program.

RENUMBER SUBSECTION: Iowa Code 124.553(8)

~~7.~~ 8. The board shall not charge a fee to a pharmacy, pharmacist, or prescribing practitioner for the establishment, maintenance, or administration of the program, including costs for forms required to submit information to or access information from the program, except that the board may charge a fee to an individual who requests the individual's own program information. A fee charged pursuant to this subsection shall not exceed the actual cost of providing the requested information and shall be considered a repayment receipt as defined in section 8.2.

SENATE/HOUSE FILE _____
BY (PROPOSED DEPARTMENT OF PUBLIC HEALTH/BOARD OF MEDICINE BILL)

A BILL FOR

1 An Act relating to the Iowa information program for drug
2 prescribing and dispensing.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DRAFT

Section 1. Section 124.553, subsection 6, Code 2013, is amended to read as follows:

6. *a.* ~~Nothing in this section shall require a~~ A pharmacist or prescribing practitioner ~~to~~ shall obtain information about a patient from the program before prescribing or renewing a prescription for a controlled substance or filling a prescription for a controlled substance if the pharmacist or prescribing practitioner believes or has reason to believe that a patient is at risk of controlled substance diversion, misuse, or abuse. The licensing board of a pharmacist or prescribing practitioner may adopt rules to implement this subsection.

b. A pharmacist or prescribing practitioner ~~does not have a duty and~~ acting reasonably and in good faith shall not be held liable in damages to any person in any civil or derivative criminal or administrative action for injury, death, or loss to person or property on the basis that the pharmacist or prescribing practitioner did or did not seek or obtain or use information from the program. A pharmacist or prescribing practitioner acting reasonably and in good faith is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting or receiving or using information from the program.

EXPLANATION

This bill relates to the information program for drug prescribing and dispensing (Iowa prescription monitoring program).

The bill requires a pharmacist or prescribing practitioner to obtain information about a patient from the information program for drug prescribing and dispensing before prescribing or renewing a prescription for a controlled substance if the pharmacist or prescribing practitioner believes or has reason to believe the patient is at risk of drug diversion, misuse, or abuse. However, the bill provides that a pharmacist or prescribing practitioner who acts reasonably and in good faith is not liable for damages on the basis that the pharmacist or

DRAFT

1 prescribing practitioner did or did not seek information from
2 the program.
3 The bill allows the licensing board of a pharmacist or
4 prescribing practitioner to adopt rules to implement the bill.
5 The bill also strikes provisions relating to pharmacist or
6 prescribing practitioner liability.

DRAFT

An Act making changes to a controlled substances schedule, making penalties applicable, and relating to the exchange of information among prescription databases and monitoring programs.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section 124.208, subsection 6, Code 2013, is amended by adding the following new paragraphs:

NEW PARAGRAPH: xx. Methasterone (2[alpha],17[alpha]-dimethyl-5[alpha]-androstan-17[beta]-ol-3-one.

NEW PARAGRAPH: xx. Prostanozol (17[beta]-hydroxy-5[alpha]-androstano[3,2-c]pyrazole.

Section 2. Section 124.553, subsection 1, Iowa Code 2013, is amended by adding the following new paragraph:

NEW PARAGRAPH: d. A prescription database or monitoring program in another jurisdiction pursuant to subsection 8.

Section 3. Section 124.553, Iowa Code 2013, is amended by adding the following new subsection:

NEW SUBSECTION: 8. The board may enter into agreements for the mutual exchange of information among prescription database or monitoring programs in other jurisdictions. Any agreement entered into pursuant to this subsection shall specify that all the information exchanged shall be used and disseminated in accordance with the laws of this state.

EXPLANATION

This bill makes changes to a controlled substance schedule, and makes penalties applicable.

The bill classifies two anabolic steroids as Schedule III controlled substances.

It is a class “C” felony pursuant to Code section 124.401(1)(c)(8), for any unauthorized person to violate a provision of Code section 124.401, involving a classified substance placed on Schedule I, II, or III pursuant to the bill. A class “C” felony for this particular offense is punishable by confinement for no more than 10 years and a fine of at least $1,000 but not more than $50,000.

If a person possesses a controlled substance in violation of Code section 124.401(5) the person commits a serious misdemeanor. A serious misdemeanor is punishable by confinement for no more than one year and a fine of at least $315 but not more than $1,875.

The bill also relates to the exchange of information among prescription databases and monitoring programs.

The bill authorizes the board of pharmacy to enter into agreements with other jurisdictions in order to exchange information from the Iowa prescription monitoring program with similar programs in other jurisdictions.

The bill requires that any agreement entered into shall specify that all the information exchanged shall be used and disseminated in accordance with the laws of this state.

The Iowa prescription monitoring program is used by prescribing practitioners and pharmacists on a need-to-know basis for determining appropriate drug therapies and for facilitating early identification of patients who may be at risk for addiction, or who may be using, abusing, or diverting drugs for unlawful or otherwise unauthorized purposes.

IOWA PRESCRIPTION MONITORING PROGRAM
https://ibpe-pmp.iowa.gov/

Iowa Board of Pharmacy
400 SW 8th Street, Suite E
Des Moines, IA 50309-4688
515-281-5944

http://www.iowa.gov/ibpe/pmp.html
terry.witkowski@iowa.gov
debbie.jorgenson@iowa.gov
eric.way@iowa.gov

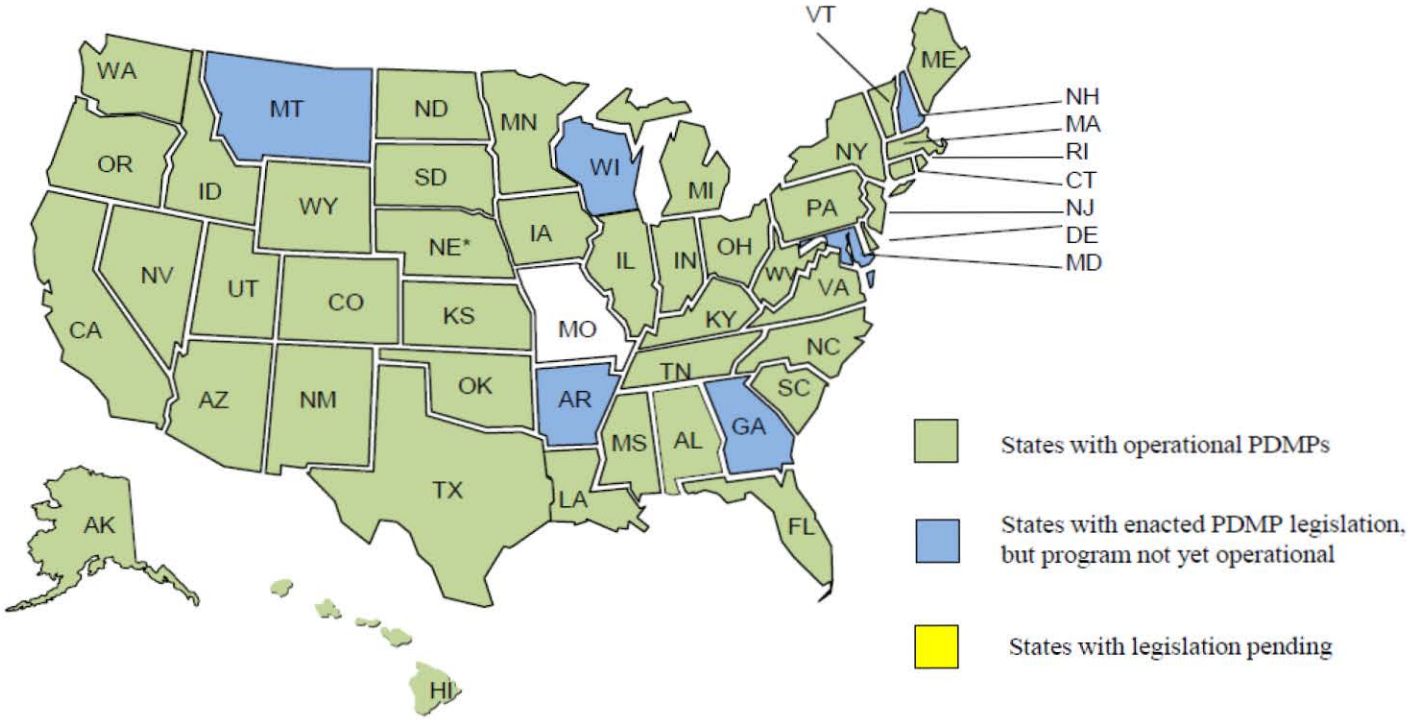
PROGRAM OBJECTIVES

- Improve patient care
- A health care tool for practitioners
  - Determine appropriate treatment options
  - Encourage appropriate prescribing
  - Reduce diversion of controlled substances
  - Identify misuse or abuse of controlled substances
- Access by practitioners is voluntary

CONFIDENTIALITY

- All program information is privileged and strictly confidential
  - Users may NOT share usernames and passwords
  - Practitioners may share information among other practitioners involved in the patient's treatment
  - Practitioners may only request information on current or prospective patients
  - Practitioner agents may only request information as directed by the supervising practitioner

Status of State Prescription Drug Monitoring Programs (PDMPs)



*The operation of Nebraska's Prescription Monitoring Program is currently being facilitated through the state's Health Information Initiative. Participation by patients, physicians, and other health care providers is voluntary.

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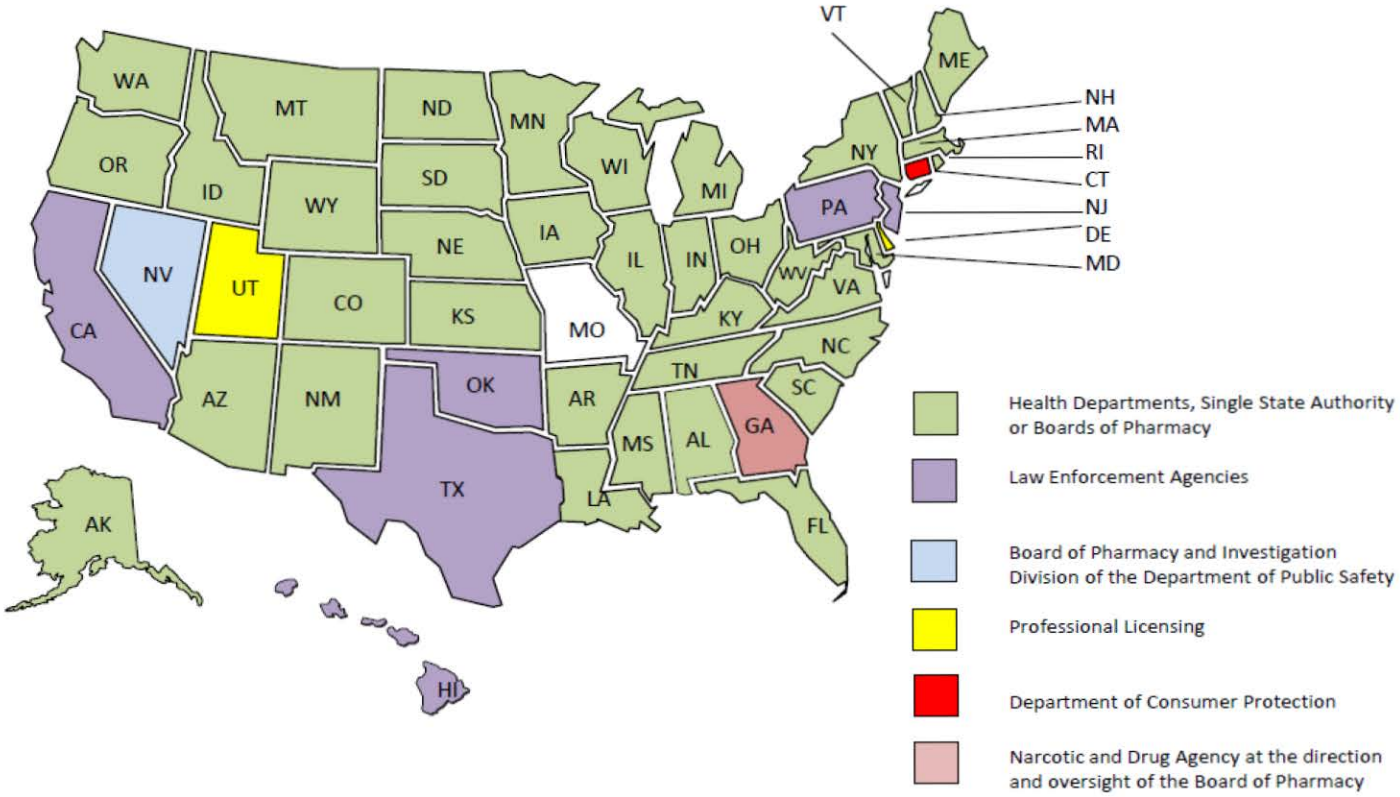
This information was compiled using legal databases, state agency websites and direct communications with state PDMP representatives.

Breakdown of Housing Entities[1]



[1] This information is based on the agency the PMP statute or regulation indicates is required to establish the PMP.

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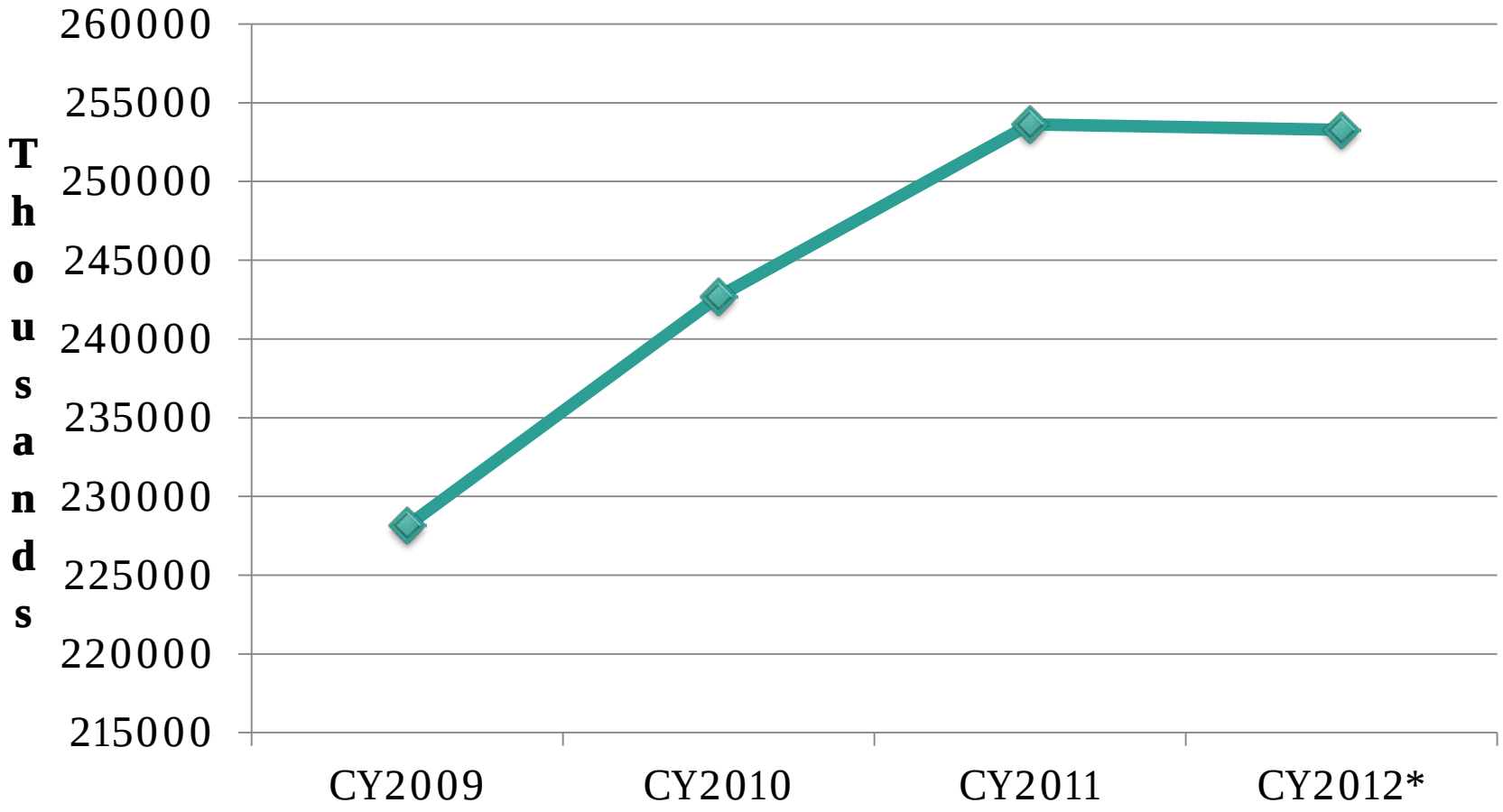
This information was compiled using legal databases, state agency websites and direct communications with state PDMP representatives

REPORTERS/DISPENSERS

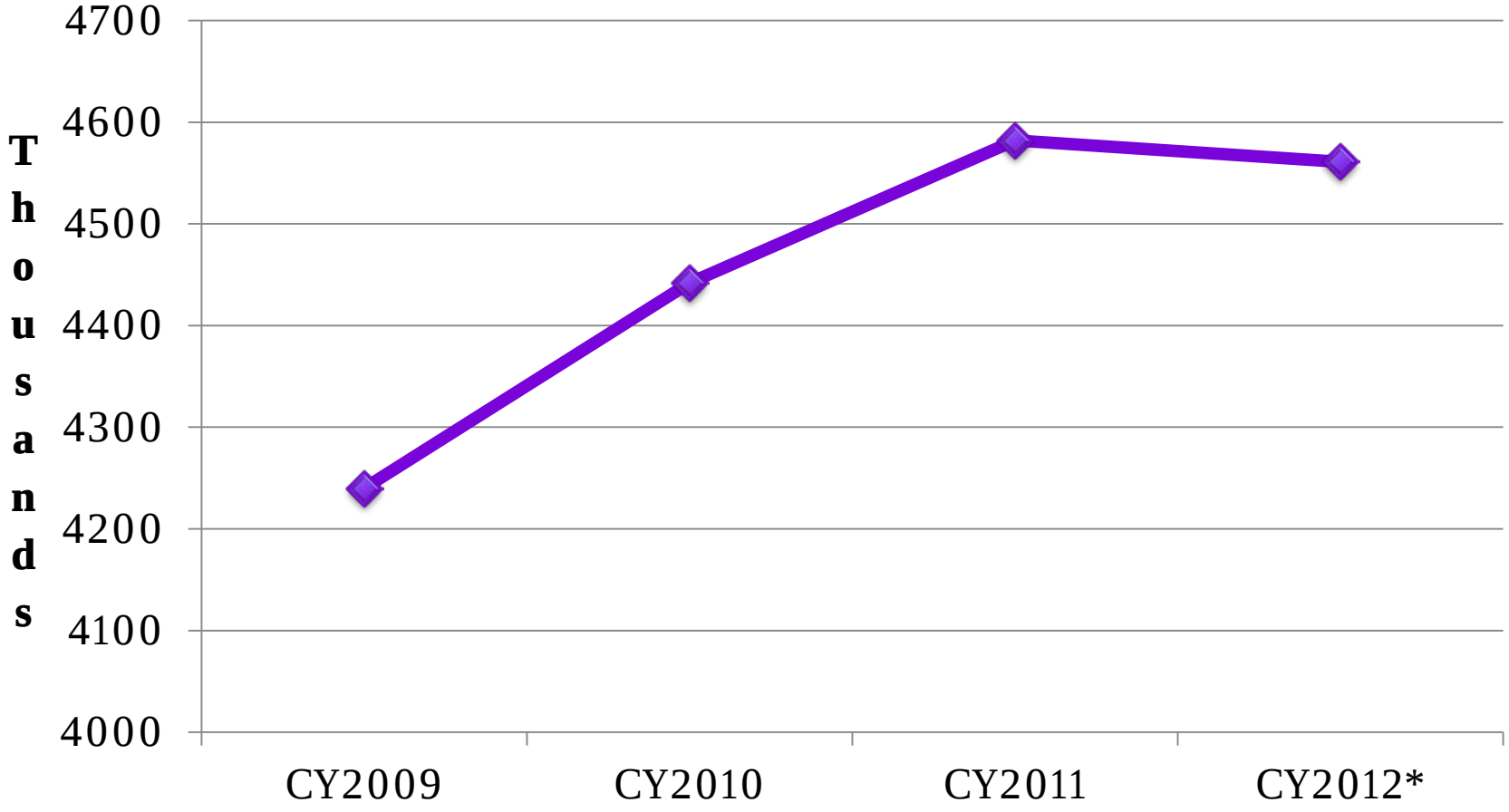
- Schedule II, III, and IV controlled substances dispensed by:
  - Retail pharmacies located in Iowa
  - Nonresident pharmacies dispensing controlled substances to patients located in Iowa *(eff. 1/1/13)*
- Excludes
  - Hospital inpatient and ER dispensing
  - Long-term care residents
  - Hospice facility residents
  - Prescriber dispensing

CONTROLLED SUBSTANCE DOSES



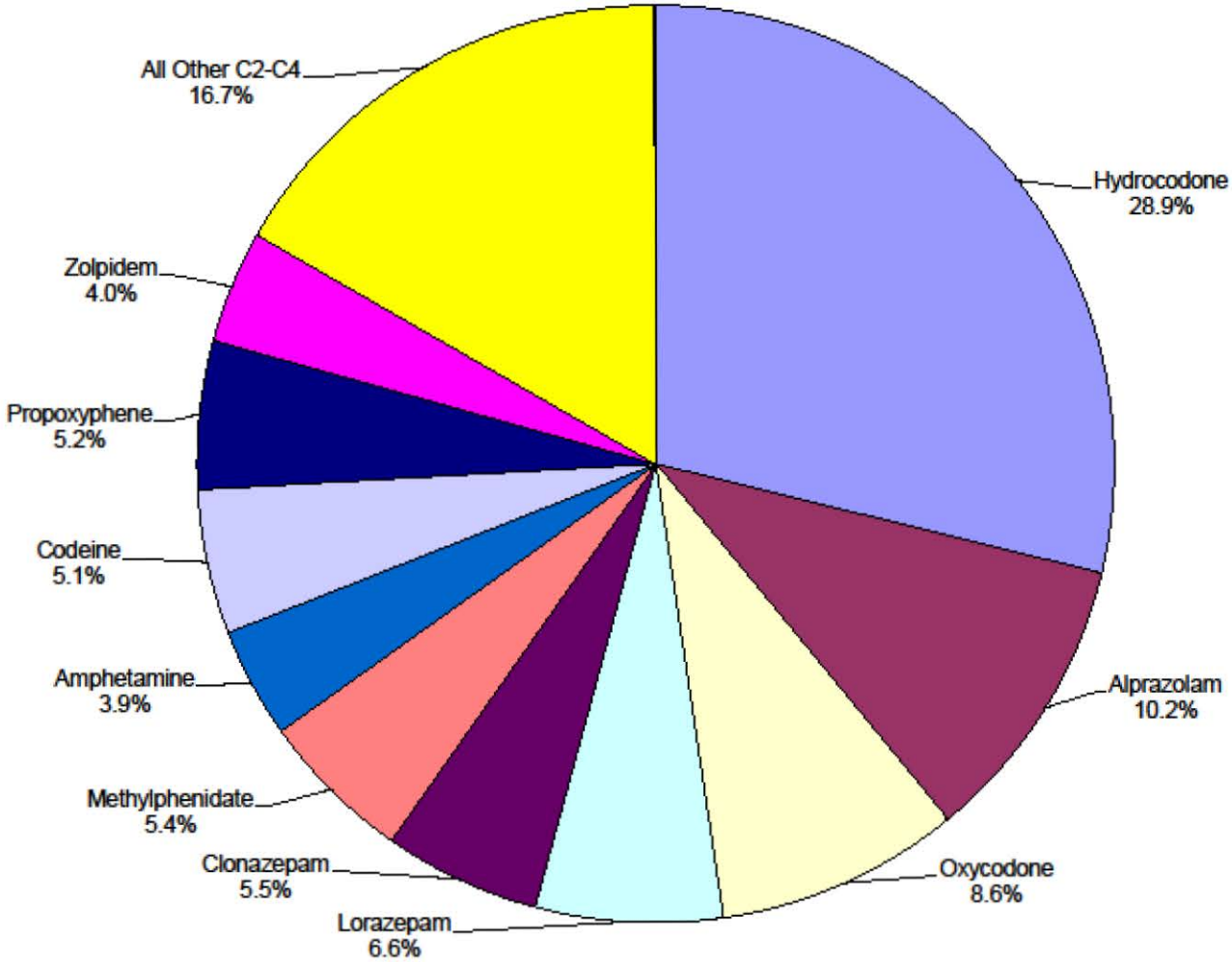
*CY2012 annualized; 6 months data available

CONTROLLED SUBSTANCE Rxs



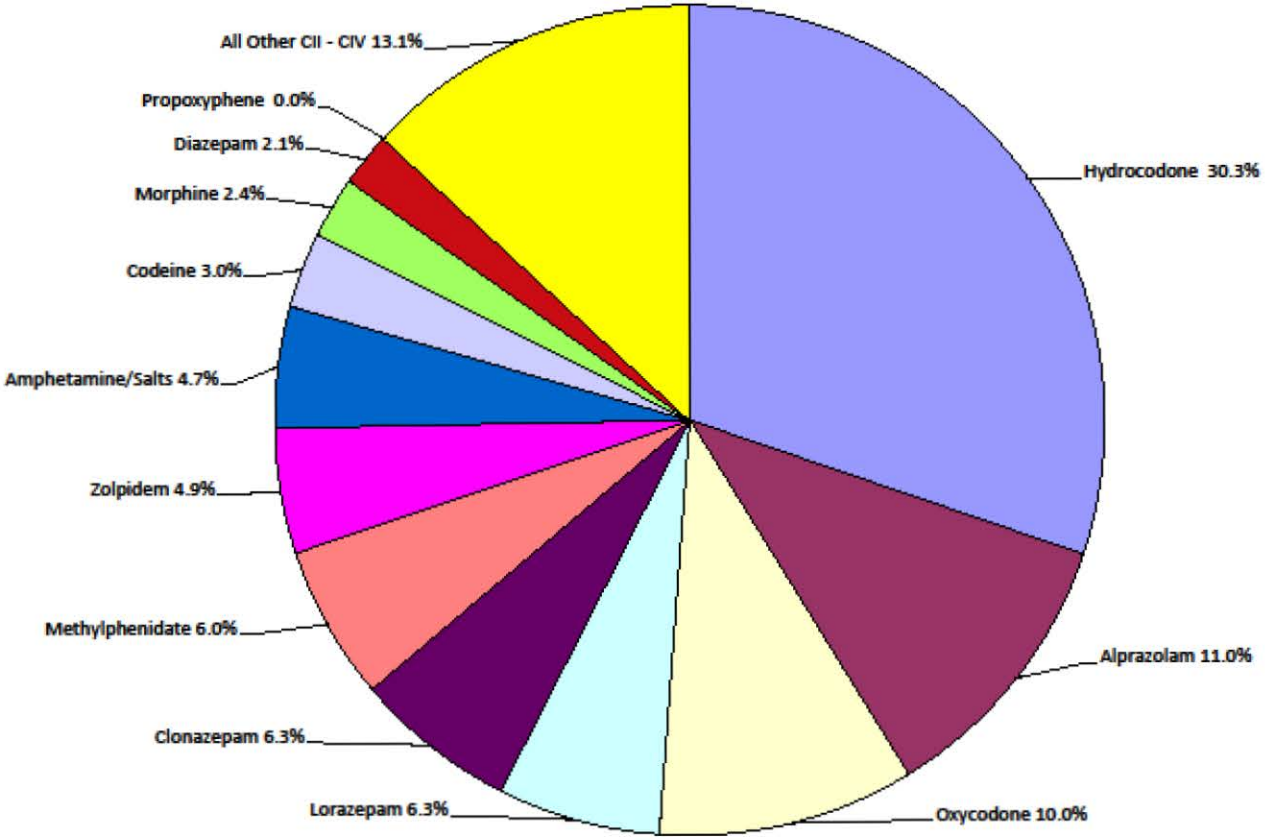
***CY2012 annualized; 6 months data available**

IOWA PMP CONTROLLED SUBSTANCE DOSES DISPENSED IN 2008

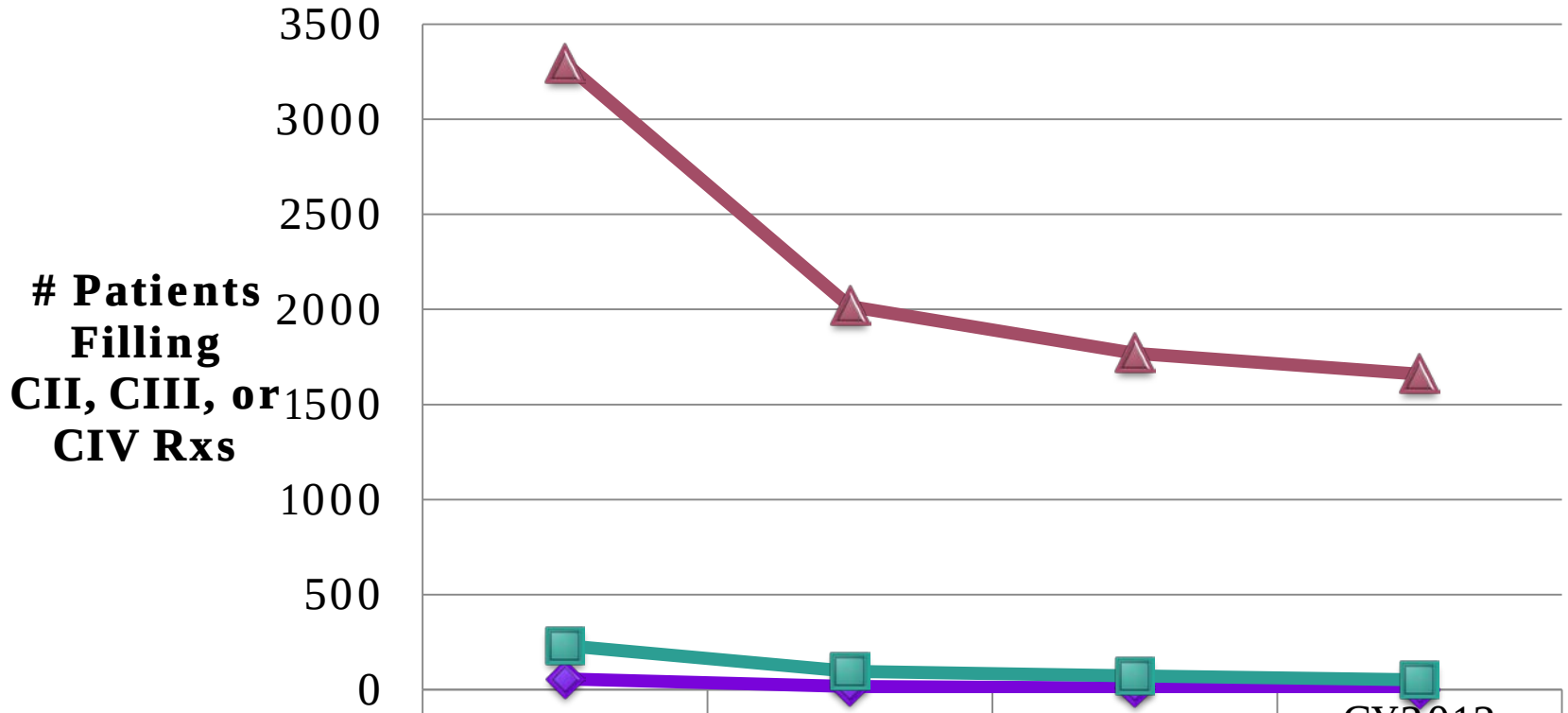


12/30/2011

IOWA PRESCRIPTION MONITORING PROGRAM REPORT 2011 CONTROLLED SUBSTANCE DOSES DISPENSED JANUARY 1 TO DECEMBER 31, 2011



Schedule II, III, or IV Prescriptions



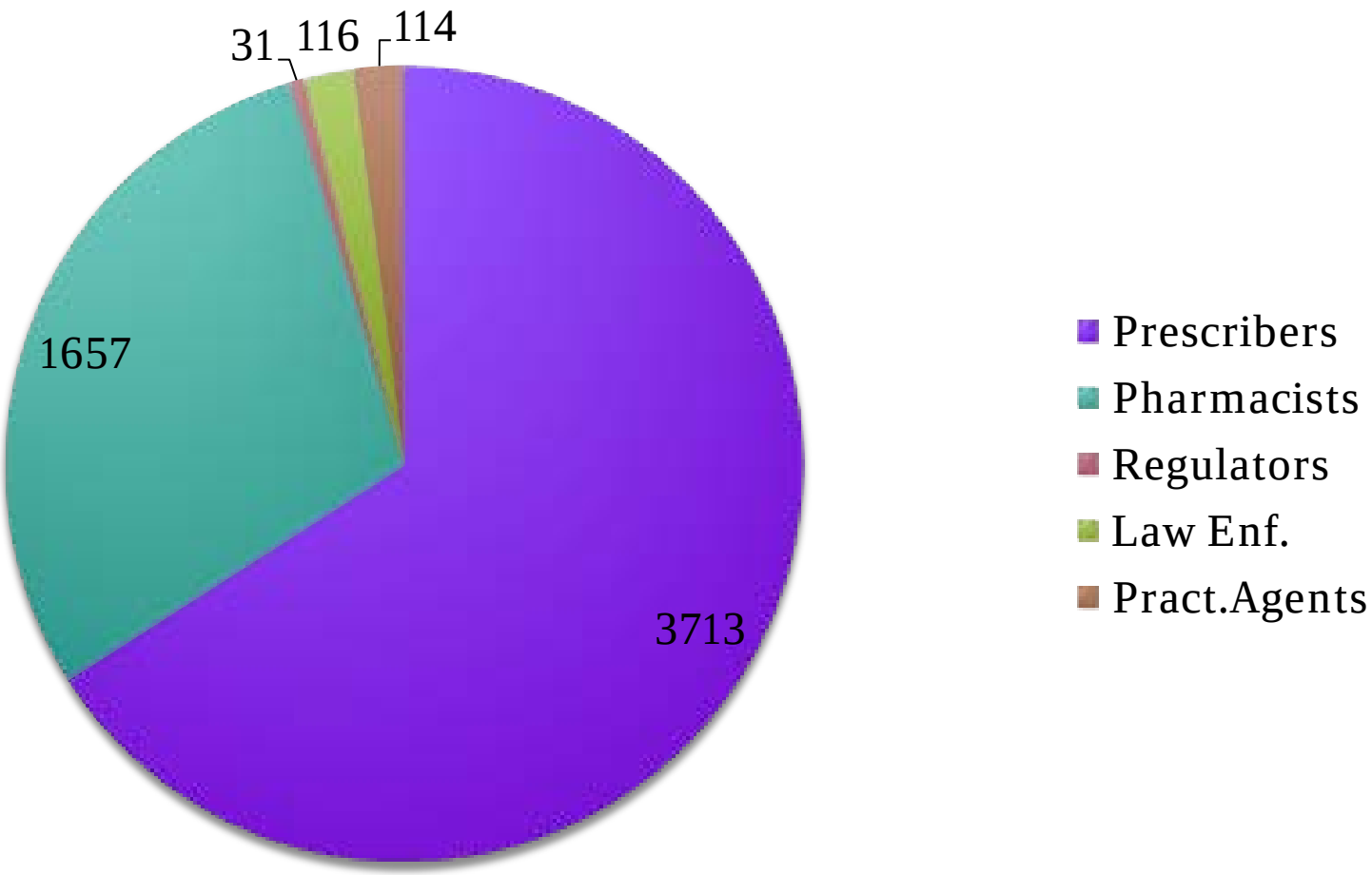
	CY2009	CY2010	CY2011	CY2012 *
>15 Rxers/Phcies	57	16	9	0
>10 Rxers/Phcies	232	96	72	52
>5 Rxers/Phcies	3293	2016	1769	1660

*CY2012 annualized; 6 months data available

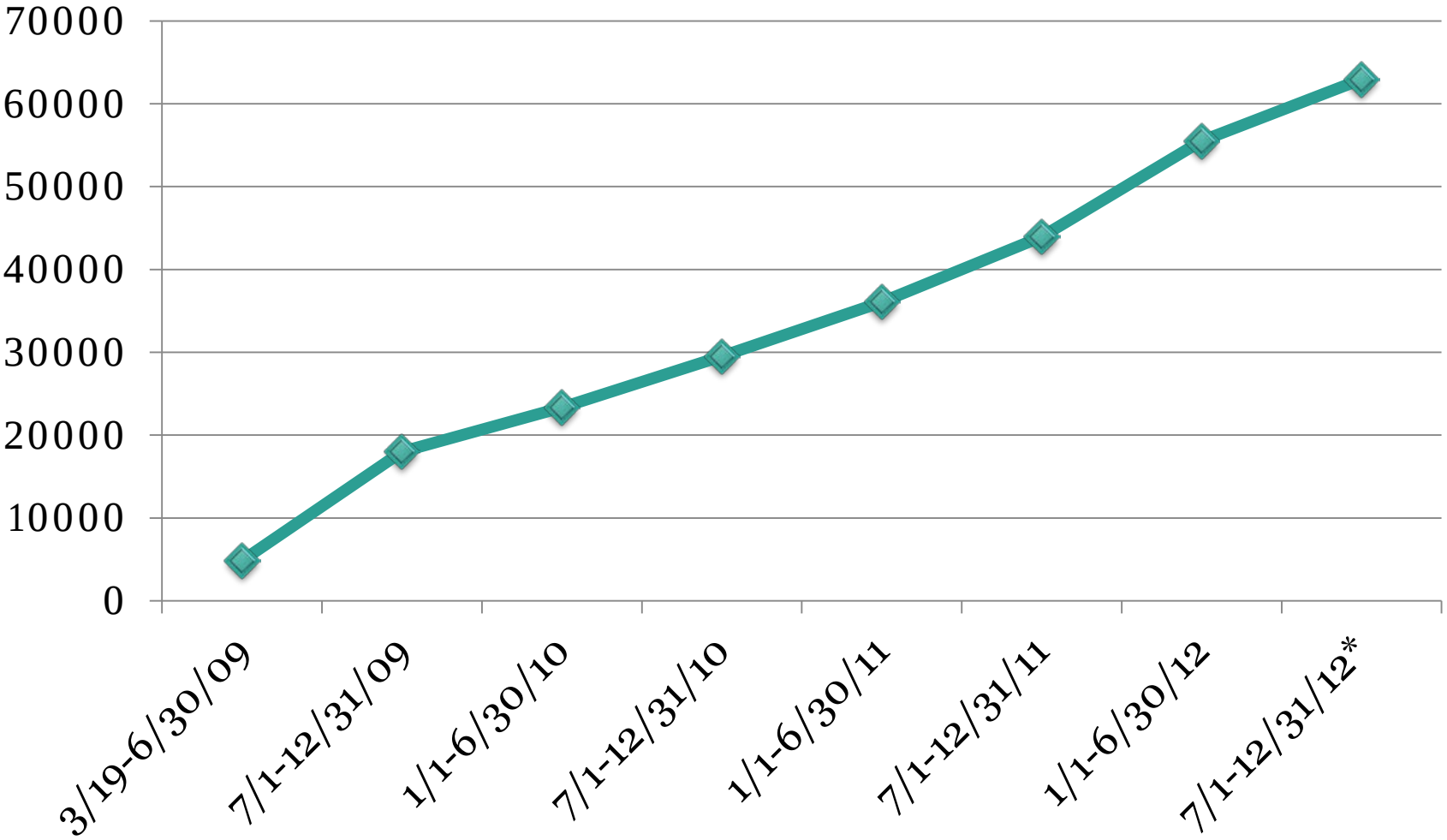
AUTHORIZED USERS

- Prescribers – regarding their patients
- Pharmacists – regarding their patients
- Individual patients – regarding prescriptions dispensed to patient only
- Law enforcement agents – for specific investigation upon showing of probable cause
- Regulatory agents – for specific investigation upon showing of probable cause

REGISTERED USERS

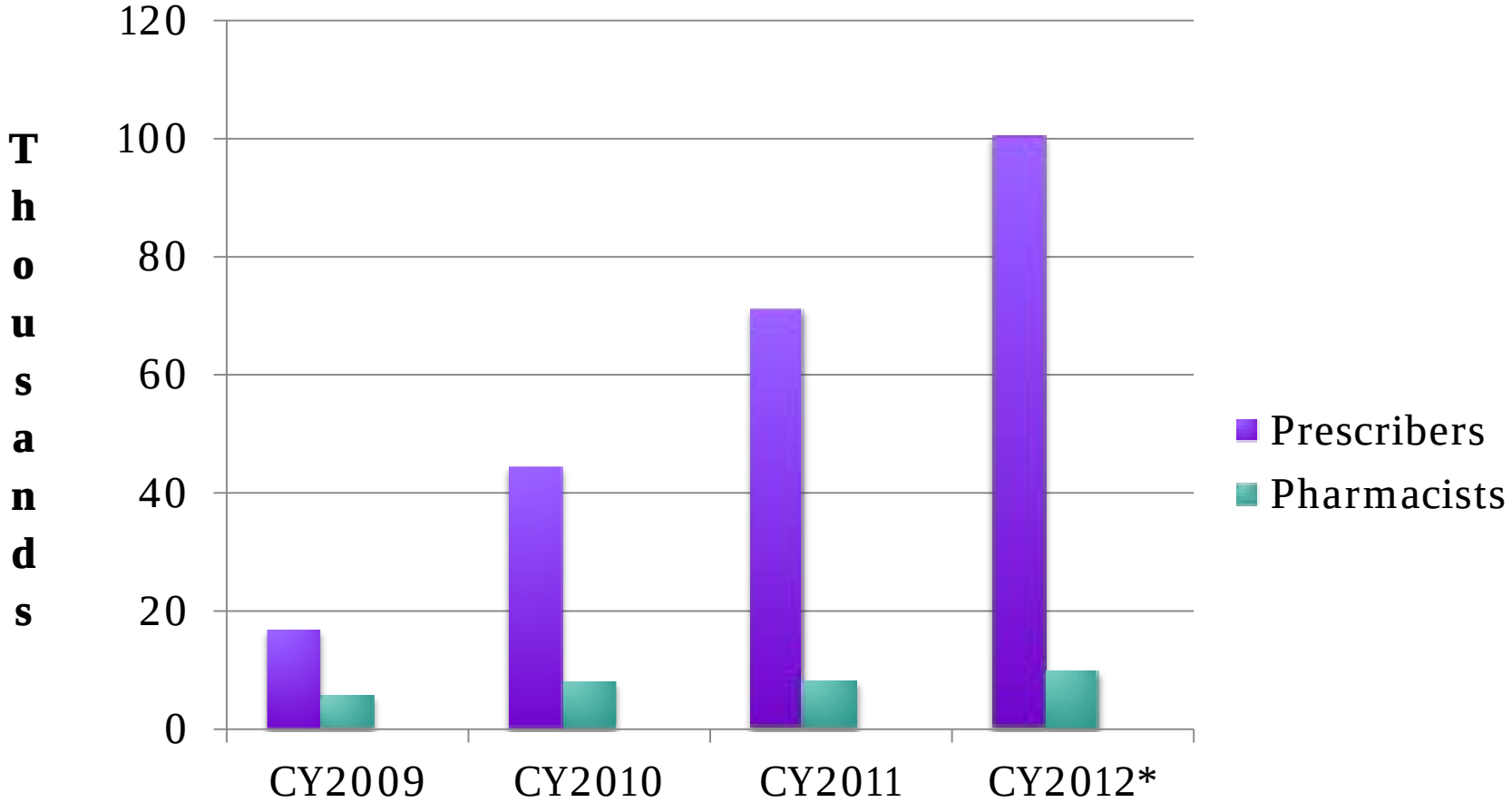


TOTAL REQUESTS PROCESSED



*CY2012 annualized; 4 months data available

PRACTITIONER REQUESTS

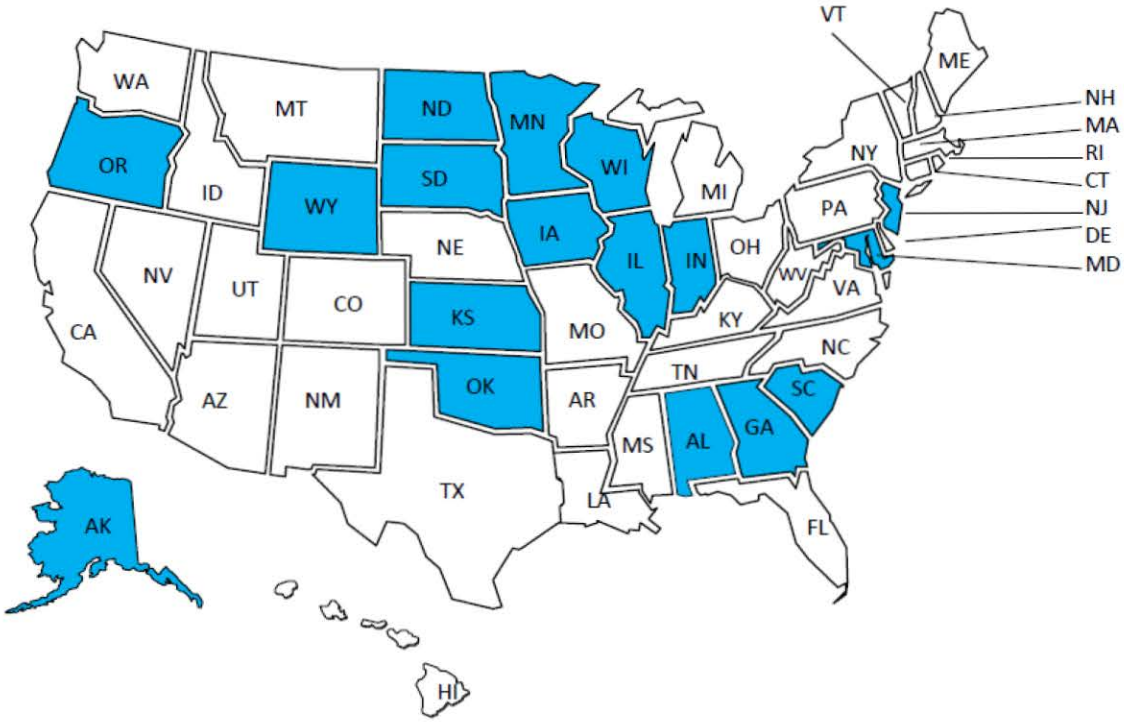


***CY2012 annualized; 6 months data available**

ACCESS BY PRACTITIONERS

- Access to and use of program information by pharmacists and prescribers is totally voluntary
- Pharmacists and prescribers are NOT required to access the program to review a patient's controlled substances prescription history
- Pharmacists and prescribers cannot be held liable for using or for failing to use information available in the program

State PMP Laws that Explicitly Do Not Require Prescribers or Dispensers to Access PMP Information



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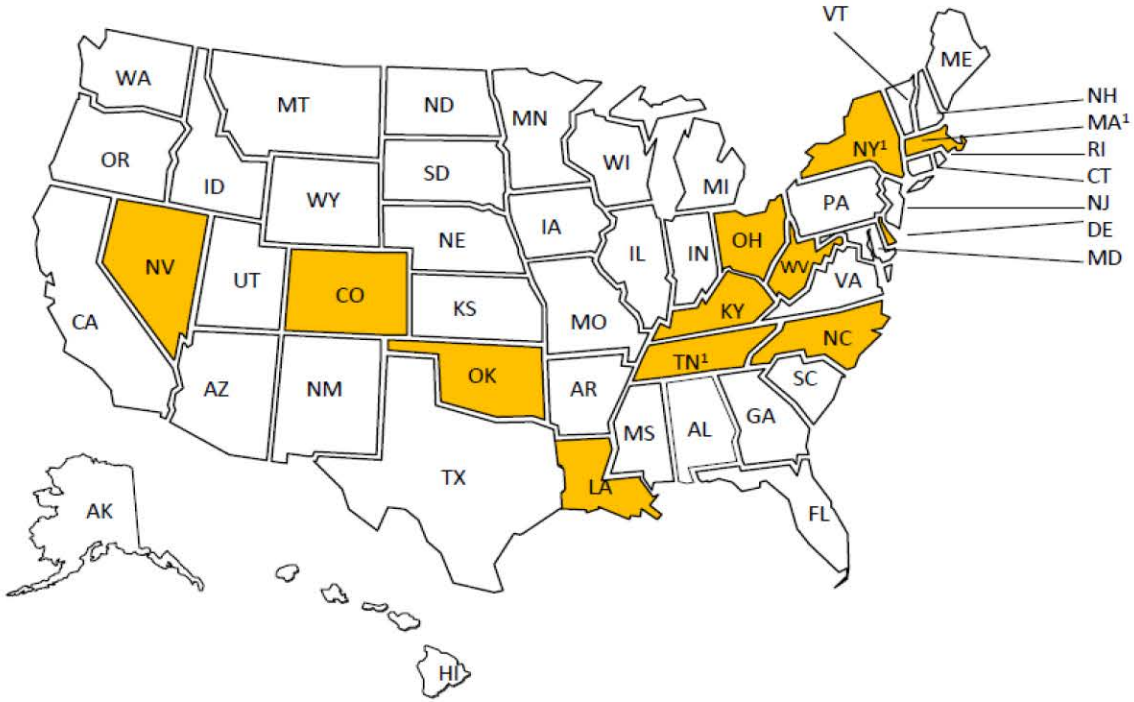
This information was compiled using legal databases, state agency websites and direct communications with state PDMP representatives

States that Require Prescribers and/or Dispensers to Access PMP Information in Certain Circumstances*



* Please see the accompanying memorandum for specifics as to the circumstances under which a prescriber and/or dispenser is obligated to access the PMP database in each state.

[1] Parts of the Tennessee law go into effect on January 1, 2013, while other aspects go into effect on April 1, 2013. The New York law goes into effect on August 27, 2013. The Massachusetts provision goes into effect on January 1, 2013.

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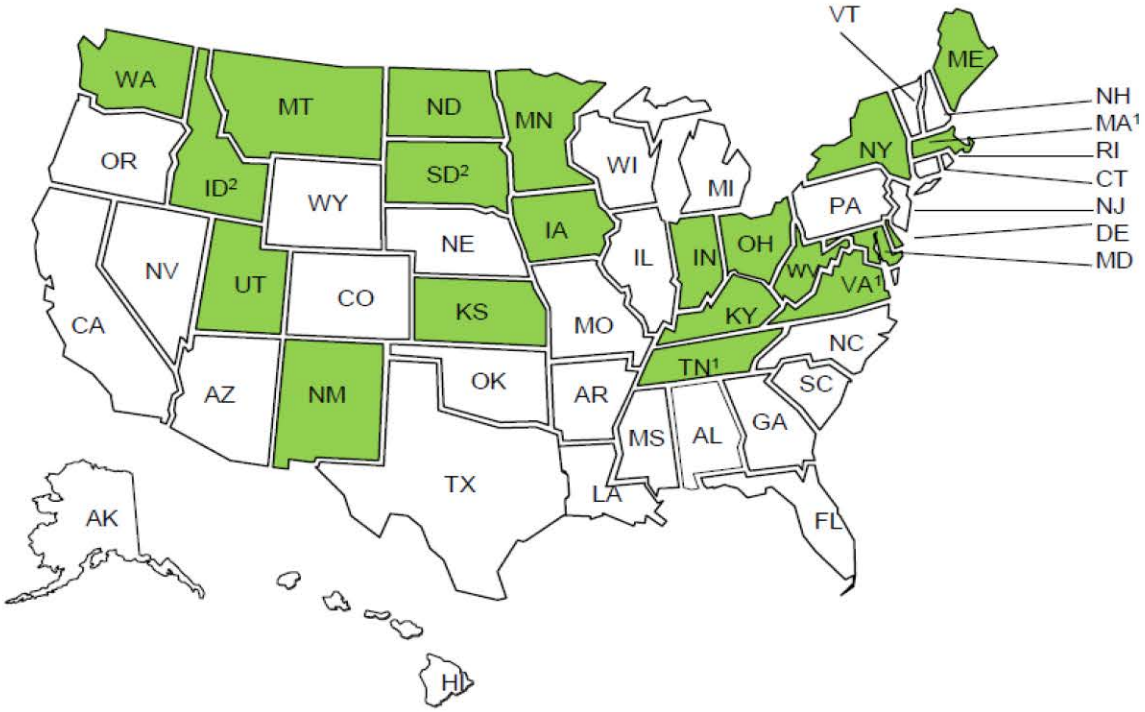
PRACTITIONER AGENTS

- Registered practitioner may designate agents to access program on behalf of practitioner
  - Health care professional (NOT office personnel)
  - No more than 3 agents per practitioner
  - Agent registers for each supervising practitioner
  - No limit on the number of supervising practitioners for whom an agent may register
  - Agent receives unique username and password
- 114 registered agents since 7/1/2012

States that Allow Practitioners to Designate an Authorized Agent to Access the PMP Database



[1] The Tennessee and Massachusetts provisions go into effect on January 1, 2013. The New York provisions go into effect on August 27, 2013.
[2] Idaho and South Dakota only allow prescribers to designate an agent at this time.

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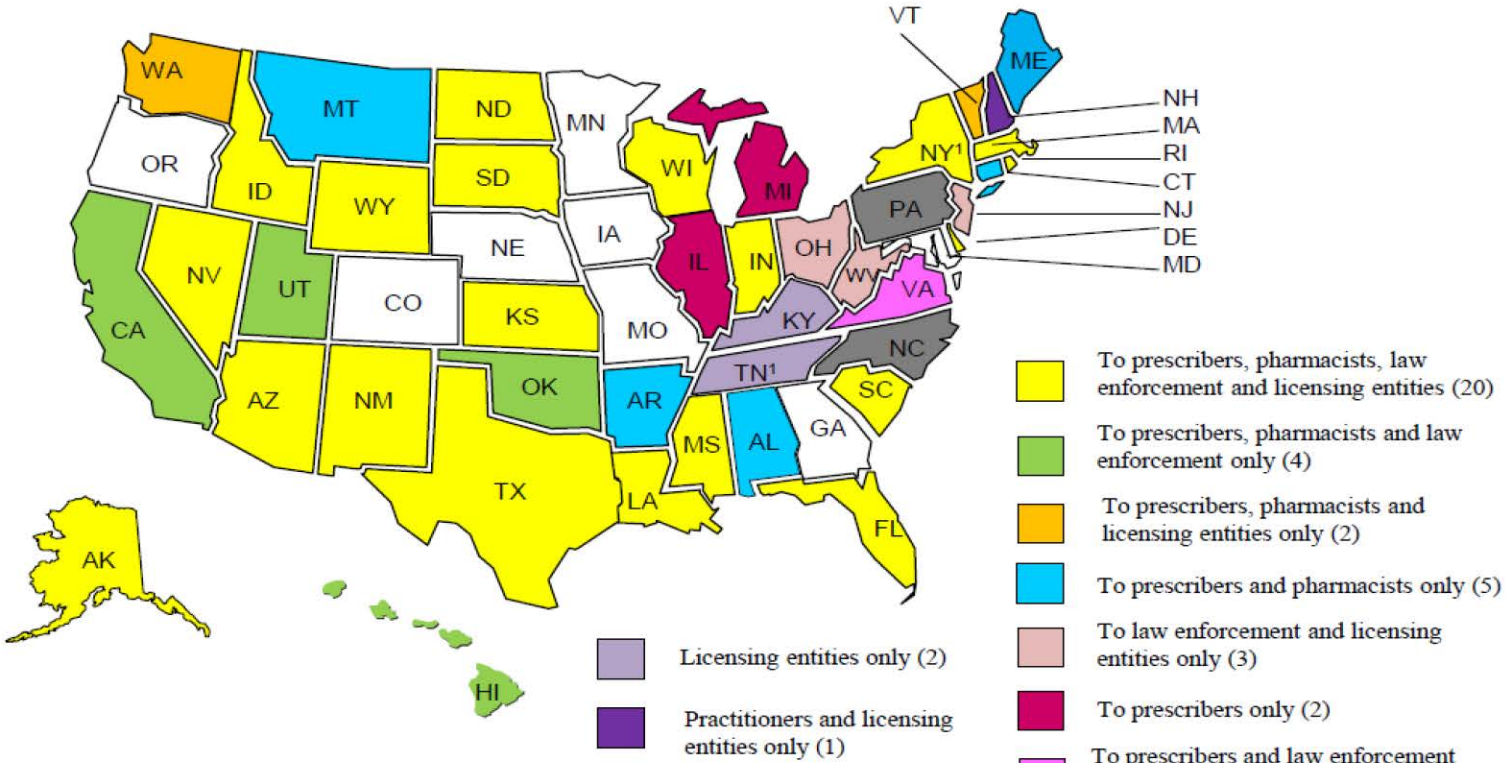
UNSOLICITED REPORTS

- Generate and distribute reports to practitioners regarding the practitioners' patients
  - Alert practitioners to abuse, misuse, or other potentially harmful patient activities
  - Thresholds to identify potential patient of concern
  - Another tool for reducing abuse, diversion, doctor/pharmacy shopping, and addiction
- Not authorized under Iowa Code

Unsolicited PMP Reports to Prescribers, Pharmacists, Law Enforcement and Licensing Entities



[1] The New York provision goes into effect August 27, 2013. Until then, New York will provide unsolicited reports to prescribers only. The Tennessee provision goes into effect on January 1, 2013.

[2] North Carolina provides unsolicited reports to the Attorney General who has the discretion to forward the information to law enforcement.

[3] Michigan send alerts to physicians when a patient surpasses the threshold but does not send the actual report.

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This information was compiled using legal databases, state agency websites and direct communications with state PDMP representatives

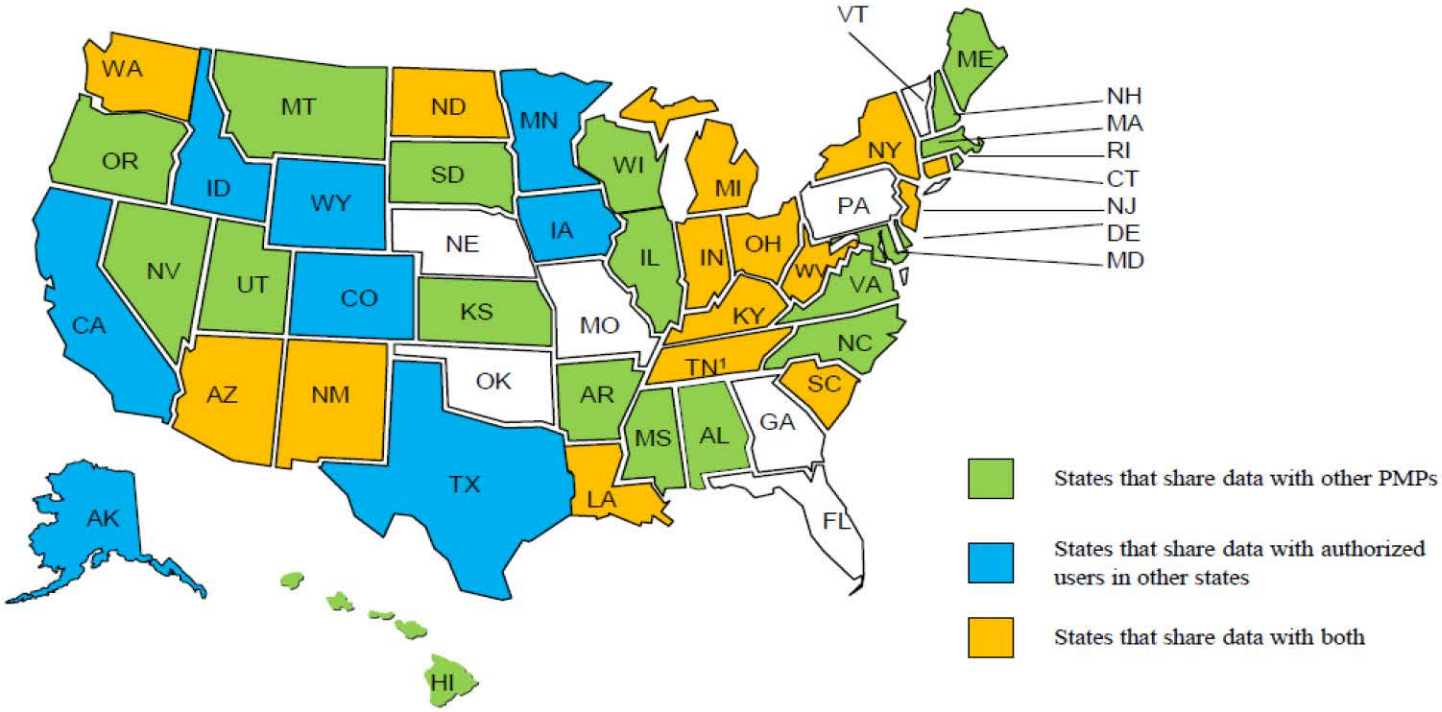
CURRENT INITIATIVES

- Web Center application upgrade (1/14/2013)
  - Compatible with all major Internet browsers
  - Improve functionality including “saved queries”
  - Unassisted user lost password fix
  - Online help feature
- Dispenser reporting enhancements (10/1/2012)
  - Nonresident pharmacies report effective 1/1/2013
  - Dispensed prescriptions submitted weekly
  - Online data correction and resubmission

LEGISLATIVE INITIATIVE

- Interstate PMP data exchange
  - Iowa user requests data from Iowa PMP
  - User identifies other state programs that may have records for the subject of the request
  - PMP Interconnect queries the multiple states and returns patient records to Iowa PMP/Iowa user
  - Users of PMP Interconnect programs are not required to register with multiple states
- 2013 Pharmacy Board legislative proposal

Interstate Sharing of Prescription Monitoring Program Data Pursuant to Statute, Regulation, and/or Statutory Interpretation



[1] The Tennessee provisions become effective on January 1, 2013.

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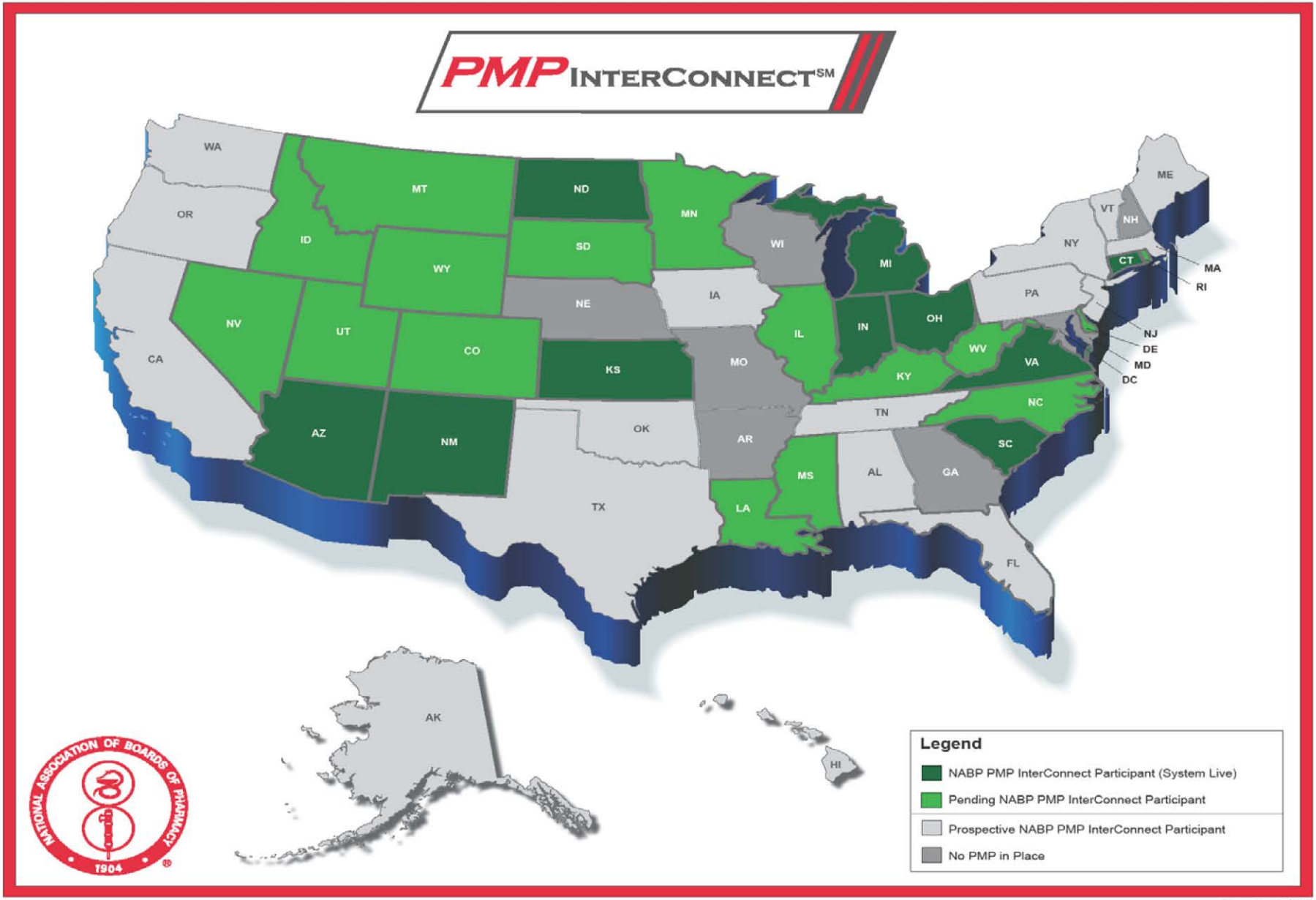
PMP InterConnect℠
WA
OR
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GA
FL
SC
NC
VA
PA
NY
VT
NH
ME
MA
RI
CT
NJ
DE
MD
DC
AK
HI
Legend
NABP PMP InterConnect Participant (System Live)
Pending NABP PMP InterConnect Participant
Prospective NABP PMP InterConnect Participant
No PMP in Place
NATIONAL ASSOCIATION OF BOARDS OF PHARMACY
1904
Current as of September 21, 2012

QUESTIONS/CONTACT US

terry.witkowski@iowa.gov
debbie.jorgenson@iowa.gov
eric.way@iowa.gov

Phone: 515-281-5944 Fax: 515-281-4609

https://ibpe-pmp.iowa.gov/

http://www.iowa.gov/ibpe/pmp.html

IOWA

PRESCRIPTION MONITORING PROGRAM

(PMP)

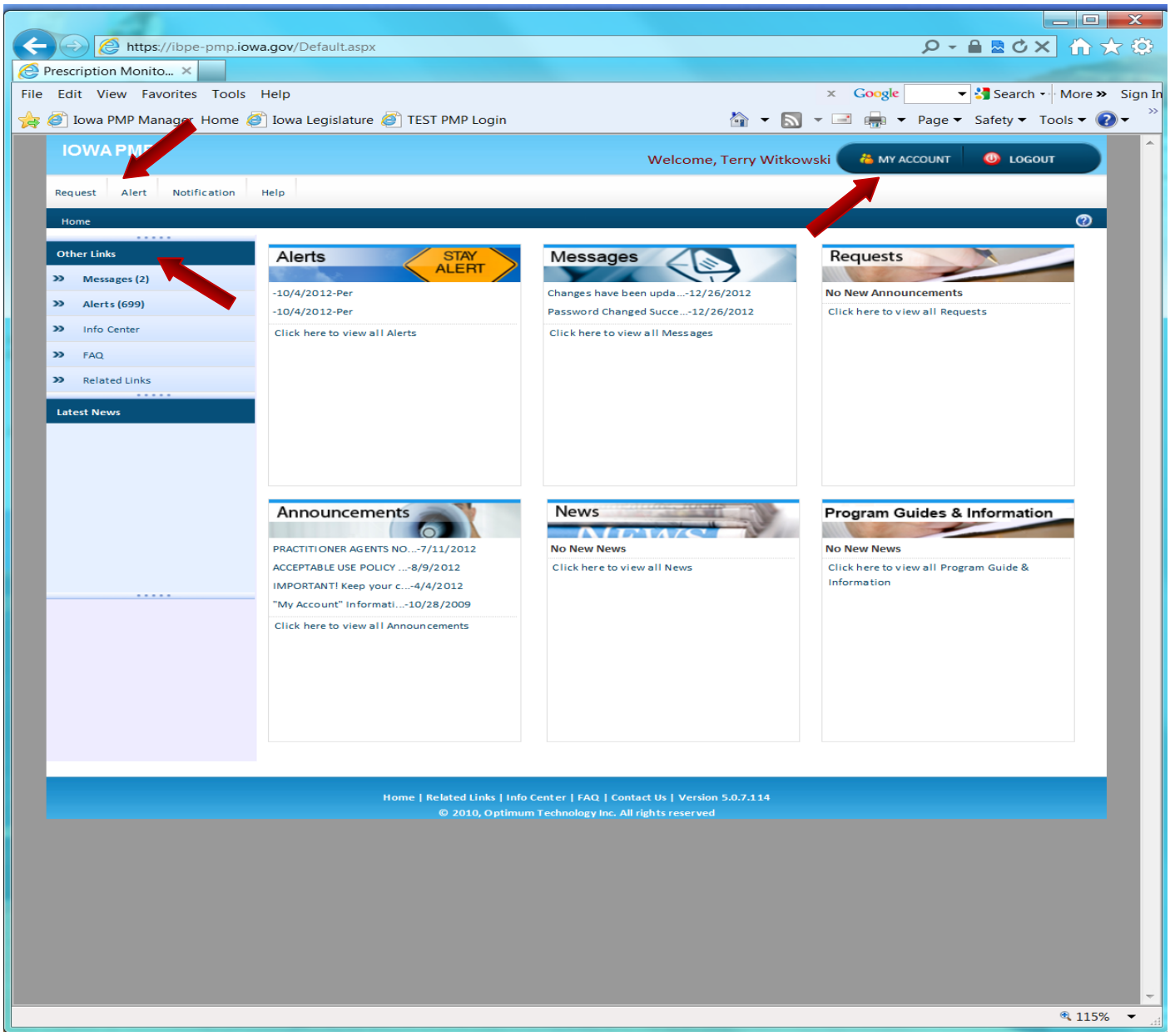
USER GUIDE

JANUARY 14, 2013

This is the login screen. If you are registered and know your username and password, enter them in the appropriate boxes and click Login. Your username is not case sensitive but your password is case sensitive and includes alpha, numeric, and special characters.

If you are registered but have lost or forgotten your password, you may be able to set a new password by clicking Forgot/Reset Password and following the screen prompts.

If you have not registered to use the Iowa PMP, click the link on Register just below the padlock on the left side. Complete and submit the user registration form.

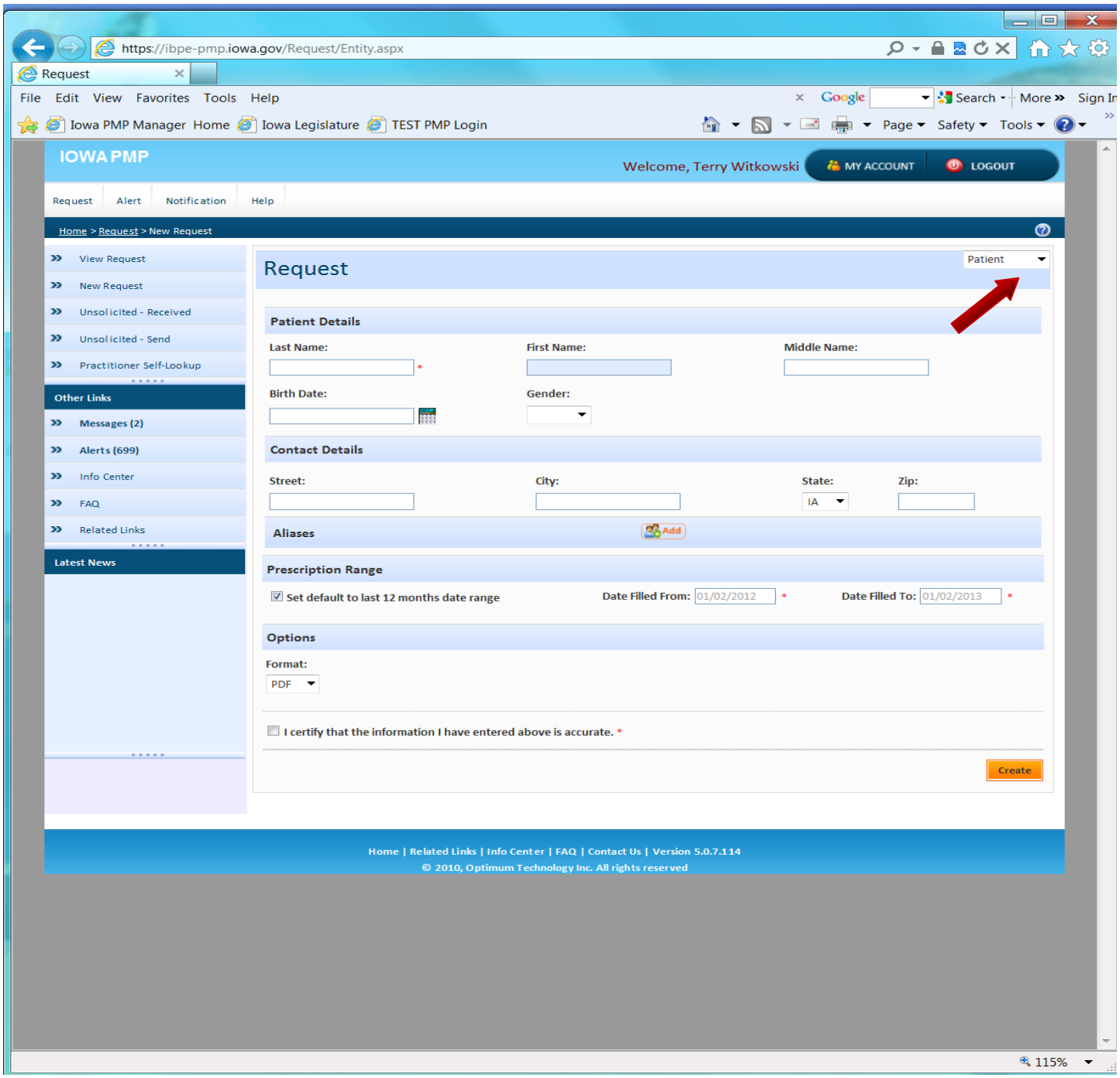


This screen is your home screen. Note “My Account” in the upper right corner – this is where you make changes to your PMP profile including changing your password, address, email, and telephone numbers.

Also note the “Other Links” on the left. These sections include information regarding using the PMP website and valuable resources for PMP users.

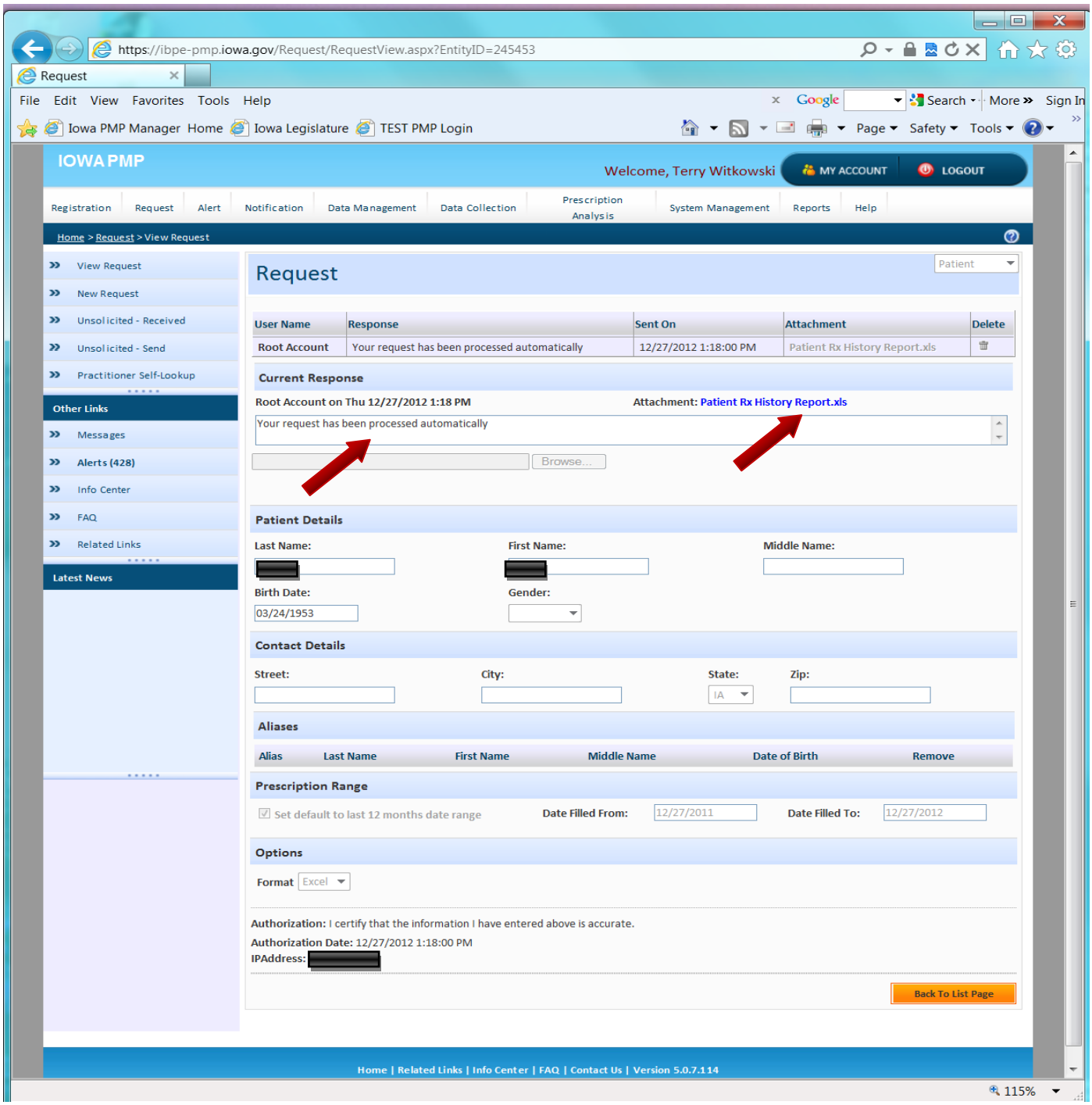
The menu bar across the top includes “Request” and “Alert” where you will create patient information queries or alerts on patients of concern. You can view your Alerts, Messages, Requests, and other program information from the dashboard boxes in the center of the screen.

Also note the question mark in the upper right below the “Logout” button. By clicking the “?” you will be able to review content-specific help information for the open screen.



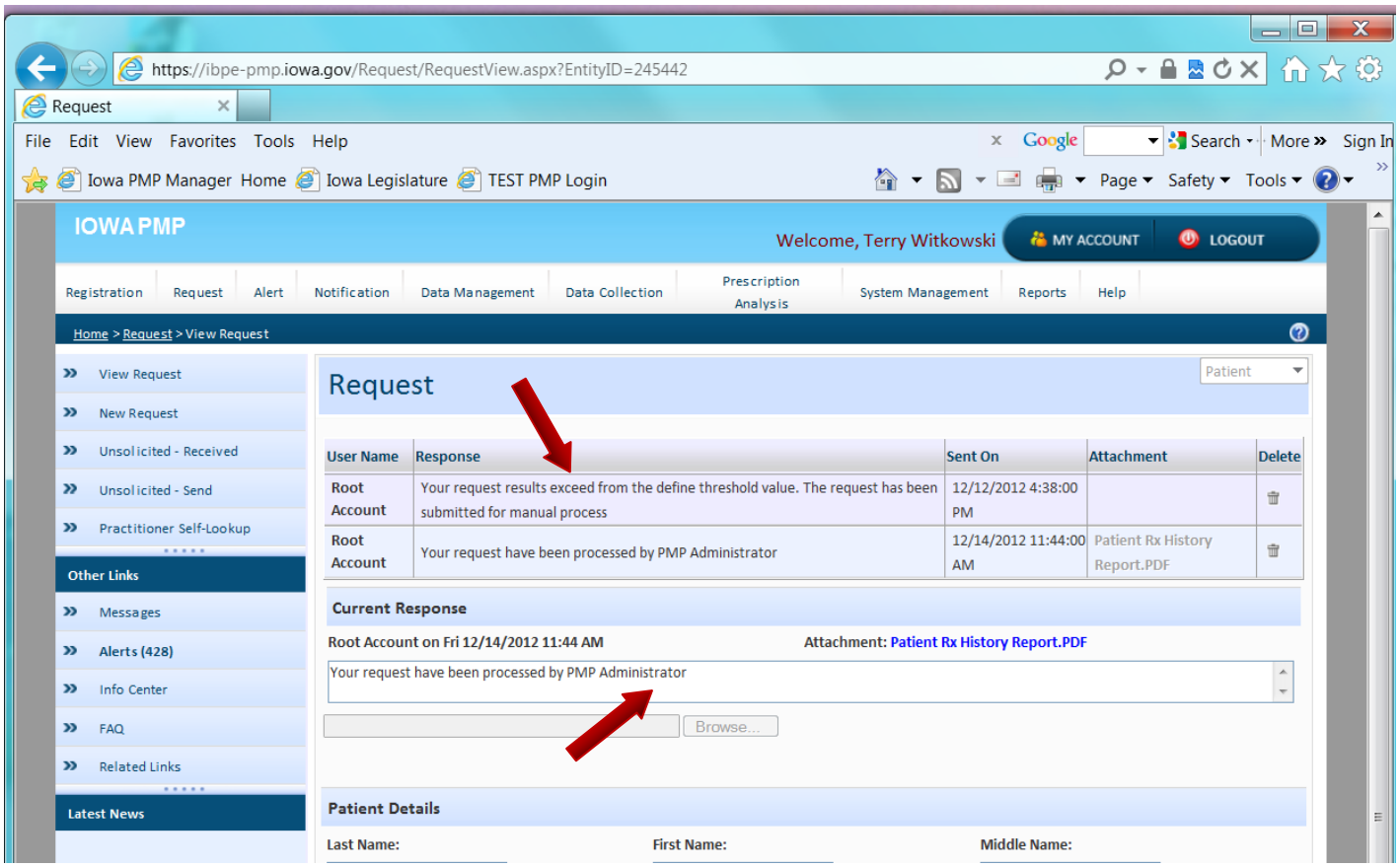
This form is used to submit a Request for patient prescription history. Required fields are identified by *. Date range will default to the last 12 months but can be changed by unchecking the box and typing new beginning and ending dates. Click CREATE.

A prescriber may Request the prescriptions authorized by the prescriber and filled by the prescriber's patients. A "Practitioner Self-Lookup" will not process automatically; the Request must be reviewed and processed by a PMP Administrator. To submit a Request for your prescriptions, select "Practitioner Self-Lookup" from the request menu (left side of the screen) and complete the required fields. Click CREATE.



Once your Request has processed (usually within a few seconds) you should see a screen similar to this one. Note that the "Current Response" includes 2 parts – the statement regarding processing your account and the "Attachment."

Click on the name of the Attachment, "Patient Rx History Report," to open the report. You may view, save, or print the report but **don't forget the PMP confidentiality provisions**! Do not give the report to the patient or to a law enforcement or regulatory agent.



If the response indicates that your Request could not be processed automatically for any reason, **please do not** submit a duplicate Request for that patient (the results will not change). A PMP Administrator will process your Request as soon as possible.

Once your Request has been processed, an email will be sent to your registered emaill address advising you that the requested report is ready. Log into the PMP website, select "View Request," click on the patient's name to open your Request. The top of the screen should look something like what is displayed here. Note there are multiple Responses at the top of this form but the newest response states that your Request has been processed.

Click on the "Patient Rx History Report" under Current Response to open the report. You may view, save, or print the report but **don't forget the PMP confidentiality provisions**! Do not give the report to the patient or to a law enforcement or regulatory agent.

Following is a sample Patient Rx History Report. Note the patient (red arrows), prescriber (blue arrows), and pharmacy (green arrows) identifications and keys within the report.

Automated Prescription Monitoring System
Iowa Board of Pharmacy, Des Moines, IA 50309
Phone:(515) 281-5944 Email:terry.witkowski@iowa.gov Fax:(515) 281-4609

Patient RX History Report

BETTY BOOP

Date: 12-10-2012

This report may contain another person's controlled substance information. Please review the "Patients that match search criteria" section located below to ensure all prescriptions belong to the requested individual.

Search Criteria: ((Last Name Begins 'boop' AND First Name Contains 'betty') AND (D.O.B = '01/01/1961' AND State = 'IA')) AND Request Period = '12/10/2011' To '12/10/2012'

Patients that match search criteria

Pt ID	Name	DOB	Address
4823	BOOP, BETTY	1/1/1961	9999 CENTER ST APT A, IA 55555
2884	BOOP, BETTY	1/1/1961	9999 CENTER ST IA 55555

Prescriptions

Fill Date	Product, Str, Form	Quantity	Days	Pt ID	Prescriber	Written	Rx #	N/R	Pharm	Pay
03/05/2012	HYDROCODONE BITARTRATE AND ACETAMIN, 325 MG-5 MG, TAB	10.00	3	2884	DR RO59	03/05/2012	0440137	N	AH9999999	
01/05/2012	CLONAZEPAM, 0.5 MG, TAB	90.00	30	2884	DR DO22	01/05/2012	0439460	N	AH9999999	
12/15/2011	APAP/HYDROCODONE BITARTRATE, 500 MG-5 MG, TAB	14.00	2	4823	DR LL87	12/04/2011	4127905	N	BR9999999	

N/R: N=New R=Refill

Pay:01=Private Pay 02=Medicaid 03=Medicare 04=Commercial Ins. 05=Military Inst. and VA 06=Workers Comp 07=Indian Nations 99=Other

Total Prescriptions: 3

Prescribers for prescriptions listed

DR DO22 BORIS BADINOV; 1 E 47TH ST, SOMEWHERE MO 66666

DR RO59 MOUSE MICKEY, MD; BASIC MEDICAL CENTER, 4 BASIC DR, ANTYTOWN IA 55555

DR LL87 BUZZ LIGHTYEAR, DR; 15 COSMIC STREET #100, ANYTOWN IA 55555

Pharmacies that dispensed prescriptions listed

AH9999999 HARRYS DRUG CO, INC.; 1 H ST, ANYTOWN IA 55555

BR9999999 GH FOOD AND PHARMACY; 9 W GRAND STREET, ANYTOWN IA 55555

Disclaimer: The State of Iowa does not warrant the above information to be accurate or complete. The Report is based on the search criteria entered and the data entered by the dispensing pharmacy. For more information about any prescription, please contact the dispensing pharmacy or the prescriber.

An Alert, whether the Alert concerns a “Patient” or a “Prescription,” is submitted and viewed in essentially the same manner as a Request except when entering and submitting an Alert, provide as much detailed information as known regarding the patient and your concerns. For example, if you have the patient’s address, please include that information. If you can describe the patient or the patient’s vehicle, please include that information. If the patient requests or appears to be abusing specific drugs or types of drugs, please include that information. Include the information you have found that has caused your concerns regarding the patient.

If you are submitting a “Prescription” Alert (for example, you have discovered that someone has stolen your prescription pad or is using your DEA registration number), please include as much information as you can to describe the issue. The more information you can provide in an Alert, the better informed the prescribers and pharmacists receiving the information will be if the patient requests services from those practitioners.

Alerts are posted to other registered users in the same region of the state as the patient and/or the reporting PMP user. Alerts will NOT be distributed to law enforcement or regulatory agents unless the reporting PMP user checks the box in the Suspected Activity section that corresponds with “Please notify LAW ENFORCEMENT.”

The purpose of the Iowa PMP is to make available to health care practitioners information that will assist those practitioners in making informed decisions regarding the health care treatment of their patients.

Questions or issues, please contact a PMP Administrator:

Phone: 515-281-5944
Fax: 515-281-4609
Email: terry.witkowski@iowa.gov
debbie.jorgenson@iowa.gov
eric.way@iowa.gov
www.iowa.gov/ibpe/pmp.html

SENATE/HOUSE FILE _____
BY (PROPOSED DEPARTMENT OF PUBLIC HEALTH/BOARD OF MEDICINE BILL)

A BILL FOR

1 An Act relating to disciplinary procedures before the board of
2 medicine and providing a penalty.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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Section 1. Section 148.2A, subsection 2, paragraph e, subparagraphs (3) and (4), Code 2013, are amended to read as follows:

(3) ~~The majority of a~~ At least half of the members of a hearing panel containing alternate members shall be members of the board.

(4) ~~The majority of a~~ At least half of the members of a hearing panel containing alternate members shall be licensed to practice under this chapter.

Sec. 2. Section 148.6, subsection 1, Code 2013, is amended to read as follows:

1. The board, after due notice and hearing in accordance with chapter 17A, may issue an order to discipline a licensee for any of the grounds set forth in section 147.55, chapter 272C, or this ~~subsection~~ section. Notwithstanding section 272C.3, licensee discipline may include a civil penalty not to exceed ~~ten~~ twenty thousand dollars for each violation of the laws and rules governing the practice of medicine.

Sec. 3. Section 148.7, Code 2013, is amended to read as follows:

148.7 Procedure for licensee discipline.

A proceeding for the revocation or suspension of a license to practice medicine and surgery or osteopathic medicine and surgery, or acupuncture or to discipline a person licensed to practice medicine and surgery or osteopathic medicine and surgery, or acupuncture shall be substantially in accord with the following procedure and with section 272C.6, subsection 4, to the extent the provisions in that subsection are not inconsistent with this section:

1. The board may, upon its own motion or upon receipt of a complaint ~~in writing~~, order an investigation. The board may, upon its own motion, order a hearing. A written notice of the time and place of the hearing together with a statement of the charges shall be served upon the licensee at least ten days before the hearing in the manner required for the service

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of notice of the commencement of an ordinary action or by restricted certified mail.

2. If the whereabouts of the licensee is unknown, service may be had by publication as provided in the rules of civil procedure upon filing the affidavit required by the rules. In case the licensee fails to appear, either in person or by counsel at the time and place designated in the notice, the board shall proceed with the hearing as provided in this section.

~~3. *a.* The hearing shall be before a member or members designated by the board or before an administrative law judge appointed by the board according to the requirements of section 17A.11, subsection 1. The presiding board member or administrative law judge may issue subpoenas, administer oaths, and take or cause depositions to be taken in connection with the hearing. The presiding board member or administrative law judge shall issue subpoenas at the request and on behalf of the licensee.~~

~~*b.* The administrative law judge shall be an attorney vested with full authority of the board to schedule and conduct hearings. The administrative law judge shall prepare and file with the board the administrative law judge's findings of fact and conclusions of law, together with a complete written transcript of all testimony and evidence introduced at the hearing and all exhibits, pleas, motions, objections, and rulings of the administrative law judge.~~

3. At the discretion of the board, a disciplinary hearing shall be held before one of the following:

a. A quorum of the board. A quorum of the board shall include not less than six members, at least half of whom are board members, and the remaining alternate members appointed pursuant to section 148.2A, with no more than half of the quorum being public members.

b. A panel of not less than three board members, at least two of whom are licensed in the profession.

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c. A panel of not less than three specialists appointed pursuant to section 272C.6, subsection 2.

d. An administrative law judge. The decision to assign an administrative law judge shall be within the sole discretion of the board. The administrative law judge shall be assigned by the division of administrative hearings pursuant to section 10A.801, and shall be an attorney vested with full authority of the board to schedule and conduct hearings.

4. ~~Disciplinary hearings held pursuant to section 272C.6, subsection 1, shall be heard by the board, or by a panel of not less than six members, at least three of whom are board members, and the remaining appointed pursuant to section 148.2A, with no more than three of the six being public members.~~ Notwithstanding chapters 17A and 21, a disciplinary hearing shall be open to the public at the discretion of the licensee.

5. The presiding officer may issue subpoenas, administer oaths, and take or cause depositions to be taken in connection with the hearing. The presiding officer shall issue subpoenas at the request and on behalf of the parties. If a person refuses to obey a subpoena issued by the presiding officer or to answer a proper question during the hearing, the presiding officer may invoke the aid of the district court in requiring the attendance and testimony of a person or the production of papers. A failure to obey the order of the court may be punished by the court as a civil contempt.

~~5.~~ 6. A record of the proceedings shall be kept. The licensee shall have the opportunity to appear personally and by an attorney, with the right to produce evidence on the licensee's own behalf, to examine and cross-examine witnesses, and to examine documentary evidence produced against the licensee.

~~6. If a person refuses to obey a subpoena issued by the presiding member or administrative law judge or to answer a proper question during the hearing, the presiding member or~~

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~~administrative law judge may invoke the aid of a court of competent jurisdiction or judge of this court in requiring the attendance and testimony of the person and the production of papers. A failure to obey the order of the court may be punished by the court as a civil contempt may be punished.~~

7. Unless the hearing is held before a quorum of the ~~entire~~ board, the presiding officer shall prepare and file with the board the proposed findings of fact, conclusions of law, decision, and order, with a complete written transcript of the proceeding, together with all exhibits ~~presented~~, ~~shall be considered by the entire board at the earliest practicable time~~ pleadings, motions, objections, and rulings within sixty days of the date of the hearing absent compelling circumstances. ~~The licensee and the licensee's attorney shall have the opportunity to appear personally to present the licensee's position and arguments to the board. The board shall determine the charge or charges upon the merits on the basis of the evidence in the record before it.~~

8. The proposed findings of fact, conclusions of law, decision, and order may be appealed to the full board by either party by serving on the executive director, either in person or by certified mail, a notice of appeal within thirty days after service of the proposed findings of fact, conclusions of law, decision, and order on the appealing party.

~~8.~~ 9. If a majority of the members of the board vote in favor of finding the licensee guilty of an act or offense specified in section 147.55 or 148.6, the board shall prepare written findings of fact ~~and its decision~~, conclusions of law, and a decision and order imposing one or more of the following disciplinary measures:

a. Suspend the licensee's license to practice the profession for a period to be determined by the board.

b. Revoke the licensee's license to practice the profession.

c. Suspend imposition of judgment and penalty or impose the judgment and penalty, but suspend enforcement and place

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1 the physician or acupuncturist on probation. The probation
2 ordered may be vacated upon noncompliance. The board may
3 restore and reissue a license to practice medicine and surgery
4 or osteopathic medicine and surgery, or acupuncture, but may
5 impose a disciplinary or corrective measure which the board
6 might originally have imposed. A copy of the board's order,
7 findings of fact, conclusions of law, and decision, shall be
8 served on the licensee in the manner of service of an original
9 notice or by certified mail return receipt requested.
10 ~~9.~~ 10. Judicial review of the board's action may be
11 sought in accordance with the terms of the Iowa administrative
12 procedure Act, chapter 17A.
13 ~~10.~~ 11. The board's order revoking or suspending a license
14 to practice medicine and surgery or osteopathic medicine
15 and surgery, or acupuncture, or to discipline a licensee
16 shall remain in force and effect until the appeal is finally
17 determined and disposed of upon its merit.
18 EXPLANATION
19 This bill relates to disciplinary procedures before the
20 board of medicine.
21 The bill provides that at least half of the members of a
22 disciplinary hearing panel containing alternate members shall
23 be members of the board of medicine and at least half the
24 members shall be licensed to practice under Code chapter 148.
25 The bill increases the board's maximum civil penalty from
26 $10,000 to $20,000 and specifies that this penalty may be
27 assessed for each violation.
28 Relating to disciplinary procedures, the bill rewrites
29 the existing provisions to provide additional detail. The
30 bill specifies that the procedures for licensee discipline
31 in Code section 148.7 apply to persons licensed to practice
32 acupuncture.
33 The bill specifies that a disciplinary hearing may be
34 presided over by either: a quorum of the entire board; a
35 panel of at least three board members; a panel made up of

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1 specialists; or an administrative law judge. The bill rewrites
2 existing provisions relating to the power of the presiding
3 officer to issue subpoenas and the enforcement of those
4 subpoenas.
5 The bill allows an administrative law judge to hear certain
6 board-assigned contested cases without a hearing panel. The
7 bill codifies in Code chapter 148 provisions that are generally
8 set out in Code chapter 17A relating to the decision in a
9 contested case. If a quorum of the entire board hears the
10 case, the board decision is final agency action. If less than
11 a quorum or an administrative law judge hears the case, the
12 decision may be appealed to the entire board.

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REPORT TO THE IOWA DENTAL BOARD

FYI

DATE OF MEETING: January 31, 2013

RE: **Presentation: Public Health Supervision**

SUBMITTED BY: Melanie Johnson

ACTION REQUESTED: FYI Only.

Background

At the October 24-25, 2012 Dental Board meeting there was an interest expressed in learning more about public health supervision (e.g., history, supervision agreements, oversight, etc.). There will be a presentation on this topic at the January 31st Board meeting.

Attached for Review

- Presentation Outline
- Materials from the October 24-25, 2012 Board meeting
  - Board's Formal Rule Making re PHS (2003-2009))
  - File Documents re: Public Health Supervision (1999- 2009) Included:
    - 2003 Regulatory Analysis by Board
    - Comments received
    - Information regarding other states'
    - 2008 Rule Making Petition filed by IDHA

Presentation: Public Health Supervision

January 31, 2013

1. Introductions & overview *(Melanie Johnson)*
2. Origins of public health supervision agreements – responding to a need *(Bobby Russell)*
3. PHS rulemaking history *(Melanie Johnson)*
4. Current PHS structure *(Theresa Weeg)*
    a. Board rules authorize agreements & establish required content
    b. Agreements submitted to IDPH Bureau of Oral Health
    c. Role of Iowa Dental Board
        i. Adopted rules to authorize PHS agreements
        ii. Propose amendments, as needed
        iii. Receive annual report from IDPH
        iv. Process complaints submitted concerning PHS agreements
5. Role of IDPH *(Bobby Russell, Tracy Rodgers)*
    a. Receive agreements and amendments
    b. Review agreements for compliance with IDB rules
    c. Submit annual report to IDB
6. Review of existing PHS agreements *(Lynn Curry)*

10/22/12 Supplemental

REPORT TO THE IOWA DENTAL BOARD

FYI

DATE OF MEETING: October 25-26, 2012

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

SUBMITTED BY: Melanie Johnson

ACTION REQUESTED: FYI Only.

Background

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

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

Attached for Review

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

IOWA ADMINISTRATIVE BULLETIN

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DENTAL EXAMINERS BOARD[650]

Notice of Intended Action

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

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

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

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

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

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

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

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

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

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

The following amendments are proposed.

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

Adopt the following **new** definition:

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

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

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

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

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

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

ARC 2325B

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351]

Notice of Intended Action

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

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

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

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

IOWA ADMINISTRATIVE BULLETIN

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ADMINISTRATIVE SERVICES DEPARTMENT[11]

Notice of Intended Action

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

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

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

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

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

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

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

ARC 2781B

AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]

Notice of Intended Action

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

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

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

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

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

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

The following amendment is proposed.

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

ARC 2784B

DENTAL EXAMINERS BOARD[650]

Notice of Termination

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

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

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

ARC 2783B

DENTAL EXAMINERS BOARD[650]

Notice of Intended Action

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

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

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

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

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

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ARC 2788B

ADMINISTRATIVE SERVICES DEPARTMENT[11]

Notice of Intended Action

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

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

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

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

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

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

ARC 2781B

AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]

Notice of Intended Action

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

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

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

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

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

The following amendment is proposed.

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

ARC 2784B

DENTAL EXAMINERS BOARD[650]

Notice of Termination

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

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

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

ARC 2783B *

DENTAL EXAMINERS BOARD[650]

Notice of Intended Action

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

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

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

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

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

DENTAL EXAMINERS BOARD[650](cont'd)

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

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

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

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

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

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

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

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

This amendment is intended to implement Iowa Code chapter 153.

The following amendment is proposed.

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

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

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

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

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

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

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

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

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

a. The dentist providing public health supervision must:

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

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

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

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

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

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

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

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

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

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

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

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

DENTAL EXAMINERS BOARD[650](cont'd)

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

This rule is intended to implement Iowa Code section 153.15.

ARC 2785B

DENTAL EXAMINERS BOARD[650]

Notice of Intended Action

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

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

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

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

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

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

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

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

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

The following amendments are proposed.

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

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

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

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

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

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

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

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

ARC 2755B

ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]

Notice of Intended Action

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

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

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

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

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

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

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

The following amendments are proposed.

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

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ARC 3041B

DENTAL EXAMINERS BOARD[650]

Adopted and Filed

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

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

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

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

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

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

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

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

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

This amendment is intended to implement Iowa Code chapter 153.

This amendment will become effective on January 28, 2004.

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

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

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

ARC 3026B

ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]

Adopted and Filed

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

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

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

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

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

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

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

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

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

IOWA ADMINISTRATIVE BULLETIN

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DENTAL BOARD[650]

Notice of Intended Action

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

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

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

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

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

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

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

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

This amendment is intended to implement Iowa Code section 153.15.

The following amendment is proposed.

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

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

IOWA ADMINISTRATIVE BULLETIN

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ARC 7767B

DENTAL BOARD[650]

Adopted and Filed

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

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

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

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

This amendment is intended to implement Iowa Code section 153.15.

This amendment will become effective on June 24, 2009.

The following amendment is adopted.

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

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

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

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

ARC 7790B

DENTAL BOARD[650]

Adopted and Filed

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

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

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

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

Current Rules

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

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

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

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

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

This rule is intended to implement Iowa Code section 153.15.

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The dentist providing public health supervision must:

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

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

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

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

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

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

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 153.15.

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

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

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

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

IOWA DENTAL ASSOCIATION

A Constituent of the American Dental Association

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Executive Director
Robert W. Harpster

December 30, 1999

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

RE: Proposed Changes to Implement Iowa Code Section 153.15

Dear Ms. Price:

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

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

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

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

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

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

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

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

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

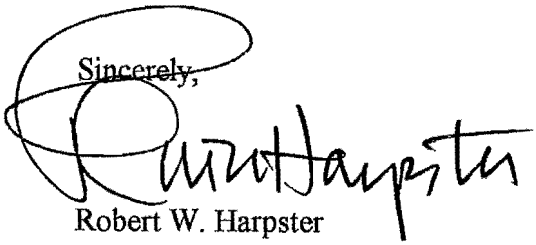
Section 153.15, Iowa Code states that "services shall be performed under supervision of a licensed dentist....".

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

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

We appreciate the opportunity to comment on the proposed rules.

Sincerely,



Robert W. Harpster
Executive Director

cc. Officers and Trustees

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SALLY J. PEDERSON
LT. GOVERNOR

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

COPY

September 30, 2002

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

Dear Ms. Temple:

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

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

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

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

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

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

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

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

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

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

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

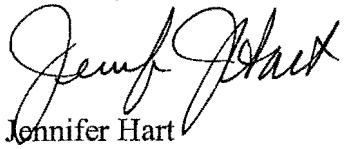
10. Would the Medicaid reimbursement be available to this practice, or does it have to be for care rendered by a dentist? If this is the case, are there any restrictions on what the hygienist could charge? If no reimbursement is available, will this actually result in additional preventive services being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

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

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

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

Sincerely,



Jennifer Hart
Executive Officer

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

October 7, 2002

RECEIVED
OCT 10 2002
IOWA BOARD OF
DENTAL EXAMINERS

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

Dear Iowa Board of Dental Examiners:

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

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

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

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

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

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

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

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

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

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

Sincerely,

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

States Permitting Unsupervised Practice/Less Restrictive Supervision

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

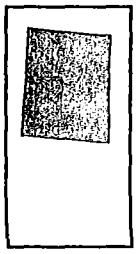
California 1998

Sec. 1768, 1770

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

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

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



Colorado - 1987

Sec. 12-35-122.5

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

Special Requirements: None.

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

Connecticut 1999

Section 20-126l.

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

Special Requirements: 2 years experience.

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

sealants, assessment and treatment planning.

Indiana 1992

Sec. 25-13-1-10

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

Special requirements: Licensed for two years.

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

Maine 2001

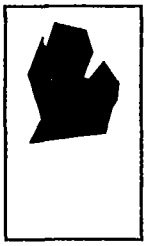
Rule 02 313 Chap. 1. Sec. 4

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

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

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

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



Michigan 1991

Sec. 333.16625

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

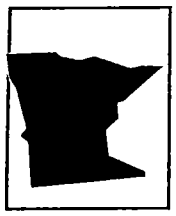
Special Requirements: No special requirements for dental hygienists. Agency must obtain

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

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

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

Services: Services that can be provided under general supervision.



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

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

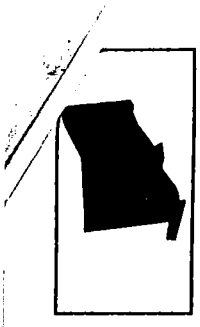
Health care facility means hospital, nursing home, home health agency, disabled/juvenile home, federal/state/local public health facility, community clinic, prison, tribal clinic or state-operated facility licensed by the commissioner of human services

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

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

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

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



Missouri 2001

Statute 332.311.2

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

Special Requirements: 3 years experience.

Services: prophylaxis, sealants, fluorides.

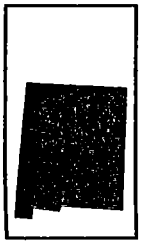
New Hampshire 1993

Rule 101.11(d)

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

Special Requirements: None.

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



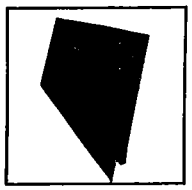
New Mexico 1999

Sec 61-5A-4D
Rule 16.5.17

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

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

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



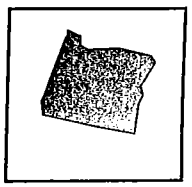
Nevada 1998

Rule 631.210.5

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

Statute 631.287

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



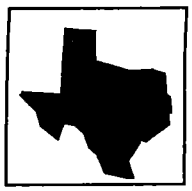
Oregon 1997

Sec. 680.200
Rule 818-035-0065

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

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

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



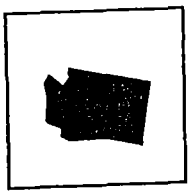
Texas 2001

Statute 262.1515

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

Special Requirements: 2 years practice experience.

Services: No limitations.



Washington 1984
Sec. 18.29.056

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

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

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

WA 2001
Statute 18.29.220

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

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

Division of Governmental Affairs *July, 2002*

Class Code: 02515

STATE OF IOWA - DEPARTMENT OF PERSONNEL

PUBLIC HEALTH DENTAL DIRECTOR

DEFINITION

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

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

WORK EXAMPLES

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

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

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

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

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

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

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

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

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

COMPETENCIES REQUIRED

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

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

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

Knowledge of the methods and media used in health education.

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

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

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

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

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

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

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

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

OR

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

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

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

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

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

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

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

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

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

IOWA DEPARTMENT OF PUBLIC HEALTH
FLUORIDE VARNISH PROTOCOL

Fluoride Varnish Facts

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

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

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

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

Application of Fluoride Varnish

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

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

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

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

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

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

6. Repeat for all remaining quadrants.

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

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

Personnel Required for Fluoride Varnish Application

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

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

PROTOCOLS FOR FOLLOW-UP SEALANT PROGRAM
WASHINGTON COUNTY

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

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

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

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

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

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

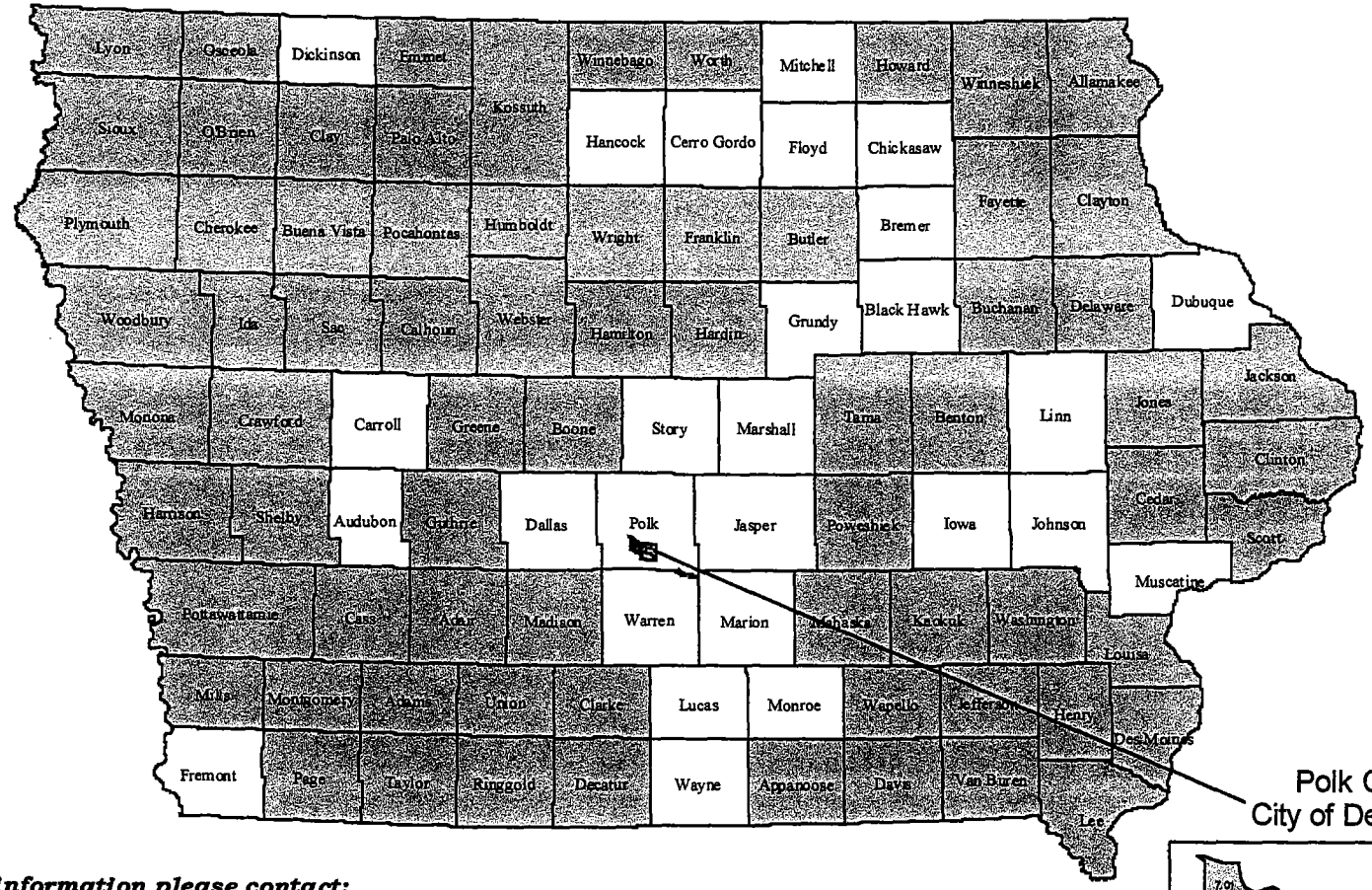
7. **After the child's scheduled appointment the social worker follows up with the dental office directly to a) make sure the child attended the appointment, b) to follow up on other scheduled appointments so reminders can be made to the family. If other appointments are scheduled then reminder of**

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

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

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

Dental Health Professional Shortage Areas (HPSAs)
November 2001



For further information please contact:

Iowa Department of Public Health
Division of Community Health
Bureau of Health Care Access
Lucas State Office Building, 5th Floor SE
321 East 12th Street
Des Moines, Iowa 50319-0075
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Carl Kulczyk, 515 281-7223
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FY 2001 Dental Screens

County Number	County Name	Agency Number	Total Eligible Age 1-20	Total Receiving Any Dental Services (00100-09999) Age 1-20	Percent Receiving Any Dental Services (00100-09999) Age 1-20	Total Receiving Preventative Dental (01000 - 01999) Age 1-20	Percent Receiving Preventative Dental (01000 - 01999) Age 1-20	Total Receiving Dental Treatment (02000 - 09999) Age 1-20	Percent Receiving Dental Treatment (02000 - 09999) Age 1-20
1	Adair	127	368	140	38.04%	117	31.79%	67	18.21%
2	Adams	112	303	87	28.71%	60	19.80%	40	13.20%
3	Allamakee	124	642	325	50.62%	280	43.61%	147	22.90%
4	Appanoose	101	1208	465	38.49%	377	31.21%	195	16.14%
5	Audubon	107	302	105	34.77%	63	20.86%	46	15.23%
6	Benton	125	967	423	43.74%	332	34.33%	182	18.82%
7	Black Hawk	102	9794	4063	41.46%	2976	30.39%	1698	17.34%
8	Boone	105	1226	387	31.57%	294	23.98%	115	9.38%
9	Bremer	102	933	385	42.64%	289	32.00%	159	17.61%
10	Buchanan	102	1226	587	47.86%	488	39.80%	269	21.94%
11	Buena Vista	113	1256	422	33.60%	317	25.24%	176	14.01%
12	Butler	111	643	290	45.10%	193	30.02%	109	16.95%
13	Calhoun	107	579	196	33.85%	160	27.63%	102	17.62%
14	Carroll	107	880	376	42.73%	311	35.34%	196	22.27%
15	Cass	123	812	284	34.98%	216	26.60%	125	15.39%
16	Cedar	103	699	221	31.62%	171	24.46%	87	12.45%
17	Cerro Gordo	111	2674	1185	44.32%	946	35.38%	477	17.84%
18	Cherokee	122	567	255	44.97%	170	29.98%	105	18.52%
19	Chickasaw	124	656	285	43.45%	226	34.76%	113	17.23%
20	Clarke	126	663	202	30.47%	158	23.83%	90	13.57%
21	Clay	113	868	329	37.90%	244	28.11%	135	15.55%
22	Clayton	124	739	331	44.79%	281	38.02%	143	19.35%
23	Clinton	134	3908	1341	34.31%	956	24.44%	601	15.38%
24	Crawford	123	1173	366	31.20%	244	20.80%	161	13.73%
25	Dallas	107	1375	424	30.84%	314	22.84%	165	12.00%
26	Davis	101	452	180	39.82%	152	33.63%	68	15.04%
27	Decatur	126	616	206	33.44%	154	25.00%	104	16.88%
28	Delaware	108	741	324	43.72%	279	37.65%	143	19.30%
29	Des Moines	110	3247	1022	31.48%	747	23.01%	386	11.89%
30	Dickinson	113	583	219	37.56%	144	24.70%	102	17.50%
31	Dubuque	108	4310	2416	56.06%	2200	51.04%	984	22.37%
32	Emmet	113	664	281	42.32%	204	30.72%	160	24.10%
33	Fayette	124	1424	656	46.09%	609	42.77%	318	22.33%
34	Floyd	111	1076	491	45.63%	404	37.55%	211	19.61%
35	Franklin	111	572	208	36.36%	167	29.20%	60	10.49%

FY 2001 Dental Screens

County Number	County Name	Agency Number	Total Eligible Age 1-20	Total Receiving Any Dental Services (00100-09999) Age 1-20	Percent Receiving Any Dental Services (00100-09999) Age 1-20	Total Receiving Preventative Dental (01000 - 01999) Age 1-20	Precent Receiving Preventative Dental (01000 - 01999) Age 1-20	Total Receiving Dental Treatment (02000 - 09999) Age 1-20	Precent Receiving Dental Treatment (02000 - 09999) Age 1-20
36	Fremont	126	569	183	32.16%	133	23.37%	89	15.64%
37	Greene	107	592	235	39.70%	201	33.95%	102	17.23%
38	Grundy	102	288	108	37.50%	72	25.00%	46	15.97%
39	Guthrie	107	636	242	38.06%	206	32.39%	129	20.28%
40	Hamilton	115	811	222	27.37%	167	20.59%	96	11.84%
41	Hancock	111	525	239	45.52%	218	41.52%	106	20.19%
42	Hardin	125	1128	386	34.22%	286	25.35%	145	12.85%
43	Harrison	123	965	430	43.65%	351	35.63%	189	19.19%
44	Henry	117	1090	472	43.30%	421	38.62%	175	16.06%
45	Howard	124	453	204	45.03%	175	38.63%	78	17.22%
46	Humboldt	115	423	169	39.95%	114	26.95%	79	18.68%
47	Ida	122	351	147	41.88%	104	29.63%	69	19.66%
48	Iowa	130	645	176	27.29%	130	20.16%	60	9.30%
49	Jackson	103	1111	493	44.37%	415	37.35%	217	19.53%
50	Jasper	133	1452	534	36.78%	321	22.11%	225	15.50%
51	Jefferson	101	997	411	41.22%	340	34.10%	179	17.95%
52	Johnson	130	3615	1252	34.63%	986	27.28%	504	13.94%
53	Jones	103	873	381	43.64%	302	34.59%	185	21.19%
54	Keokuk	101	759	297	38.62%	246	31.99%	117	15.21%
55	Kossuth	111	724	307	42.40%	246	33.98%	136	18.78%
56	Lee	135	3060	930	30.39%	636	20.78%	372	12.16%
57	Linn	131	9585	3940	41.11%	3260	34.01%	1676	17.49%
58	Louisa	106	956	263	27.51%	195	20.40%	133	13.91%
59	Lucas	126	722	275	38.09%	228	31.30%	139	19.25%
60	Lyon	122	458	137	29.27%	100	21.37%	67	14.32%
61	Madison	127	611	239	39.12%	196	32.08%	86	14.08%
62	Mahaska	133	1359	580	42.69%	480	35.32%	211	15.53%
63	Marion	126	1351	402	29.76%	290	21.47%	167	12.35%
64	Marshall	125	2774	912	32.86%	706	25.45%	329	11.86%
65	Mills	126	882	331	37.53%	254	28.80%	151	17.12%
66	Mitchell	111	393	198	51.70%	157	40.99%	84	21.93%
67	Monona	123	630	237	37.62%	193	30.63%	110	17.46%
68	Monroe	126	596	245	41.11%	191	32.05%	113	18.96%
69	Montgomery	112	896	321	35.83%	222	24.76%	159	17.75%
70	Muscatine	106	3181	897	28.20%	619	19.46%	363	11.41%

EPSDT HCFA 416 Lpo4

FY 2001 Dental Screens

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71	O'Brien	113	598	209	34.95%	163	27.26%	108	18.06%
72	Osceola	113	252	62	24.60%	42	16.67%	30	11.90%
73	Page	112	1176	375	31.89%	287	24.40%	173	14.71%
74	Palo Alto	113	430	155	36.05%	108	25.12%	71	16.51%
75	Plymouth	122	919	272	29.60%	205	22.31%	128	13.93%
76	Pocahontas	113	438	145	33.26%	111	25.46%	68	15.60%
77	Polk	132	22958	8492	36.99%	6909	30.10%	3623	15.78%
78	Pottawattamie	126	6817	2571	37.71%	1989	29.18%	1181	17.32%
79	Poweshiek	133	760	283	37.24%	202	26.58%	120	15.79%
80	Ringgold	127	349	116	33.24%	64	18.34%	45	12.89%
81	Sac	107	589	222	37.69%	155	26.32%	105	17.83%
82	Scott	120	12656	4784	37.80%	3585	28.33%	2090	16.51%
83	Shelby	123	517	225	43.52%	167	32.30%	105	20.31%
84	Sioux	122	1173	392	33.42%	293	24.98%	209	17.82%
85	Story	105	2127	673	31.64%	558	26.23%	241	11.33%
86	Tama	125	883	268	30.35%	200	22.65%	113	12.80%
87	Taylor	112	541	184	34.01%	137	25.32%	80	14.79%
88	Union	127	751	251	33.42%	188	25.03%	107	14.25%
89	Van Buren	101	490	168	34.29%	142	28.98%	56	11.43%
90	Wapello	101	3312	1387	41.88%	1183	35.72%	518	15.64%
91	Warren	126	1332	506	37.99%	396	29.73%	200	15.02%
92	Washington	117	964	399	41.39%	339	35.17%	148	15.35%
93	Wayne	126	453	164	36.20%	126	27.81%	77	17.00%
94	Webster	115	2882	1084	37.6[illegible]%	864	29.98%	446	15.48%
95	Winnebago	111	547	209	38.2[illegible]%	156	28.55%	88	16.09%
96	Winneshiek	124	673	281	41.75%	224	33.28%	110	16.34%
97	Woodbury	116	8518	2486	29.19%	1703	19.99%	1220	14.32%
98	Worth	111	241	107	44.40%	77	31.95%	47	19.50%
99	Wright	115	797	279	35.01%	214	26.85%	133	16.69%
	State		167746	63061	37.59%	49192	29.33%	26945	16.06%

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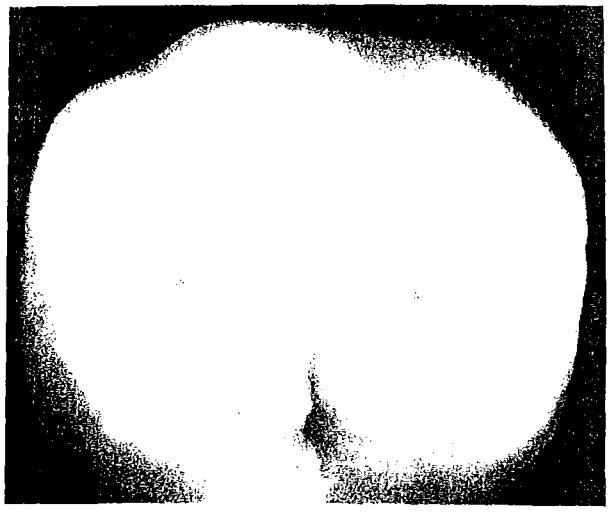
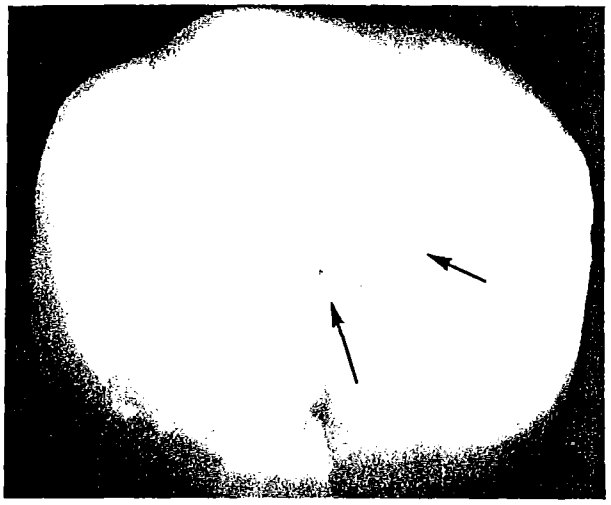
Journal of Public Health Dentistry

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



Caries free



Enamel caries

Dentin caries

ies activity in the mouth (Figure 2).

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

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

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

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

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

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

September 19, 2002

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

Dear Ms. Temple:

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

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

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

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

Respectfully Submitted,

Hayley L. Harvey, DDS MS
Public Health Dental Director

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DIV. OF ENVIRONMENTAL HEALTH 515-281-7726 FAX/515-281-4529
DIV. OF FAMILY & COMMUNITY HEALTH 515-281-3931 FAX/515-242-6384
DIV. OF HEALTH PROMOTION, PREVENTION & ADDICTIVE BEHAVIORS 515-281-3641 FAX/515-281-4535
DIV. OF TOBACCO USE PREVENTION & CONTROL 515-281-6225 FAX/515-281-6475

THE UNIVERSITY OF IOWA

October 8, 2002

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

Dear Ms. Temple,

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

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

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

Sincerely,

Catherine Watkins

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

THE UNIVERSITY OF IOWA

September 23, 2002

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

Dear Members of the Dental Hygiene Committee:

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

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

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

Sincerely,

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

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

September 17, 2002

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

Dear Members of the Dental Hygiene Committee:

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

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

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

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

Sincerely,

Marcia A. Manter
Region VII Head Start Health Specialist

Mid-Iowa Community Action, Inc.

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

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

October 7, 2002

Dear IBOBE and IDHA Members:

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

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

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

Sincerely,

Cecelia Nassif, A.R.N.P.

October 7, 2002

Dear IBODE and IDHA members:

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

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

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

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

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

Sincerely,

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

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

Sheila Temple

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

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

Dear Members of the Dental Hygiene Committee:

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

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

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

Sincerely,

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

DesMoines
PUBLIC SCHOOLS

Department of Health Services

August 13, 2002

To whom it may concern:

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

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

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

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

Jean Phillips

Jean Phillips
Health Services Facilitator

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

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

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

Agenda

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

Noon Call Meeting to Order

Consideration of Rules

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

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

4:00 p.m. * Consideration of Complaints

5:00 p.m. Adjourn

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

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

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

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

Brown, Winick, Graves, Gross,
Baskerville and Schoenebaum, P.L.C.
ATTORNEYS AT LAW

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Deborah J. Schmudlach
Danielle K. Dixon
Brian P. Rickert
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Alexander M. Johnson
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James A. Napier

Washington, D.C. Office
Brian Kennedy

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(515) 242-2418
WRITER'S E-MAIL ADDRESS
schmudlach@ialawyers.com

November 13, 2002

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

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

Dear Dr. Strohman:

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

Summary of Relevant Statutory and Regulatory Provisions

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

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

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

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

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

(Emphasis added).

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

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

local anesthesia with the proper permit; (d) administering nitrous oxide inhalation analgesia in accordance with 650-subrules 29.6(4) and 29.6(5); (f) applying or administering medicaments prescribed by a dentist, including chemotherapeutic agents and medicaments or therapies for the treatment of periodontal disease and caries.

3. Preventive: Applying put and fissure sealants and other medications or methods for caries and periodontal disease control; organizing and administering fluoride rinse or sealant programs.

4. Diagnostic: Reviewing medical and dental health histories; performing oral inspection; indexing dental and periodontal disease; making occlusal registrations for mounting study casts; testing pulp vitality; analyzing dietary surveys.

The following services may only be delegated by a dentist to a dental hygienist: administration of local anesthesia, placement of sealants, and the removal of any plaque, stain, calculus, or hard natural or synthetic material except by toothbrush, floss, or rubber cup coronal polish.

(Emphasis added).

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

10.3(1) The administration of local anesthesia or nitrous oxide inhalation analgesia shall only be provided under the direct supervision of a dentist. Direct supervision of the dental hygienist requires that the supervising dentist be present in the treatment facility, but it is not required that the dentist be physically present in the treatment room.

10.3(2) *All other authorized services provided by a dental hygienist shall be performed under the general supervision of a dentist currently licensed in the state of Iowa.* General supervision shall mean that a dentist has examined the patient and has prescribed authorized services to be provided by a dental hygienist. The dentist need not be present in the facility while these services are being provided. If a dentist will not be present, the following requirements shall be met:

. . . [sections deleted]

Subsequent examination and monitoring of the patient, including definitive diagnosis and treatment planning, is the responsibility of the dentist and shall be carried out in a reasonable period of time in accordance with the professional

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

. . .

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

(Emphasis added).

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

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

Summary of Proposed Rulemaking By Iowa Dental Hygienists' Association

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

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

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

Iowa Dental Association Comments and Concerns Regarding Proposed Rulemaking

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

explanation of these concerns.

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

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

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

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

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

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

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

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

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

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

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

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

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

* How will the proposed hygienist services be reimbursed?

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

Sincerely,

Deborah J. Schmudlach

RECEIVED
DEC 10 2002
IOWA BOARD OF
DENTAL EXAMINERS

December 8, 2002

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

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

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

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

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

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

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

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

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

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

Sincerely,

Sheila Temple

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

MEMORANDUM

TO : Members, Dental Hygiene Committee

FROM: Nancy LePeau

DATE: April 17, 2000

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

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

650--10.3(153) Supervision of Dental Hygienists

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

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

MEMORANDUM

TO : Members, Dental Hygiene Committee

FROM: Nancy LePeau

DATE: April 17, 2000

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

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

650--10.3(153) Supervision of Dental Hygienists

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

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

August 21, 2002

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

Dear Iowa Board of Dental Examiners:

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

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

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

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

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

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

Sincerely

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

C.G. EGELAND, DDS

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

Date 10/22/02

RECEIVED

OCT 23 2002

IOWA BOARD OF
DENTAL EXAMINERS

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

Dear Members of the Iowa Board of Dental Examiners.

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

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

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

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

Sincerely,

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

Ames
Pediatric
Dental

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

RECEIVED
OCT 24 2002
IOWA BOARD OF
DENTAL EXAMINERS

October 22, 2002

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

Dear Members of the Iowa Board of Dental Examiners:

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

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

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

Sincerely,

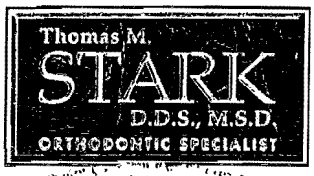
Debbie Grandgenett

Dr. Debbie Grandgenett, DDS

RECEIVED

OCT 2 5 2002

IOWA BOARD OF
DENTAL EXAMINERS



October 24, 2002

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

Dear Members of the Iowa Board of Dental Examiners,

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

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

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

Sincerely,

Tom Stark

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

TMS/ck

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

Member American Association of Orthodontists

DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

RECEIVED

OCT 2 9 2002

BOARD OF
DENTAL EXAMINERS

October 28, 2002

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

Dear Members of the Iowa Board of Dental Examiners:

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

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

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

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

Sincerely,

Sheila Riggs

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

AMES ORAL SURGEONS, P.C.

Fellows
American Association of
Oral and Maxillofacial Surgeons

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

RECEIVED
OCT 30 2002
IOWA BOARD OF
DENTAL EXAMINERS

October 28, 2002

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

Dear Members of the Iowa Board of Dental Examiners:

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

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

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

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

Sincerely,

John Kazwell, DDS

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

AMES ORAL SURGEONS, P.C.

Fellows
American Association of
Oral and Maxillofacial Surgeons

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

October 28, 2002

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Sincerely,

Robert Rudman, DDS

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

AMES ORAL SURGEONS, P.C.

Fellows
American Association of
Oral and Maxillofacial Surgeons

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

October 28, 2002

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

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

Sincerely,

Charles Farrell

Charles Farrell, DDS

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

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OCT 2 8 2002
IOWA BOARD OF
DENTAL EXAMINERS

Paul Readhead, D.D.S.

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

October 24, 2002

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

Dear Members of the Iowa Board of Dental Examiners:

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

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

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

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

Sincerely,

Paul Readhead

Paul Readhead, DDS, FAGD

Jennifer Hart

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

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

Dear Members of the Iowa Board of Dental Examiners,

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

Respectfully,

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

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Jennifer Hart

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

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

To the Iowa Board of Dental Examiners,

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

Respectfully,

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

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

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Jennifer Hart

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

dntl1030.doc

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

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

(See attached file: dntl1030.doc)

October 30, 2002

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

Dear Ms. Temple:

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

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

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

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

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

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

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

Sincerely,

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

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NOV 01 2002

IOWA BOARD OF
DENTAL EXAMINERS

THE UNIVERSITY OF IOWA

October 29, 2002

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

Dear Ms. Hart:

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

Thank you.

Sincerely,

David Johnsen

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

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

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NOV 01 2002

IOWA BOARD OF
DENTAL EXAMINERS

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

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

Dear Members of the Iowa Board of Dental Examiners:

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

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

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

Sincerely,

10-25-02

Neil Calhoun DDS

Fields of Opportunities

STATE OF IOWA

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

DEPARTMENT OF EDUCATION
TED STILWILL, DIRECTOR

January 23, 2004

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FEB 04 2004

IOWA BOARD OF
DENTAL EXAMINERS

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

Dear Ms. Hart:

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

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

National problems of decreased access to oral health care are mirrored in Iowa. Iowa is seeing a decrease in the number of dentists practicing in the state. Seventy-two of Iowa's 99 counties are designated as Dental Health Professional Shortage Areas, based on federal guidelines and approval by the Health Resources and Services Administration. The 1999 Oral Health Survey, conducted by the Iowa Department of Public Health and the University of Iowa College of Dentistry, showed the twice as many children from low-income families had untreated decay as children from high-income families. Twenty-four percent of low-income children had a preventive sealant, versus 37 percent of high-income children. In FFY02, 60 percent of children enrolled in Medicaid in Iowa did not receive any dental care. The currently proposed rule, incorporating a definition of public health supervision for dental hygienists, is one way to increase access to oral health services for at-risk populations in the state.

Because we know that oral health affects learning, this traditionally health-related concern is also an educational one. Children with poor oral health have more frequent absences and suffer academically. Early tooth loss caused by dental decay can result in

failure to thrive, impaired speech development, absence from and inability to concentrate in school, and reduced self-esteem.

Conversely, the most successful early childhood programs in our state, including Shared Visions and Head Start, emphasize dental screening, connecting children and their families to dental services, and the establishment of dental homes for all enrolled students. Preschool programs that do this are demonstrating a commitment to quality that is consistent with the expectations of the governor's leadership plan.

Iowa Department of Education supports efforts to ensure that all families have a dental home, defined as a primary dental office where comprehensive care is accessible. We are aware of Iowa Department of Public Health's programs that target at-risk populations and provide enabling and preventive services and see them as vital to our educational mission because these same populations are often at-risk academically. For many low-income families, these programs are their introduction to dental care and the importance of oral health.

Some public health programs in Iowa already use dental hygienists to provide screening and fluoride varnish services for children and pregnant women. The hygienists also educate families about the need for regular dental care and assist families with referrals to a dental office. Counties in Iowa that use dental hygienists in this way have higher percentages of Medicaid-enrolled children that receive any dental care (Dubuque 56%, Fayette 49%, Floyd 46%, Mahaska 43%, Mitchell 52%, Wapello 42%, Washington 42%). This is a documented improvement in access to oral health care.

The proposed rule change would allow additional services (prophylaxis and sealants) to be provided to children or individuals through public health programs, further increasing their access to oral health care.

Oral health is integral to overall health and the Iowa Department of Education strives to promote and protect the health of all Iowans. In an effort to improve access to oral health for low-income families and other at-risk populations, we support and ask that you approve this amendment to add the definition of public health supervision of a dental hygienist to your rules.

Sincerely,

Ted Stilwill, Director
Department of Education

Jennifer Hart

From: Kathy Kell [rudkell@msn.com]
Sent: Tuesday, December 02, 2003 8:45 AM
To: The Halburs; Jennifer Hart; Allen Carrell; Larry Carl; Martin Averill; P T Grimes
Subject: Re: IBDE Report

Marty,
Good analysis. The report does another good job of describing the problem, but still does not come up with conclusions that will work.
KK

----- Original Message -----
From: The Halburs
To: Jennifer Hart ; Allen Carrell ; Kathy Kell ; Larry Carl ; Martin Averill ; P T Grimes
Sent: Tuesday, December 02, 2003 12:10 AM
Subject: IBDE Report

Dear All,

I must say that the report is well written and contains alot of data but does not answer the question of cost or the question of what is the best solution. The report comes close in especially two places to the real answer. Those places are in the last section of page 2 and last section of page 28. These state that, "The board's rules cannot address the real needs of patients - to provide dental providers who are willing to accept new Medicaid patients and attend to their restorative treatment needs. Combating this problem will require action and commitment from the Iowa legislature." ie: better Medicaid reimbursement Why should we pass something that is not a solution to the problem, has not worked where it has been used in other states and is not a good business solution. Passing this will use up alot of our already inadeguate Medicaid dollars and thus reduce the number of procedures that can be delivered in the dentist offices. Remember we alocated over $100,000 at the ADA HOD to study this problem and report back next year. Let us wait for this report before we get into something that just won't work. As a last resort if something needs to be passed immediately then put a sunset clause on it to end in one or two years unless it has the statistics to justify renewal.

Jennifer Hart put alot of sincere effort into this report and we should build from it but the new rule related to public health supervision is not the answer. Please enlighten me if I am wrong.

Sincerely,
Marty Halbur DDS

Jennifer Hart

From: The Halburs [dmmkea@win-4-u.net]
Sent: Tuesday, December 02, 2003 12:10 AM
To: Jennifer Hart; Allen Carrell; Kathy Kell; Larry Carl; Martin Averill; P T Grimes
Subject: IBDE Report

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Sincerely,
Marty Halbur DDS

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OCT 1 0 2003

IOWA BOARD OF
DENTAL EXAMINERS

4001 Meadowknolls Road
Marion, Iowa 52302-9405
October 5, 2003

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

Dear Ms. Hardt,

I am writing to you to ask that my you bring before the Iowa Board of Dental Examiners that I am strongly in favor of keeping dental sealants in the scope of services that dental hygienists can provide in the proposed rule change of Chapter 10 of the General Requirements of the Iowa Administrative Code.

I am currently a licensed practicing dental hygienist in Iowa. I have been in practice for 34 years. I have seen what a tremendous tooth saving measure that dental sealants provide. I worked in the same practice in Vermont for 20 years (we started doing sealants in 1976) and I was personally able to follow the effective benefits of sealants.

The concern that sealants can be unknowingly places over carious lesions due to lack of evaluation by a dentist should not preclude this service from the neediest part of the population. We observed that if this was done in our practice the sealant would simply lose its retention and not cause any further damage to the tooth. In contrast unsealed teeth have a great risk of deep caries at a very young age leading to tooth loss. I know, because I lost three first permanent molars, due to occlusal caries by 9 years of age. That is when my family moved from a very rural area to a small city where we had access to dental care.

Please let the board members know how important it is for sealants to be done to the underserved under this new level of supervision. We know the board members and Governor Vilsack have a kind heart for the needy children of Iowa and this measure would provide a great tooth saving benefit for them.

Sincerely yours,
Carol Hennessy R.D.H.

Carol Hennessy

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OCT 1 0 2003

IOWA BOARD OF
DENTAL EXAMINERS

Barbara J Fiori, RDH
314 East Walnut St.
Ogden, IA 50212

September 22, 2003

Jennifer Hart, Executive Officer
Board of Dental Examiners
400 SW 8th St
Des Moines, IA 50309-4687

TO: The Iowa Board of Dental Examiners:

I am contracted as a public health dental hygienist by Mid-Iowa Community Action to serve Boone and Story counties. I witness the need, first hand to expand the scope of practice of Public Health Dental Hygienist to provide preventive services for the numerous under-served areas of rural Iowa. A majority of dentists, in Iowa do not accept Medicaid in their private offices. Therefore a large number of people are going without dental care. This proposal will not change treatment needs for these people. It will simply allow dental hygienists to provide fluoride, sealants, cleanings and oral health education to people who would otherwise be unserved. Restorative needs remain with the dentist. However maybe we can reduce the urgency for such services.

Sincerely,

Barbara J. Fiori, RDH

Barbara J Fiori, RDH

Monticello Family Dentistry & Stone Creek Dental

630 S. Main St. * Monticello
319-465-3533

613 16th Avenue* Dyersville
319-875-9180

Brian L. James, D.D.S.
Craig Puffer, D.D.S.

RECEIVED
OCT 1 0 2003
IOWA BOARD OF
DENTAL EXAMINERS

Dear Board of Examiners,

I am writing you in regard to your proposed ruling regarding dental hygienists' public health supervision. I am very much in favor of allowing dental hygienists to practice their professional duties outside the traditional dental office setting. There currently is a tremendous population of patients not having their dental health care needs met. You have identified many of these groups. I would urge you to go one step further and allow dentists to employ hygienists who can directly provide hygiene services to <u>any</u> nursing home or assisted care facility, not just those with a public health program. Allow a dentist to provide on site care for this population by utilizing assisted hygienists.

Please strongly consider allowing an assistant to aid in the delivery of such care. By allowing the hygienist an auxiliary you will provide a much higher standard of care. Assistants can record the perio pocket depths; they can assist in suctioning during scaling and root planning and in keeping a dry field during placement of sealants. With an assistant dentists and hygienists can better serve more patients effectively and efficiently. Currently, when a dentist is out of the office and the hygienist is caring for patients of record, the hygienist is not allowed to have an assistant to aid them in the delivery of care. I believe this is not in the patient's best interest. Perhaps it is an oversight in our practice act. As dentists, we all realize how much more effective we are with auxiliaries. Let's afford the hygienist the same luxury.

As a practicing dentist in this state for 16 years, I have witnessed an adversarial relationship between dentists and hygienists. This has been to the detriment of the respective professions and to our patients. I truly believe that when evaluating proposals; significant enhancement to our dental practice act can be accomplished in a win, win manner. As a dental board I applaud that you are addressing many of the issues that make our state dental practice act less than progressive.

I am in favor of expanding our care to the many underserved populations by expanding the function and scope of practice for hygienists and assistants. Let's do it in a way that makes economic sense for the dentist, hygienist, assistant and public without adding costly bureaucratic restraints and regulations. Dentists should be given the latitude to train their staff (hygienists and assistants) to provide for the expanded function capacity, which will enhance our effectiveness as a profession.

I would urge you to move swiftly and enact rules that allow dentists to employ hygienists in non traditional settings such as nursing homes, mobile dental clinics, schools, etc. Allow them to work without direct supervision and let them utilize assistants to aid them in their delivery of care. Establish criteria that make the dentist responsible for this training. It is time to move forward with a progressive dental practice act.

Thank you for your consideration!

Sincerely,

Brian L. James, D.D.S.

BLJ/arh

Fields of Opportunities

STATE OF IOWA

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

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

October 3, 2003

RECEIVED
OCT 0 6 2003
IOWA BOARD OF
DENTAL EXAMINERS

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

RE: Proposed Rule Changes – IAC 650-10.5 – Public Health Supervision

Dear Ms. Hart:

The Department of Human Services supports the rule changes proposed by the Board of Dental Examiners that permit the provision of dental hygiene services in public health settings with contracted supervision of a dentist. Although the screening, prophylaxis, sealants and fluoride varnish applications to be provided by the hygienists in such settings will have a calculated fiscal impact on the Medicaid budget, these services are preventative services. It is cost effective to provide preventative dental services rather than more costly restorative services. Thus, the immediate fiscal impact must be evaluated in terms of the offset in savings from restorative dental services.

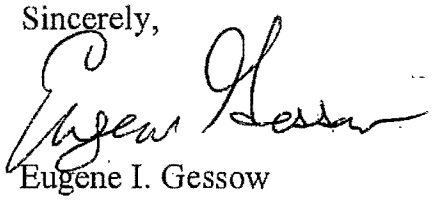
Total estimated savings are impossible to predict. Research results reported by the National Center for Disease Control however enable calculation of a savings from providing dental sealants to children. Sealants are applied to the pit and fissures in molars where 90% of decay in children has been determined to occur. Sealants are nearly 100% effective in preventing decay. In fiscal year 2003, Medicaid paid a total of $2,077,577 for restorations provided to 13,894 unique Medicaid recipients under 21 years of age. Assuming 90% of this expenditure was for restorations on molars, a total $1,869,819 could have been saved had these children received sealants. The potential savings from sealants alone exceeds the estimated minimum $1,237,790 fiscal impact to Medicaid for dental hygiene services provided to both children and adults.

Untreated dental decay only worsens over time to such that more costly repair is required. In fiscal year 2003, Medicaid paid a total of $656,273 for to place crowns on the teeth of children that could not be restored with conventional fillings. A total of $911,456 was spent to extract teeth in children under 21 years of age. The savings from services that could have prevented some of this need further offsets the impact to the Medicaid budget.

Iowa has a critical dental access problem for Medicaid recipients. The reasons are complex and not unique to Iowa. The result however is that less that one third (32.5%) of

Medicaid recipients saw a dentist in fiscal year 2003. Currently, 72 counties and one urban area have been designated as Federal Dental Health Professional Shortage Areas (HPSAs). As Iowa's currently practicing dentists age toward retirement and dental colleges graduate fewer new dentists to replace them, the access problem can be expected to worsen. Utilizing dental hygienists in public health settings will help fill the void.

Sincerely,



Eugene I. Gessow
Medicaid Director

Sept 19, 03

Dear Members of the IBODE,

I am writing in support of the proposed rule change involving Public health. I have read through the rules and it is clear to me that the client receiving the service will have to be referred to a dentist, but the dentist is not required to provide future dental treatment. It seems that we will be working together. We need each others talents and expertise. I am so impressed with the handful of Public health hygienists that I come in contact with. (I work in a Private Practice setting). They want to use our Dental Hygiene Scope of Practice to HELP PEOPLE especially the underserved.

Thank You,

Crystal Hartel, RDH

1024 ~~02~~ 43rd St NW
Altoona, IA 50009

RECEIVED
SEP 22 2003
IOWA BOARD OF DENTAL EXAMINERS

August 20, 2003

TO: Iowa Board of Dental Examiners

FROM: John E. Clary, D.D.S.

RE: Expanded functions for dental assistants – follow-up thoughts

Dear Board,

I recently sent a letter to you via e-mail outlining my thoughts and strong support for expanded function dental assisting in Iowa. In the letter I expressed my thoughts regarding why I feel that expanded function dental assisting is vitally necessary to the growth and progression of dentistry in our State. In addition, I discussed why I firmly believe that expanded function is also of definite benefit to the public by helping provide more dental care at reasonable cost. Since the attending dentist is ultimately responsible for the actions of the expanded function assistant, I feel that the public is also well protected.

While our profession appears solid in it's support for expanded dental assisting, the main question seems to be format – a "list" approach or a "non-list" approach. In my initial letter to the Board I outlined why I ultimately preferred the "non-list" approach. I still feel that this is the best approach long-term. However, I also understand that we have to begin somewhere. I have faith that the Board of Dental Examiners has done an excellent job in thoroughly researching and evaluating all of the aspects of this question. I have had lengthy discussions with past and current members of the Board on this topic. I am confident that the Board has the best understanding of the proper course to take to finally accomplish expanded function dental assisting in Iowa. Many dentists in our state, myself included, have worked long and hard to make expanded function a reality in Iowa. It is time it finally happens. As a result, I support the Board in their proposed "list" approach. While not perfect, I feel that this approach is an excellent step for the future of dentistry in Iowa.

Respectfully submitted,

John E. Clary, D.D.S.

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

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

AGENDA

DENTAL HYGIENE COMMITTEE MEETING
JANUARY 8, 2003

Teleconference Meeting Originating From:
Conference Room
400 S.W. 8th Street, Suite D
Des Moines, Iowa

12:15 p.m. Call meeting to order

Agenda

Petition for Rulemaking submitted by Iowa Dental Hygienists' Association
Request to amend 650—1.1(153) by amending the definition of "general supervision of a dental hygienist," adopting a new definition of collaborative agreement, and amending 650—10.3(153)

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

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

IOWA DENTAL NEWS

A newsletter for Iowa dentists

Member Publication
American Association of Dental Editors

Volume XXIV, Number 1
February, 2003

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- **Executive Director's Message**
- **District Meetings**

Page three
- **2003 Annual Session**
- **PFA Academy Foundation**

Page four
- **NCDHM**

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Iowa Board of Dental Examiner Actions

At the January 23 meeting of the Iowa Board of Dental Examiners (IBDE), action was taken on proposed rules implementing expanded functions for dental assistants. See Executive Director's Message for further details.

In other action at the meeting, board members voted to approve the Petition for Rulemaking submitted by the Iowa Dental Hygienists' Association. This petition seeks to add the following definition of general supervision to 650-1.1(153): "In settings other than the private dental office, the dental hygienist, with the proper qualifications, may perform preventive services without the patient first being examined by a licensed dentist, if the dental hygienist has entered into a collaborative agreement with one or more 'consulting' dentists." The petition defines collaborative agreement as "...a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The agreement will contain protocols or standing orders for the dental hygienist to follow when providing services". The IBDE's will now officially notice a revised rule and gather public comment.

HIPAA Update

We have been notified by the ADA that VHS and DVD versions of the popular HIPAA Seminar are now available for purchase. The three-hour seminar breaks down HIPAA privacy requirements into manageable tasks to ease compliance. The seminar also gives tips on real world implications of HIPAA, including individuals' rights to control access and disclosure of protected health information; responsibilities of information holders to safeguard against inappropriate use of disclosure; how to train dental staff on privacy practice, consent and authorization; required business associate agreements; and sanctions for violations. This is the same seminar that was offered December 4 in Iowa. The seminar is available on VHS tape or DVD and can be purchased through the ADA catalog for $99.95. To order, call 1-800-947-4746 or log on to adacatalog.org.

The deadline for implementation of privacy rules is April 14, 2003.

THE DENTAL PRACTICE, P.C.

Steven G. Rabedeaux, DDS, FAGD

104 N. 2nd Ave. E., Newton, IA. 50208 641-792-2780 / drrab@pcpartner.net www.thedentalpractice.net

Iowa Board of Dental Examiners
400 S.W. 8th St.
Suite D
Des Moines, IA. 50309-4687

RECEIVED
FEB 21 2003
BOARD OF
DENTAL EXAMINERS

RE: General concern

I recently attended the Academy of General Dentistry meeting 2-7-03. The end of the meeting was informational about what challenges the board is facing. Iowa dentists were encouraged to provide any meaningful input. I have several thoughts.

1. Concerning fees for dentists, hygienists, and assistants. I have just learned that the fees for dentistry don't all go to dentistry. With the additional work load the legislature has put upon you, of registering dental assistants and administering training exams, the job you have done this far is amazing. I can't imagine having my work load double, lose part of my staff, and have to do it with less money. I don't think most dentists realize the position the board has been put in. They only see the additional hassle factors involved with practice administration and they blame the board.

I will encourage all the dentists I know to make it clear to our legislature that we feel all fees from dental related license and administrative fees go 100% back to dentistry. It is unbelievable that our fees go to the general fund and then we only get a portion of it returned.

2. There was discussion about an unknown change regarding dental radiography training. Several dentists stated that they were told there would no longer be student status or in office training after Jan. 2003. This was unknown by two board member dentists present at the meeting. Hopefully this is not the case and is some type of horrible misunderstanding. If it is the case, hopefully, this action can be amended.

This will seriously handicap dentists statewide, including myself, from having adequate staff. Currently there is no other training available anywhere and there is not any on the immediate horizon to my knowledge. The inability to have adequate staff creates barriers to care for Iowans. It becomes an access to care issue in rural areas and a handicap to the profession.

I don't believe that dental radiography has caused a patient harm since I have been in

practice. I do believe that our impending shortage of dental personnel does have consequences. We need to be able to train dental assistants in dental radiography in our offices with our equipment (which is state inspected on a regular basis). The current system has served both dentists and the public very well for many years with very few problems.

I have not been very impressed with the radiographic skills of assistants who were trained in a formal program. Without fail they have required retraining on the job to take diagnostic quality films. In fact the radiology course has far too much theory that has little to do with the practical reality of dental radiography

A change at a time when training has become more complex in all other areas, and with additional regulation, does not make sense. If this is a ruling from the state radiology agency, we need to work together to correct this damaging situation.

3. There is an issue before you that deals with the supervision of hygienists. I have responded previously to the board my feelings concerning independent hygiene practice and will provide that reference if requested. If I understand correctly, this deals with hygienists serving in nursing homes, care facilities and public health settings where the dentist is not present. The issues are the same: proper diagnosis of disease and the public receiving timely proper care.

I have seen the oral hygiene care given at some care facilities. It can be deplorable, non existent and an embarrassment for Iowa. One might be tempted to follow the logic that some care is better than none. Is this good public policy? Is this a foot in the door toward independent practice? I, for one, am not certain I would put my license and credentials at risk to enter into such an arrangement. This requires careful thought and consideration, both for me and for the board.

In the school and public health arena, the issues are far more serious. I have restored way too many poorly placed sealants with rampant caries under them, some requiring endodontic therapy. Those patients were lead to feel safe, yet they suffered a form of harm.

I place sealants in my office with magnification, and with air abrasion to be certain they are done properly and not placed over existing caries and in a well controlled field. This is a serious procedure with the very real possibility of harm to the patient if not done properly. I do not delegate this task and question whether it should ever be delegated. The actual placement is simple, it is the proper diagnosis and preparation that makes or breaks a sealant. According to the dental practice act, I am responsible, and I take that seriously.

School screening and instruction on oral hygiene can no doubt be of benefit. The

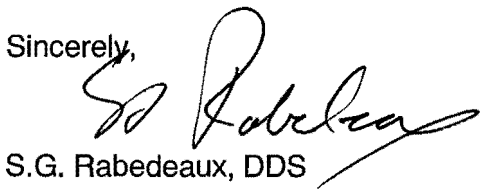
danger lies in the parent whose child is seen and told "I don't see any decay" or "everything looks OK" and there is an undiagnosed problem. The parent may not have easy access or perhaps is financially unable to follow up with a dentist. They may feel a false sense of security and dental health may not even come to mind for several more years, or when there is a problem.

Most hygienists I have worked with are very skilled and have excellent clinical skills. They often bring diagnostic concerns to my attention. They do not however, all have equal diagnostic skills. How well a concern is communicated to a care facility, school staff member or parent may be critical for timely patient care.

4. You have on record my thoughts about expanded function for dental assistants. I believe you are on a reasonable course by having multiple training avenues for approved training and not totally tied to institutional training. We will never agree on a list of duties. That is OK, it is more important to get started and realize this will be an ongoing and evolutionary process. It is fun to get it right the first time, but in this case it might not be possible or realistic.

You as the governing body for dentistry again are faced with finding the balance between protecting and serving the public dental health and the profession. I take the time to share my thoughts with you because I love my profession. God willing, I hope to practice for many more years and I seek the proper balance as well. Thank you for considering my input.

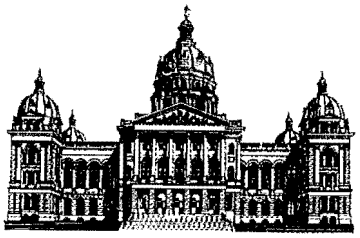
Sincerely,



S.G. Rabedeaux, DDS

Jane Greimann
STATE REPRESENTATIVE
Forty-Fifth District
Statehouse: (515) 281-7742
e-mail – jane.greimann@legis.state.ia.us

HOME ADDRESS
1518 13th Street
Ames, Iowa 50010
Home: (515) 232-5238



House of Representatives
State of Iowa
Eighteenth General Assembly
STATEHOUSE
Des Moines, Iowa 50319

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IOWA BOARD OF
DENTAL EXAMINERS

March 4, 2003

Jennifer Hart
400 SW 8th St , Ste D
Des Moines, IA 50309

Dear Jennifer,

I support the Iowa Dental Hygienists' Association (IDHA) in attempting to modify the rules to change the sequence by which dental hygienists provide care. This allows clients to receive screenings, data gathering and education, in addition to preventative services such as cleanings and sealants while they are awaiting referral to a dentist. The modified rules would require referral to a licensed dentist for a follow-up examination and additional dental care that may only be provided by a dentist.

In Story Country we want to utilize dental hygienists for data gathering, triage, and preventative services while awaiting referral at our two public clinics. Less time will be spent on an initial exam as data gathering and preventative work would already have been done. This increases the dentists' ability to be able to see and treat patients in a more efficient manner.

This proposal would allow a dentist to assume professional responsibility for a hygienist working beyond the confines of a private dental office. It does not expand a dental hygienist's scope of practice nor change the professional oversight by a dentist in any meaningful way.

Sincerely,

Jane Greimann

Representative Jane Greimann

IOWA BOARD OF DENTAL EXAMINERS
PUBLIC HEARING

APRIL 1, 2003

DES MOINES, IOWA

Pursuant to the Notice of Intended Action published in the March 5, 2003, as **ARC 2327B**, a public hearing on proposed amendments to 650- Chapter 1, "Administration," and Chapter 10, "General Requirements," was held in the Conference Room, 400 S.W. 8th St, Suite D, Des Moines, Iowa, on April 1, 2003, beginning at 10 a.m.

Staff present:
Constance L. Price, Executive Director
Jennifer Hart, Executive Officer

Also present:
Sheila Temple, RDH, President, Iowa Dental Hygienists' Association
Larry Carl, Executive Director, Iowa Dental Association
Sandra Leggett, RDH, Des Moines Area Community College Dental Hygiene Program
Mike DeAnda, Des Moines Health Center

Larry Carl provided written comments on behalf of the Iowa Dental Association.

Sandra Leggett read a copy of the written comments she submitted. In addition, Ms. Leggett noted that Iowa was one of the first states to have hygienists in public health roles. Around the 1920s, hygienists played a role in school settings working under the supervision of a dentist. The model has been in place for a long time. Ms. Leggett suggested considering additional facilities to meet these basic needs. Ms. Leggett also suggested that there should be greater collaboration between medicine and dentistry to provide greater access to care. Ms. Leggett stated that dentists and hygienists need to cooperate in this effort.

Sheila Temple read a copy of the written comments submitted on behalf of the Iowa Dental Hygienists' Association.

Mike DeAnda stated that he did not have formal comments prepared, but indicated that he is supportive of ways to improve access to care. Mr. DeAnda is the administrator for the Des Moines Health Center. The center utilizes hygienists in their programs and operates mobile dental clinics. The center also operates in school settings and is one of the few organizations that accepts Medicaid. Mr. DeAnda suggested that the Board look closely at ways to work this out to make it acceptable for hygienists to play an increased role. He indicated that he would like to see the locations specified where care under collaborative agreements could be provided so that it is not subject to

interpretation. For example, limited to public health organizations or federally funded community health centers. The board should keep this narrow in scope to prevent possible abuse.

Additional written comments have been received concerning the proposed amendments. All comments will be submitted to the Board for consideration.

Respectfully submitted,

CONSTANCE L. PRICE
Executive Director

CLP/jh

Patricia G Larson
716 Peosta St.
Peosta, Iowa 52068

attn
J. Hart

April 6, 2003

Iowa Board of Dental Examiners
400 SW 8th Street, Suite D
Des Moines, Iowa 50309-4687

Dear Board Members,

I am writing to you with several concerns regarding the issue of the expanded function rules proposal that has recently come to my attention.

As I understand it, under the expanded function rules proposal Certified or Registered Dental assistants would have the capability of extending their skills into some of the work that only dentists do now. Such as root canal drying, crown preparation and packing retraction cord etc.

As the proposal now reads you have no standards set for the protection of the public. The dentist is set up as the educator and there are no statewide uniform standards for certification or testing. How will I, as a patient, know what the assistants have been trained in especially if I were to change dental offices? Will all assistants in the same office have the same training? Will assistants be training other assistants at some point? Also, how is the public to know what training an assistant has when they are not required to wear a name badge listing their credentials? Frankly, at this point, the public has little or no idea who does what in their dental office. I was totally in the dark about the fact that until recently dental assistants could just be hired off the street and begin to work in my mouth with whatever training the dentist deemed relevant. That fortunately, is no longer true. I am appalled at the idea that you, the people that we the public depend upon to protect us, would allow the expanded functions proposal to go through as it now reads with no statewide standard for testing and certification.

It is my sincere hope that you will take into consideration all the information that you have before you and make a decision that protects the rights of the public that you serve.

Thank you for your time and consideration.

Patricia G. Larson

Patricia G. Larson

14395 Christoph Rd.
Dyersville, IA 52040
April 5, 2003

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

Dear Board Members,

The letter will, in part, address the issue of extended care rules; who will decide upon them, how they are decided on and what impact will they have on not only the Dental Profession but on the public as well.

On Friday, April 4, 2003, I spoke via telephone with Jennifer Hart. During this conversation Jennifer informed me that a large number of letters had been received by the board from dentists expressing their opinion concerning the expanded rules issue but very few had been received by dental assistants. Five dentists sit on The Iowa Board of Dental Examiners. However, there is **no** representation on the board for dental assistants although it is required that we are apprised regarding all issues, nor does the board ever *request* a statewide survey of our opinions or ideas. With no representation how do you propose we stay up-to-date on the latest issues? Thus, we are consistently uninformed about issues, which pertain to and directly affect us.

It is my understanding that because of the deluge of letters written by dentists, there is now a third proposal for the expanded function rules. This proposal sets no statewide standards, the patient has no way of knowing what procedure the dental assistant can perform and could lead to one dental assistant training another. How is any investigator or member of the public supposed to know if that assistant was properly trained? Is this safeguarding the public? I would hope that the members of The IBDE have the **public's** best interests in mind when you make these life altering decisions, not the dentist's.

What happened to the expanded function group with dental assistants on it? For our voice to be heard, this group was very substantial. This group put in many long hours to come up with some resolution for expanded functions. The proposal that came from them was tabled. I can say I was much more comfortable with those two proposals than this third one. The board disregarded what time and effort that expanded function group put forth. I am dissatisfied in the way the board is managing this proposition. This group looked at what other states had accomplished and learned that with expanded function, assistants have some type of registration process and statewide uniform training. Thank you for your attention to this matter.

Sincerely,

Karen Nurre

Karen Nurre, CDA, RDA

Additional Comments submitted by IDHA

VISUALIZING THE COLLABORATIVE AGREEMENT

The collaborative agreement is a creative way of making dental services available to those who are in dire need of care, but because of their situation, are unable to be treated in the same sequence as occurs in the private practice. The dental hygienist will become the case manager who will attempt to distribute patients to a variety of dental providers who will share the responsibility for these population groups.

In discussions with board members, it became obvious that it was difficult for them to visualize what the elements of a collaborative agreement would be. I conferred with the dentists in my areas as to what data they would like included in such an agreement. We agreed that the following information should be included: medical considerations that would prohibit care, methods of assessment, preventive services to be provided, referral protocols, and requirements for ongoing review of the agreement. We would support adding these stipulations to the definition of collaborative agreement, if the change would not be substantial enough to necessitate starting the rulemaking process over. If these changes would necessitate starting the process over, we would recommend instead that the Dental Hygiene Committee and the Board of Examiners have the authority to make these changes and any others that may be needed as time goes on. We would hope that this rule could be implemented without further delay because the need is so great.

Jennifer Hart

From: Punkingeesh@aol.com

Sent: Sunday, April 06, 2003 9:22 PM

To: jhart@bon.state.ia.us

Subject: general supervision of dental hygienist

Hello, my name is Brian Ancell, DDS. I am a member of the Iowa dental association, and I am writing to say that I oppose the revision of General Supervision of A Dental hygienist. I do not feel that dental hygienists are properly trained to deal with medical emergencies, and should not be practicing without a dentist present to perform examinations. I currently practice in a public health facility, and have not noticed any problems with patients getting proper access to care.

I agree with the statements written in the March 13th letter sent from Larry Carl outlining the limitations of dental assistants. I feel that this proposal is not in the best interest of the patients,and I am opposed to it.

I understand that I am past the April 1st deadline for submitting a letter, but feel strongly that I should make my opinion known. Please contact me if any other information is needed.

Sincerely,

Brian Ancell, DDS

JERSEY RIDGE DENTAL ASSOCIATES
DAVID L. SAMUELSON, D.D.S. H. DOUGLAS ROBERTSON, D.D.S.
Comprehensive Family, Cosmetic, and Implant Dentistry
5105 JERSEY RIDGE ROAD
DAVENPORT, IOWA 52807
PHONE (563) 359-9144
FAX (563) 359-9146

RECEIVED
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IOWA BOARD OF
DENTAL EXAMINERS

April 2, 2003

Ms. Jennifer Hart
Executive Officer
Board of Dental Examiners
400 S.W. 8th St.
Suite D
Des Moines, Iowa 50309

Dear Ms. Hart,

I am writing in regard to the potential rule changes allowing expanded functions for Dental Assistants. I have opposed the registration of Dental Assistants in the past. I have found it very difficult to hire, train, and have assisting staff pass both the registration and radiology examinations. Requiring these examinations have turned potential staff away from dentistry into other professions where they can earn the same or higher pay with no study time or examinations. Many of the applicants we have had for dental assistants are young mother's some married and some single mom's. These young people simply do not have the time to study to pass the registration examination and keep up with their homes and children. In visiting with other Dentists, this is a problem in cities and a greater problem in rural communities.

Now I understand the Board of Dental Examiners are considering developing a laundry list of expanded functions for Assistants. I feel developing specifics and putting specific procedures into the practice act is a bad idea. This is best left to the Dentist. Every practioner is different, each one must determine his comfort level allow assistants to do various expanded functions. Each one of us have different abilities to train staff for various duties. Most expanded functions require the Dentist to work harder, utilizing more chairs, giving us less time with each patient, while taking more time for training and supervision. This is simply heading dentistry in the wrong direction. It is turning us into technicians and office managers. Most patients do not want to be treated in assembly lines and like the personal attention they have received by Dentists.

I strongly recommend before implementing any rule changes in Dental Assisting or Dental Hygiene, a study of manpower needs in regards to both professions be completed. This study has to include both city and rural communities. We as a profession need to look at what changes are needed to allow us to provide optimal dental care for the public while protecting them at the same time. Changes are forever, lets think this through so whatever changes are made have the best interest of the public in mind.

As always, I would be happy to discuss this matter with any Board member at any time. Thank you for you work on behalf of the profession.

Sincerely,

David L. Samuelson, D.D.S.

Summary of Comments on ARC 2327B

117 written comments received.

31 expressed support for the amendments

9 Nurses
6 Hygienists (including IDHA)
5 Dentists
11 Other (IDPH, social worker, MD, administrators, Pres of Iowa Caregivers Assoc)

79 expressed serious concern regarding the amendments

76 Dentists (including IAGD)
2 Hygienists
1 Other (Iowa Dental Association)

7 were undecided, or supportive if changes were made

7 Dentists

SUMMARY OF COMMENTS IN SUPPORT:

- This will potentially have a large impact on dental health, especially for the rural poor
- If hygienists could provide cleanings and sealants, could decrease dental caries
- There is a huge problem with lack of access to dental health care, especially for children and low income groups
- This will allow the hygienist to do data gathering, triage, and preventive services while awaiting referral; means less time spent at initial exam thereby increasing efficiency; enables more families to access services if efficiency is increased
- Affordable, accessible preventive care can impact the need for more expensive dental care later on; Problems are more expensive to fix than prevention
- Local dentists who work with public health are already supportive of preventive services under their consultation
- Will help to meet Healthy Iowans 2010 oral health goals
- Missing opportunity to provide sealants because dentists are unwilling to do initial screenings in schools
- Can increase the number of patients seen by increasing settings
- Same type of system with nurse practitioners and medical directors – nurses practice following protocols/standing orders and refers to doctor; nurse practitioners also do physical exams for physicians
- This does not expand the scope of practice of hygiene or need for professional oversight by a dentist, it just changes the sequence of services .
- Lack of hygiene creates problems and suffering that could have been prevented
- Oral health in nursing facilities and other institutional care settings often go unmet due to staff shortage, lack of training, etc
- Partnerships with hygienists will increase referrals and timely screenings, increase school readiness and success

- Protocols help to protect the hygienist, dentist, and patients
- Public health clinics now are impeded because can't provide care unless dentist has seen patient first
- These highly trained and educated professionals are capable of providing treatment in these settings
- These expanded services would personally aid this dentist in providing care for residents of care facilities
- Need flexibility when it comes to public health concerns
- Screening and basic care will prevent backlog in basic services for underserved
- Because many dentists won't accept Medicaid there is a huge access problem
- Pleased with success of current public health hygiene programs and would be beneficial if they could do more
- So far only hygienists have put their intentions in writing and taken steps to solve the access problem
- Don't need to limit the number of agreements
- Need to work together to provide care because the problem is not getting smaller
- Contractual collaboration does not expand scope it just makes it less cumbersome to identify and provide prevention and referral
- Research demonstrates that education can have a significant impact on oral health
- Some kids may only have two levels of care: no care or prevention
- Hygienists have passed a national board exam and regional practice exam to demonstrate qualification to provide these services without direct supervision
- Also need to add dental assistants to help hygienist in providing care, especially with sealants, isolation, radiographic developing
- 72 of Iowa's 99 counties are dentally underserved
- Counties in Iowa that use hygienists for screening, education, & fluoride show higher percentages of Medicaid-enrolled kids that receive any dental care; this is documented improvement in access to oral health care
- Sealants can reduce incidence of tooth decay. Allowing hygienists to provide prior to seeing a dentist would allow more children to be served and decrease costs
- Providing prophys is esp. beneficial for low income pregnant women based on research linking periodontal disease to incidence of pre-term, low birth-weight deliveries and preeclampsia
- Hygienists are educationally prepared to provide this care based on accreditation guidelines, national and regional board exams that assess this preparation. Exams cover special needs and medically compromised patients. Additional experience required further ensures higher standard
- Has board dealt with complaints of unsafe practice by hygienists in public health – public health hygiene has been in place since the 1930s and has been successful due to the knowledge and skill of these practitioners
- Need to ensure changes do not adversely impact existing public health programs to ensure that educational services, assessment, fluoride, and screening programs can continue to operate as they now do, by changing wording to state the hygienist must ensure the patient has been examined prior to providing an additional prophylaxis or series of sealants

- Research on sealants shows placing them on incipient caries and a frank cavitated lesion can arrest development of caries
- Rule change does not mean hygienists will no longer be supervised, this rule expands the definition of supervision and changes the sequence of treatment
- Requirement for collaborative agreement strengthens the referral process
- Hygienists cannot now prescribe - dentist in collaborative agreement will be responsible for this just like in private practice
- IDHA agreeable to specifying agreement must be with Iowa licensed dentist
- Cannot force patients to see a dentist – this concern is addressed by limiting services that can be provided until the patient is examined
- May need to collaborate with more than one dentist to spread responsibility for treatment of these patients
- IDHA agreeable to eliminating "such as" clause to specify settings
- In states that allow collaborative agreements, has not increased liability coverage
- IDHA supports adding additional specifics in definition of collaborative agreement

SUMMARY OF CONCERNS:

- Concerned about proposal as written – the access to dentists required in the proposal is just not possible; need to be able to provide existing public health services even if patient has not been examined
- Liability questions are not adequately addressed
- Hygienists do not have enough education in pharmacology, anatomy, oral pathology, physiology, and biochemistry to provide care without a patient first being examined by a dentist; Hygienists need additional education and training to be able to do this; Two year hygiene education is too limited in scope
- Concern about having multiple agreements with multiple hygienists to the extent that actual supervision would not take place – suggest limit to single agreement per dentist and specify Iowa licensed dentist
- Need to specify the time period for a dental exam under a collaborative agreement and ensure exam takes place within reasonable amount of time
- Schools have not indicated they want this – not the school's role, questions about where will they provide the care and keep track of records in schools
- This will not solve the problem of the dentally underserved patients; not a good answer to helping the underserved
- Some care is not always better than no care
- Problem with placing sealants on teeth with caries; results in more expensive dental care later on and the real possibility of patient harm if not done right; Placement of sealants is relatively simple but proper diagnosis and preparation is the key
- If sealants are placed prior to exam, dentist cannot then probe with explorer or us Diagnodent to diagnose occlusal caries
- Problem for patients if they are told everything looks OK and there is an undiagnosed problem that is not addressed
- Gives patients a false sense of security that dental care has been provided
- This allows care without an exam and supervision. Concern that patients leave after being seen by a hygienist without proper diagnosis and tx planning

- Need to specify the settings; Too vague as to where hygienist can provide care outside of private office; too open to interpretation
- The training of a hygienist is predicated on supervision of a dentist
- Concern about lack of training in pharmacology and how to ensure patients that need appropriate pre-meds are prescribed this medication
- Concern about providing treatment to medically compromised patients – in these patients due to potential complications it is especially important that dental exam take place first; especially in nursing facilities these patients require additional diagnostic, evaluation and management
- Should first try to put pressure on Iowa dentists to find a way to treat these underserved groups
- Need to tighten up language to be more specific
- Concern if patients had a life-threatening reaction and no dentist was present to manage or prescribe for these potential complications
- What happens if a restoration fractures or is removed during hygiene services – who is responsible and how will the patient afford that
- This is a stepping stone for independent practice
- Hygienists are trained to work in a team with a dentist and need to provide tx together
- Need to increase dental participation
- Answer to access problem is not to provide substandard care
- This could impact the cost of hygiene without providing needed services to targeted groups
- Need to fully study consequences before taking action
- Difficult to imagine a scenario where tx by a hygienist without diagnosis and treatment planning would be beneficial
- State financial programs are to blame for part of the access problem – this does not change that problem; Title XIX reimbursement is too low
- There may just be an administrative problem in reaching people rather than an access problem; to totally change the way care is delivered is not the answer
- Need to decide if these groups deserve a lower standard of care than other citizens
- Total dental care requires an exam by a dentist; Dental hygiene services cannot be separated from total patient care ; There's no reason to leave dentists out of the sequence just because these settings are different; general supervision already addresses most of these issues
- Public does not understand distinction between hygiene assessment and dental exam by a dentist
- Problem with care in these settings is often more limited by lack of appropriate facilities and equipment rather than time
- This creates inefficiency for the patient and requires an increased time commitment by the patient to get complete care
- Increases health risks because patients are receiving fractured care
- If any subgingival scaling is done, it is periodontal treatment, requiring more knowledge, skill and judgment
- Very few nursing residents have a healthy mouth only needing prophylaxis
- Who is responsible if patient is misdiagnosed or a problem is not discovered

- Allowing hygienists to practice without a dental exam or treatment plan is not giving equal protection to all citizens; Treatment of an untreated population by providing substandard care is simply swapping one problem for another.
- Could alter malpractice coverage for all licensees, resulting in increased dental fees
- Hygienists lack equipment and supplies to adequately provide care in these settings; for example, may need radiography to determine bone loss or tell depth of calculus prior to giving services
- The real problem is a shortage of general dentists and also a shortage of hygienists, esp. in rural areas
- Need same standard of experience for all – a hygienist who is currently employed as public health hygienist may not have same experience level
- An exam has to be done to prescribe sealants and root planning because these are invasive treatments
- Facilitate licensure by credentials to help access problem
- Why separate health of gums from rest of oral cavity; Prophylaxis has no benefit if there are other disease processes in the mouth
- Part of problem is lack of education in routine care like brushing rather than a lack of professional cleaning
- Inferior out of office practice decreases quality and patients are the ones who are least likely to detect the change
- Need to be more specific rather than saying ensure patient has been examined – need to specify that written and prescribed treatment is directed for additional care; who will verify patient has been examined unless there is written prescribed treatment for additional services
- How will authority for treatment be provided for students and nursing home patients
- What about patient records – who maintains them, how will treatment be entered, where are they kept, how is insurance of other costs billed
- How can you tell who is the collaborating dentist and responsible for each patient if there is more than one agreement
- Does this require dentist to make these patients of record?
- Need to look at long range implications before rushing forward
- Given the direction the board is taking to regulate dental assistants it seems inappropriate to change hygiene requirements
- There is a potential for economic abuse; this could provide fertile ground for shady practitioners driven by financial interests
- Medicaid problems such as funding, valuing care and keeping appointments won't be resolved by this
- Consider delaying action on this proposal to enable Dental Access Committee proposal to collaborate with nursing facilities in matching them with dental provider can develop and move forward; may significantly improve chances of success for this unprecedented collaboration

IOWA ORAL & MAXILLOFACIAL SURGEONS, P.C.

Dr. John A. Maletta • Dr. Steven T. Reynolds • Dr. Neil T. Dunbar • Dr. Darren R. Jirsa

April 10, 2003

LeRoy I. Strohman, DDS, Chairperson
Iowa Board of Dental Examiners
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Dr. Strohman:

By way of this correspondence, I wish to inform you of an exciting activity being undertaken by the Iowa Department of Public Health's Dental Advisory Committee (DAC). This may well represent one of the most important opportunities for addressing many of the "access to dental care" issues being grappled with by the various health care leaders in Iowa including the Iowa Board of Dental Examiners.

As you know, the Iowa Department of Public Health initiated an oral health professional forum made up of dentists, dental hygienists, dental assistants, representatives from U of I College of Dentistry and the Iowa Board of Dental Examiners which is responsible for advising the Director of Public Health regarding issues related to improving access to dental health. More specifically, one of the group's more significant responsibilities is to develop plans to address the barriers to oral health care for our most vulnerable populations.

At our April 9, 2003 meeting, our DAC chairperson, Peter C. Damiano, DDS, MPH from the University of Iowa Health Policy Research Program introduced a proposal designed to match oral health care practitioners with one of our most vulnerable populations...nursing home residents. Dr. Damiano's proposed plan incorporates resources from the University of Iowa College of Dentistry, the Iowa Department of Inspections and Appeals, the Iowa Department of Public Heath, the Iowa Dental Association and the Iowa Dental Hygienists Association. The nursing homes themselves would naturally play a significant role in any final plan of action adopted by the DAC. I know myself, as a current officer of the Iowa Dental Association that the IDA welcomes the leadership being demonstrated by Dr. Damiano and the Dental Advisory Council.

As a founding member of the Dental Advisory Council, I wish to bring this action to the attention of the Iowa Board of Dental Examiners in hopes that your Board will consider taking no action related to access to oral health care. By eliminating or delaying any planned regulatory action, the Board of Dental Examiners may significantly improve the chances of this unprecedented collaboration of oral health care practitioners and related organizations to succeed.

My expectation is that the successes realized in this endeavor will translate success to many other Iowa vulnerable populations.

Sincerely,

Dr John A. Maletta

John A. Maletta, DDS, MS
Member
Dental Advisory Council
Iowa Department of Public Health

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Iowa Board of Dental Examiners

Memo

To: George North, DDS, Rick Reay, DDS, Deb Yossi, RDH, & Elizabeth Brennan

From: Jennifer Hart

Date: 05/06/2003

Re: Committee Meeting – May 16, 2003

Just a reminder that the Board committee concerning the proposed amendments to 650—Chapters 1 and 10 (dental hygiene collaborative practice) will meet on Friday, May 16, 2003, beginning at 10 a.m. at the Board office.

Representatives from the Iowa Dental Association and Iowa Dental Hygienists' Association have been invited to this meeting.

Dr. North asked that the following additional information be copied for your review:

- Copy of the original Notice of Intended Action
- Article submitted by Dr. Reay for committee review;
- Copy of law/rules from other states with collaborative practice/public health supervision;
- Administrative Rules Digest article concerning proposed amendments & article from ARRC meeting minutes on this rule;
- Copy of nursing home access proposal from IDHP Dental Advisory Meeting on April 9,2003.

If you would like any additional information copied for committee review, please let me know.

ARC 2327B

DENTAL EXAMINERS BOARD[650]

Notice of Intended Action

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

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

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

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

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

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

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

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

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

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

The following amendments are proposed.

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

Adopt the following **new** definition:

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

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

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

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

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

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

ARC 2325B

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351]

Notice of Intended Action

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

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

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

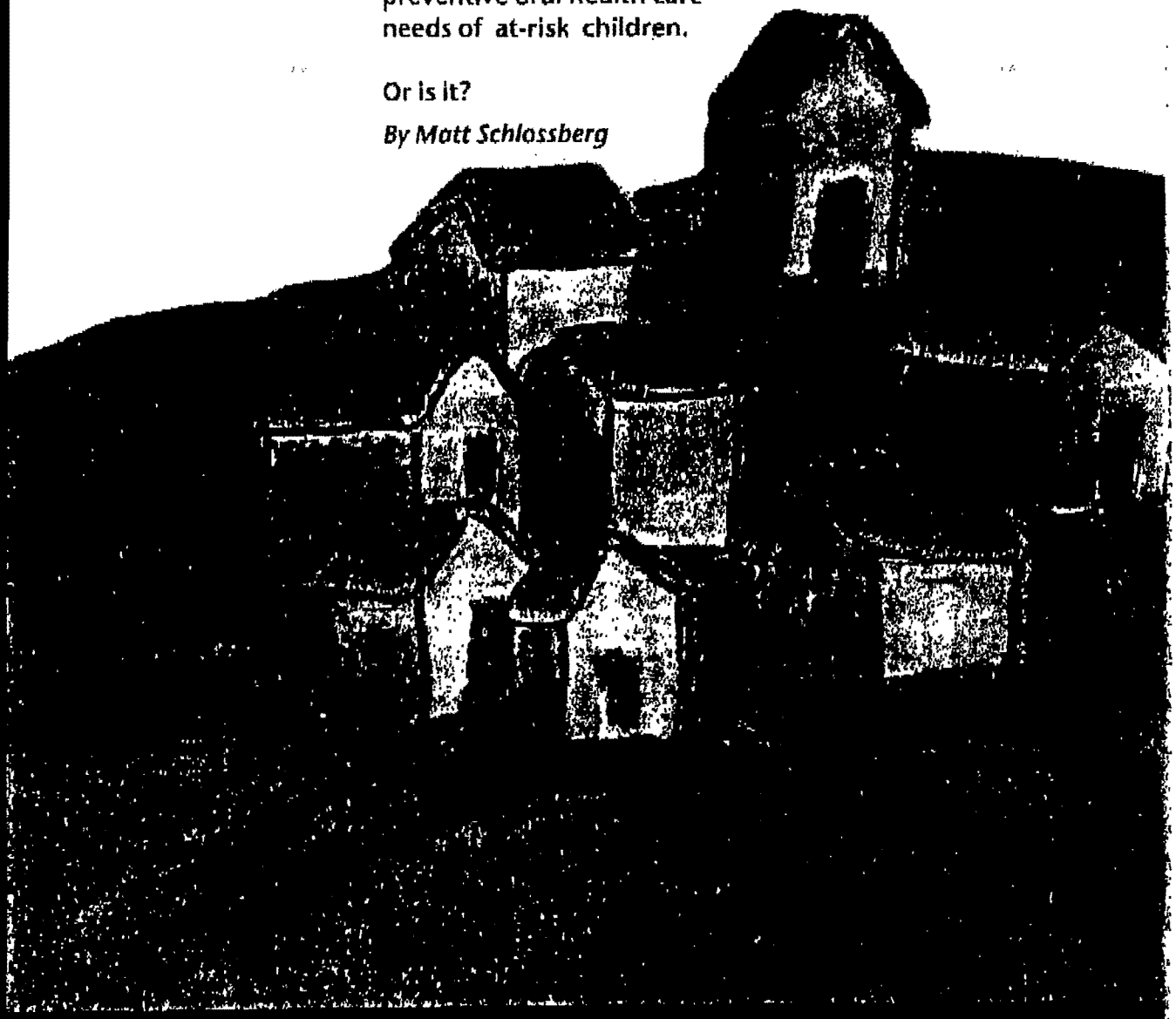
This proposed amendment renumbers the current rules on campaign disclosure procedures to eliminate rules that have been previously rescinded and reserved. Two rules are left reserved to reflect anticipated future rule makings. No

Does it take a village to treat a child?

It's hard to argue with programs aimed at addressing the preventive oral health care needs of at-risk children.

Or is it?

By Matt Schlossberg



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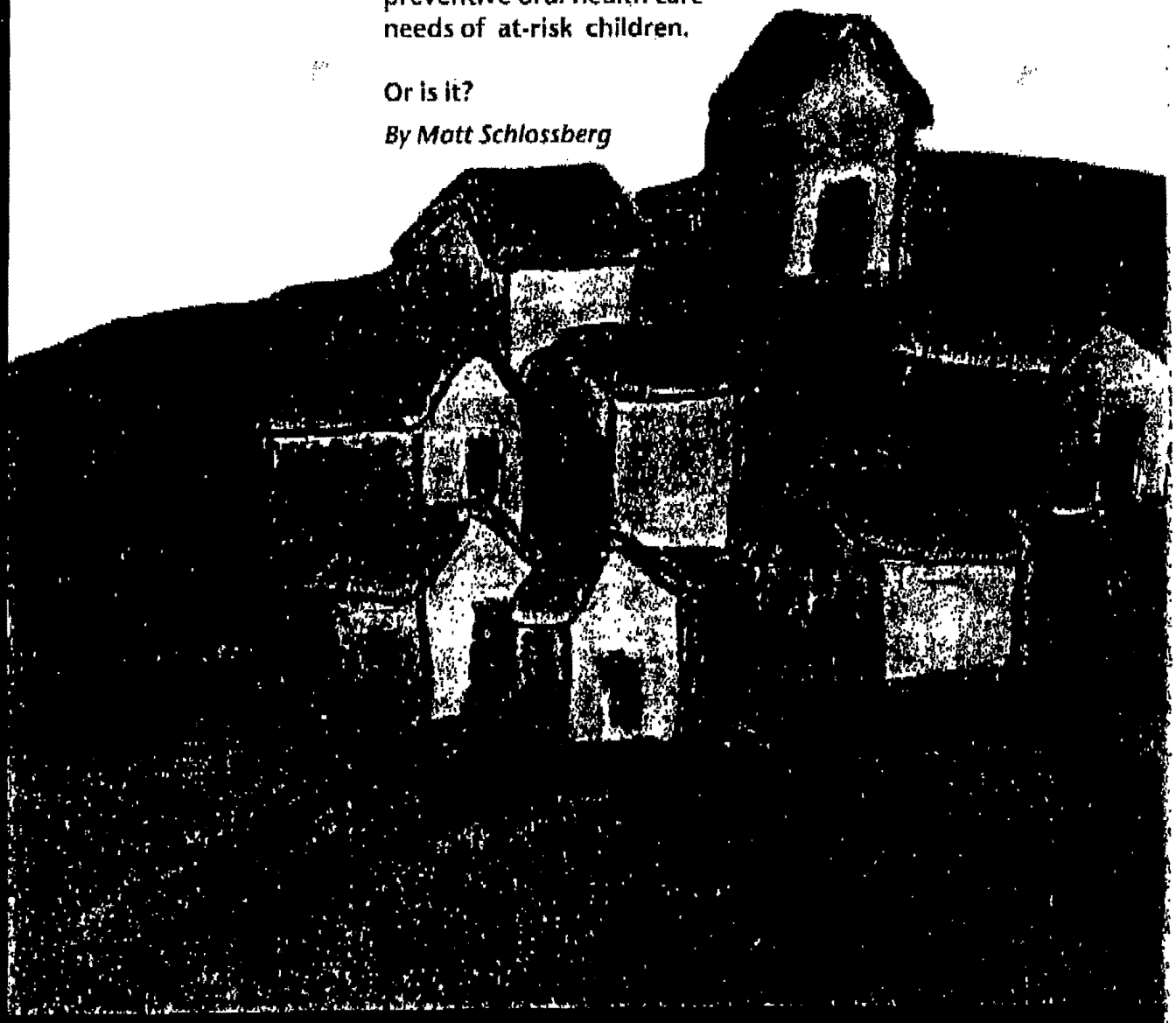

Access to dental care continues to be the "silent epidemic" described in the Surgeon General's 2000 report "Oral Health in America."

Dentistry has responded to the multifaceted problem in several ways, including licensure reform, oral health literacy initiatives, loan forgiveness, volunteerism, and lobbying for increased Medicaid reimbursement.

But some health care professions, legislators, and the public believe this is not enough. Most states—through regulatory agencies or legislators—are reaching out to the underserved through the use of alternative models of oral care delivery through the collaboration of various health care professions, including dentists, dental auxiliaries, physicians, pediatricians and registered nurses.

"I work directly with nurse practitioners, pharmacists and dieticians. We're just beginning to put dental care on the map for these other professions," says Judy Boothby, RDHAP, consultant, Alta California Regional Center, Sacramento.

Ms. Boothby is a Registered Dental Hygienist in Alternative Practice (RDHAP), a special designation for qualified dental hygienists who treat patients at private residences, daycare programs, and public institutions.

The idea behind many of the programs is akin to a "health care village" to meet the oral health needs of indigent and low-income residents. The alternative model is one more weapon in the battle for greater access. Collaborations vary in scope and partnerships, but most are statewide and commonly depend on one of two professions: physicians and dental hygienists.

Many of these collaborators say dentists are instrumental in shaping the programs. They also are one of they key factors in the success or failure of a given program. Alternative models exist in nearly every state and involve many health care professions, but dentists remain at the center of oral health care.

The existence of an alternative delivery model doesn't hinge simply on the thumbs up/thumbs down judgment of local dentists—other crucial factors, such as funding, are necessary to its success (see sidebar, page 11). But a recent study suggests that support from organized dentistry, as well as individual dentists, is "perhaps the most important factor."

The 266-page report, "The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children," examined alternative models in all 50 states, and the factors that decided the programs' success or failure. The alternative model study was published in January by the Center for Health Services, Research and Policy at The George Washington University Medical Center, Washington D.C.

"I don't think dentists can handle access alone. We all have to be involved, the whole system—

dentists,

lab techs,

hygienists,

assistants.

It's everybody's responsibility to look toward a solution."

Ann Battrell,
American Dental Hygienists' Association

"Without dentists' support, [alternative models] just aren't going to happen," says Walt Wolford, DDS, former dental director of New Mexico. The state's alternative model has met enormous barriers in large part because organized dentistry was unhappy with it.

The 500-pound gorilla

Within dentistry there is friction over the need for—and the safety of—alternative programs. Some dentists believe all dental care should begin and end in the dental office.

"I have a healthy level of discomfort when it comes to dental procedures being performed outside the dental office," says Myron Bromberg, DDS, chair, Academy of General Dentistry (AGD) Council on Dental Care. "I personally believe this opens the door for the potential of allowing other dental procedures outside dental offices."

Other dentists give their blessings to alternative models, though there are divisions over which models are acceptable.

Take two states, for example, with similar access problems approached with different solutions.

The physician-based fluoride varnish program launched in North Carolina has met with considerable success. According to Kelly Haupt, RDH, MHA, she has trained more than 1,000 private-practice physicians in fluoride varnish application. It's estimated that more than 5,000 children have received initial applications in about 200 private medical offices. She adds that more than 22 states have inquired about the program.

This alternative model is not unusual. Thirty-two states allow, either through legislation or state board regulation, physicians to provide preventive oral health treatments such as fluoride varnish.

"Into the Mouths of Babes," a North Carolina dental screening and varnish program, launched as a pilot project in several counties in 1999, went statewide in April 2001. The project's goal was to train private-practice physicians, pediatricians, and registered nurses to apply fluoride varnish to the teeth of Medicaid-dependent children from birth to age three.

About the same time, New Mexico was laying the groundwork for an alternative program, this one focusing on dental hygienists.

New Mexico, like North Carolina, has one of the worst access problems in the country. The dearth of general practitioners in rural areas has been compounded by the lack of a dental school to produce more dentists. Poor Medicaid participation, due in part to low reimbursement, also is a major access barrier.

In New Mexico, the state legislature passed a bill allowing qualified dental hygienists to practice in rural and underserved areas without the supervision of a dentist.

Supervision

There are at least five basic levels of supervision for dental hygienists to perform basic prophylaxis.

Independent practice. Dental hygienists can provide scope-of-practice dental services without dental supervision in independently owned practices. Dentists must consult. Colorado is the only state that allows dental hygienists to practice unrestricted and unsupervised by a dentist.

Unsupervised practice. Dental hygienists can provide scope-of-practice dental services without dental supervision. At least 10 states permit this type of practice.

General supervision. Forty-two states allow for general supervision in institutional settings. Though a dentist's presence is not required to perform scope-of-practice hygiene services, the supervising dentist usually sees the patient first, maps a treatment plan, and/or issues a work order. Thirty-six states allow general supervision in the dental office.

Indirect supervision. Dentist is required to be on premises when treatment is delivered. He or she must authorize the procedures.

Direct supervision. Dentist is required to be on premises when treatment is delivered. He or she must authorize the procedures and approve all services provided by the dental hygienist.

Called collaborative practice, the law allows dental hygienists to own and manage a practice while consulting with one or more dentists who provide treatment recommendations, prescriptions and diagnostic services for certain procedures.

Collaborative practice has struggled. Estimates of dental hygienists participating in the program range from 15 to 30 out of more than 600 practicing in the state. But while North Carolina had the advantage of being one of a majority of states with physician-based models, New Mexico is one of only seven states that allow the unsupervised practice of dental hygienists.

The telltale signs that North Carolina and New Mexico are burdened with a significant access problem are as clear as day. Both turned to non-dentists to provide preventive treatment. Why are the results strikingly different?

Dentists' support—or lack of it—is the primary reason given in both instances.

"[Into the Mouths of Babes] is endorsed by many members of the dental community. Dental input in terms of intervention has been extensive," says Gary Rozier, DDS, who's been with the project since its inception.

The program is the result of collaboration among the University of North Carolina (UNC) School of Dentistry, the state Medicaid agency, the state division of public health, the UNC School of Public Health, the North Carolina Academy of Family Physicians and the North Carolina Pediatric Society. Dr. Rozier, a professor of health policy and administration at the UNC School of Public Health, evaluates the efficacy of the statewide program, and says that the collaborative efforts of the health care community, among other things, points to the success of the program.

"One of the model characteristics that I see is screening and referral. You're not going to get 200,000 Medicaid kids from ages zero to three into a dental office, but [through physician screenings] you can get high-risk kids in the dental office," Dr. Rozier says.

New Mexico, initially, didn't fare as well. Dentists were dissatisfied with the legislation that created collaborative practice, even though local dental organizations helped shape the law. The controversy surrounding the law focused on dental hygienists practicing without the supervision of a dentist.

Today, more than four years since the bill's passage, less than 30 out of more than 600 dental hygienists are participating in the program. And according to the study, many can't find a dentist to collaborate with. Until recently, dental hygienists in collaborative practice couldn't bill Medicaid directly; they had to go through a dentist.

"Organized dentistry just felt it was one more step to independent practice. They perceived that it was the ultimate goal of collaborative practice," Dr. Wolford says.

Supervision

American Dental Association (ADA) policy recognizes that many state medical boards define limited preventive oral health care as being within a physician's scope of practice. The ADA, however, frowns on dental hygienist-based projects because that requires hygienists to provide services without the general or direct supervision of a licensed dentist.

ADA policy on dental auxiliaries states: "Supervision and coordination of treatment by a dentist are essential to comprehensive oral care. Unsupervised practice by dental auxiliaries reduces the quality of oral health care, fails to protect the dental health of the public and is opposed by the American Dental Association."

Because the profession of dental hygiene is not completely autonomous (except in Colorado), the success of a dental hygiene-based program depends very much on how local dentists feel about it. The degree of supervision dentists have over dental hygienists was a key concern of dentists in New Mexico.

"The more restrictive the supervisory requirements are, the less flexibility states will have in designing alternate models of preventive oral health delivery by dental hygienists. The efforts to control dental auxiliaries by procedure and varying degrees of supervision lead to confusion in what can be done, where, with what level of supervision, and approval. This confusion, in itself, is a deterrent to designing alternate delivery models," states the alternative model report.

There are several different degrees of supervision (see sidebar, left). New Mexico is one of seven states that permit the unsupervised practice of dental hygienists. Forty-four states allow general supervision of dental hygienists, meaning the supervising dentist is not required to be on premises (be it a private office or

public institution) when a dental hygienist delivers preventive treatment. Other states have stricter regulations and require dentists to on the premises before a dental hygienist can go to work; this is known as direct supervision.

The AGD and the ADA oppose unsupervised practice of dental auxiliaries. The organizations argue that general or direct supervision is necessary to ensure patients receive the highest quality comprehensive dental care safely and effectively.

"Traditionally, the team approach has been the most efficient and beneficial to the patient," says Jon Holtzee, director of state government affairs at the ADA.

For years, the American Dental Hygienists' Association (ADHA) and its components have fought for relaxing restrictions on dentists' supervision. "If dentists and dental hygienists work in a collaborative team role, [the number of] patients seeing dentists actually increases," says Ann Bartrell, director of education at the ADHA. "I don't think dentists can handle access alone. We all have to be involved, the whole system—dentists, lab techs, hygienists, assistants. It's everybody's responsibility to look toward a solution."

The ADA argues unsupervised practice has not made a dent in access to care.

"It's specious to make this claim that [unsupervised practice] increases access to care," Mr. Holtzee says. "And even if a large number of hygienists worked unsupervised, the most they could do is provide hygiene services. There's still no comprehensive dental care."

Hot topic

Supervision is the hot-button issue that may be the greatest schism between organized dentistry and organized dental hygiene.

Testifying before the Public Health Subcommittee of the U.S. Senate Committee of Health, Education, Labor and Pensions, in June 2002, the ADHA stated, "restrictive dental hygiene supervision laws constitute one of the most significant barriers to oral health services."

ADHA executive director Stanley Peck also testified that "increased utilization of dental hygienists in non-traditional settings such as schools, medical clinics, after-school programs, and nursing homes would promote increased use of dental services among low-income persons. These dental hygienists can serve as a pipeline that can refer patients to dentists. Increased utilization of dental hygiene services is critical to addressing the nation's crisis in access to oral health care for vulnerable populations."

Although a dental hygienist trains all physicians participating in the Into the Mouths of Babes program, the North Carolina State Board of Dental Examiners does not allow the state's 3,600 dental hygienists to perform any dental procedure without the direct supervision of a dentist unless a public institution employs the auxiliary.

"[Fluoride varnish is] a tremendous benefit for low-income children, but the only way it can get done by dental professional is if a dentist does it himself, or a dental hygienist is under the direct supervision of a dentist," Deana Billings, executive director of the Wilkes County Health Department in North Carolina, says.

Other factors play role in alternative models' success

According to a recent report, dentists play a crucial role in the success or failure of alternative models. But the report, "The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children," published by the Center for Health Services, Research and Policy at The George Washington University Medical Center, Washington, D.C., concludes that at least seven other factors also play important roles in their success.

The report notes success is often dependent on:

Medicaid support. North Carolina's Medicaid agency promises [illegible] reimbursement, special billing codes and training to the state's physician-based fluoride varnish program, "Into the Mouths of Babes."

Develop reimbursement plan. Until recently, New Mexico dental hygienists who wanted to participate in the state's collaborative practice program had to route all Medicaid bills through a dentist's office. This hurt interest in the program, says Christine Nathe, RDH, M.[illegible], associate professor, University of New Mexico Division of Dental Hygiene, Albuquerque. After Medicaid began allowing hygienists to bill directly, interest grew.

Develop referral mechanisms. Like most alternative models, both programs in New Mexico and North Carolina are designed to deliver preventive treatment only. Patients still need to see a dentist in order to receive comprehensive care.

Type of alternative practice. Because organized dentistry may [illegible] models involved unsupervised dental hygienists, [illegible] issues, such as these, the report states, would make the program difficult to implement.

Outreach and training. Dentists and auxiliaries [illegible] other professionals to deliver limited preventive services and provide health education.

Incremental approaches. The report states that alternative models should be designed to meet a great need. North Carolina took this approach by restricting its fluoride varnish program to Medicaid-dependent children ages zero to three because there are fewer than 50 pediatric dentists in the state.

Professional recognition. This factor says that local dentists and dental organizations realize that the alternative model is addressing a need. In Iowa, for example, the report states, that an alternative program was not fully embraced by dentistry because the access need isn't as severe as in other states.

Read the report

Go online and read the report "The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children." The study is available in a PDF format at www.gwhealthpolicy.org/downloads/Oral_Health.pdf.

"I had special permission from the state health director to work outside the direct supervision," says Ms. Haupt, who trains physicians to apply fluoride varnish. "I've had physicians who'd love to hire a dental hygienist, but it's not possible, not right now."

Though relaxing supervision requirements of hygienists would probably be viewed as an opportunity for Wilkes County, Ms. Billings says the health department has not made any overtures to the state dental board, and probably won't in the future. "In North Carolina the best way to get something like that approved is for it to come out of UNC [School of Dentistry] or a dental society. It tends to be a more accepted thing," Ms. Billings said.

The ADA plans to examine the effect unsupervised practice purports to have on access to care. In October 2002, at the ADA's Annual Session in New Orleans, the House of Delegates adopted a resolution to examine the feasibility of conducting a study to determine the impact independent practice settings for dental hygienists had on access to care for the underserved.

"I think the House wanted to examine the argument that unsupervised practice somehow increases access to care. In the states where this is allowed, very few hygienists avail themselves of this," Mr. Holtzee says.

Under pressure

Organized dentistry is under increased pressure to better address oral health disparities.

In a way, alternative models have put enormous pressure on dentistry, in some cases forcing dentists to adopt access programs they may not believe serve patients best interests.

"While I trust the judgment of good legislators, decisions can be made in an environment of hostility," says Carl Ebert, DDS, director of community dentistry, Apple Tree Dental, Minneapolis, and advocate of unsupervised dental hygiene. "[Solutions to access] will be imposed on us."

According to Dr. Wolford and a report by the ADA, the New Mexico Dental Association was under a lot of pressure from legislators to reach a compromise

AGD access initiatives

Working with the professions in the health care community as well as associations, organizations and government offices, the Academy of General Dentistry (AGD) has put forth a variety of initiatives to address the access to care problem affecting much of the country.

"The Academy's been proactive in responding to the United States' crisis involving access to dental care for the poor," says Cynthia Sherwood, DDS, chair, AGD Council on Legislative and Governmental Affairs (LGA). "The dental profession did not cause the lack of access to care for the poor, but we must be willing to join in the crusade to promote preventive, educational, legislative and regulatory changes that will make a difference to the disadvantaged."

Below are a few of the Academy's most recent access initiatives. Information about these initiatives can be found on the AGD Web site, www.agd.org.

Memorandum of Understanding (MOU). This five year agreement was signed by the AGD and the U.S. Department of Health and Human Services (HHS) in June 2002 to encourage the two organizations to work together to meet Healthy People 2010 goals. The Academy will work with other medical and public health groups to address the oral health component of Healthy People 2010. Where applicable, the AGD will tailor programs to Healthy People 2010 goals; in return the AGD will be able to leverage HHS resources in spreading the message that good oral health is a crucial component of good overall health. The AGD is the first dental organization involved in the project and the only dental organization with a written commitment and outline to incorporate the Healthy People 2010 objectives into existing and/or new programs. The MOU was the springboard for the Academy's access initiatives.

Oral Health Literacy. In 2002 the AGD created a task force to investigate ways to develop an oral health curriculum from kindergarten through high school. The surgeon general's 2000 report, "Oral Health in America," cited a major gap in the nation's oral health literacy. At the task force's February meeting, it set a course for the AGD to convince teachers, school boards, legislators and parents that a widespread public education program can work to vastly improve a nation's oral health and provide measurable results. A pilot program was established to begin in the fall. When implemented, the public school program would add to the Academy's repertoire of public information campaigns, which includes Smile the Dentist Project, the 1-877-2X-A-YEAR consumer referral number, and public service announcements.

Age 1 dental visit. "Oral Health in America" highlights children's access issues and the dangers of early childhood caries. The AGD, as well as the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD), are actively encouraging members to see children within six months of the first eruption of the child's first tooth, on around age 1. Academy is working with the AAPD and the American Association of Pediatricians to build member awareness and develop continuing education programs on how to provide this valuable service.

with dental hygienists on collaborative practice.

Just prior to the passage of the Collaborative Practice Act, New Mexico lawmakers flirted with a bill that would have required dentists to treat a certain percentage of Medicaid patients in order to renew their licenses. Dentists balked and agreed to the alternative model, though many did not embrace it.

The access problem in North Carolina provides an adequate snapshot of the myriad access barriers facing many areas of the nation.

Approximately 79 percent of North Carolina's counties are federally designated dental professional shortage areas. Of the state's 3,000 dentists, only 16 percent accept Medicaid, which covers 665,000 children.

But even in counties where participation is high, access to dental offices has proved to be a significant barrier. The outlook is even darker for the youngest patients. The entire state has fewer than 50 pediatric dentists. Although the AGD, American Academy of Pediatric Dentists, and ADA encourage the age-1 dental visit, few general practitioners have opened their practices to children that young.

Access doesn't stop at Medicaid or even perceived shortages or mal-distributions of dental professionals. Geographic and cultural barriers are equally formidable. "There are a lot of children who just don't have access to transportation," says Ms. Billings.

Though 80 percent of Wilkes County dentists are Medicaid providers, the dentist/population ratio stands at a grim 1-to-5631, according to Ms. Billings in a 1999 fluoride varnish proposal she co-authored. State and national dentist/population ratios average 1-to-2631 and 1-to-1667, respectively.

The patients themselves can act as an access barrier. "I know that among parents and children there's a lot of apathy. Compliance is the problem," said Christophe Roberts, DDS, president, Blue Ridge Dental Society, North Carolina.

The alternative model study concludes that although many of these programs have been in operation for years, it may be too soon to gauge their impact on increasing access to oral health services. "We're not implying that we've come close to solving the problem," Dr. Rozier says. "The reason we are doing this program is because we don't have enough dentists to meet the demand in the [North Carolina]."

In the case of dental hygienists, the lack of dentists' support and their ability to bill Medicaid directly has certainly hindered efforts. And because many physicians lack an adequate referral system, the ideal of comprehensive care is still far on the horizon for underserved populations. **AGD**

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Access to dental care continues to be the "silent epidemic" described in the Surgeon General's 2000 report "Oral Health in America."

Dentistry has responded to the multifaceted problem in several ways, including licensure reform, oral health literacy initiatives, loan forgiveness, volunteerism, and lobbying for increased Medicaid reimbursement.

But some health care professions, legislators, and the public believe this is not enough. Most states—through regulatory agencies or legislators—are reaching out to the underserved through the use of alternative models of oral care delivery through the collaboration of various health care professions, including dentists, dental auxiliaries, physicians, pediatricians and registered nurses.

"I work directly with nurse practitioners, pharmacists and dieticians. We're just beginning to put dental care on the map for these other professions," says Judy Boothby, RDHAP, consultant, Alta California Regional Center, Sacramento.

Ms. Boothby is a Registered Dental Hygienist in Alternative Practice (RDHAP), a special designation for qualified dental hygienists who treat patients at private residences, daycare programs, and public institutions.

The idea behind many of the programs is akin to a "health care village" to meet the oral health needs of indigent and low-income residents. The alternative model is one more weapon in the battle for greater access. Collaborations vary in scope and partnerships, but most are statewide and commonly depend on one of two professions: physicians and dental hygienists.

Many of these collaborators say dentists are instrumental in shaping the programs. They also are one of they key factors in the success or failure of a given program. Alternative models exist in nearly every state and involve many health care professions, but dentists remain at the center of oral health care.

The existence of an alternative delivery model doesn't hinge simply on the thumbs up/thumbs down judgment of local dentists—other crucial factors, such as funding, are necessary to its success (see sidebar, page 11). But a recent study suggests that support from organized dentistry, as well as individual dentists, is "perhaps the most important factor."

The 266-page report, "The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children," examined alternative models in all 50 states, and the factors that decided the programs' success or failure. The alternative model study was published in January by the Center for Health Services, Research and Policy at The George Washington University Medical Center, Washington D.C.

"I don't think dentists can handle access alone. We all have to be involved, the whole system—

dentists,

lab techs,

hygienists,

assistants.

It's everybody's responsibility to look toward a solution."

Ann Battrell,
American Dental Hygienists' Association

"Without dentists' support, [alternative models] just aren't going to happen," says Walt Wolford, DDS, former dental director of New Mexico. The state's alternative model has met enormous barriers in large part because organized dentistry was unhappy with it.

The 500-pound gorilla

Within dentistry there is friction over the need for—and the safety of—alternative programs. Some dentists believe all dental care should begin and end in the dental office.

"I have a healthy level of discomfort when it comes to dental procedures being performed outside the dental office," says Myron Bromberg, DDS, chair, Academy of General Dentistry (AGD) Council on Dental Care. "I personally believe this opens the door for the potential of allowing other dental procedures outside dental offices."

Other dentists give their blessings to alternative models, though there are divisions over which models are acceptable.

Take two states, for example, with similar access problems approached with different solutions.

The physician-based fluoride varnish program launched in North Carolina has met with considerable success. According to Kelly Haupt, RDH, MHA, she has trained more than 1,000 private-practice physicians in fluoride varnish application. It's estimated that more than 5,000 children have received initial applications in about 200 private medical offices. She adds that more than 22 states have inquired about the program.

This alternative model is not unusual. Thirty-two states allow, either through legislation or state board regulation, physicians to provide preventive oral health treatments such as fluoride varnish.

"Into the Mouths of Babes," a North Carolina dental screening and varnish program, launched as a pilot project in several counties in 1999, went statewide in April 2001. The project's goal was to train private-practice physicians, pediatricians, and registered nurses to apply fluoride varnish to the teeth of Medicaid-dependent children from birth to age three.

About the same time, New Mexico was laying the groundwork for an alternative program, this one focusing on dental hygienists.

New Mexico, like North Carolina, has one of the worst access problems in the country. The dearth of general practitioners in rural areas has been compounded by the lack of a dental school to produce more dentists. Poor Medicaid participation, due in part to low reimbursement, also is a major access barrier.

In New Mexico, the state legislature passed a bill allowing qualified dental hygienists to practice in rural and underserved areas without the supervision of a dentist.

COLLABORATIVE PRACTICE/PUBLIC HEALTH SUPERVISION – RULES FROM OTHER STATES

California

Some limits on what these hygienists can do, can't do expanded duties, like local, nitrous, soft tissue curettage. Need to have a prescription for each patient authorizing general hygiene services. Barriers getting prescription and coursework. To be eligible, need to have additional education program of 150 hours. Only had one program come forward to offer the hours and courses.
21 people have permit, out of 13,300 hygienists. These 21 were grandfathered into the program.

Colorado

I. DENTAL PRACTICE LAW (Updated July 1, 1996)
12-35-122.5. What constitutes practicing unsupervised dental hygiene.
(1) Unless licensed to practice dentistry, any person shall be deemed to be practicing unsupervised dental hygiene who:
(a) Removes deposits, accretions, and stains by scaling with hand, ultrasonic, or other devices from all surfaces of the tooth and smoothes and polishes natural and restored tooth surfaces;
(b) Removes granulation and degenerated tissue from the gingival wall of the periodontal pocket through the process of gingival curettage;
(c) Provides preventive measures including the application of fluorides and other recognized topical agents for the prevention of oral disease;
(d) Gathers and assembles information including, but not limited to, fact-finding and patient history, oral inspection, and dental and periodontal charting;
(e) Administers a topical anesthetic to a patient in the course of providing dental care.
(2) Unsupervised dental hygiene may be performed by licensed dentists and licensed dental hygienists without the supervision of a licensed dentist.
(3) Notwithstanding the provisions of section 12-35-103 (5) or 12-35-110 (1) (b), a dental hygienist may be the proprietor of a place where supervised or unsupervised dental hygiene is performed and may purchase, own, or lease equipment necessary to perform supervised or unsupervised dental hygiene.

12-35-122.6. What constitutes practicing supervised dental hygiene. (1) Unless licensed to practice dentistry, any person shall be deemed to be practicing supervised dental hygiene who:
(a) Removes deposits, accretions, and stains by scaling with hand, ultrasonic, or other devices from all surfaces of the tooth and smoothes and polishes natural and restored tooth surfaces, including root planing;
(b) Removes granulation and degenerated tissue from the gingival wall of the periodontal pocket through the process of gingival curettage. Such curettage may include the incidental removal of live epithelial tissue and is to be performed under the general supervision of a licensed dentist.
(c) Provides preventive measures including, but not limited to, the application of fluorides and other recognized topical agents for the prevention of oral disease;
(d) Gathers and assembles information including, but not limited to, fact-finding and patient history, radiographic and x-ray survey, preparation of study casts, oral inspection, and dental and periodontal charting;
(e) Administers a topical anesthetic to a patient in the course of providing dental care;

(f) Administers local anesthetic under the direct supervision of a licensed dentist pursuant to rules and regulations of the Board, which rules shall include minimum education requirements and procedures for such administration.

(2) Supervised dental hygiene may be performed by licensed dentists and, except for the administration of local anesthetic performed under paragraph (f) of subsection (1) of this section, by licensed dental hygienists under the general supervision of a licensed dentist in accordance with rules and regulations adopted by the Board.

Connecticut

Public health facility defined as an institution, community health center, group home or school, preschool operated by local/regional board of health, or Head Start Program. Can practice without supervision if done in public health setting and (1) refer for treatment patients with needs outside scope of practice of hygienist and (2) coordinate referral to licensed dentist. Rules allow hygienist to be reimbursed directly. Need 2 years of practice as a hygienist.

Dental Hygiene Regs at **http://www.dph.state.ct.us/Licensure/apps/denhy.pdf**

Sec. 20-126l. Definitions. Scope of practice. Limitations. Continuing education.

(a) As used in this section:

(1) "General supervision of a licensed dentist" means supervision that authorizes dental hygiene procedures to be performed with the knowledge of said licensed dentist, whether or not the dentist is on the premises when such procedures are being performed;

(2) "Public health facility" means an institution, as defined in section 19a-490, a community health Center, a group home or a school, a school, a preschool operated by a local or regional board of education or a head start program; and

(3) The "practice of dental hygiene" means the performance of educational, preventive and therapeutic services including: Complete prophylaxis; the removal of calcerous deposits, accretions and stains from the supragingival and subgingival surfaces of the teeth by scaling, root planing and polishing; the application of pit and fissure sealants and topical solutions to exposed portions of the teeth; dental hygiene examinations and the charting of oral conditions; dental hygiene assessment, treatment planning and evaluation; and collaboration in the implementation of the oral health care regimen.

(b) No person shall engage in the practice of dental hygiene unless such person (1) has a dental hygiene license issued by the Department of Public Health and (A) is practicing under the general supervision of a licensed dentist, or (B) has been practicing as licensed dental hygienist for at least two years, is practicing in a public health facility and complies with the requirements of subsection (e) of this section, or (2) has a dental license.

(c) A dental hygienist licensed under sections 20-126h to 20-126w, inclusive, shall be known as a "dental hygienist" and no other person shall assume such title or use the abbreviation "R.D.H." or any other words, letters or figures which indicate that the person using such words, letters or figures is a licensed dental hygienist. Any person who employs or permits any other person except a licensed dental hygienist to practice dental hygiene shall be subject to the penalties provided in section 20-126t. Licensed dental hygienists may provide dental hygiene services in any office of a licensed dentist or in any public or private institution or in any convalescent home under the general supervision of a licensed dentist.

(d) A licensed dental hygienist shall in no event perform the following dental services: (1) Diagnosis for dental procedures or dental treatment; (2) the cutting or removal of any hard or soft tissue or suturing; (3) the prescribing of drugs or medication which require the written or oral order of a licensed dentist or physician; (4) the administration of local, parenteral, inhalation or general

anesthetic agents in connection with any dental operative procedure; (5) the taking of any impression of the teeth or jaws or the relationship of the teeth or jaws for the purpose of fabricating any appliance or prosthesis; (6) the placing, finishing and adjustment of temporary or final restorations, capping materials and cement bases.

(e) Each dental hygienist practicing in a public health facility shall (1) refer for treatment any patient with needs outside the dental hygienist's scope of practice, and (2) coordinate such referral for treatment to dentists licensed pursuant to chapter 379.

Sec. 20-126s. Payment for dental hygiene care of patients in chronic and convalescent hospitals and convalescent homes. Payment for dental hygiene care rendered to patients in chronic and convalescent hospitals or convalescent homes shall be made directly to the dental hygienist rendering such care. The commissioner of social services shall not be required to recognize the cost of employing or contracting with a dental hygienist in the rates established for convalescent homes pursuant to section 17b-340.

Delaware

TITLE 24 - Professions and Occupations, CHAPTER 11. DENTISTRY AND DENTAL HYGIENE, Subchapter III. Dental Hygiene

§ 1157. Employment and duties of dental hygienists.

(a) Any licensed dentist, public institution or school authority may employ dental hygienists registered under this subchapter.

(b) The registered dental hygienist may remove calculus deposits, plaque, accretions and stains from all surfaces of the teeth and make instrumental examinations of the teeth for cavities and assemble all necessary information for use by the dentist in diagnosis and treatment planning and may perform such prophylactic or preventive measures in the case of teeth, including the application of chemicals to the teeth, designed and approved for the prevention of dental caries, as the Board may from time to time authorize, but shall not perform any other operation on the teeth or tissues of the mouth.

(c) A registered dental hygienist may operate only under the general direction or supervision of a licensed dentist, in the dentist's office or in any public school or other institution.

(d) A dental hygienist may practice under the general supervision of the Delaware State Dental Director in state institutions, federally qualified health centers, non-profit organizations or other locations as designated by the Delaware Health Care Commission in consultation with DIDER.

(e) The Board may suspend or revoke, with power to reinstate, the license of any dentist who permits any dental hygienist, operating under the dentist's supervision, to perform any operation other than that permitted under this section.

(f) The Board may also suspend or revoke, with power to reinstate, the certificate of registration of any dental hygienist violating this subchapter. The procedure to be followed in the case of such suspension, revocation or reinstatement shall be the same as that prescribed by law in the case of suspension, revocation or reinstatement of a licensed dentist. (Code 1915, § 892-I; 38 Del. Laws, c. 48, § 2; Code 1935, § 982; 24 Del. C. 1953, § 1157; 49 Del. Laws, c. 409; 65 Del. Laws, c. 210, §§ 11, 12; 70 Del. Laws, c. 186, § 1; 72 Del. Laws, c. 481, §§ 4, 5.)

1.0 Supervision: Definitions - There are 3 recognized levels of supervision:

1.1 Direct Supervision - The dentist is present in the office, personally examines the patient and specifically authorized the work to be performed. The dentist checks the work before the patient leaves the office.

1.2 Indirect Supervision - A dentist is present in the office and generally authorizes the work to be performed. The dentist may examine the patient, either before or after work is performed. The dentist is available for consultation during the patient visit.
1.3 General Supervision - A dentist may or may not be present in the office while the work is performed. The dentist authorizes the work to be performed. Emergency care and consultant services are provided by an "on-call" dentist not present in the treatment facility, if the primary dentist is not present.
1.4 Dental Technician - Any person not licensed to practice dentistry in this State, engaged in the business of constructing, altering, repairing or duplicating full dentures ("plates"), partial dentures, splints, orthodontic appliances, fixed bridges or any other prosthetic appliances.

5.0 Supervision
5.1 Conditions Applicable to General Supervision - A licensed dental hygienist, by virtue of having passed a licensure examination and being duly licensed by the State, is capable of performing those services allowed by law under supervision, the following conditions shall exist:
5.2 Advance Notice to Patient - The patient is notified, as soon as it is known, that the dentist will not be present, and is given the option to reschedule to a time when the dentist will be present in the office.
5.3 Dentist Review of Records - The dentist shall review the treatment records of each patient prior to and following the patient treatment.
5.4 Patient Contraindications - Patients for whom it is medically or dentally contraindicated,will not be scheduled when the dentist is not present.
5.5 Office Requirements - A second office employee shall be present in the treatment facility at all times when patient care is performed. This is both for safety and security reasons.
5.6 Practice in a Public Health Institution - A licensed dental hygienist, per 24 Del.C. §1157(c), may operate under the general direction of a dentist in an institution, provided that all of the conditions of general supervision are met.

Georgia

150-7-.01 Public Health License. Amended.

(1) In order to provide urgent and necessary dental care for the patients and inmates at state-operated eleemosynary or correctional institutions, the Board may, in its discretion, issue a temporary public health license to a graduate of an accredited dental school who holds a dental license in good standing in another state, and shall be valid only for the period set forth below, and for the particular institution(s) named in the temporary public health license.

(2) A temporary public health license issued pursuant to this Rule shall expire automatically in the event that the applicant fails to register for or successfully complete, the next scheduled examination given after the granting of the temporary public health license. Provided, however, the Board may, in its discretion, renew a temporary public health license issued pursuant to this Rule one time, to permit a dentist who has failed the first scheduled board examination to take and receive the results of the next regularly scheduled board examination.

New Rule of same title adopted. F. Oct. 25, 1989; eff. Nov. 14, 1989. Amended: F. Oct. 29, 1996; eff Nov. 18, 1996.

Indiana

IC 25-13. ARTICLE 13. DENTAL HYGIENISTS

IC 25-13-1-10 Locations; practice of dental hygiene; instruction and in-service training

Sec. 10. (a) A licensed dental hygienist may be employed to practice dental hygiene in Indiana in the following:

(1) The office of a legally practicing proprietor dentist.

(2) A dental school or dental hygiene school to teach and demonstrate the practice of dental hygiene.

(3) The dental clinic of any public, parochial, or private school or other institution supported by public or private funds in which the licensee is employed by the state department of health or any county or city board of health or board of education or school trustee or parochial authority or the governing body of any private school. However, institutional practice, other than dental hygiene instruction and dental prophylaxis for children up to and including grade 12 pupils at all times must be under the supervision of a licensed dentist.

(4) The dental clinic of a bona fide hospital, sanitarium, or eleemosynary institution duly established and being operated under the laws of Indiana in which the licensee is employed by the directors or governing board of such hospital, sanitarium, or institution. However, such practice must be under the supervision at all times of a licensed dentist who is a staff member of the hospital or sanitarium or a member of the governing board of the institution.

(5) The dental clinic of an industrial or a commercial establishment in which the licensee's services are under the supervision of a licensed dentist.

(b) A licensed dental hygienist may provide without supervision the following:

(1) Dental hygiene instruction and in-service training without restriction on location.

(2) Dental prophylaxis for children up to and including grade 12 if the dental hygienist is employed by any of the following:

(A) The state department of health.

(B) The department of education.

(C) The elementary or secondary school where the services are provided.

(3) Screening and referrals for any person in a public health setting.

(Formerly: Acts 1945, c.90, s.10.) As amended by Acts 1981, P.L.222, SEC.116; P.L.169-1985, SEC.42; P.L.155-1988, SEC.4; P.L.185-1991, SEC.4; P.L.2-1992, SEC.766.

Kansas

65-1456. Dental hygienists; suspension or revocation of licenses, when; notice and hearing; practice of dental hygiene defined; rules and regulations; supervision defined; issuance of permits for dental screening; authorized activities, requirements. (a) The board may suspend or revoke the license of any dentist who shall permit any dental hygienist operating under such dentist's supervision to perform any operation other than that permitted under the provisions of article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof, and may suspend or revoke the license of any hygienist found guilty of performing any operation other than those permitted under article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof. No license of any dentist or dental hygienist shall be suspended or revoked in any administrative proceedings without first complying with the notice and hearing requirements of the Kansas administrative procedure act.

(b) The practice of dental hygiene shall include those educational, preventive, and therapeutic procedures which result in the removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci. Included among those educational, preventive and therapeutic procedures are the instruction of the patient as to daily personal

care, protecting the teeth from dental caries, the scaling and polishing of the crown surfaces and the planing of the root surfaces, in addition to the curettage of those soft tissues lining the free gingiva to the depth of the gingival sulcus and such additional educational, preventive and therapeutic procedures as the board may establish by rules and regulations.

(c) Subject to such prohibitions, limitations and conditions as the board may prescribe by rules and regulations, any licensed dental hygienist may practice dental hygiene and may also perform such dental service as may be performed by a dental assistant under the provisions of K.S.A. 65-1423 and amendments thereto.

(d) Except as otherwise provided in this section, the practice of dental hygiene shall be performed under the direct or general supervision of a licensed dentist at the office of such licensed dentist. The board shall designate by rules and regulations the procedures which may be performed by a dental hygienist under direct supervision and the procedures which may be performed under general supervision of a licensed dentist. As used in this section: (1) "Direct supervision" means that the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and before dismissal of the patient evaluates the performance; and (2) "general supervision" means a Kansas licensed dentist may delegate verbally or by written authorization the performance of a service, task or procedure to a licensed dental hygienist under the supervision and responsibility of the dentist, if the dental hygienist is licensed to perform the function, and the supervising dentist examines the patient at the time the dental hygiene procedure is performed, or during the 12 calendar months preceding the performance of the procedure, except that the licensed hygienist shall not be permitted to diagnose a dental disease or ailment, prescribe any treatment or a regimen thereof, prescribe, order or dispense medication or perform any procedure which is irreversible or which involves the intentional cutting of the soft or hard tissue by any means. A dentist is not required to be on the premises at the time a hygienist performs a function delegated under part (2) of this subsection.

(e) The practice of dental hygiene may be performed at an adult care home, hospital long-term care unit, state institution, local health department or indigent health care clinic on a resident of a facility, client or patient thereof so long as:

(1) A licensed dentist has delegated the performance of the service, task or procedure;

(2) the dental hygienist is under the supervision and responsibility of the dentist;

(3) either the supervising dentist is personally present or the services, tasks and procedures are limited to the cleaning of teeth, education and preventive care;

(4) the supervising dentist examines the patient at the time the dental hygiene procedure is performed or has examined the patient during the 12 calendar months preceding performance of the procedure; and

(5) nothing in this subsection (e) shall be construed to prevent a dental hygienist from providing dental education in a school setting.

(f) The board may issue a permit to a licensed dental hygienist to provide dental screening under such terms and conditions as the board may reasonably establish in such permit. Such permit shall be for a period of one year and shall be subject to renewal at the time the license for dental hygiene is renewed.

(g) In addition to the duties specifically mentioned in subsection (b) of K.S.A. 65-1456, and amendments thereto, any duly licensed dental hygienist may:

(1) Give fluoride treatments as a prophylactic measure, as defined by the United States public health service and as recommended for use in dentistry;

(2) remove overhanging restoration margins and periodontal surgery materials by hand scaling instruments; and

(3) administer local block and infiltration anesthesia and nitrous oxide. (A) The administration of local anesthesia shall be performed under the direct supervision of a licensed dentist. (B) Each dental hygienist who administers local anesthesia shall have completed courses of instruction in local anesthesia and nitrous oxide which have been approved by the board.

(h) (1) The courses of instruction required in subsection (g)(3)(B) of K.S.A. 65-1456, and amendments thereto, shall provide a minimum of 12 hours of instruction at a teaching institution accredited by the American dental association.

(2) The courses of instruction shall include courses which provide both didactic and clinical instruction in: (A) Theory of pain control; (B) anatomy; (C) medical history; (D) pharmacology; and (E) emergencies and complications.

(3) Certification in cardiac pulmonary resuscitation shall be required in all cases.

History: L. 1943, ch. 221, § 40; L. 1976, ch. 269, § 1; L. 1984, ch. 313, § 103; L. 1996, ch. 210, § 4; L. 1997, ch. 30, § 3; L. 1998, ch. 141, § 2; L. 2000, ch. 169, § 13; July 1.

Source or prior law: 65-1414.

Attorney General's Opinions: Act inapplicable to certain practices, acts and operations; exceptions. 89-70.

Attorney General's Opinions: Dental hygienists; dental hygiene practice defined; rules and regulations; supervision; permits for dental screening. 93-151.

Dental act not applicable to certain practices, acts and operations. 95-29.

Dentists providing anesthesia services operate independently and with same qualifications to supervise as anesthesiologist M.D. and D.O. 1998-57.

Maine

Program been in place since 98/99. Requires very formal detailed process run through the board office. Staff report practitioners are hard to keep track of. They are supposed to file reports with the board office that detail the number of patients seen, # screened, # sealants done, # cleanings and referrals, etc. Reports not always filed. Big access problem in the state and shortage of dentists.

130 practitioners have been authorized.

MAINE: RULES 02-313, chapter 1,

Section 1. DEFINITIONS.

A. General Supervision: "General supervision" shall mean that the dentist is not required to be in the dental office at the time the procedures are being performed on a patient of record.

B. Direct Supervision: "Direct supervision" shall mean that the dentist must be in the dental office at the time the duties under his/her supervision are being performed. In order to provide direct supervision of patient treatment, the dentist must at least diagnose the condition to be treated, authorize the treatment procedure prior to implementation, and examine the condition after treatment and prior to the patient's discharge.

C. Public Health Supervision: "Public Health Supervision" means that:

(1) The dentist provides general supervision to a dental hygienist who is practicing in a Public Health Supervision status that has been approved by the Board under Section 4 of this Chapter, with the exception that the patient being treated shall not be deemed to be a patient of record of the dentist providing Public Health Supervision; and

(2) The dental hygienist has an active Maine license and practices in settings other than a traditional dental practice, provided that the service is rendered under the supervision of a dentist with an active Maine license. These settings may include but are not necessarily limited to public and private schools, medical facilities, nursing homes, residential care facilities, dental vans, and any other setting where adequate parameters of care, infection control, and public health guidelines can and will be followed.

(Under list of services RDH may perform:

K. Apply sealants, provided that a licensed dentist first makes the determination and diagnosis as to the surfaces on which the sealants shall be applied; In Public health or school sealant programs only, determination and diagnosis of the sealant site by a dentist need not occur.

Section 4. PUBLIC HEALTH SUPERVISION STATUS

A. Public Health Supervision Status Allowed. The Board may grant "Public Health Supervision" status, as defined in Section 1(C), to a dental hygienist in situations the Board deems appropriate in its discretion, giving due consideration to the protection of the public.

B. Roles and Responsibilities. When working together in a Public Health Supervision relationship, dentists and dental hygienists shall enter into a Public Health Supervision Agreement based on the following roles and responsibilities:

(1) The dentist providing Public Health Supervision must:

☐ Be available to provide an appropriate level of contact, communication, collaboration, and consultation with the dental hygienist;

☐ Have specific standing orders or policy guidelines for procedures which are to be carried out for each location or program, although the dentist need not be present when the procedures are being performed;

☐ Help provide for the patient's additional needed care in collaboration with the dental hygienist, although the dentist has no responsibility for providing treatment.

(2) A dental hygienist providing services under Public Health Supervision may perform only those duties within the accepted scope of practice of dental hygiene, as specified in Section 2 (General Supervision of Dental Hygienists), and must:

☐ Provide to the patient, parent or guardian a written plan for referral or an agreement for follow-up recording all conditions that should be called to the attention of a dentist;

☐ Have each patient sign a permission slip or consent form that informs them that the service to be received does not take the place of regular dental checkups at a dental office and is meant for people who otherwise would not have access to the service;

☐ Inform each patient who may require further dental services of that need;

☐ Inform the Board in writing of any changes in or termination of the Public Health Supervision Agreement; and

☐ Maintain an appropriate level of contact and communication with the dentist providing Public Health Supervision.

C. Criteria. In deciding whether to grant Public Health Supervision status to a dental hygienist, the Board shall consider the following criteria:

(1) The proposal fills a need not currently being met;

(2) The particular proposed practice setting(s), including the proposed supervisor, will be adequate to accomplish the goal;

(3) Appropriate public health guidelines can be followed in the proposed setting(s);

(4) Adequate parameters of care can be maintained in the proposed practice setting(s);

(5) A dentist is available to provide Public Health Supervision to the dental hygienist and specific standing orders are submitted to and approved by the Board; and

(6) If criteria (1) – (4) are met, but a dentist is not readily available under (5), the Board shall assist the dental hygienist in finding a dentist to provide Public Health Supervision.

D. Application and Approval Process. A dental hygienist wishing to practice under Public Health Supervision must apply to the Board for approval, on an application form specified by the Board, providing such information as the Board may deem necessary. The dental hygienist shall list all known locations at which he or she expects to practice. Upon approval by the Board, the dental hygienist may practice under Public Health Supervision for a specified period determined by the board not to exceed three years. If, during the specified period, the dental hygienist finds that he or she will be providing services at additional locations than those described in the application form, he or she shall notify the Board about each of these locations, in the manner specified by the Board. Any application approved for a specified period may be amended, upon submission by the dental hygienist and approval by the Board. The Board may revoke its approval if a program does not continue to meet the criteria specified in 4(C).

E. Reporting Requirements. Each dental hygienist who has rendered services under Public Health Supervision must complete a summary report at the completion of a program, or, in the case of an ongoing program, at least annually. The report must be completed in the manner specified by the Board, including information about each location where the dental hygienist has rendered these services. The dental hygienist must submit the form to the dentist providing Public Health Supervision for his or her signature, before sending it to the Board.

no dental

F. Reimbursement. Dental hygienists providing services under Public Health Supervision may be compensated for their work by salary, honoraria, and other mechanisms by the employing or sponsoring entity. Nothing in this rule shall preclude the entity that employs or sponsors a dental hygienist from seeking payment, reimbursement, or other source of funding for the services provided.

Michigan

Program run through the public health department (recently renamed to something else). Board not involved in determining qualifications. Board is an umbrella agency, not specific authority.

Michigan: PUBLIC HEALTH CODE (EXCERPT) - Act 368 of 1978 (statute)

333.16625 Rules as to dental hygienist or dental assistant; dental hygiene services performed under supervision of dentist as part of program for dentally underserved program; designation of grantee health agency; advisory committee; "supervision" defined.

Sec. 16625.

(1) The board may promulgate rules to prohibit or otherwise restrict the assignment of procedures to a dental hygienist or a dental assistant if the board determines that the assignment constitutes or may constitute a danger to the health, safety, or welfare of the patient or the public.

(2) Notwithstanding section 16601(1)(f) or the rules promulgated under subsection (1), a dental hygienist may perform dental hygiene services under the supervision of a dentist as part of a program for dentally underserved populations in this state conducted by a local, state, or federal grantee health agency for patients who are not assigned by a dentist. The director of public health shall designate a person as a grantee health agency for a 2-year period if the person applies to the department of public health on a form provided by the department of public health and meets all of the following requirements:

(a) Is a public or nonprofit agency administering a program of dental care to a dentally underserved population.

(b) Obtains more than 50% of its total revenue from public or nonprofit organization sources.

(c) Employs or contracts with at least 1 dentist and 1 dental hygienist.

(d) Is not associated with a private dental practice or an incorporated dental service provider whose only source of state or federal funding is reimbursement under the program for medical assistance administered by the department of social services under the social welfare act, Act No. 280 of the Public Acts of 1939, being sections 400.1 to 400.121 of the Michigan Compiled Laws.

(e) Submits a program overview indicating the approximate population to be served, the method by which the service is to be provided, and the procedures for program oversight and direction.

(3) The director of public health may appoint an advisory committee to assist the director of public health in designating grantee health agencies under subsection (2). If the director of public health does appoint an advisory committee under this subsection, the director of public health shall include on the advisory committee, at a minimum, a representative from the Michigan dental hygienist association or its successor organization and a representative from the Michigan dental association or its successor organization.

(4) As used in this section, "supervision" means the overseeing of or participation in the work of any other individual by a health professional licensed under this article in circumstances in which 1 or more of the following exist:

(a) The continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and a licensed health professional.

(b) The availability of a licensed health professional on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation to the supervised individual, to review

records, and to further educate the supervised individual in the performance of the individual's functions.

(c) The provision by the licensed supervising health professional of predetermined procedures and drug protocol.

History: 1978, Act 368, Eff. Sept. 30, 1978 ;--Am. 1991, Act 58, Imd. Eff. June 27, 1991 .

Popular Name: Act 368

Minnesota

150A.10 Allied dental personnel.

Subdivision 1. Dental hygienists. Any licensed dentist, public institution, or school authority may obtain services from a licensed dental hygienist. Such licensed dental hygienist may provide those services defined in section 150A.05, subdivision 1a. Such services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Such services shall be provided under supervision of a licensed dentist. Any licensed dentist who shall permit any dental service by a dental hygienist other than those authorized by the board of dentistry, shall be deemed to be violating the provisions of sections 150A.01 to 150A.12, and any such unauthorized dental service by a dental hygienist shall constitute a violation of sections 150A.01 to 150A.12.

Subd. 1a. Limited authorization for dental hygienists.

(a) Notwithstanding subdivision 1, a dental hygienist licensed under this chapter may be employed or retained by a health care facility to perform dental hygiene services described under paragraph (b) without the patient first being examined by a licensed dentist if the dental hygienist:

(1) has two years practical clinical experience with a licensed dentist within the preceding five years; and

(2) has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

(b) The dental hygiene services authorized to be performed by a dental hygienist under this subdivision are limited to removal of deposits and stains from the surfaces of the teeth, application of topical preventive or prophylactic agents, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking of radiographs, and performance of root planing and soft-tissue curettage. The dental hygienist shall not place pit and fissure sealants, unless the patient has been recently examined and the treatment planned by a licensed dentist. The dental hygienist shall not perform injections of anesthetic agents or the administration of nitrous oxide unless under the indirect supervision of a licensed dentist. The performance of dental hygiene services in a health care facility is limited to patients, students, and residents of the facility.

(c) A collaborating dentist must be licensed under this chapter and may enter into a collaborative agreement with no more than four dental hygienists. The collaborative agreement must include:

(1) consideration for medically compromised patients and medical conditions for which a dental evaluation and treatment plan must occur prior to the provision of dental hygiene services; and

(2) a period of time in which an examination by a dentist should occur.

The collaborative agreement must be maintained by the dentist and the dental hygienist and must be made available to the board upon request.

(d) For the purposes of this subdivision, a "health care facility" is limited to a hospital; nursing home; home health agency; group home serving the elderly, disabled, or juveniles; state-operated

facility licensed by the commissioner of human services or the commissioner of corrections; and federal, state, or local public health facility, community clinic, or tribal clinic.

(e) For purposes of this subdivision, a "collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services authorized under this subdivision and the collaborative agreement may be performed without the presence of a licensed dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

Missouri

Section 332.311 Dental Hygienists allowed to practice without supervision in Public Health settings - conditions apply. A currently licensed dental hygienist who has been in practice at least three years and who is practicing in a public health setting may provide fluoride
treatments, teeth cleaning and sealants, if appropriate, to children who are eligible for medical assistance, pursuant to chapter 208, RSMo, without the supervision of a dentist. Public health settings will be defined jointly by the Department of Health and the Missouri Dental Board by rule. This provision expires on August 28, 2006.

4 CSR 110-2.131 Definition of a Public Health Setting
PURPOSE: The purpose of this rule is to implement section 332.311, RSMo as amended by HB567 of the 91st General Assembly and defines the public health settings in which a dental hygienist may practice without the supervision of a dentist.

(1) For the purposes of section 332.311, RSMo only, the term "public health setting" shall be defined as a location where dental services authorized by section 332.311, RSMo are performed so long as the delivery of services are sponsored by a governmental health entity which includes:

(A) Department of Health and Senior Services;

(B) A county health department;

(C) A city health department operating under a city charter;

(D) A combined city/county health department; or

(E) A nonprofit community health center qualified as exempt from federal taxation under section 501(c)(3) of the *Internal Revenue Code* including a community health center that receives funding authorized by sections 329, 330, and 340 of the United States Public Health Services Act.

Nevada

Law went into effect in 2000. Can practice in health facility, school, or other place designated by board without supervision. Most go out into clinics run by the state where there is a dentist, so not very many people interested in program.

1 person has applied to board

New Hampshire

http://gencourt.state.nh.us/rules/den100-500.html
Den 101.13 "Public health supervision" means a dentist with an active license authorizes procedures to be carried out by a dental hygienist with an active license practicing in a school, hospital, or institution without the dentist having to be present but the dentist will review the records once in a 12 month period.
Den 402.01 Hygienists' Duties. A dental hygienist shall perform the following duties:

(c) Under public health supervision as defined in Den 101.12 and arranged by degree of supervision in Den 302.02:

(1) Collect and assess medical and dental histories, including preliminary inspection of the oral cavity, surrounding structures and periodontal probing and charting;

(2) Perform complete oral prophylaxis as appropriate, including the removal of calciferous deposits and the removal of subgingival accretions and stains by scaling and root planing;

(3) Apply topical fluoride; and

(4) Instruct in oral hygiene techniques.

New Mexico

16.5.29.10 PRACTICE SETTINGS: New Mexico licensed dental hygienists may practice in the following settings:

A. the office of a licensed dentist;

B. a clinic or clinics operated or approved by an executive agency of the State of New Mexico;

C. a hospital with written authorization;

D. a state licensed nursing home or long term care facility with written authorization; or

E. a school regulated by the New Mexico Department of Education.

[5-31-95, A, 12-15-97; Recompiled 12/31/01]

16.5.17.2 SCOPE: The provisions of 16.5.17 NMAC apply to all dentists, dental hygienists and dental assistants who work in a collaborative practice arrangement.

16.5.17.3 STATUTORY AUTHORITY: 16.5.17 NMAC is promulgated pursuant to the Dental Health Care Act, NMSA 1978 Section 61-5A-4 (1999 Repl. Pamp.).

16.5.17.4 DURATION: Permanent

16.5.17.5 EFFECTIVE DATE: February 14, 2000, unless a different date is cited at the end of a Section or Paragraph.

16.5.17.6 OBJECTIVE: To regulate the collaborative practice of dental hygiene in New Mexico.

16.5.17.7 DEFINITIONS:

A. "Acting Consulting Dentist" means a dentist who meets the qualifications of a consulting dentist who is named by a consulting dentist to act in his place when that dentist will be away from his practice for more than two weeks.

B. "Collaborative Practice Agreement" means a written agreement between a dentist who meets the qualifications of 16.5.17.9 NMAC to be a consulting dentist as defined in 16.5.17 NMAC of these rules, and a collaborative practice dental hygienist. This agreement shall follow the format as determined by the Board.

C. "Collaborative Practice of Dental Hygiene" means the science of the prevention and treatment of oral disease through the provision of educational, assessment, preventive, clinical and other therapeutic services as specified in Section 61-5A-4(B) in a cooperative working relationship with a consulting dentist but without general supervision, as set forth by the rules jointly established by the board and committee.

D. "Consulting (Collaborative) Dentist" means a dentist who meets the qualifications specified in Section 16.5.17.9 NMAC of this rule and who agrees to serve or continues to serve as a patient's dentist of record in collaboration and consultation with the practice dental hygienist as specified in the rules.

E. "Non-participating Dentist" is a dentist who does not wish to collaborate with a collaborative practice dental hygienist.
F. "Standard collaborative practice protocols" is the protocol to be used by the collaborative practice dental hygienist to treat a patient, as specified in Section 16.5.17.13 NMAC of this part.
G. "Written prescription orders" means instructions from the consulting dentist to the collaborative hygienist to perform those allowable treatments requiring a diagnosis and treatment plan, subject to the limitations of Section 16.5.17.12 NMAC of these rules, or directions written to modify the standard collaborative practice protocols, or the collaborative practice agreement.
H. "Verbal prescription or orders" means instructions not communicated in written form, which must be recorded in the patient's record or the protocol agreement by both the collaborative hygienist and the consulting dentist when given.
[2-14-00; 16.5.17.7 NMAC - Rn & A, 16 NMAC 5.17.7, 12-14-00]

16.5.17.8 Certification for the Collaborative Practice of Dental Hygiene: The Board, based on the recommendation of the Dental Hygienists Committee, will certify qualified dental hygienists for collaborative practice.
A. Prerequisite Requirements for Certification. Each applicant for certification as a collaborative practice dental hygienist must possess the following qualifications:
(1) Possess a current New Mexico dental hygiene license in good standing.
(2) Have been engaged in the active practice of dental hygiene as defined in 61-5A-4(B) of the Act for not less than:
(a) 2400 hours of active practice for the past eighteen months; or
(b) a total of 3,000 hours of active practice and has been engaged in active practice for two of the past three years.
(3) Meet the educational criteria for licensure in Section 61-5A-13 (A) of the Act.
(4) Have 15 hours of continuing education in clinical dental hygiene in the twelve (12) months prior to certification, which includes courses in infection control and medical emergencies.
B. Documentation Requirements: Each applicant for certification as a collaborative practice dental hygiene must submit a completed application, the required fees and following documentation:
(1) Verification of a current active license;
(2) Proof of the active practice of dental hygiene as defined in paragraph (2) Subsection A of 16.5.17.8 NMAC of this Part. This proof may be in the form of notarized letters from employers, supervisors of dental clinics of one of the Uniformed Services of the United States, or faculty administrators of accredited schools. If this documentation cannot be obtained, the applicant may request to provide other proof of the required hours to the Committee for consideration;
(3) Copy of proof of current basic life support;
(4) Proof of 15 hours of continuing education related to the clinical practice of dental hygiene; and
(5) A copy of a signed collaborative practice agreement between a dental hygienist and a consulting dentist.
C. Renewal Requirements: Each dental hygienist certified for collaborative practice shall:
(1) Submit a completed renewal application for certification for collaborative practice, along with the triennial renewal application for their license, accompanied by the required fees as defined in 16.5.18 NMAC.
(2) Complete 60 hours of continuing education every triennial renewal period. If the initial certification period is less than three years, the required continuing education will be prorated at 20 hours per full year of certification.
(3) Submit a current list of all consulting dentists to the Board with each renewal application.
[2-14-00; 16.5.17.8 NMAC - Rn, 16 NMAC 5.17.8, 12-14-00]

16.5.17.9 Qualifications for Consulting Dentists: A consulting dentist must meet the following qualifications:

A. Possess a current New Mexico dental license in good standing;

B. Maintains an active clinical general dentistry or public health practice within the State and within a reasonable referral distance from the collaborative dental hygiene practice as determined by the Board upon recommendation of the Dental Hygienists Committee.

[2-14-00; 16.5.17.9 NMAC - Rn & A, 16 NMAC 5.17.9, 12-14-00]

16.5.17.10 Responsibilities of a Consulting Dentist: The consulting dentist shall:

A. In collaboration with the dental hygienist, provide for the patient's additional needed dental care;

B. Be available to provide consultation to the collaborative practice dental hygienist;

C. Make provisions for a qualified acting consulting dentist to act in his/her place should he/she be away from his practice for more than two weeks;

D. Maintain an appropriate level of contact and communication with the collaborative practice dental hygienist;

E. In conjunction with the collaborative practice dental hygienist, be responsible and liable for acts and omissions in the collaborative dental hygiene practice; and

F. Assure that each collaborative practice dental hygienist is duly licensed and certified for collaborative practice by the Board of Dental Health Care.

G. Maintain a separate and distinct collaborative practice agreement with each collaborative practice dental hygienist for whom he/she serves as a consulting dentist.

H. Provide verbal and/or written prescriptions to the collaborative practice dental hygienist for those procedures requiring a diagnosis.

I. Provide verbal and/or written prescriptions to the collaborative practice dental hygienist when the consulting dentist deems it appropriate to provide exception to the standardized protocols.

J. Provide a written prescription within (7) business days following a verbal prescription or order.

K. Maintain in the patients record a duplicate of the written prescriptions and/or orders as described in Subsection H of 16.5.17.10 NMAC through Subsection J of 16.5.17.10 NMAC

L. Provide a written diagnosis and treatment recommendations from the records provided by the collaborative practice dental hygienist to the patient and the hygienist with in thirty days of receipt of such records.

N. Each collaborative agreement will be kept on file by the collaborative practice dental hygienist and the consulting dentist, the basic format of the agreement will be provided with the application by the Board.

[2-14-00; 16.5.17.10 NMAC - Rn & A, 16 NMAC 5.17.10, 12-14-00]

16.5.17.11 Responsibilities of a Collaborative Practice Dental Hygienist: The collaborative practice dental hygienist shall:

A. Refer each patient for a dental examination every twelve (12) months, as well as anyone who may require further dental services, to the patient's consulting dentist or to a dental specialist in the case of an emergency.

B. In conjunction with the consulting dentist, be responsible and liable for acts and omissions in the collaborative dental hygiene practice;

C. Assure that each consulting dentist is duly licensed by the Board of Dental Health Care; by verification with the Board Office.

D. Maintain a collaborative practice agreement with each consulting dentist; and

E. Maintain an appropriate level of contact and communication with the consulting dentist.

F. Shall contact the patient's dentist of record, if not a consulting dentist, prior to treating the patient to give the dentist the option of becoming a consulting dentist.

G. Shall offer the patient a choice of the collaborative practice dental hygienist's consulting dentists if the patient's dentist of record chooses to be a non-participating dentist.

H. Not to perform any treatment if the patient does not have an active consulting dentist on record with the collaborative practice dental hygienist.

I. Follow the standardized protocol unless modified by the consulting dentist by prescription or order.

J. Follow the verbal and written prescriptions and orders of the consulting dentist for those treatments requiring a diagnosis.

K. Forward all records and x-rays, or duplicates, to the consulting dentist within 14 days.

L. Assure that each consulting dentist meets the requirements of a consulting dentist as stated in 16.5.17.9 NMAC.

[2-14-00; 16.5.17.11 NMAC - Rn & A, 16 NMAC 5.17.11, 12-14-00]

16.5.17.12 Collaborative Dental Hygiene Practice and Limitations:

A. A collaborative practice dental hygienist may have more than one consulting dentist.

B. A dentist shall have a consulting agreement with no more than three collaborative practice dental hygienists. The board may grant exception to this limitation for public health settings on a case-by-case basis.

C. The collaborative practice dental hygienist may own and/or manage a dental hygiene practice, or enter into a contractual arrangement, in any location or setting in New Mexico.

E. The Committee, through the Board, may take any disciplinary action allowed by the Uniform Licensing Act, against a dental hygienist certified in collaborative practice.

F. A collaborative practice dental hygienist shall not:

(1) Administer local anesthesia except under the indirect supervision of a dentist; and only if certified to do so by the Board.

(2) Administer a drug or medication, except those directly indicated as Dental topical therapeutic or preventive agents. Other therapeutic agents may only be dispensed if the collaborative practice dental hygienist holds a Class C clinic license. Any drugs dispensed as a Class C clinic must be on the specific individual authorization of a dentist.

(a) All non-controlled substance medications requiring a prescription or order from the dentist may only be dispensed for immediate use in the collaborative practice dental hygienist office, and only on the specific order or protocol from the consulting dentist. A log of these dispensing shall be kept and a copy of this log shall be sent to the corresponding consulting dentist every 6 months. Collaborative practice dental hygienists may not dispense or administer any controlled substance.

(b) Prescription drugs, which are kept in bulk at the collaborative practice dental hygienist's office, to be dispensed or used by the collaborative practice dental hygienist as in paragraph (2) of Subsection F 16.5.17.12 NMAC, must be purchased on an order or prescription by a consulting dentist.

(3) Diagnose dental disease, but may advise the patient of suspected pathology and periodontal status;

(4) Perform oral hygiene procedures on any patient identified as having a significant health risk from the procedures; unless the patients' current health history has been reviewed by the patient's dentist of record or the consulting dentist; or for patients who reside in residential or long term care facilities, the patient's dentist or physician.

(5) Perform treatments requiring the diagnosis of a dentist without a prescription/order from the consulting dentist. Such treatments include but are not limited to, root planning, sealant application, administration of therapeutic agents and other services defined in Section 61-5A-4(B) as within the scope of dental hygiene practice but which require a dentists diagnosis.

(6) Modify the standard collaborative practice protocol without a prescription or order from the consulting dentist.

(7) Take impressions for bleaching trays, deliver bleaching materials or provide systems of home bleaching, or provide instructions to patients on using bleaching materials unless it is authorized on a case by case basis by prescription from a consulting dentist.

(8) Provide in office bleaching systems unless under indirect supervision of a Consulting Dentist.

[2-14-00; 16.5.17.12 NMAC - Rn & A, 16 NMAC 5.17.12,12-14-00; A, 06-14-01]

16.5.17.13 Standard Collaborative Practice Protocols: All protocols will include but are not limited to; Review of health history charting of existing teeth and restorations, periodontal charting as necessary, and notations of potential pathology. Protocols may be amended upon written order of the consulting dentist. Time intervals for these protocols must be established in the Collaborative Practice Agreement as provided in Subsection G of 16.5.17.13 NMAC.

A. Protocols for children 12 and under:

(1) Appropriate panoramic or occlusal x-rays
(2) Two bitewing x-rays
(3) Prophylaxis/scaling
(4) Topical fluoride treatment
(5) Other radiographs as indicated by consultation with the dentist.

B. Protocols for teenagers:

(1) Appropriate panoramic or full mouth radiographs
(2) Two or four bitewing x-rays
(3) Prophylaxis/scaling
(4) Topical fluoride treatment
(5) Other radiographs as indicated by consultation with the dentist.

C. Protocols for adults:

(1) Full mouth or panoramic radiograph
(2) Bitewing radiographs annually
(3) Complete periodontal charting
(4) Prophylaxis/scaling or gross debridement and consultation with the consulting dentist if periodontal assessment suggests periodontal involvement.

D. All other procedures not listed in the protocols shall require a prescription from the consulting dentist as stated in Subsection H of 16.5.17.10 NMAC and Subsection N of 16.5.17.10 NMAC.

E. Guidelines for patient release forms, to include a disclaimer signed by the patient or legal guardian that the dental hygiene services rendered do not preclude the need for routine examinations by a dentist.

F. Both the consulting dentist and the collaborative practice dental hygienist shall sign a copy of this or amended protocol and keep on file.

G. Changes to practice protocol and/or agreements must be in prescribed in writing by the consulting dentist and recorded by both the consulting dentist and the collaborative practice dental hygienist.

[2-14-00; 16.5.17.13 NMAC - Rn, & A, 16 NMAC 5.17.13, 12-14-00]

16.5.17.14 Dental Assistants in Collaborative Dental Hygiene Practice: Collaborative practice dental hygienists may work with and supervise dental assistants, including dental assistants certified to perform functions as defined in 16.5.39 NMAC of these rules.
[2-14-00; 16.5.17.14 NMAC - Rn, 16 NMAC 5.17.14, 12-14-00]

North Carolina:

SUBCHAPTER 16W - PUBLIC HEALTH HYGIENISTS
SECTION .0100 - PUBLIC HEALTH HYGIENISTS

.0101 DIRECTION DEFINED
Pursuant to G.S. 90-233(a), a public health hygienist may perform clinical procedures under the direction of a licensed dentist who is employed by a State government dental public health program or a local health department as a public health dentist. The specific clinical procedures delegated to the hygienist must be completed, in accordance with a written order from the dentist, within 60 days of the dentist's in-person evaluation of the patient. The dentist's evaluation of the patient shall include a complete oral examination, thorough health history and diagnosis of the patient's condition.
History Note: Authority G.S. 90-223; 90-233(a); Temporary Adoption Eff. October 1, 1999.

.0102 TRAINING FOR PUBLIC HEALTH HYGIENISTS
(a) Prior to performing clinical procedures pursuant to G.S. 90-233(a) under the direction of a duly licensed dentist, a public health hygienist must have:
(1) five years of experience in clinical dental hygiene;
(2) CPR certification, updated annually;
(3) six hours of continuing education in medical emergencies each year; and
(4) such other training as may be required by the Dental Health Section of the Department of Health and Human Services.
(b) For purposes of this Rule, a minimum of 4000 hours performing primarily prophylaxis or periodontal debridement unde r the supervision of a duly licensed dentist shall be equivalent to five years experience in clinical dental hygiene.
History Note: Authority G.S. 90-223; 90-233(a); Temporary Adoption Eff. October 1, 1999.

.0103 TRAINING FOR PUBLIC HEALTH HYGIENISTS PERFORMING PREVENTIVE PROCEDURES
(a) Public health hygienists who provide only educational and preventive procedures such as application of fluorides, fluoride varnishes, and oral screenings, and not clinical procedures, shall be subject to the training provisions set out in Paragraph (b) of this Rule instead of the training provisions required by 21 NCAC 16W .0102.
(b) A public health hygienist may perform preventive procedures as set out in Paragraph (a) of this Rule under the direction of a duly licensed public health dentist if the hygienist:
(1) maintains CPR certification; and
(2) completes such other training as may be required by the Oral Health Section of the Department of Health and Human Services.
History Note: Authority G.S. 90-223; 90-233(a); Temporary Adoption Eff. February 8, 2000; Eff. April 1, 20

Oregon

1997 legislation, effective late October, rules in 1998. Requires Limited Access Permit, issued by the Board, in order to practice. Executive Director reports no problems with the program, however, not enough people are applying. There were some problems getting the extended coursework that is required. Law was expanded in 2001 to allow additional facilities where people with permit can practice to include schools. Hygienists cannot already provide assessments or screenings because the board has interpreted Oregon law to say that they are diagnosing. In 2003, the hygiene group will be trying to change the statute to make it clear hygienists can provide these assessments and screenings. The definition of supervision is in statute. Reimbursement not too much of issue, about 25% of the hygienists have needed the Executive Director to write a letter saying they are authorized to provide the services and be reimbursed directly.
24 people received permit so far

(Limited Access Permits)

680.200 Issuing permit. (1) Upon application accompanied by the fee established by the Oregon Board of Dentistry, the board shall grant a permit to practice as a limited access permit dental hygienist to any applicant who:

(a) Holds a valid, unrestricted Oregon dental hygiene license;

(b) Presents evidence satisfactory to the board of at least 5,000 hours of supervised dental hygiene clinical practice within the previous five years;

(c) Presents proof of current professional liability insurance coverage; and

(d) Presents documentation satisfactory to the board of successful completion of a total of 40 classroom hours of courses from a formal, post-secondary educational institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency and approved by the board, including but not limited to:

(A) General medicine and physical diagnosis;

(B) Pharmacology;

(C) Medical emergencies and cardiopulmonary resuscitation;

(D) Oral pathology;

(E) Management and psychology of geriatric and disabled patients; and

(F) Jurisprudence relating to unsupervised practice with limited access patients.

(2) All permits issued pursuant to subsection (1) of this section expire two years following the date of issuance unless renewed on or before that date by:

(a) Payment of the renewal fee as set by the board;

(b) Submission to the board of satisfactory evidence of completion of at least 36 hours of continuing education, 12 hours of which shall be in the coursework areas required in subsection (1) of this section; and

(c) Presentation to the board of proof of professional liability insurance coverage.

(3) The board may refuse to issue or renew a limited access permit or may suspend or revoke the permit of a limited access permit dental hygienist who has been convicted of an offense or been disciplined by a dental licensing body in a manner that bears, in the judgment of the board, a demonstrable relationship to the ability of the applicant to practice limited access permit dental hygiene in accordance with the provisions of this chapter or ORS chapter 679, or who has falsified an application for permit, or any person for any cause described under ORS 679.140 or 679.170. [1997 c.251 §2]

680.205 Services rendered under permit. (1) A dental hygienist issued a permit to act as a limited access permit dental hygienist under ORS 680.200 shall be authorized to render all services within the scope of practice of dental hygiene as defined in ORS 679.010 and as authorized by the limited access permit to:

(a) Patients or residents of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:

(A) Nursing homes as defined in ORS 678.710;

(B) Adult foster homes as defined in ORS 443.705;

(C) Residential care facilities as defined in ORS 443.400;

(D) Adult congregate living facilities as defined in ORS 441.525;

(E) Mental health residential programs administered by the Department of Human Services;

(F) Facilities for mentally ill persons, as defined in ORS 426.005;

(G) Facilities for persons with mental retardation, as defined in ORS 427.005; or

(H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth correction facilities as

defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005.

(b) Students or enrollees of nursery schools and day care programs, Job Corps and other similar employment training facilities and primary and secondary schools, including private schools and public charter schools.

(2) At least once each calendar year, a dental hygienist issued a permit to act as a limited access permit dental hygienist shall refer each patient or resident to a dentist who is available to treat the patient or resident.

(3) Nothing in this section shall be construed to authorize a limited access permit dental hygienist to administer local anesthesia, to provide sealants, denture soft lines, temporary restorations and radiographs except under the general supervision of a dentist licensed under ORS chapter 679, or to administer nitrous oxide except under the indirect supervision of a dentist licensed under ORS chapter 679.

(4) The Oregon Board of Dentistry may not expand the scope of unsupervised practice of a limited access dental hygienist by rule.

(5) A person granted a limited access permit under ORS 680.200 shall also procure all other permits or certificates required by the board under ORS 679.250. [1997 c.251 §3; 2001 c.592 §1]

Texas

Sec. 262.1515. DELEGATION OF DUTIES TO DENTAL HYGIENIST PRACTICING IN CERTAIN LONG-TERM CARE FACILITIES AND SCHOOL-BASED HEALTH CENTERS.

(a) A licensed dentist may delegate a service, task, or procedure, pursuant to this section, to a dental hygienist, without complying with Section 262.151(a)(2) if:

(1) the dental hygienist has at least two years' experience in the practice of dental hygiene; and

(2) the service, task, or procedure is performed in one of the following locations:

(A) a nursing facility as defined in Section 242.301, Health and Safety Code; or

(B) a school-based health center established under Section 38.011, Education Code, as added by Chapter 1418, Acts of the 76th Legislature, Regular Session, 1999.

(b) The patient must be referred to a licensed dentist after the completion of a service, task, or procedure performed under Subsection (a).

(c) A dental hygienist may not perform a second set of delegated tasks or procedures until the patient has been examined by a dentist in compliance with Section 262.151(a)(2).

(d) A dental hygienist may not perform any service, task, or procedure under this section without the express authorization of a dentist.

(e) The nursing facility or school-based health center shall note each delegated service, task, or procedure performed by the dental hygienist under this section in the patient's medical records.

Washington

RCW 18.29.220

Community-based sealant programs in schools.

(1) For low-income, rural, and other at-risk populations and in coordination with local public health jurisdictions and local oral health coalitions, a dental hygienist licensed in this state as of April 19, 2001, may assess for and apply sealants and apply fluoride varnishes in community-based sealant programs carried out in schools without attending the department's school sealant endorsement program.

(2) For low-income, rural, and other at-risk populations and in coordination with local public health jurisdictions and local oral health coalitions, dental hygienists who are school sealant endorsed under RCW 43.70.650 may assess for and apply sealants and fluoride varnishes in community-based sealant programs carried out in schools.
[2001 c 93 § 3.]NOTES: Findings -- Intent -- Effective date -- 2001 c 93:

RCW 18.29.180 Exemptions from chapter.
The following practices, acts, and operations are excepted from the operation of this chapter:
(1) The practice of dental hygiene in the discharge of official duties by dental hygienists in the United States armed services, coast guard, public health services, veterans' bureau, or bureau of Indian affairs;
(2) Dental hygiene programs approved by the secretary and the practice of dental hygiene by students in dental hygiene programs approved by the secretary, when acting under the direction and supervision of persons licensed under chapter 18.29 or 18.32 RCW acting as instructors.

RCW 18.29.056 Employment by health care facilities authorized -- Limitations.
(1) Dental hygienists licensed under this chapter with two years' practical clinical experience with a licensed dentist within the preceding five years may be employed or retained by health care facilities to perform authorized dental hygiene operations and services without dental supervision, limited to removal of deposits and stains from the surfaces of the teeth, application of topical preventive or prophylactic agents, polishing and smoothing restorations, and performance of root planing and soft-tissue curettage, but shall not perform injections of anesthetic agents, administration of nitrous oxide, or diagnosis for dental treatment. The performance of dental hygiene operations and services in health care facilities shall be limited to patients, students, and residents of the facilities. For dental planning and dental treatment, dental hygienists shall refer patients to licensed dentists.
(2) For the purposes of this section, "health care facilities" are limited to hospitals; nursing homes; home health agencies; group homes serving the elderly, handicapped, and juveniles; state-operated institutions under the jurisdiction of the department of social and health services or the department of corrections; and federal, state, and local public health facilities, state or federally funded community and migrant health centers, and tribal clinics.
[1997 c 37 § 2; 1984 c 279 § 63.] NOTES:Severability -- 1984 c 279: See RCW 18.130.901.

WAC 246-815-170 General provisions. (1) "Unprofessional conduct" as used in this chapter shall mean the conduct described in RCW 18.130.180.
(2) "Hospital" means any health care institution licensed pursuant to chapter 70.41 RCW.
(3) "Nursing home" means any health care institution which comes under chapter 18.51 RCW.
(4) "Department" means the department of health.
(5) "Dental hygienist" means a person licensed pursuant to chapter 18.29 RCW.
(6) "Mentally or physically disabled dental hygienist" means a dental hygienist who is currently mentally incompetent or mentally ill as determined by a court, or who is unable to practice dental hygiene with reasonable skill and safety to patients by reason of any mental or physical condition and who continues to practice while so impaired.

WAC 246-815-190 Health care institutions. The chief administrator or executive officer or their designee of any hospital or nursing home shall report to the department when any dental hygienist's services are terminated or are restricted based on a determination that the dental hygienist has either committed an act or acts which may constitute unprofessional conduct or that the dental hygienist may be unable to practice with reasonable skill or safety to the client by reason of a mental or physical condition.

IOWA GENERAL ASSEMBLY

ARRC

Administrative Rules Review Committee

STATEHOUSE * ROOM 116 * DES MOINES, IOWA 50319 * (515) 281-3084/3355
FAX (515) 281-5995/4424 * E-MAIL jroyce@legis.state.ia.us

THE RULES DIGEST

April, 2003

Scheduled for committee review
Monday, April 14th, 2003
Statehouse Room #116

Reference
XXV IAB No. 18 (03/05/03)
XXV IAB No. 19 (03/19/03)
XXV IAB No. 20 (04/02/03)

HIGHLIGHTS IN THIS ISSUE:

DRAM SHOP REQUIREMENTS, Alcoholic Beverages Commission 1
DENTAL HYGIENISTS: COLLABORATIVE AGREEMENTS, Dental Board of Examiners 2
TEACHER EVALUATIONS, Department of Education 3
CLOSING ATTENDANCE CENTERS, Department of Education 3
CAMPAIGN FINANCE PROCEDURES, Ethics & Campaign Finance 5
MEDICAID DRUG REIMBURSEMENT, Department of Human Services 6
UNFAIR TRADE PRACTICES, Insurance Division 8
CHILD PROTECTION GRANTS, Public Health Department 10
ALTERNATE ENERGY PRODUCTION, Utilities Division 10

ALCOHOLIC BEVERAGES DIVISION

9:15

Dram shop requirements, IAB Vol. IAB Vol. XXV, No. 20, ADOPTED.

In August 2001 the division proposed the first increase in dram shop insurance requirement in three decades. The current level is $35,000--$10,000 for bodily injury, with a $20,000 maximum for multiple injuries and $5,000 for property damage. The August, 2001 proposal would raise these amounts to $50,000, $100,000 and $20,000 respectively. A new category is added--$50,000 or loss of support, for a total of $220,000. Department representatives stated this level was well within the range of limits for those states requiring dram shop insurance, although it was noted many states had no such requirement at all. Committee members were generally supportive of some dram shop reform, but felt more information was needed on the cost impact of these revisions. For that reason the committee requested a regulatory analysis to estimate the financial impact this increase would have an licensees. This request delayed the final adoption of the rule until this study was completed.

The study was reviewed by the ARRC in September, 2002. It stated that the current requirements were was adopted in 1973 and in the following years, according to the consumer price index, the cost of living has increased nearly 400%. Of Iowa's 5,000 licensees 25% would experience an increase from 18% to 158% in their rates while 60% would have no increase because they already had more coverage than the amount required by the proposed amendments. The analysis estimates that the total costs of alcohol-related accidents was $1.2 billion in 2001.

The study did set out a number of alternatives to dram shop insurance; these include surety bonds, risk pools, and deposits with the State Treasurer and even additional training for servers. However,

all of these alternatives will require legislative action.

The division has now completed action on this rule-making. The support provisions have been reduced from $50,000 to $25,000 for an individual and reduced from $100,000 to $50,000 for two or more persons. Provisions for $25,000 property damage coverage have been eliminated entirely. Newly added coverage for assault and battery injury has been retained.

AGRICULTURAL DEVELOPMENT AUTHORITY
10:10

Loan participation program, IAB Vol. XXV, No. 19, ARC 2359B, NOTICE.

The IADA loan participation program assists lenders and qualified farmers by providing government participation in a loan for the purchase of agricultural improvements, machinery, breeding livestock or property. To be eligible, an individual farmer may have a net worth no greater than $200,000, a partnership, no greater than $400,000. Debt is limited to $400,000 for an individual and $800,000 for a partnership. Those amounts are now being raised to $300,000 and $600,000 respectively. The aggregate amount of the participated loan can be no more than two times the net worth of the borrower, however, the amount of the loan is being raised from $50,000 to $100,000.

DENTAL EXAMINERS BOARD
9:30

Dental hygienist: collaborative agreements, IAB Vol. XXV, No. 18, ARC 2327B, NOTICE.

Under Iowa Code §153.15 the Board of Dental Examiners may define the *"educational, therapeutic, and preventive"* services performed by a licensed hygienist. These services are set out in great detail in rule 650 IAC 10.3. The statute also requires these services to be performed under *"supervision"* of a licensed dentist in a dental office, a school, public health agencies, hospitals, or the armed forces. Supervision is clearly defined in rule 650 IAC 1.1. Under this definition a dentist does not need to be in the facility while hygienist services are being provided, with four conditions:

- ⌘ Informed consent by the patient;
- ⌘ Consent by the hygienist;
- ⌘ Basic emergency procedures must be established;
- ⌘ The treatment to be provided must be prior prescribed by a licensed dentist and entered in writing in the patient record.

Based on the existing statutory and regulatory framework this proposed rule administratively creates a function roughly similar to that of physician assistants. This rulemaking would allow a dental hygienist who has 2,500 hours of clinical practice or who is employed as a public health hygienist to perform *preventive* services in a variety of settings such as schools, public health agencies, and health care facilities without the patient's first being examined by a dentist. The hygienist must have a collaborative agreement with a dentist who authorizes and accepts responsibility for the services provided by the hygienist. The collaborative agreement must contain protocols or standing orders for the hygienist to follow. The agreement and protocols would need to meet the four conditions required for general supervision.

ECONOMIC DEVELOPMENT
9:40

Entrepreneurial ventures assistance program, IAB Vol. XXV, No. 19, ARC 2360B, NOTICE.

The entrepreneurial ventures assistance (EVA) program is in part a training program. It encourages the development of entrepreneurial venture planning and managerial skills in conjunction with the delivery of a financial assistance program for business start-ups and expansions. Eligible businesses include start–up or early–stage companies, or existing companies developing a new product or technology. The owners must provide evidence that they are currently participating in, or have completed an "entrepreneurial venture development curriculum." This course of study covers such things as entrepreneurial training, management team development, intellectual property management, market research and analysis, sales and distribution

March 2003 ARRC Meeting

Summary of Issues

The May meeting of the Administrative Rules Review Committee will be on Tuesday, May 13th, 2003 in Statehouse Room #116. For more information contact Joe Royce at 281-3084; email: joe.royce@legis.state.ia.us.

ALCOHOLIC BEVERAGES, Dram shop insurance, 04/02/03 IAB, ARC 2385B, ADOPTED.

BACKGROUND: After a two year rulemaking, the division completion action on the first increase in dram shop requirements in 30 years. The Iowa Dram Shop Law, Iowa Code § 123.92 imposes liability on any licensee or permittee for any personal or property injury resulting from the intoxication of a person. Licensees and permitees are required by law to maintain liability insurance in an amount determined by the division.

COMMENTARY: The previous level was $35,000 maximum: $10,000 for bodily injury, $20,000 maximum for multiple injuries and $5,000 for property damage. The new levels are $50,000, $100,000 and $20,000 respectively. A new category is added-- $25,000 or loss of support. Assault and battery is also now included as a compensable loss. A regulatory analysis of these changes was completed in August, 2002; it revealed that of Iowa's 5,000 licensees 25% would experience an increase from 18% to 158% in their rates while 60% would have no increase because they already had more coverage than the amount required by the proposed amendments. Implementation of the new coverage will occur as policies are renewed-- beginning September 1, 2003, and ending August 31, 2004. It was felt that a long lead time was needed to allow the insurance industry an opportunity to properly rate these changes. Division representatives noted these levels were reasonable when compared to other states.

The committee generally agreed the changes were within the authority of the division, but some members felt that setting these requirements should be accomplished in statute. More specifically members expressed concern over subrule 5.8(5) which made dramshop liability insurance subject to *"ordinary or customary exclusions usually found in a policy..."* Members found this language vague and they also felt this phrase implied the division might review and approve individual policies. Division representatives responded this language was added at the request of the industry. Committee members were still uneasy with the idea that dramshop insurance was detailed in rule, not statute; for that reason, the committee voted to refer these rules to the General Assembly for additional review.

ACTION: GENERAL REFERRAL. Final discussion at May meeting.

DENTAL BOARD OF EXAMINERS, Dental hygienist: collaborative agreements, 3/5/03 IAB, ARC 2327B, NOTICE.

BACKGROUND: Under a limited set of circumstances a dental hygienist may provide certain educational, therapeutic, and preventive services when the dentist is not present. The board proposes to expand this privilege by allowing a hygienist to perform *preventive* services in a variety of settings such as schools, public health agencies, and health care facilities without the patient's first being examined by a dentist.

COMMENTARY: This change is the result of a petition for rulemaking; it would allow the hygienist to provide preventative services to a patient who has never seen the

dentist. It was noted this was a significant expansion in the current practice of a dental hygienist.

ACTION: NO ACTION. Additional review when the rule is adopted in final form.

EDUCATION DEPARTMENT, Closing attendance centers, 4/2/03 IAB, NOTICE.

BACKGROUND: Over 25 years, on a case-by-case basis the department has evolved a policy on the closing of "attendance centers" by local boards; it now proposes to codify that policy, called the "Barker guidelines", in rule—thus formally giving the policy the force and effect of law.

COMMENTARY: Under Iowa law the state board hears appeals from persons who are aggrieved by local board actions; school closings are a common source of these appeals. Over the years these decisions have formulated a process for public notice that a district must follow before it can close a school. This process is not judicial---there is no right to present evidence and have the final decision based on that evidence. It sets out seven requirement that provide for public notice and a right to be heard prior to the final board decision.

ACTION: NO ACTION.

ENVIRONMENTAL PROTECTION COMMISSION, Postclosure accounts, 567 IAC Ch. 111, SELECTIVE.

BACKGROUND: Iowa Code §455B.306(8) requires that landfill operators maintain postclosure accounts. The amounts placed in these accounts is to be based on the amount of solid waste received by the facility. In 2002 the EPC adopted rules which essentially required current reveneues should finance the costs of postclosure.

COMMENTARY: The EPC maintains that a variety of mechanisms exist to provided the required financial assurance, and that over half of the public landfills have chosen to fund a separate account in advance of closure. The EPC representatives stated that the intent of the statute is to require those who generate the waste to pay for the post closure costs. They noted that four landfills are having problems funding postclosure and stated that the EPC was working with those facilities. Opponents of this requirement contended that municipalities should have discretion to fund post closure work as they see fit; they felt the Divisions role was to ensure the work was done, not specify the method of finance. They noted that municipalities remain liable for the cost of post closure and, unlike private corporations, cannot simply file for bankruptcy and walk away from the site. Opponents also stated that in some cases the timeframe for funding the account was short and would result in greatly increased tipping fees to fully fund the account.

ACTION: NO ACTION

HUMAN SERVICES DEPARTMENT, Electronic foodstamps, 4/2/03 IAB, ARC 2333B, ADOPTED.

BACKGROUND: The department will replace the current food stamp books with ATM-like cards that can used at the client's grocery store. The changeover is mandated by the federal government and Iowa is one of the last states to implement this measure. Once the client receives the card the client will then contact the department to obtain a personal identification number.

COMMENTARY: Department representatives noted that most larger stores would simply use their current devices to process the cards. In those locations where the

Proposal for a systematic approach to providing assessment and triage of dental care for nursing home residents in Iowa DRAFT

Proposal: To match oral health providers with Iowa nursing homes in an effort to enhance the oral health of residents while meeting the cost considerations of dental providers and nursing homes.

Need

1. Nursing home residents are one of the most dentally underserved populations in Iowa.
2. Many nursing homes in Iowa are in need of oral health professionals who can provide oral health assessments, triage emergency and definitive care as well as staff training to meet regulatory mandates.

Purpose

1. To provide nursing home residents in Iowa with appropriate dental assessments, oral health care plans and access to needed dental services.
2. To provide nursing homes with the oral health-related services and training needed to provide residents with appropriate oral health care and meet regulatory mandates.

Possible roles

The Iowa Department of Public Health Dental Advisory Council, in coordination with the University of Iowa College of Dentistry, the Iowa Dental Association, the Iowa Dental Hygiene Association, the dental practices in Iowa and the Iowa Department of Inspections and Appeals could collaborate to develop a coordinated system of oral health care-related services to nursing homes throughout Iowa.

1. The University of Iowa, College of Dentistry could be responsible for developing practical models for oral health care in Iowa nursing homes. These models would include options for assessing the nursing home residents' oral health needs, developing daily oral health care plans, prescribing/referring residents to appropriate oral health professionals when needs are identified and providing annual in-service training for nursing home staff members. Models for the financing of such care would also be included.

   Annual certificate-level continuing education programs could be provided by College of Dentistry faculty and staff. Financial support for these programs could be solicited to reduce or eliminate the cost for dentists/hygienists/assistants willing to participate in this certificate-level training program.

2. The Iowa Department of Inspections and Appeals **(This needs to be confirmed with the Department)** could be responsible for helping to locate Nursing homes in need of a dentist of record (DOR). The Iowa Department of Inspections and Appeals is currently responsible for evaluating the compliance of nursing homes with regulations regarding the adequacy of oral health-related services in long term care facilities including:
   a. Oral health assessments for the Minimum Data Set upon entry into the facility
   b. Annual training of staff regarding oral health care of residents
   c. Care for treatment needs found during assessments
   d. Access to emergency and palliative care

3. The Iowa Dental Association could be responsible for identifying dentists willing to participate as the dentist of record for nursing homes (as identified by the Dept of Inspections and Appeals). The Iowa Dental Hygiene Association could provide similar support in locating hygienists in areas where the hygienist from a private practice is not interested/available to provide these services.

4. The dentist of record (DOR) could be responsible for (but not necessarily perform themselves) oral health assessments, daily oral care plans, triage and referral and possibly emergency care for either an entire nursing home or, where feasible, for a portion of a home. The DOR is not automatically responsible for providing all definitive treatment but is responsible for appropriate referral of problems identified in assessments. The DOR for a facility could also be a rotating position among a number of dentists in a community.

   The goal would be to have as much emergency and routine care as possible provided by dentists in their own practice with transportation provided by the nursing home. Many dentists in a community already provide services for residents in nursing homes who were patients in their practice prior to moving to the facility. An effort would be made to keep these relationships when possible for both emergency and routine care.

5. Financing the care would be the responsibility of both the nursing home and the nursing home resident/responsible party. The nursing home could pay the dentist a fee of $X/bed per month. For this fee, the dentist would be responsible for providing services such as the following (these need to be refined):
   a. Oral health assessments for the Minimum Data Set upon entry into the facility
   b. Annual training of staff regarding oral health care of residents
   c. Assessment of emergencies or problems that arise
   d. Notification of identified problems to an staff member of the nursing home to receive approval from responsible party
   e. Referral of residents to appropriate care provider
   f. Additional treatment could be provided by the DOR/hygienist as recommended by DOR with the responsible party charged on a fee for service basis. This could include
      1. Preventive therapies including prophylaxis, fluoride varnish, etc at the nursing home
      2. Emergency and routine care if the patient does not have a personal dentist of record.

Many of the services provided under this contract could be provided under existing practice act authority by the DOR, a hygienist (could be from the dentist's practice), or a public health hygienist is available in the area and the DOR prefers not to provide these directly. Many of these concepts could also be relevant for other underserved sites such as head start centers.

Iowa Board of Dental Examiners
Rulemaking Analysis

Proposed Rule(s):

This rulemaking analysis is intended to ensure that rules are in compliance with the criteria for regulatory review contained in Executive Order Number 8 and the regulatory principles of Executive Order Number 9, signed by Governor Vilsack in September 1999.

The basic principles of these executive orders state that rules must be authorized by state law and (1) aid in interpreting the law or (2) serve an important public need.

NEED:

1. **Is there a need for the proposed rule?**

2. **What is the problem or important public need the proposed rule attempts to correct?**

3. **Is the problem or public need significant?**

4. **What is the degree and nature of the risk?**

5. **Have any existing rules or laws contributed to the problem?**

6. **Should these existing laws or rules be modified or eliminated in order to correct the problem?**

7. **Can the provision of economic incentives correct the problem?**

8. **Can the provision of more information correct the problem?**

9. **Is there a scientific, technical, or economic basis for the proposed rule?**

10. Does any other information establish the need for the proposed rule?

INTENT & STATUTORY AUTHORITY:

11. Is the proposed rule authorized by statute(s)?

Cite authority: _____

12. Is the statutory authority sufficient?

13. Is the proposed rule necessary to comply with the statute that authorizes it?

14. Is the proposed rule consistent with the legislative intent of the authorizing statute(s)?

15. Is there a need to develop additional legislative authorization in order to protect the health, safety, and welfare of the people of Iowa?

CLARITY:

16. Is the proposed rule simple and easy to understand?

17. Is the proposed rule concise and narrowly-tailored?

18. Is the proposed rule duplicative or does it conflict with other Board rules or rules of other state agencies?

19. Has the proposed rule been harmonized with related local regulations and have the views of affected local officials been sought prior to adopting the rule?

20. Does the proposed rule minimize the potential for uncertainty and litigation?

COST:

21. What are the qualitative benefits of the proposed rule (including economic, environmental, public health and safety, and other benefits)?

22. What are the quantitative benefits of the rule (including economic, environmental, public health and safety, and other benefits)?

23. What are the qualitative costs of the proposed rule (including economic, environmental, public health and safety, and other costs)?

24. What are the quantitative costs of the rule (including economic, environmental, public health and safety, and other benefits)?

25. Do the qualitative and quantitative benefits of the proposed rule exceed the costs of the rule?

26. What are the qualitative and quantitative benefits of not adopting the proposed rule?

27. What are the qualitative and quantitative costs of not adopting the proposed rule?

28. Is there an alternative regulatory approach other than rulemaking?

29. Does the proposed rule or alternative regulatory approach maximize net benefits?

30. Is the proposed rule cost-effective?

Considerations:
-Cost of cumulative regulations
-Incentives
-Innovation
-Consistency
-Predictability
-Flexibility
-Equity
-Enforcement & Compliance Costs
-to government
-to regulated entities
-to the public

31. Do the benefits of the proposed rule justify its costs?

FAIRNESS:

32. Is the proposed rule fair?

33. Does the proposed rule apply equally to all those affected by it?

34. Is the proposed rule or an alternative regulatory approach most equitable?

35. Is the proposed rule the best available method of achieving the desired outcome?

36. Does the proposed rule impose the least possible burden on society, including individuals, businesses, and other entities?

37. Has the public participated in the development of this proposed rule prior to filing notice of intended action?

38. Have interested parties participated in the development of this proposed rule prior to filing notice of intended action?

39. Date of completion of analysis:

RECOMMENDATION:

DATE OF ACTION:

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THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER
WASHINGTON DC

Center for Health Services Research and Policy
School of Public Health and Health Services

Report

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

EXECUTIVE SUMMARY

January 17, 2003

Lea Nolan, MA[*], Brian Kamoie, JD, MPH[*], Jennel Harvey, MHSA[±], Lissette Vaquerano[*], Sarah Blake, MA[¥], Satvinder Chawla[£], Jeffrey Levi, PhD[*], Sara Rosenbaum, JD[*]

The Center for Health Services Research and Policy (CHSRP) was funded by the Centers for Disease Control and Prevention's (CDC) Public Health Practice Program Office to examine state dental practice laws that permit alternative models of delivering preventive oral health care to low-income children[1].

BACKGROUND

Although the incidence of tooth decay has decreased considerably over the past two decades, the prevalence of caries among children and adolescents remains high. Minorities and low-income populations experience more dental decay than those with higher incomes, and they are also more likely to have a higher proportion of untreated decayed teeth.[2] Low oral health care utilization is the primary reason for higher tooth decay among low-income and minority populations. Low use of

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

[2] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, page 63.

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dental services among low-income and minority children is related to several factors that reduce their access to such services, which include low dentist Medicaid participation, shortage of dentists, mal-distribution of dentists, restrictive state laws, patients' lack of health insurance, and families' lack of understanding and awareness of the need for preventive oral health care.

PROJECT OVERVIEW

Project Purpose

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

METHODS

Review State Dental and Medical Practice Laws

We reviewed state dental practice acts for the 50 states and the District of Columbia to determine how they address the delivery of preventive oral health care services by dentists and dental hygienists.[3] We also examined any applicable exemptions for physicians and nurses to deliver oral health care. In addition, we reviewed the statutes for supervision requirements for dental hygienists, consultation between dentists and hygienists when delivery of oral health services is unsupervised or independent, and the educational and competency requirements for dental hygienists.

Case Studies

We opted to study six states that had: 1) enacted a statute that permitted/encouraged an alternative model; and/or 2) had or had not yet implemented the alternative model. We chose to examine two types of

[3] We reviewed state dental and medical practice laws during 2000-2001. The full report contains a full description of the scope of our review.

alternative models: 1) a model that uses dental hygienists working under either general supervision or without a dentist's supervision (but not independent practice) to provide preventive services; and 2) a model that uses physicians to provide screening, education, and in some cases, topical fluoride application to very young children. Our study states included Connecticut, Iowa, New Mexico, North Carolina, South Carolina, and Washington.

FINDINGS

Analysis of State Health Professions Laws

The licensing of dentists, as with other health professionals, is governed by state law. Health professions licensing statutes are implemented by boards dominated by the relevant professionals themselves.[4] In the case of dental practice, definitions and scope of practice provisions become important when considering the role of dental hygienists. Generally, dental hygienists are subject to governance by boards of dentistry, which define and in many jurisdictions limit the scope of permissible practice.

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

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

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[4] *See* Furrow et al., Health Law. 2000. St. Paul, Minnesota: West Group Publishing, at 59. *See also* Orentlicher D, "The Role of Professional Self Regulation" in *Regulation of the Healthcare Professions* at 129 (Timothy S. Jost, ed. 1997).

State Options

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

Supervision Requirements for Dental Hygienists

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

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

Case Studies

Our findings reveal that making a change in the law does not result in an *immediate* change to the oral health care delivery system. In fact, in three of the cases (IA, NC, and WA) the alternative model could be developed *without* the creation of a new public health-oriented law. In

these states, existing dental and medical practice laws, accompanied by changes to rules, regulations, or administrative policies, were sufficient to permit a new model. In the remaining cases the alternative model could not be pursued unless the law was changed. Where laws are changed, it may take a substantial amount of time for the dental profession and the market to respond to such changes. However, in all cases we learned that the success of the alternative oral health care models lay not merely in the laws themselves, but in certain factors essential to their implementation.

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

- Gaining the **support of dentists**, either through their organizational representatives or through the leadership of individual dentists is perhaps the most important factor in the success of an alternative model.

- Creating a **reimbursement mechanisms** for providers in the alternative model.

- Gaining **state Medicaid agency support** is essential.

- The **lack of a formal referral mechanism** severely hindered the successful implementation of most of the alternative models.

- The **type of alternative model** may predetermine how easily it is implemented in a state.

- Alternative models that utilize an **incremental approach** seem to have more success.

- **Outreach and training** are necessary.

- **Professional recognition and acceptance of the need** for the alternative model.

CONCLUSION

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

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

RECOMMENDATIONS

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

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

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

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

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

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

- Further study is needed on successfully implemented preventive oral health care models. Study should be undertaken at the individual provider level to learn exactly what elements are necessary to make a particular model successful.

Administrative Rules Review Committee

INTEROFFICE MEMORANDUM

TO: JENNIFER HART
IOWA DENTAL BOARD

FROM: JOE ROYCE, STAFF-ADMINISTRATIVE RULES REVIEW COMMITTEE

SUBJECT: INFORMAL REGULATORY ANALYSIS: ARC 2783B, RELATING TO PUBLIC HEALTH SUPERVISION OF DENTAL HYGIENISTS

DATE: 10/15/2003

At its October 13th 2003 meeting the Administrative Rules Review Committee voted to request an informal regulatory analysis concerning ARC 2783B, which establishes rules relating to the "public health supervision" of hygienists under collaborative agreements with a supervising dentist. This filing appears as a notice of intended action, published in IAB Vol. XXVI, No. 06 (09/17/03).. ARRC members have determined that more information is needed relative to the regulatory impact of the proposal and more generally to the workings and goals of the proposal. However, the members did not wish to delay the adoption of this filing, so an "informal" regulatory analysis has been requested to obtain this additional information, but without the publication and adoption delays imposed by the formal process detailed in Iowa Code §17A.4A.

This analysis should address the bulleted items contained in the October 13th, 2003 memorandum provided to the committee by the Iowa Dental Association; a copy of that memorandum is included for your convenience. Please include whatever additional information you feel appropriate.

IOWA BOARD OF DENTAL EXAMINERS
PUBLIC HEARING
OCTOBER 16, 2003

DES MOINES, IOWA

Pursuant to the Notice of Intended Action published in the Iowa Administrative Bulletin on September 17, 2003, as **ARC 2783B**, a public hearing on proposed amendments to 650—Chapter 10, "General Requirements," was held in the Conference Room, 400 S.W. 8th St, Suite D, Des Moines, Iowa, on October 16, 2003, beginning at 10 a.m.

Board members present:
George North, DDS, Chairperson
Debra Yossi, RDH, Secretary
Elizabeth Brennan, Public Member
Richard M. Reay, DDS
Gary D. Roth, DDS
Suzan Stewart, Public Member

Staff present:
Jennifer Hart, Executive Officer
Theresa Weeg, Assistant Attorney General

Also present:
Frank Severino, Iowa Dental Association
Larry Carl, Executive Director, Iowa Dental Association
Mary Mariani, DDS, Iowa Dental Association
Kathy Kell, DDS, Iowa Dental Association
Brice Oakley, Iowa Dental Hygienists' Association
Joe Royce, Legal Counsel, Administrative Rules Review Committee
Barb Blough, Iowa Dental Association
Tracy Rodgers, Oral Health Bureau, Iowa Department of Public Health
Heather Miller, Oral Health Bureau, Iowa Department of Public Health
Jane Slach, RDA, Iowa Dental Assistants Association
Maureen T. Mosse, CDA, RDA, Iowa Dental Assistants Association
Sandra Leggett, RDH, Des Moines Area Community College
Mary Kelly, RDH
Daniel Venker, DDS
Nancy Adrianse, RDH, Iowa Dental Hygienists' Association
Peggy Funk, RDH, Iowa Dental Hygienists' Association
Sheila Temple, RDH, Iowa Dental Hygienists' Association
Sue Hyland, RDH, Iowa Dental Hygienists' Association
Tom Cope, Iowa Dental Hygienists' Association

ARC 2783B relates to public health supervision of a dental hygienist. The proposed amendment allows a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting. The amendment defines public health settings and details the responsibilities of each licensee operating under public health supervision.

Kathryn Kell, DDS, President of the Iowa Dental Association (IDA) read written comments on behalf of the IDA. The IDA has serious concerns about the proposed amendments and suggested several changes.

Mary Mariani, DDS, read written comments expressing opposition to the proposed amendments.

Sandra Leggett, RDH, from Des Moines Area Community College, read written testimony previously submitted in support of the proposed amendments.

Dr. Daniel Venker, DDS, read written comments in support of the proposed amendments.

Mary Kelly, RDH, offered oral testimony in support of the proposed amendments. Ms. Kelly currently works in a school-based sealant programs in Des Moines. The program provided 1,300 sealants last year, with a 99 percent retention rate. With respect to testimony previously provided about patients with problems caused by sealants, those cases apply to situations where a dentist examined the patient, showing that a dental exam alone does not prevent problems.

Tracy Rodgers, RDH, from the Oral Health Bureau of the Iowa Department of Public Health indicated that the department is very supportive of the board's proposed amendments.

Sheila Temple, RDH, Immediate Past President of the Iowa Dental Hygienists' Association, read written comments in support of the proposed amendments. Ms. Temple provided a copy of a caries risk assessment tool that can be used by dental hygienists in conducting risk assessments.

Peggy Funk, President of the Iowa Dental Hygienists' Association read written comments in support of the proposed amendments.

Additional written comments have been received concerning the proposed amendments. All comments will be submitted to the Board for consideration.

Respectfully submitted,

CONSTANCE L. PRICE
Executive Director

CLP/jh

IOWA BOARD OF DENTAL EXAMINERS - PUBLIC HEARING SIGN-IN SHEET
400 S.W. 8th St, Suite D, Des Moines
October 16, 2003 - 10 a.m.

Hearing For:
Public Health Supervision; ARC 2783B

NAME	ADDRESS	ORGANIZATION
Frank Severino	4401 75th. D.M. 50322	IDA
LARRY CARL	505 5TH AVE SUITE 333	IDA
Mary Mariani DDS	500 W River Dr. Davenport 52801	IDA
Kathryn Ku DDS	5359 Eastern Davenport	IDA
Brice Oakley	418-38 PL. DSM	IDHA
Joe Royce	STATE Capitol	Legis
Barb Blough	505th Ave, DM	IDA
Tracy Rodgers	Lucas Bldg. 321 E 12th DSM	IDPH
Heather K. Miller	" "	IDPH
Jane Slack	231 Edgewater Ave Cedar Rapids Ia. 52241	IDAH
Maureen Mosse	2608 Valley Dr DA	IDHA

Hearing Info

IOWA BOARD OF DENTAL EXAMINERS - PUBLIC HEARING SIGN-IN SHEET
400 S.W. 8th St, Suite D, Des Moines
October 16, 2003 - 10 a.m.

Hearing For:
Public Health Supervision; ARC 2783B

NAME	ADDRESS	ORGANIZATION
Brenda Lagatt	4900 Ruscoat St #3 W. Des Moines	DMACC
Mary Kelly	5707 Walnut Hill	self
Daniel Venker	4613 SW 6th St. Des Moines	self
Nancy Adriance	3210 SW 33rd St. DM IA	IDHA
Peggy Funk	2228 385th St Osage IA	IDHA
Sheila Temple	2565 Brockway Ave Kenta, IA	IDHA
Sue Hyland	1111 9th Street Suite 109 DM IA	IDHA
Tom Cope	8073 Cobblestone Rd Urbandale IA	IDHA

Ladies and gentlemen my name is Mary Mariani and for the past 14 years I have practiced dentistry in a federally qualified health center in Davenport. I am currently and for the last five years the dental director of Community Health Care.
I am here to express my deep opposition to the purposed rule change that would allow a hygienist in public health settings to perform preventive services without the patients first being examined by a dentist. This is particularly disturbing because it puts at risk those patients of low socioeconomic circumstance, the patients that I treat every day.

I do not understand why anyone would want to provide care to patients who are already at risk for oral disease without benefit of an exam with radiographs. The current standard of care, as I understand it, is that all patients receive an exam by a dentist before treatment. This is what is taught in every dental school in the country. This proposed rule change would mean that dental patients receiving treatment in free clinics, FQHC's, nonprofit health centers and public schools could receive hygiene care **including sealants** without the benefit of an exam. Why would anyone advocate for substandard care for children and poor people.

Failure to diagnose caries before the placement of sealants can have devastating consequences and without adequate isolation, sealants can and do fail. Many a time in our office I have consoled a mother of a child who thought she was doing the right thing by having her child's teeth sealed at school. Who was led to believe that sealants would prevent her child from getting cavities only to discover that now her child has such a big cavity that the tooth needs a root canal or an extraction. These at risk children do not have the economic means to afford root canal, buildup and crown and in most cases unless the child has Medicaid, the permanent tooth is extracted. It breaks my heart to see 8, 9, and 10 year children losing their permanent first molars because someone in a school setting place a sealant over caries. What's more, if the law does not require an exam prior to treatment then there is no liability for failure. If a hygienist places a sealant over caries and subsequently, the tooth develops irreversible pulpitis, under the proposed rule, there is no recourse for the patient to recover damages, as there was no requirement that a dentist would examine or diagnose caries prior to the sealant being placed.

While we do place sealants in our office, it is only after and exam by a dentist including radiographs. These sealants are checked at 6-month recall and radiographed once per year. The hygienists in our office place only those

sealants, where the tooth is newly erupted, where there is no dark staining or incipient caries. They use a dental assistant and high-speed evacuation to insure adequate isolation. These teeth are examined by a dentist and radiographed at regular intervals. The parents are informed that sealants only prevent decay on the chewing surfaces of the teeth and that the sealants need to be regularly examined for signs of failure such as chipping or leaking.
I do not understand the logic that says that if you are a patient in private practice, a dentist will examine your teeth before any treatment is rendered including cleaning. However if you are a patient receiving care in a free clinic or a federally qualified health center or if you are a public school child receiving dental care at school irregardless of your socioeconomic status sealants can be placed without an exam or radiographs by a hygienist. And I might add without parental consent.

I am very concerned about patient safety. Without at dentist supervising, what happens if a patient has a sudden allergic reaction to latex or prophy paste? Theses reactions can be fatal if not treated immediately and are becoming more and more common. While 911 can be called, it takes only 7 minutes of depriving the human body of oxygen before the brain starts to die. In rural Iowa emergency response times can be 15 minutes or more. If a dentist is present he or she can administer the necessary medicine to keep the patient alive. Under current law the hygienist cannot and doesn't have the necessary training to administer any drugs other than local anesthetic, if certified. In their two-year training programs, hygienists receive only minimal training in pharmacology. They are certified in CPR but CPR will not help if a patient's airway is swollen shut. While anaphylaxis is the most devastating emergency, smaller emergencies also occur with the practice of dental hygiene. Many a time in the last 14 years I have been called over to hygiene operatory because while scaling and root planing, a restoration has been fractured or removed. I have placed many temporaries over the years for hygiene patients. I have also removed stuck floss and tips of broken curettes and other foreign bodies from the oral cavity. Without a dentist supervising who is going to help these patients? Under the proposed "public health supervision" (10.5(2) b.) the dentist in the agreement **is not** required to provide future dental treatment. Then, I ask who will provide even emergency follow-up care? This purposed rule change seems irresponsible and not well thought out.

Please don't think that for one minute this is not about money. The federal government is pouring thousands of dollars into sealant programs and other oral health care programs. The federally qualified health centers that apply for

these grants use this as a means of improving their bottom lines. They do not have to pay a hygienist as much as they would have to pay a dentist and therefore actually can make money on these programs.
I am also aware that the National Dental Hygiene Association and well as the Iowa Dental Hygiene Associations ultimate goal is the independent practice of dental hygiene and an independent state dental hygiene board. This purposed rule change is a stepping-stone to further these goals.

I have the utmost respect for dental hygienists. The three hygienists in our office do wonderful work. They are well trained in the cleaning of teeth, prevention of oral disease and dental patient education. They are specifically trained to work with a dentist. **We are a team**. We provide a very high quality of care for our underserved patients. These patients need it and deserve it. To provide less care could lead to dangerous consequences and I believe is morally and ethically wrong. There are those that say that some care is better than no care. I disagree. Some care can lead the patient to a false sense of security. Some care can result in pain, infection, tooth loss and in rare instances loss of life.

Having dental hygienists provide substandard care is not a solution to dental access problems. You need to look at encouraging dentists to treat the underserved by providing tax incentives, increasing Medicaid reimbursement, loan repayment programs and federal and state grant programs. You need to make it easier for dentists to stay in Iowa to practice by not over regulating them to the point where they retire early or move to a state with fewer regulations.
There is an oral health care access problem in the state of Iowa but let's not add to it by providing substandard care. I respectfully ask that you abandon this purposed rule change and I urge you to look at other options for providing access to oral health care for the citizens of Iowa.

I am honored to have been chosen to speak to you today and I thank you for your attention to this matter.

Iowa

Department of Public Health

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The Iowa Department of Public Health supports the petition before the board regarding public health supervision of dental hygienists.

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

National problems of decreased access to oral health care are mirrored in Iowa. Oral health is integral to overall health and the Iowa Department of Public Health strives to promote and protect the health of all Iowans. In an effort to improve access to oral health care for low-income families and other at-risk populations, we support and ask that you approve this amendment to add the definition of public health supervision of a dental hygienist to your rules.

Iowa Dental Hygienists' Association

Speaking on behalf of the Iowa Dental Hygienists' Association (IDHA) as the Immediate Past President, I would like to start my testimony with a short quote sent to me by a fellow public health hygienist.

"For those who believe, no explanation is necessary.
For those who do not believe, none will suffice."-Unknown

Where do we turn to substantiate or make decisions about the issues that we believe in? Common sense tells us that we should look toward evidence to establish our beliefs and our own individual code of ethics. So what does evidence show us at this time?

- Almost 52 million school hours are missed annually by children because of oral problems.
- Extensive tooth decay can lead to developmental as well as emotional problems in children.
- Vulnerable populations (i.e.-low income children, pregnant women, and elderly) have more oral problems and less access to adequate dental care.
- Periodontal health is directly linked to overall health and plays a significant role in healthy children being born and quality of life issues for the elderly.
- In the United States, 25% of children and adolescents experience 80% of dental decay in permanent teeth.
- Prevention is the best and most cost effective form of treatment for all populations, not just those who can afford it.
- Dental sealants are one of the most effective means of preventing decay or arresting incipient lesions, but is the most under utilized because it is not cost effective in private practice.
- We are graduating fewer dentists and of those we are graduating, a very low percentage stay in Iowa to replace older retiring dentists, especially in rural areas of the state.
- Approximately 80 hygienists are graduating every year in Iowa and most stay in Iowa to practice.
- Dental hygienists, on basis of their education, are well-trained to educate others about oral health and to provide oral disease assessments and prevention services.

Concerns have been raised about the effect this petition will have on private practice dentistry. There are many dentists in Iowa who are Medicare/Medicaid or Title XIX providers, but there is a huge disparity between those who are "providers" and those who accept "NEW" Medicare/Medicaid patients. This petition will actually help those offices providing the most care to these underserved populations. Their loss margin would be reduced dramatically by having the patients screened and data gathering information plus preventative services done before they even set foot in their offices. This type of time management can only help improve the private practices' ability to meet overhead costs.

As far as hygienists leaving private practice to do public health service, thus causing a

shortage of allied personnel in offices, I would emphatically say, "NONSENSE". Many will volunteer for a day or two a year but Public Health hygienists go into public health because they wish to serve and feel a calling to this type of service. We can make much more in private practice and work in much more esthetically beautiful facilities. Instead we work in institutions, on stages and in closets at schools, and out of our cars. We carry heavy equipment up multiple levels of stairs and set up and tear down sometimes multiple times in a day. Paperwork and follow up are a never ending process to name just a few glamours of our jobs. We write plans and grants, lead and implement programs, supervise employees and volunteers. We network, partner, promote and advocate for oral health, plus we provide care to high risk/high need patients others are "too busy" for. Our patients have AIDS, head lice, diabetes, mental illness, and physical disabilities. They are 12 and up single, low income pregnant women. They are teenagers who are current or former drug users. They are veterans of war and on the other extreme they are prisoners. They are migrant or seasonal farm workers and refugees who have never been to a dentist. They are infants and toddlers who sleep with bottles and drink soda all day, and finally our patients are everyone's child when they learn about oral health at school, get a sealant, or participate in fluoride programs through school. We see patients and do what is in the best interest of that patient regardless of their ability to pay for those services. Public Health hygienists practice autonomously and are mid-level oral health care providers. We don't do this for the money. We do it out of love. We do it because we make a difference and improve the lives of those we touch.

The last point I would like to address in my testimony today is information on the tools that Public Health hygienists utilize everyday in our programs. The caries-risk assessment tool (CAT) was developed, using evidence based research by the American Academy of Pediatric Dentists, as a framework for classifying caries risk in infant, children and adolescents based on a set of physical, environmental and general health factors. CAT is intended to be used when clinical guidelines call for caries-risk assessment. It does NOT render a diagnosis, however clinicians using CAT must be familiar with the clinical presentation of dental caries and factors related to caries initiation and progression. It is within the scope of practice for hygienists, medical doctors and nurses to use this tool. Unfortunately the oral health component is severely lacking for medical doctors and nurses during their education, so it stands to reason that the hygienists are the most qualified to use this assessment tool to help determine the need for prevention and treatment services. I have included a copy of this tool with my testimony today for your further perusal. I would like to thank you all again on behalf of the Iowa Dental Hygienists' Association and the underserved populations in Iowa, for your dedication and commitment in helping to develop workable solutions to lesson the dental access to care crisis in our state.

Respectfully submitted,

Sheila Temple, RDH

Sheila Temple, RDH
Immediate Past President-Iowa Dental Hygienists' Association

AAPD Caries-risk Assessment Tool (CAT)

Caries-risk indicators	Low risk	Moderate risk	High risk
Clinical conditions			
	• No carious teeth in past 24 months	• Carious teeth in the past 24 months	• Carious teeth in the past 12 months
	• No enamel demineralization (enamel caries "white-spot lesions")	• 1 area of enamel demineralization (enamel caries "white-spot lesions")	• More than 1 area of enamel demineralization (enamel caries "white-spot lesions")
	• No visible plaque; no gingivitis	• Gingivitis*	• Visible plaque on anterior (front) teeth
			• Radiographic enamel caries
			• High titers of mutans streptococci
			• Wearing dental or orthodontic appliances†
			• Enamel hypoplasia‡
Environmental characteristics			
	• Optimal systemic and topical fluoride exposure§	• Suboptimal systemic fluoride exposure with optimal topical exposure§	• Suboptimal topical fluoride exposure§
	• Consumption of simple sugars or foods strongly associated with caries initiation‖ primarily at mealtimes	• Occasional (ie, 1-2) between-meal exposures to simple sugars or foods strongly associated with caries	• Frequent (ie, 3 or more) between-meal exposures to simple sugars or foods strongly associated with caries
	• High caregiver socioeconomic status¶	• Midlevel caregiver socioeconomic status (ie, eligible for school lunch program or SCHIP)	• Low-level caregiver socioeconomic status (ie, eligible for Medicaid)
	• Regular use of dental care in an established dental home	• Irregular use of dental services	• No usual source of dental care
			• Active caries present in the mother
General health conditions			
			• Children with special health care needs#
			• Conditions impairing saliva composition/flow**

*Although microbial organisms responsible for gingivitis may be different than those primarily implicated in dental caries, the presence of gingivitis is an indicator of poor or infrequent oral hygiene practices and has been associated with caries progression

†Orthodontic appliances include both fixed and removable appliances, space maintainers and other devices that remain in the mouth continuously or for prolonged time intervals and which may trap food and plaque, prevent oral hygiene, compromise access of tooth surfaces to fluoride or otherwise create an environment supporting dental caries initiation

‡Tooth anatomy and hypoplastic defects such as poorly formed enamel, developmental pits and deep pits may predispose a child to develop dental caries

§Optimal systemic and topical fluoride exposure is based on the American Dental Association/American Academy of Pediatrics guidelines for exposure from fluoride drinking water and/or supplementation[4] and use of a fluoride dentifrice

‖Examples of sources of simple sugars include carbonated beverages, cookies, cake, candy, cereal, potato chips, french fries, corn chips, pretzels, breads, juices and fruits. Clinicians using caries-risk assessment should investigate individual exposures to sugars known to be involved in caries initiation.

¶National surveys have demonstrated that children in low-income and moderate-income households are more likely to have dental caries and more decayed or filled primary teeth than children from more affluent households. Also, within income levels, minority children are more likely to have caries. Thus, sociodemographic status should be viewed as an initial indicator of risk that may be offset by the absence of other risk indicators.

#Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally[9]

**Alteration in salivary flow can be the result of congenital or acquired conditions, surgery, radiation, medication or age-related changes in salivary function. Any condition, treatment or process known or reported to alter saliva flow should be considered an indication of risk unless proven otherwise.

TOP 15 REASONS SEALANTS ARE A PUBLIC HEALTH MEASURE

1. Sealants are one of the best preventive measures for tooth decay that we can offer the public.

2. Sealants are esthetic, non-invasive, performed with no anesthetic and are a cost-effective method of prevention.

3. Sealants have been in use for almost 40 years.

4. Pit and fissure (where sealants are placed on the top of the tooth) tooth decay accounts for 88 percent of total tooth decay in children.

5. Sealants are 100 percent effective in preventing pit and fissure tooth decay if they are completely retained.

6. With proper placement techniques, sealant retention rates for the first year are as high as 98 percent.

7. Sealants remaining in place for up to 15 years is common.

8. Over the course of 20 years, studies have shown 65 percent of sealants are fully retained and 22 percent are partially retained and the teeth are free of tooth decay.

9. Only 2% to 4% of all sealants need some form of repair over the lifetime of the tooth.

10. Sealants have proven to be effective in more than 15 years of study.

11. The fee for a sealant is one-third the cost of a permanent filling.

12. Sealants should be placed on molars as soon after eruption as possible because decay susceptibility in molars remains the highest.

13. Studies have shown that sealing in beginning decay will block off the nutrient source from the decay which stops the decay process.

14. According to the Centers for Disease Control Oral Health 2000 Facts & Figures, tooth decay remains one of the most common childhood diseases.

15. The goal is to prevent tooth decay and maintain health throughout life.

References from the American Dental Association Library

My name is Peggy Funk. I grew up on a farm and still am a farmer's wife as well as a dental hygienist. Farming can be a dangerous profession and often in the busy season of fall or spring, someone is hurt and neighbors will take a day and work together to help each other out. I thought that was the American way. I am also the President of the Iowa Dental Hygienists' Association. I'm new to the legislative arena and have really had my eyes opened in the last year.

Having been a dental hygienist for the past 28 years, and having worked in both private offices and public health settings, I have worked closely with the people this proposal will affect.

I would like to quote from a recent article in the October issue of the IDA journal. Some of you on the board ~~are~~ may be familiar with this since you were listed as contributors to this article. "Current estimates show there will be a substantial decline in the number of dentists in Iowa within the next 10-20 years due to the disproportionate attrition of Iowa dentists primarily from retirement." This article goes on to state "The 3rd issue is the gradual erosion in the number of dentists in rural areas of the state. Generally, there are larger percentages of older dentists practicing in rural counties. This problem will become more acute when many of these practitioners retire and there is no replacement with a younger dentist. While there has always been a maldistribution of dentists with a much higher percentage concentrated in suburban and the outer core of urban centers, attracting dentists to rural environs has been increasingly more difficult. States-and in some instances counties are now, only starting to realize the issue of an aging dentist workforce. End of quote. I could go on in other research and give you numbers like only around 2-3 graduating dentists stay in the state where around 80 graduating hygienists stay in the

state. I realize there are always facts and figures a person can give to substantiate a claim so instead I will tell you about the people I've met.

I worked in private practice for 25 years. Throughout this career, I worked in 5 offices and was told more than once that we need to be careful how many Title XIX patients we see, as those people tell everyone they know and pretty soon our practice will be full of only Title XIX patients. In the last office I worked in, we saw a few nursing home people and a few comprehensive patients. Many of these people were physically compromised due to their age. They needed help getting in and out of the chair. Oftentimes, they were unable to hold a toothbrush so that they could really clean their teeth and flossing was out of the question. The difficulty in getting these people to the office ~~often~~ caused them to only come for visits to fix the pain of a tooth allowing their gums to go untreated. We all know how serious this can be, especially with so many of the elderly having heart, diabetes and other health problems. Many times, the dentist would ask me to clean their teeth before he could see them well enough to do a proper examination. A nursing home once sent an elderly patient to us claiming she had a bony growth protruding from her gums. This actually turned out to be a ledge of calculus. You can imagine the inflammation in the tissue surrounding these teeth.

When giving an in-service to aides working in nursing homes, I was told by the aides, they don't have the time or the inclination to put their hands in someone else's mouth to help them brush. One day in visiting my own Grandma in a care facility in Rochester, Minnesota, I was stunned to find out she had someone else's denture in her mouth. No one at the facility knew this had happened. I worked in a nursing home in both high school and college. I learned the elderly still have their pride and it can be

very difficult for them to ask for help for their own daily care. They would rather go without or endure pain, than admit they need help. As these people age, they can't even feed themselves let alone care for their teeth properly. Have you ever seen a complete meal that is totally pureed because someone can't chew due to tooth loss? This was 30 years ago. The fastest growing demographic is the oldest old, those over 85. Today's elders are also better educated, more politically aware and have higher health care expectations than any generation of seniors, previously. How will Iowa meet the needs and health concerns of these elderly?

I've heard the argument that this proposal will take more hygienists away from private practice. This is hard for me to believe. Let me tell you about my public health job. It is not a glamorous position nor is the pay as good as private practice. I took this job because I thought I could make a difference. I work with WIC clinics in 9 counties. Usually we set up in churches. In the hot Iowa summer there is no air conditioning. You can become quite warm carrying your equipment up stairs in the heat and humidity of July and August. In the winter, churches will turn down their heat right after Sunday services, to save money. They are reluctant to turn them up very high for only one day and do you know how long it takes to heat a church up? I drive by myself and carry my equipment in my car. I often drive over an hour to reach the clinic and the mileage compensation does not make up for the wear and tear on my car.

At least once a week, I see at least one child whose parent tells me they can't get them in to see a dentist. The mother tells me of the numerous long distance phone calls she has made, how she'll take off work if she has to but no one will see her child. What do ~~you~~ I tell a mother who has tears in her eyes, when she asks me why these dentists can

refuse to see her child just because she is on Title XIX. As a professional, I must simply help her find a dentist. I've also had mothers practically talk with their mouths closed because they are ashamed of their own teeth but are willing to live with pain and embarrassing smiles as long as we can help their children. Just imagine what prevention could have done for these families.

More attention has now been given to the studies showing how a pregnant woman's oral health can affect the unborn child. We have a maternal health clinic with our WIC clinics. We have 6 people who work with care coordination trying to get children and pregnant women in to see a dentist. They tell me getting a pregnant woman in to a dentist is extremely difficult. With all of the children I see, it's very difficult for me to have the time to work with the pregnant women showing them how to properly brush and floss and explain the importance of both. Even though the importance of this continues to emerge, it is difficult to find dentists willing to take these clients.

One can't even pick up a magazine anymore without seeing the word prevention in it. We are told we can prevent many ailments or at least help lessen some of the worst symptoms of diseases with prevention such as good periodontal maintanence, sealants and fluorides. Studies also show prevention is less expensive then fixing something after the fact. How many lives in Iowa can we improve by preventing oral diseases? How much money in the long run will this save the state for reimbursement for multiple expensive restorative work?

There are several states in the United States, who are helping to solve their access issue by using the trained professionals already available to them.This proposal is one of the many ways we can help the less fortunate and elderly maintain and improve both their

oral and total health. Let's make sure in our effort to protect Iowa's citizens we aren't depriving them instead.

Thank you for allowing me to speak to you today. - and thanks so much for the time, effort, and dedication you give to serve the people of Iowa.

Peggy A. Frank RDH, BS
President IDHA

DMACC

DES MOINES AREA COMMUNITY COLLEGE

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

October 16, 2003

Dear Board Members:

I appreciate the opportunity to provide testimony in support of the proposal to amend Chapter 10, "General Requirements," Iowa Administrative Code, to allow a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting.

In April 2003, I provided a brief overview of dental hygiene education including the American Dental Association, standards for program accreditation, the National Board Dental Hygiene Examination, and the Central Regional Dental Testing Service Examination all of which are required for dental hygiene licensure in Iowa. Today I will focus on curricula that support the education and skills necessary for the practice of dental hygiene in public health settings.

Community Dental/Oral Health is a required course for dental hygiene accreditation. According to Accreditation Standard 2-14, "Dental hygiene science must include oral health education and preventive counseling, health promotion, patient management, clinical dental hygiene, provision of services for and management of patients with special needs, community dental/oral health, medical and dental emergencies including basic life support, legal and ethical aspects of dental hygiene practice, infection and hazard control management, and the provision of oral health care services to patients with bloodborne infectious diseases.

The American Dental Education Association (ADEA), Section on Dental Hygiene Education Competency Development Committee, developed dental hygiene competencies to assist dental hygiene schools in meeting the accreditation standards. The ADEA Community Dental/Oral Health Competencies are as follows:

- Assess the oral health needs of the community and the quality of resources and services.
- Provide screening, referral, and educational services that allow clients to access the resources of the health care system.
- Provide community oral health services in a variety of settings.
- Facilitate client access to oral health services by influencing individuals and organizations for the provision of oral health care.
- Evaluate reimbursement mechanisms and their impact on the patient's or client's access to oral health care.
- Evaluate the outcomes of community-based programs and plan for future activities.

In order to implement these competencies, students are enrolled in courses such as Dental Health Education, and Community Health. These courses provide activities in a variety of community settings that introduce them to excellent programs addressing dental health needs on a community (public health) level. There are many similarities between community oral health practice and private practice. Community oral health practice extends the role of the dental hygienist in private practice to include the people of the community as a whole. Students are involved in providing education and treatment in many public health settings such as the hospital, community clinic, school or agency, in addition to their on campus clinical experience.

Dental hygienists learn to appreciate their role as health professionals at the local, state and national levels. This role requires the graduate dental hygienist to assess, plan and implement programs and activities to benefit the general population. In this role, the dental hygienist is prepared to promote the values of oral and general health and wellness to the public and organizations within and outside the profession.

Oral health, as an integral component of the overall health and well-being of individuals, must be available and attainable by all populations. Throughout my many years of working in dental hygiene, I have observed the dedication and commitment of dental health professionals working toward this goal. They need to be commended and thanked and told to keep up their efforts. Many worthwhile programs and services have been provided, but there is still much to be done.

I want to assure you that dental hygiene education is preparing dental hygiene graduates to address community oral health needs. I appreciate the Board of Dental Examiners willingness to advocate for cooperation among the communities of education, regulation, dental and dental hygiene practice, and other health professionals. Much will be gained by the coming together of public and private policymakers to establish partnerships to reduce oral health disparities in vulnerable populations in Iowa.

Sincerely,

Sandra Leggett

Sandra Leggett, D.H., M.A.
Dental Hygiene Program Chair

October 15, 2003

Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, IA. 50309

Dear Board Members,

I'd like to introduce myself, Dr. Daniel J. Venker. I graduated from the University of Iowa College of Dentistry in Iowa City, Iowa in 1983. In my 20 years of dental practice, I have practiced about 10 years in the public health setting and 10 years in solo private practice in family dentistry. In August 2003, I received my Master of Science degree in dental public health from the University of Iowa College of Dentistry. My thesis research was in the area of dental sealants. I have submitted a manuscript for publication of my school-based dental sealant program research to the Journal of Public Health in Dentistry. I also have a Bachelor of Science degree in microbiology and chemistry from the University of Iowa. I have worked closely and interactively on a clinical basis with the Des Moines school-based dental sealant program over five of its six-year history. I teach part-time at the Des Moines Area Community College, both in the classroom and clinically, with dental assisting and hygiene students. I still practice clinical family dentistry on a limited basis in West Des Moines, Iowa.

I want to personally thank you for your time and energy you have put into considering the matter of public health supervision of the dental hygienist in the State of Iowa. I know this issue is of concern to all licensed dental professionals in our state. I also know that many dentists are concerned and some are not supporting the amendment to Chapter 10 "General Requirements", Iowa Administrative Code. As a licensed dentist in the state of Iowa the past 20 years, I want to let you know I do support the amendment regarding the matter of public health supervision of the dental hygienist in our state. I have several reasons why I am supporting the proposed amendment.

First, definitions in the amendment must be clearly stated and understood. There is a difference between "screening" and an "examination". The term "screening" must not imply to anyone, including the patient, that a complete examination is being performed. If the patient understands and consents to screening through a signed consent form, then the patient knowingly and positively understands what is being provided in

the public health setting. Right now, in our school-based dental sealant program for the Des Moines school district, we use such a consent form. The screening does not replace a complete examination by a licensed dentist. The patient's parent or guardian has agreed to have an examination by a dentist after the hygienist has performed the screening, which may include education, prophylaxis and fluoride application. If the patient does not have an examination, no further treatment will be provided other than education, assessments, screenings and fluoride. The amendment criteria in which the public health hygienist can work are limited until the collaborating dentist does a complete exam, which includes medically compromised patients or medical conditions for which a dentist needs to be consulted prior to any treatment being delivered.

In the amendment to Chapter 10 the hygienist is under general supervision. In order for the hygienist to qualify for designation as a public health hygienist, they have to have several years of clinical experience. Therefore, a recent graduate of an accredited hygiene program cannot qualify for a clinical public health position. I do not see this as an avenue for dental hygienist to proceed toward independent practice. The public health setting is obviously different from private practice. Some may be uncomfortable in the beginning since this is new to many in the profession. The patient is not physically brought to the private dental office, however, the services being rendered by the hygienist are the same. Quality of care is assured by the contract the hygienist signs with the dentist. The patient cannot continue to receive preventive services in the public health setting without routine examination by a licensed dentist. A similar model has been done with nurses and physicians in the medical field for many years and can work for us in dentistry. Patient protection is essential and guaranteed even if the patient does not follow through with their part of the agreement to see a dentist for a complete examination.

Second, I am in my sixth year of participating in the school-based dental sealant program for the Des Moines Independent School District. Our "School Smiles" program is administered through the Des Moines Health Center, a federally qualified health center, in Des Moines, Iowa. I have volunteered with the same hygienists and assistants since Fall 1998. It may seem unreasonable for the hygienists to be evaluating second and third graders for the placement of sealants, however it really is not in this public health setting. In the sealant program, radiographs are not exposed to detect the presence of caries not clinically detectable or apparent. Neither the dentist or the hygienist both do not have the added benefit of radiographs. Dental research has shown through more than one research study that caries

that are sealed into the tooth will not progress. Since the parents and guardians of the children give a positive or negative consent, they understand that the sealant "screening" does not replace the regular (and more complete) dental examinations they receive from their regular dentist (which might include radiographs). The reality of the situation is that some of these students are probably having incipient caries sealed in their teeth. Many public health dentists in the area of dental sealants have acknowledged this and this fact is published in guidelines pertaining to sealant placement. This can possibly happen if radiographs are not exposed. Is that of concern to me as a professional in the field? No, not if the parents or guardians are taking their children for regular dental examinations. If the sealed tooth should happen to need to be restored, then the student's regular dentist can provide those services. In our Smiles Program, if students do not have an established dentist of record ("a dental home"), we do our best through our program and the aid of the school nurse, to help those students needing referrals to establish a dental home. When a dentist identifies caries around their crowns they have provided for patients, this does not mean they stop doing crowns. The same rationale needs to be applied to dental sealants.

Licensed dental hygienists are able to do caries risk assessments and caries detection. Caries detection is part of their education and board examination experiences. Currently, in the sealant program, the dentist performs only a clinical assessment of the tooth structure. A hygienist performing the same clinical assessment, including caries risk assessment, can detect if there is active caries that necessitates the student seeing their regular dentist for definitive diagnosis. In the case of suspicious caries, a sealant is not to be placed and referred for definitive diagnosis. I am comfortable with the public health hygienists in the Des Moines sealant program being able to know whether a tooth needs to be sealed or not be sealed since the child will eventually be seeing a dentist. Even if enamel caries are sealed into the tooth and the child does not see their dentist for an examination, research supports that there is no harm done. In fact, research supports that caries sealed into a tooth will be arrested and will remain arrested as long as the sealant remains fully intact in the pit and fissured surface. When the public hygienist is able to perform these assessments and seal the teeth, the time the dentist spends doing the sealant assessments can be better spent providing restorative care. Research even supports that if a tooth is sealed that has dentinal caries present, the caries process will be arrested as long as the sealant remains fully intact.

As a recent graduate of the master's program in dental public health at the University of Iowa College of Dentistry, I feel comfortable with public

health hygienists performing these needed preventive services under public health supervision. My thesis for my master's degree was in the area of dental sealants. The thesis examined sealant retention in the area of school-based sealant programs. I am confident of the sealant treatment that the public health hygienists are providing in the school-based program in Des Moines, which is comparable to (if not slightly better) than published research on other school-based programs in the United States. Their expertise in this sealant program, along with their clinical experience in a public health setting and prior hygiene education, put them in excellent clinical practice to assess students for active caries and making appropriate, timely referrals to the dentist for definitive diagnosis and treatment.

Third, the geriatric populations of the nursing care facilities have access problems to routine preventive dental services. As the Baby Boomers approach retirement, this population is expecting and wanting maintenance of their natural dentitions. Many of them have expended time, money and energy into complex restorative care, including fixed prostheses and implants. There is an expectation that dental care will still be provided at a professional level they had as young and middle-aged adults. Fifty percent of the nursing care facilities in Polk County have a dentist and hygienist that routinely come to their facility to provide preventive and restorative dental care. That number is may seem large, however those services are provided by only one dental office. That percentage is significantly less in the rural areas of Iowa. By allowing dental hygienists to work collaboratively with public health supervision, many more nursing care residents will have access to routine preventive dental services. Again, the patient or their guardian will give consent for at least an annual dental examination to be performed by a licensed dentist. If routine dental examinations are not performed, then the hygienist cannot perform any services other than educational services, assessments, screenings, and fluoride.

Over my 20-year dental career I have seen the benefits sealants have given to many children, both in the public health and private practice settings. This also includes the benefits of the school-based program sealant program I have seen the last six years. Low-income children receive a necessary preventive service to help prevent the high percentage of caries that occurs in this population of children in the most susceptible sites for caries; the pit and fissured surfaces of the molar teeth. The education that hygienists receive in accredited dental hygiene programs provide an excellent foundation for the public health setting. After several years of clinical experience, this experience can help in providing needed services to an underserved population. Preventive services they provide can also be

translated to another underserved population; the geriatric population in the nursing care facilities. Though my experience in the nursing care facilities is limited, as a volunteer on a dental pilot program for nursing care facilities in Polk County, some interesting information from the nursing staff has been gathered. Many of the staff are uncomfortable entering the oral cavity to do assessments and screenings. Their training is minimal and limited regarding the health of teeth, gingiva and oral mucosa. Generally, I have observed that the nursing staff is unable to do an adequate oral assessment due to lack of education and familiarity with oral soft and hard tissues. Public health hygienists provide not only a source of preventive services but provide a resource to the nursing care facility to educate and assist the staff members. Nursing care facilities will be able to better identify potential dental and other oral problems earlier with the help of hygienists, so to better help the residents avoid pain and maintain a healthy oral environment.

With the current issues regarding access to dental care, this proposed amendment change is a good one as long as:

1. Terms and definitions are well defined in the proposed amendment change.
2. Written consent forms are well defined and understood by patient and dental professionals, including the necessity of an annual dental examination by a licensed dentist (at a minimum).
3. Further treatment is terminated by the hygienist if the patient does not adhere to the request of an annual dental examination by a licensed dentist. Then, the hygienist can *only* provide education, assessment, screening and fluoride until a complete examination is performed by a licensed dentist.

This proposed amendment change is a good step towards helping underserved-populations to receive much needed preventive dental care and show that our profession is keeping pace with changing times and situations. The Surgeon General's Oral Health Report in Year 2000 stated "oral health is integral to general health". Recently published research in the Journal of the American Dental Association shows the association between the impact of poor oral health on nutrition. All of us know the importance of good nutrition in the elderly. The proposed amendment change is needed to help alleviate the disparities in dental care we are see between certain populations, mainly the poor and the affluent. This disparity is also addressed and recognized in the Surgeon General's Oral Health Report in Year 2000.

Thank you for your time in considering my thoughts and expertise on this matter regarding the proposed amendment change in Chapter 10. If you have any further questions regarding what I have written about in this letter, please feel free to contact me at the address below.

Sincerely,

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Iowa Board of Dental Examiners
Regulatory Analysis – ARC 2783B
Public Health Supervision of a Dental Hygienist

Prepared by Jennifer Hart, Agency Rules Administrator,
Iowa Board of Dental Examiners
Approved December 2, 2003

Introduction

On August 21, 2003, the Board of Dental Examiners voted unanimously to file a Notice of Intended Action to amend 650—Chapter 10 by adopting a new rule related to public health supervision. Notice of Intended Action was published in the *Iowa Administrative Bulletin* on September 17, 2003, as **ARC 2783B.** The proposed amendment would allow a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting. The amendment defines public health settings and details the responsibilities of each licensee operating under public health supervision. The proposed rule differs significantly in one important aspect from existing dental hygiene supervision rules: under public health supervision, a dental hygienist may render services prior to a dentist examining the patient.

On October 13, 2003, the Administrative Rules Review Committee (ARRC) discussed the Noticed rules and requested an informal regulatory analysis from the Board of Dental Examiners related to the proposed amendments. The request for an informal analysis asked the Board to address specific concerns raised by the Iowa Dental Association in their memo to the ARRC, dated October 13, 2003. The informal regulatory analysis provided here will address the IDA's concerns within the framework of the requirements for an analysis as specified in Iowa Code section 17A.4A. However, because this was an informal request for an analysis, the Board was advised by the committee that it is not under an obligation to publish the findings of this analysis in the Iowa Administrative Bulletin or to hold additional public hearings. The information provided in this analysis is informational in nature to address questions raised by members of the ARRC, concerns of the IDA, and to guide the board in its decision making while considering adoption of the proposed amendments.

Executive Summary

- There is clear agreement that a dental access problem exists in the state of Iowa, just as in other parts of the U.S. Seventy-two of Iowa's 99 counties, and one urban area, have been designated as dental health profession shortage areas.
- Less than one-third of Iowa Medicaid recipients received any dental services in FY 2003.
- Dental caries is the single most common chronic childhood disease. Twenty-five percent of children suffer 80 percent of tooth decay. Poor children suffer twice as much tooth decay as their more affluent peers. [1]
- A number of factors are responsible for the access problem, including: low reimbursement rate for Medicaid claims; administrative burden of filing Medicaid claims; high failure rate of appointments for Medicaid patients; a lack of understanding of the

importance of oral health; a general shortage/maldistribution of dentists in Iowa; and a lack of dentist providers in Medicaid.

- The Iowa Board of Dental Examiners became involved in the dental access debate for the first time in September 2002 in response to a petition for rulemaking. The Board studied and debated this issue for over a year. The Board believes its current rulemaking action strikes a compromise between the competing views of the IDA and IDHA and the Board's obligation to protect the public.
- The Board's proposed amendment will allow a dentist to provide public health supervision to a dental hygienist who is providing services within the scope of practice of dental hygiene in a public health setting. The Board's proposal addresses previously identified concerns of maintaining board authority over licensees, ensuring practice protocols are written by a dentist, ensuring that protocols address medically compromised patients, ensuring that patients are advised in writing that the hygiene services do not substitute for a dental exam, that a written plan for referral to a dentist is made for all patients, that hygiene services are limited if a dental exam does not take place, and that procedures for maintaining dental records are established.
- The Board's proposed amendment is voluntary. Both a dentist and a dental hygienist must agree to practice under public health supervision.
- The Board's proposed amendments address the regulatory barriers involving the high failure rate of Medicaid patients, the lack of understanding of the importance of oral health needs, and access to preventive services and treatment.
- Dental sealants are a comparatively inexpensive, easy way to prevent tooth decay, especially in high-risk populations. Research supports the safety of sealant placement, even in cases of incipient tooth decay.
- The cost of implementing the proposed amendments is minimal compared to other alternatives. Providing preventive care is cheaper than paying for more costly treatment needs. Long-term savings can be realized by increasing access to preventive care. The Iowa Department of Human Services supports the rule change proposed by the Board.
- The dental access problem has been debated and studied in Iowa and across the nation for many years, with little or no progress in the state of Iowa. Financial barriers seem to be a major limitation – most attempts to resolve the problem will require a substantial on-going commitment of public funds. With the difficult financial situation faced by the state legislature, there is only limited opportunity to fight the dental access problem using approaches that do not require a major commitment of public funds. Many states are seeking innovative approaches to combat dental access, like expanding the role of dental hygienists through public health supervision.
- The Board's proposed rules have a limited ability to address the dental access problem, but do address important barriers to access. By focusing on providing preventive services, access issues will be tackled by trying to reduce the need for more costly restorative dental treatment. The board's rules cannot address the real needs of patients—to find dental providers who are willing to accept new Medicaid patients and attend to their restorative treatment needs. Combating this problem will require action and commitment from the Iowa legislature. Given current budget realities, the Board's approach is a relatively low-cost method of removing some regulatory barriers to positively impact the ability of patients who do not otherwise have access to care to receive preventive oral health services.

Oral Health in Iowa

According to the report *Oral Health in America: A Report of the Surgeon General*,[2] the following facts summarize the oral health problem in America:

- Tooth decay is the single most common chronic childhood disease; it is five times more common than asthma and seven times more common than hay fever.
- Over 50 percent of 5-9 year old children have at least one cavity or filling.
- Poor children suffer twice as much decay as their more affluent peers, and their disease is more likely to be untreated.
- Over 108 million children and adults lack dental insurance, which is over 2.5 times the number that lack medical insurance.
- Children from families without dental insurance are 3 times more likely to have dental needs than children with dental insurance.
- More than 51 million school hours are lost each year to dental-related illness.

Specific surveys by the Iowa Department of Public Health (IDPH) further illustrate the oral health problem for Iowa children.[3] An oral health survey of grades 2-4 conducted by department in 1999 found that:

- 57% of children had a history of decay;
- 68% of low-income children had a history of decay;
- 33% had untreated decay;
- 47% of low-income children had untreated decay; and
- 30% of low-income children had more than one decayed tooth.

Data from the 2002-03 School-based Sealant Program[4] (grades 2-7) also found that:

- 58% of children had a history of decay;
- 64% of Medicaid-enrolled children had a history of decay;
- 33% of children had untreated decay; and
- 39% of Medicaid-enrolled children had untreated decay.

Claims data provided by the Department of Human Services show that less than one-third (32.5 percent) of Iowa Medicaid-enrollees saw a dentist during fiscal year 2003.[5] This figure compares to statistics from the Centers for Disease Control and Prevention National Center for Health Care Statistics that nationally approximately 73.3 percent of persons ages 2-17 had a dental visit in the last year and 64.6 percent of persons ages 18-64 were able to see a dentist in the last year.[6] Even when poverty status is factored into these statistics, nationally 61.0 percent of poor children (family with income less than 100 percent of federal poverty level) and 63.2 percent of "near poor" children (family with income between 100 and 200 percent of the poverty threshold) were able to see a dentist in the last year. For adults ages 18-64, these rates drop to 45.8 percent of poor and 46.9 percent of near poor. [7]

The Iowa Department of Public Health Bureau of Health Care Access is responsible for designating health professional shortage areas (HPSAs) in the state of Iowa. A designation of a dental health shortage area is based on either a geographic area or a special population group designation. A geographic shortage designation is based on a population to provider ratio of 5,000 to 1. A special population group shortage designation is measured by using the income

rates of population below 200 percent of poverty and the physicians that participate in the Medicaid program. The ratio must be 4,000 to 1. In Iowa, there are 72 counties with dental health care shortage designations. Seventy-two counties are whole county designations. In addition, one county (a portion of Polk County) is designated as a census tract Low-Income Population designation.[8] See Attachment A for specific information on counties in Iowa that have been designated as dental shortage areas.

Iowa's 99 counties are scheduled to be reviewed later this year for updates. According to the Bureau of Health Care Access, it is expected that more counties will qualify as shortage designation areas. Bureau representatives also noted that if dental access were judged based on the ability of the uninsured to access care using a sliding fee scale, then virtually every county would qualify as the only dentists that are using a sliding fee scale are the community health centers, a United Way sponsored dental clinic in Polk County, and a solo practitioner in Lyon County.

Results from these surveys and other findings clearly illustrate that, like the rest of the nation, Iowa is faced with a severe dental access problem. Multiple barriers contribute to the dental access problem in Iowa and across the nation; these barriers are numerous, multi-dimensional, and complex. The next section of this report will attempt to briefly describe the major barriers to dental access.

Barriers to Access to Dental Care

Numerous studies and groups have convened over the years to discuss the dental access problem and identify the barriers that contribute to the problem. Nationally, many different government organizations and dental-related groups have identified barriers to greater oral health care access. Similar groups in Iowa have also identified these same barriers. These barriers will be listed in brief and then addressed in more detail. Barriers include the following:

- Low reimbursement rate for Medicaid claims;
- Administrative burden of filing Medicaid claims;
- High failure rate of appointments for Medicaid patients, which increases the financial burden on providers;
- Lack of understanding of the importance of oral health;
- General shortage/maldistribution of dentists in Iowa; and
- Lack of dentist providers in Medicaid that will take new patients.

Reimbursement

A low reimbursement rate for dental services provided to Medicaid patients is one of the most significant barriers affecting access to care for low-income patients. Until July 2000, reimbursement to dentists treating Medicaid patients was based on a fee schedule that was last updated in 1987. Previous increases allocated by the General Assembly were less than one-fourth the rate of inflation for the dental component of the Consumer Price Index.[9] In July 2000, reimbursement rates were increased using tobacco settlement funds to permit reimbursement at 75 percent of the usual and customary fees. However, budget shortfalls for the state general fund resulted in a 3% reduction in dental reimbursement beginning in July 2001. When added to the

Consumer Price Index for medical inflation in the years 2000, 2001, and 2002, rates have returned dental reimbursement almost to the pre-2000 level.[10]

The American Dental Association recently published a report that compares Medicaid reimbursement rates for 15 common pediatric dental services against prevailing fees charged for the same procedures by general practitioner dentists located in a given region. In Iowa, the ADA report shows that Medicaid reimbursement rates for 12 of the 15 procedures are in the 9th percentile or below in relation to regional fees. This means that 9 percent or fewer dentists charged the Medicaid fee or a lower fee for a specific procedure, while 91 percent charged a higher fee than the Medicaid reimbursement level. The remaining 3 procedure reimbursement rates for Iowa are in the 10th to 24th percentile compared to regional fees.[11]

Administrative Burden

The administrative burden of filing Medicaid claims has historically been cited as a contributing barrier to access to care for Medicaid patients. The perception that filing Medicaid claims is an overly complex process with multiple rejected claims and heavy paperwork prohibits some dental providers from participating in the program. Even when the reality of the administrative requirements for Medicaid does not differ significantly from similar claims issues with other insurance companies, perceptions of a high administrative burden persist.

According to discussions of the Dental Advisory Council (DAC) of the Department of Public Health, complaints about the process from providers include the following: a high rate of rejected claims, sometimes for little mistakes; delayed payment based on rejected claims; requirements for multiple claims re-submissions; additional paperwork burdens for prior authorizations, claims, and resubmissions; a lengthy and cumbersome application process; difficulty accessing a "live person" for customer service; and problems with the claims agency not recognizing standard ADA code procedures.[12] Another common administrative complaint cited is the need for prior authorizations for certain dental work. Prior authorizations are required for some periodontics work, crowns, dentures, and orthodontia dental work. According to a representative from the Iowa Department of Human Services (DHS), however, there have not been complaints about the prior authorization requirements for several years.[13]

Furthermore, DHS reports that other improvements have been made in an attempt to reduce administrative requirements. According to the DAC, however, the overall feeling was that although the system for claims submission was deemed "doable" it was very labor intensive, thereby resulting in doing more work for less money. Coupled with negative provider perceptions about the process, administrative issues with Medicaid continue to contribute to the dental access problem.

High Failure Rate of Appointments

The 1997 IDA Medicaid Dental Task Force identified a high failure rate of appointments as a major reason that dentists did not participate in the Medicaid program.[14] Broken appointments and a high "no-show" rate increase the financial burden on providers. A recent study that assessed the appointment-keeping behavior of Medicaid-enrolled pediatric dental patients in Eastern Iowa found that 35 percent of Medicaid dental appointments cancelled, failed, or were late, compared to 15% of non-Medicaid appointments at these same practices.[15]

Various reasons contribute to the high failure rate of appointments for Medicaid beneficiaries. Getting time off from work to visit the dentist, arranging transportation to the dentist, and finding or affording child care for dental appointments, while minor inconveniences for higher-income patients, can be significant barriers for low-income patients.[16] Although there are programs like Medicaid's Early & Periodic Screening, Diagnosis & Treatment (EPSDT) care coordination that can assist children on Medicaid with these barriers, more must be done to educate beneficiaries and providers on the availability of these programs.

Lack of understanding of the importance of oral health

A lack of understanding of the importance of oral health prevention and treatment needs is another barrier to achieving greater access to dental care. All patients, regardless of income, must understand the importance of regular and ongoing oral health care. Policymakers must also understand the impact of inadequate oral health to the overall health of their constituents and communities. Education should stress the cost savings to individuals and to state budgets on accessing preventive services to avoid more costly dental treatment services.

Both patients and policymakers must understand that poor oral health can lead to more significant and costly health problems. For example, research has established a link between periodontal disease and low-birthweight babies in mothers with higher levels of periodontal disease. In addition, several studies have found that people with periodontal disease are more likely to have cardiovascular disease and are more likely to have difficulty controlling blood sugar with diabetes. Another study found that mother's with untreated decay were more likely to pass decay-causing bacteria from their mouths to the mouth of their infants.

For families with limited incomes or families that have other barriers to care like a lack of transportation, dental services are often considered deferrable until dental problems become painful. As a result, oral health needs often receive low priority and patients may not practice good oral hygiene or follow dentists' instructions. Adult patients and parents of children need to be educated about the importance of oral health, the need for early care to prevent common dental problems, and how to access services, such as the EPSDT program, that will facilitate referral to dentists, appointment reminders, and transportation to care. Until oral health is valued as equally important as other health services, disparities in access to care will continue to exist.

General shortage of dentists in Iowa

Further exacerbating the dental access problem is a general shortage of dentists in certain areas of the state. Rural areas of the state are especially vulnerable due to an aging dentist population and the challenges of recruiting new dental practitioners. As discussed earlier, 72 of Iowa's 99 counties are designated as dental health profession shortage areas. The simple fact is that for many of Iowa's counties, there simply are not enough dentists.

Statistics from the Office of Statewide Clinical Education Programs, UI Carver College of Medicine, show that Iowa had 1,302 private practice dentists in 2001; 173 of these dentists were age 60 or older. This figure also represents a consistent decline in Iowa's overall private practice dentist population between 1997 and 2001. In 1998 there was a net loss of 18 private practice dentists in Iowa; in 1999, there was a net loss of 1 dentist, followed by a net loss of 13 dentists in

2000, and a net loss of 11 dentists in 2001. Retirement is responsible for just over half of the attrition rate. Relocation was responsible for about 30 percent of the attrition, while death and other reasons accounted for about 15 percent of the attrition.[17]

While 2002 brought the first net gain (+19) in Iowa's private practice dentist workforce in several years, critical shortages still remain in many areas of the state.[18] The age distribution of Iowa's dentists also shows some cause for concern. Only about 22 percent of Iowa's dentist workforce is under 40 years of age. About 32 percent of all Iowa dentists are between 40 to 49 years of age, while 31 percent are between 50 and 59 years of age, and 14.5 percent are age 60 or older. Cumulatively, 45.5 percent of Iowa's dentists are age 50 or older.[19]

Iowa's dental workforce shortage is not unique. While a 2001 Report on Dental Workforce by the American Dental Association argued that the national dental workforce seems to be adequate, the report acknowledged that regional workforce issues do exist and may become more pronounced in the future.[20]

Nationally, the number of dental school graduates is decreasing. Last year there were 344 vacant faculty positions at 54 dental schools nationwide.[21] Shortages in dental school faculty affect the ability of schools to educate and train more graduates and dental specialists. Coupled with a rising U.S. population and the large number of dentists who are eligible for retirement in the near future, these shortages are particularly troubling. Even in states where the number of practicing dentists is deemed adequate for the state's population, a maldistribution of dentists in the state can severely hamper access to care, particularly in rural areas. In a state that is predominately rural like Iowa, these problems are more apparent.

The dental workforce issue is also complicated by the lack of an adequate number of practitioners who are trained to treat children. There is a severe shortage of pediatric dentists in Iowa and around the nation. Nationwide, only about 2.5 percent of dentists specialize in pediatric dentistry.[22] In Iowa, there were only 30 pediatric dental specialists in private practice in 2002.[23] For children with special health needs who require the services of a pediatric specialist, this creates unique access difficulties.

A particular access problem for children under age 3 also exists because a large number of general dental practitioners will not treat children this young. Both the American Academy of Pediatrics and the American Association of Pediatric Dentistry recommend that all children be seen by a dentist within 6 months of the first eruption of teeth or by age one. EPSDT guidelines recommend dental visits at least yearly thereafter until the age of 3 and twice yearly after that. Despite these recommendations, the vast majority of dentists will not treat children under age 3. Only 200 dental providers statewide are listed on the EPSDT Registry as being willing to treat children under age 3.[24] In fact, a 1996 survey of dentists conducted by Dr. Michael Kannelis through the Public Policy Center at the University of Iowa, found that only 11 percent of dentists surveyed thought that children should be seen by age 1.

For low-income children who are especially vulnerable to dental disease, this situation is especially troubling. Significant dental disease can occur in young children. Of particular concern is a condition called early childhood carries or ECC. Early childhood caries, sometimes

called baby bottle tooth decay, is rampant caries in the primary teeth of infants and toddlers, typically the result of a child going to bed with a bottle of sugared drinks or pop or drinking at will from a bottle during the day. Most cases of ECC are preventable, but early detection is necessary to prevent or stop the progression of the disease.[25] Studies show that up to twenty percent of children from families with low incomes have ECC.

Because of the risk of ECC for children from low-income families, it is especially important that early access to dental care take place. When treatment for rampant decay is delayed, costs can increase dramatically. In some cases, hospital care is required to treat rampant decay by providing restorative care to young children under general anesthesia. In a study of expenditures for restorative dental care delivered under general anesthesia to Iowa Medicaid children, costs were $2,009 per case.[26] According to the study, "less than 2 percent of Medicaid-enrolled children under 6 years of age who received any dental service accounted for 25 percent of all dollars spent on dental services for this age group, including hospital and anesthesia care." The minimal costs of educating parents of young children, providing early preventive services like fluoride varnish, and ensuring routine early access to care pales in comparison.

Lack of dentist providers in Medicaid

Faced with an overall shortage of dentists for the entire population, the problem of finding dentists to treat Medicaid and other low-income patients is exacerbated. Even where there is an adequate supply of dentists, few treat a significant number of Medicaid patients. According to the United States General Accounting Office (GAO), "While several factors influence the access low-income groups have to dental care, the primary one is limited dentist participation in Medicaid."[27] This national problem is mirrored in the state of Iowa.

During fiscal year 2003, there were 1,118 dentists in Iowa who billed Medicaid, including 58 staff and residents at the University of Iowa College of Dentistry. However, 160 of these dentists, *about 14 percent*, saw 10 or fewer Medicaid patients. Only 394 dentists saw 100 or more Medicaid patients. The median number of patients seen was 55: half of all the dentists saw more than 55 patients, while half saw fewer than 55 patients.[28]

Of more significant concern is the number of dental providers who are willing to treat new Medicaid patients. According to a statewide survey of dentists conducted in March of 2002 by the University of Iowa Department of Pediatric Dentistry, only 168 providers in the state of Iowa were willing to have their name listed on the EPSDT Registry as accepting new Medicaid patients. Only 200 providers statewide would see children under the age of 3, regardless of payment source.[29]

The problem of finding dentists willing to treat new Medicaid patients is particularly difficult in rural areas of the state where there is already a limited number of dentists for all patients. However the problem is not uniquely rural. For example, in Polk County there are only 9 providers on the registry that accept new Medicaid patients out of a total of 223 providers.

Although there are a few more dentists who accept patients in all three categories, but who did not want to have their names listed on the registry, the number does not significantly affect access for new Medicaid patients (in 2000, the discrepancy was about 7% of dentists who saw

patients in any of the three categories but who did not want their name published on the registry).[30] Indeed, the fact that many dentists are fearful of advertising their willingness to treat new Medicaid patients is indicative of the severe problems faced by the program. Because the need is so great, some dentists are unwilling to have their name published on the registry for fear of being overwhelmed by new patients seeking care. While there was some increase in the number of providers published in the EPSDT Registry between 2000 and 2002, there is still a severe shortage of providers willing to treat new Medicaid patients and children under age three.

According to the GAO, the primary reason cited for not treating Medicaid patients are that payment rates are too low. Coupled with the perceived administrative burden in treating Medicaid patients, patient issues like appointment-keeping, and dentists' attitudes toward low-income patients, provider participation will continue to be a problem. In a study of states that took various steps to improve access to care among Medicaid recipients, including raising payment rates, streamlining administrative processes, and conducting outreach activities to both dentists and beneficiaries, the GAO found that low utilization remained a problem.[31]

In the conclusion of its study, the GAO stated

> *Despite the availability of dental coverage through public programs such as Medicaid, SCHIP, and other HHS programs, access to dental services remains low for low-income populations. Structural issues that affect service use across all income levels – including the availability of dentists and the priority that individuals assign to preventive dental care – are often more pronounced for low-income populations. Despite federal and state programs to improve access to dental care for low-income or otherwise disadvantaged populations, difficulties remain. The experience of states working to attract more dentists to Medicaid by paying higher fees, streamlining administrative requirements, and providing patient education has resulted typically in some incremental improvements in access…this is a public health issue that requires the concerted attention of many, especially the public and private sectors at the federal, state, and local levels.*[32]

The Board's Proposed Amendment

This section of the regulatory analysis will provide a brief history of the Board of Dental Examiners proposed amendment and specific information about what the amendment requires.

History of the Amendment

The Iowa Board of Dental Examiners became involved in the dental access problem for the first time in September 2002 in response to a petition for rulemaking filed by the Iowa Dental Hygienists' Association. Prior to this petition, the Board had not been involved in any previous efforts to study or address the dental access issue. The petition for rulemaking was the first time that the Board was asked to address the access issue from a regulatory perspective.

The petition proposed to amend 650—1.1(153) by adopting a new definition of "public health supervision" to allow dental hygienists with a specified level of education and experience to provide services to dentally underserved and at-risk populations as long as the hygienist follows protocols approved by the Bureau of Oral Health of the Department of Public Health. Following

review of the petition and related information, the Board voted in November 2002 to deny that petition. In its written denial, the Board identified several flaws with the petition:

- The original petition placed responsibility for writing practice protocols with the Bureau of Oral Health, with no mechanism for Board oversight. No protocols currently existed and the Board lacked legal authority to determine if supervision and practice protocols were appropriate.
- The Board was concerned that the Bureau of Oral Health would soon be without a dental director, meaning that a person without dental training could potentially be responsible for writing dental protocols. Since only a dentist can supervise a dental hygienist, it would have seriously undermined the program.
- The petition lacked a clear and specified plan to ensure dental diagnosis takes place. The Board was concerned that patients may mistakenly believe that no further treatment was needed and that a hygienist could diagnose dental problems.
- The petition did not fully define the settings where public health supervision could take place.
- The Board was concerned that the petition lacked a substantive plan to ensure that patients requiring care beyond the scope of dental hygiene services would be referred to a dentist for other treatment needs. The Board noted that of the 16 states reviewed that allowed alternative public health practice, almost all required some type of formal involvement by a dentist.
- The Board was concerned that the petition would be a step backwards from existing programs by placing responsibility for supervision in an entity and not a dentist.

While the Board noted that the petition was flawed in several respects, the Board expressed its desire to formally explore the access to care issue, to explore other alternatives, and its pledge to work with all interested parties on this issue. Following denial of the petition, the Board worked to put together an Access to Care Committee with representation from all interested parties. However, after considering that the Board's committee was duplicative to a Dental Advisory Committee (DAC) of the Iowa Department of Public Health, the Board decided to instead seek representation on the DAC. In the interim, while the Board was in the process of forming a committee, it was asked to consider another petition for rulemaking.

In December 2002, the Iowa Dental Hygienists' Association filed a second petition for rulemaking with the Board of Dental Examiners. The second petition sought to amend the Board's rules by changing the definition of "general supervision of a dental hygienist" and adding a new definition of "collaborative agreement." The amendments would have allowed a dental hygienist who has 2,500 hours of clinical practice or who is employed as a public health hygienist as of June 1, 2003, to perform preventive services in settings other than a private dental office without the patient's first being examined by a dentist. The hygienist must have entered into a collaborative agreement with a dentist who authorizes and accepts responsibility for the services provided by the hygienist. The collaborative agreement must contain protocols or standing orders for the hygienist to follow.

In a split vote in January 2003, the Board voted to accept the petition and file Notice of Intended Action on the amendments proposed in the petition. Notice of Intended Action was published in the Iowa Administrative Bulletin as ARC 2327B on March 5, 2003. A public hearing on the

noticed rules was held in April 2003. Approximately 120 written and oral comments on the proposed rules are received: about one-third of the comments expressed support, while the vast majority expressed opposition and others were undecided or supportive only if changes were made. Most of the comments received in opposition to the proposed amendments reiterated the concerns of the Iowa Dental Association (IDA). Concerns expressed by the IDA in their written comments were as follows:

- The IDA felt the proposed amendments were contrary to Iowa law because they failed to ensure that a dentist would look over, inspect, or oversee the work of a dental hygienist.
- The IDA was concerned that ongoing hygiene services could potentially be provided without assurance that a dentist would see the patient. The IDA expressed concern that there was not a mechanism to ensure that a dental exam takes place.
- The IDA expressed concern about the potential liability of a dentist under a collaborative agreement.
- The IDA expressed concern about services being provided to medically compromised patients.
- The IDA expressed concern about lack of training in diagnosing dental conditions and disease by dental hygienists, which could lead to delayed or missed diagnosis. Concern was also expressed that hygienists lack education to formulate comprehensive dental treatment plans.
- The IDA expressed concern about lack of training in pharmacology by hygienists and the inability of hygienists to prescribe medications. According to the IDA, this could create concerns for medically compromised patients or in the event of an allergic reaction.
- The IDA expressed the concern that without the presence of a dentist, patients might believe critical diagnosis and treatment planning services were rendered.

Other comments in opposition to the proposal identified the following issues:

- Many comments expressed concerns about a dentist possibly having multiple agreements with multiple hygienists;
- Numerous comments suggested that the time period for a dental exam be specified under a collaborative agreement to ensure an exam takes place within a reasonable amount of time;
- Many expressed the belief that some care is not always better than no care – because it could give a false sense of security to patients or could lead to problems diagnosing decay if a sealant was placed;
- Many comments suggested specifying the settings where care could be rendered;
- Multiple dentists commented on their belief that the proposal will not help the access problem because of lack of adequate reimbursement in Title XIX, lack of appropriate facilities and equipment to provide care to underserved, administrative burden in reaching target populations, the problems of keeping appointments; and a lack of adequate dental and dental hygiene providers;
- There was concern about dental record issues including where records would be maintained and stored; and
- Many expressed their belief that the proposal creates substandard care for underserved populations.

In April 2003, the Board of Dental Examiners met to review the Notice and the comments received. Due to the number of concerns, the Board voted unanimously to refer consideration of the pending rules to a Board committee, with committee recommendations due back at the August Board meeting.

The Board committee met with representatives from the Iowa Dental Association and Iowa Dental Hygienists' Association in May 2003 to discuss the proposed rules further. At the May meeting, the Board committee identified the following concerns with the proposed amendments:

- The committee and legal counsel for the Board expressed significant concern about whether the placement of sealants without a dental exam met the standard of care. Sealants were a major component of the proposal. However, at the time the committee felt that whether a tooth is appropriate to be sealed requires a dental diagnosis and that the standard of care for this diagnosis should not be different in two different settings.
- The committee discussed the question of liability, which had also been raised a number of times. The Board is not involved in typical questions of liability – that is a determination between an insurance company and the policy holder. However, the Board needs to be able to address responsibility from an enforcement perspective. If a complaint about one of these cases would come in, the Board must be able to answer questions related to who is the dentist of record, where to find dental records, etc.
- The committee expressed concern regarding if a hygienist was working under multiple agreements, each with different protocols, then how do you determine for any given patient who the dentist of record is and what protocols the hygienist is supposed to be working under? If records had to be subpoenaed, who do you issue the subpoena to?
- The committee discussed some concern that the current wording was ambiguous and did not make it clear whether this created a new level of supervision under the collaborative agreement. The wording needed to be modified for clarity.
- The proposal also referred to a public health hygienist. However, there is no definition of a public health hygienist anywhere in the rules. It is not clear if it meant someone with specific public health education or just anyone with experience in public health.
- The amendments also referred to preventive services. However, the term "preventive services" has a very narrow meaning under board rules. Preventive services only refer to sealant and fluoride rinse programs. Therapeutic services deal with prophylaxis, scaling and root planing. Under the proposal, a hygienist could continually perform scaling and root planing without a dentist ever examining a patient.
- Questions concerning record keeping and who is responsible also need to be addressed.
- The committee also discussed that the meaning of health care facility was also unclear, overly broad, and needed to be more clearly defined.

Committee members felt that it should not be the Board's responsibility to work out a solution to the many unanswered questions with the proposal. Committee members felt that the associations needed to work out a solution together. In the meantime, the committee suggested the waiver process as a mechanism to work out problems on a case-by-case basis. The committee recommended that the Board not move forward with the Notice of Intended Action. The committee also unanimously suggested that the dental and dental hygiene association work together to discuss their concerns and attempt to resolve this issue.

Following the May committee meeting, the associations failed to meet and attempt to resolve differences related to the proposed amendments. The Director of the Iowa Department of Public Health, in consultation with the Governor's office, also attempted to facilitate meetings between the groups to resolve concerns. These attempts were also unsuccessful. Following unsuccessful attempts to mediate a resolution and with the support of the Governor's office, the Board's committee worked to develop a compromise proposal that would address many of the concerns previously identified, ensure sufficient patient protections were established, and facilitate access to services in public health settings.

Committee members developed the current proposal based on a review of programs in other states, feedback from the earlier petitions and rulemaking actions, and comments received. The full Board met in August and unanimously voted to support the committee's proposal. The Board voted to terminate the rule making commenced in ARC 2327B and file Notice of Intended Action to amend Iowa Administrative Code 650—Chapter 10, "General Requirements," by adopting a new amendment related to public health supervision, as proposed in ARC 2783B.

The Board's Public Health Supervision Amendment

The proposed amendment in ARC 2783B would allow a dentist to provide public health supervision to a dental hygienist providing services within the scope of practice of dental hygiene in a public health setting. The amendment defines public health settings and details the responsibilities of each licensee operating under public health supervision. The proposed rule differs significantly in one important aspect from existing dental hygiene supervision rules: under public health supervision, a dental hygienist may render services prior to a dental exam of the patient based upon written protocols

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

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

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

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

In creating its current proposal, the Board carefully considered the concerns previously identified with the first two petitions for rulemaking, the many written comments received, and similar programs and supervision rules from other states. The Board sought to balance competing views on this complex issue, with the need to provide more services to the underserved and the overwhelming need to ensure that public health, safety, and welfare is protected under the rules. After considering the issue at length, the Board believes that there may be regulatory barriers that could be removed that may impact access to care for some underserved people. The Board's believes its current rulemaking action strikes a compromise between the competing views of the IDA and IDHA and the Board's obligation to protect the public.

Barriers Addressed by the Proposed Amendments

While the Board acknowledges that it cannot begin to address all of the barriers contributing to Iowa's overwhelming dental access problem, the Board believes it can remove certain regulatory obstacles. Any action that the Board takes will be innovative from the perspective that the Board has not previously been involved in the dental access issue in Iowa. However, as with any innovative approach, it is impossible for the Board to accurately predict the true impact the change will have on addressing the many complex barriers to oral health care. With that in mind, there are three main areas that the Board's proposed amendments can impact:

- *Lack of understanding of the importance of oral health needs;*
- *High failure rate of appointments; and*
- *Access to preventive services.*

Dental hygienists are licensed oral health professionals who focus on preventing and treating oral diseases by providing clinical and therapeutic services as well as oral health education. In the state of Iowa, all dental hygienists are required to graduate from an accredited dental hygiene program that is at least two years in length. Hygienists must also successful complete the written National Board Dental Hygiene Examination as well as a regional examination that includes both written and clinical components. According to education standards for dental hygiene education, students are prepared to assume responsibility for individual oral health counseling, community health programs, assessment, planning, and implementation of preventive and therapeutic services.[33]

Dental hygienists are front-line providers in educating the public and patients in the importance of oral health and preventive care. In fact, Board rules at Iowa Administrative Code 650—10.3(153) specify four categories of dental hygiene services: educational, therapeutic, preventive, and diagnostic. Education on the importance of oral health is a large component of dental hygiene and one of their primary responsibilities.

Dental hygienists can play an important role in educating patients and policymakers about the importance of oral health so that this barrier can be reduced or eliminated. Dental hygienists can help to educate and counsel patients about oral hygiene techniques to maintain healthy teeth and gums, teach strategies for plaque control, stress the importance of good nutrition to maintain optimal oral health, provide prevention strategies for parents to eliminate or reduce the risk of early childhood caries/ baby bottle syndrome, and communicate the importance of regular and on-going preventive dental care. Hygienists can also educate parents on the importance of keeping appointments and how early preventive care can help prevent more costly and time-consuming restorative dental care. With better education, treatment needs can be reduced because much of the disease experience by children and adults could be prevented with better personal care.

As discussed previously, a high failure rate of patient appointments is another contributing barrier to greater access to dental care. A lack of transportation, inability to get time off from work, inability to find child care, and a lack of understanding of the importance of oral health needs all contribute to the problem that low-income patients have keeping appointments. If more services can be provided in fewer appointments, this barrier becomes less of an obstacle for low-income patients.

Under existing programs, it may require the coordination and time commitment of at least three different appointments to have an oral prophylaxis: the initial screening at a public health clinic and referral to a dentist; the appointment and initial exam by the dentist following the lengthy wait for the appointment (or inability to find a provider accepting new Medicaid patients); followed by the appointment for the prophylaxis/cleaning and any additional appointments for further treatment needs. If a hygienist is working under public health supervision, the hygienist could provide the cleaning at the initial screening visit, thereby reducing the number of appointments needed. If fewer appointments are necessary, there is less of an opportunity to miss appointments and it may be easier to keep future ones.

Under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) component of Medicaid, dental hygienists can also help by facilitating care coordination for families with children from birth to 21 years of age. The Iowa Department of Public Health administers informing and care coordination services for the Department of Human Services. IDPH contracts with 26 Title V agencies in the state to provide 'informing' and care coordination services in all 99 Iowa counties. Care coordination services help by educating families about the importance of preventive dental care for children; assisting families in locating dentists who are Title V or Title XIX providers and by scheduling appointments; reminding families that exams are due; reminding individuals and families about appointments, counseling families on the importance of keeping appointments and providing follow-up if appointments are missed; assisting families with finding child care for the day of an appointment; providing transportation; and providing follow-up education and monitoring of the dental plan.[34, 35]

While nurses and other health professionals can serve as care coordinators, Title V agencies that utilize dental hygienists in this capacity tend to be the most successful at reducing the high failure rate for appointments and in facilitating oral health care. Rates of Medicaid-enrolled children receiving dental services in counties that have Title V agencies using dental hygienists

have increased at a higher rate than agencies where hygienists are not involved in this capacity.[36] The opportunity to expand the success of EPSDT care coordination can only be enhanced by increasing the ability of dental hygienists, operating within their scope of practice, to do more in fewer appointments.

Studies also support the belief that missed appointments are less of an issue in public health settings. The same study of the appointment-keeping behavior of pediatric patients in Eastern Iowa also found that appointment rates for Medicaid patients were better at the public health clinic and University-based pediatric dentistry clinic than in the private practice setting.[37] The report by the U.S. General Accounting Office also confirmed this phenomenon, noting, "The effect of missed appointments by Medicaid and other low-income patients appears to be less of a problem at public health clinics and community health centers, where officials report that walk-in patients and emergency cases generally fill any appointment times."[38]

Increasing access to preventive dental hygiene services will also address several barriers to oral health care. If dental treatment is not available due to a lack of providers or lack of willing providers, more must be done to reduce treatment needs through prevention. For example, fluoride varnish can reduce tooth decay in children. According to the Iowa Department of Public Health most studies have shown 25 to 45 percent reductions in the decay rate with the use of fluoride varnish. Of special note is the reduction of decay in pits and fissures, as well as on smooth surfaces of teeth. A two-year study by Holm using 225 three year-olds resulted in a 44 percent caries reduction rate following semi-annual varnish applications.[39]

Under the Board's proposed amendment hygienists would also be able to provide preventive services like an oral prophylaxis prior to a dental exam. An oral prophylaxis consists of removal of plaque, calculus, and stain from the exposed and unexposed (below the gumline) surfaces of the teeth. An oral prophylaxis helps to maintain oral health and prevent the initiation of dental diseases, like periodontitis. Preventing periodontitis is especially important because bacteria from the disease can enter the blood stream and travel to major organs to begin new infections. According to the American Academy of Periodontology, research suggests that this may increase a patient's risk of stroke, increase a woman's risk of having a pre-term baby, contribute to the development of heart disease, and pose a serious threat to people whose health is compromised from diabetes, respiratory diseases, or osteoporosis.[40]

Other preventive services that hygienists can provide can also significantly reduce the need for more expensive restorative dental treatment. Dental sealants are thin plastic coatings that are applied to the chewing surfaces of the back teeth to prevent tooth decay by creating a physical barrier against plaque and food.[41] Dental hygienists are educated and trained to apply dental sealants and are also authorized under Board rules to do so. According to the National Institutes of Health, dental sealants are almost 100 percent effective in preventing decay.

Dental hygienists currently work in school-based dental sealant programs to apply dental sealants after a dentist has first examined each child. According to the Oral Health Bureau at the Department of Public Health, at the present time sealant programs are limited due to both a lack of grant funds and in certain areas of the state, the inability to find a dentist willing to conduct dental exams prior to sealant placement. Under the Board's proposed amendment, this barrier

could be eliminated by authorizing a hygienist to place sealants according to written protocols as specified by a dentist. In making this change, Iowa would be joining the ranks of an increasing number of states that recognize the value of sealants in preventing decay to help combat the dental access problem. These states include, but are not limited to: California, Connecticut, Idaho, Maine, Minnesota, Missouri, Montana, New Mexico, Oregon, South Carolina, and Texas.

If decay can be prevented in the first place, treatment needs will be reduced, helping the access problem. In addition, substantial savings can be realized because the cost of sealants is less than half the cost of filing a tooth. Because sealants have been an issue of particular concern with respect to the proposed amendments, the next section of this report will discuss this issue in more detail.

Sealants

Dental sealants were first developed and used beginning in the 1960s. The application of sealants is a relatively simple and painless procedure. In simple terms, sealants are placed by painting on a liquid material that quickly hardens to form a shield over the tooth. This shield protects the teeth from decay by keeping out the germs and food that cause decay. Sealants are applied to the chewing surfaces of molar teeth where small pits and fissures can harbor bacteria that lead to decay. According to the Centers for Disease Control and Prevention, among children, 90 percent of decay is in pits and fissures.[42]

Once applied, sealants can last up to 10 years. However, following sealant placement, it is important to have regular dental check-ups to make sure the sealants do not chip or wear away. Chipped or worn sealants are not as effective in preventing tooth decay, but can be repaired by adding more sealant material. All of the research cited below heavily emphasizes the need for regular checks for sealant retention and maintenance where indicated. Research indicates that without regular check and maintenance, sealants can fail, leading to tooth decay.

In December 1983, the NIH hosted a consensus development conference on dental sealants in the prevention of tooth decay, which concluded that sealants were 100 percent effective in pits and fissures that remain completely sealed, though sealant retention declined over time. Since then, additional research has confirmed the effectiveness of sealants.[43] Despite their effectiveness at preventing decay, their prevalence remains low. Baseline data from *Healthy Iowans 2010* show that in 1994 only 30 percent of third graders in Iowa had sealants.[44] An Oral Health Survey conducted in 1999 by IDPH also found a large discrepancy (12.5 percent) in sealant placement rates between children of higher socioeconomic status and those of lower socioeconomic status: 36.5 percent of children with a higher socioeconomic status had at least one sealant compared to 24 percent of children with low socioeconomic status.[45] This discrepancy is particularly troubling when considering the fact that poor children suffer twice as much tooth decay as their more affluent peers. In fact, eighty percent of tooth decay is concentrated in only 25 percent of children.[46]

One of the oral health goals in *Healthy Iowans 2010* is to increase to at least 70 percent by 2010 the proportion of third grade children who have received protective sealants in permanent molar teeth. With a baseline of less than 40 percent of third grade children currently receiving sealants,

dramatic action is needed to accomplish this goal. Allowing dental hygienists to apply sealants in schools and public health settings, by following protocols written by a dentist, is one way to increase the sealant placement rate to help prevent tooth decay in high-risk children.

Sealants are extremely cost-effective compared to the cost of filling a tooth. In Iowa, the Medicaid reimbursement rate for a dental sealant is $19.40. The reimbursement rate for a single surface amalgam restoration is $43.65, up to $75.66 for a four surface restoration.[47] Once established, dental caries requires treatment. The longer a cavity remains untreated, the larger and more expensive it becomes to treat.[48] If decay progresses, it may be necessary to perform more costly dental work such as crowns, bridges, root canals, or extractions. The best approach is to use proven and cost-effective prevention methods, like fluoride and dental sealants to prevent decay.

Although much anecdotal testimony has been presented to the Board related to possible harm from sealant placement, all of the research presented on this issue supports the safety of dental sealants, even in cases where sealants are placed on teeth with incipient decay. The U.S. Department of Health and Human Services advocates using sealants on incipient lesions stating, "If incipient lesions are sealed instead of restored, the total cost of treatment is lower."[49] In fact, a retrospective study by Heller et al found that sealants were much more effective in preventing further caries on surfaces that had incipient lesions than initially sound surfaces.[50] The study by Heller compared a group of patients who received sealants with a group of patients who did not receive sealants. After 5 years in the study, molars that were initially found to be incipient became carious at a rate of 11 percent in sealed cases compared to a rate of 52 percent in nonsealed cases.

JA Weintraub reviewed multiple studies concerning the use of sealants in high-risk individuals. In her review of a 1991 study by Handelman that looked at the therapeutic use of sealants in cases of dental caries she found, "caries is inhibited and may in fact regress under intact sealants."[51] Weintraub goes on to state that a Diagnodent laser can be used to detect caries beneath an unfilled sealed surface to alleviate concerns regarding hidden caries. She also notes that in 1994 a federally funded workshop recommended, "based on the available evidence and consensus of workshop participants, that teeth with questionable caries or enamel caries be sealed in addition to caries-free teeth determined to be at-risk, and dentin caries be restored."[52]

As explained by Trost and Kaiser:

> *Bacteria can be trapped beneath a sealant, and inadvertent sealing of incipient primary decay can also occur. The ability of bacteria to survive beneath a dental sealant is substantially low because the ingested carbohydrates cannot penetrate the chewing surfaces of an intact sealant. Additionally, trapped bacteria can diminish over time. Even incipient decay that was intentionally left before sealant placement was shown radiographically not to progress. Sealants can then become a significant barrier—not only for the initial presentation of caries, but also for preventing further decay progression.*[53]

The FAQs section on dental sealants by the National Institutes of Dental and Craniofacial Research simplifies this best with the following question and answer: What if a small cavity is

accidentally covered by a sealant? The decay will not spread because it is sealed off from its food and germ supply."[54]

Additional research by Mertz-Fairhurst et al (1998),[55] Hassall et al (2001),[56] Adair (2003),[57] and others further supports these theories that placing a sealant over incipient decay reduces the number of microorganisms present and has no deleterious effect. [58]

The Board recognizes that isolated cases of poor tooth selection for sealant placement and improper sealant placement may happen. Board rules provide appropriate remedies to address cases of incompetent care. In fact, anecdotal testimony about problems seen in Iowa patients due to inappropriate sealants apply to situations in which teeth were first examined by a dentist, as required by current board rules. This illustrates the fact that even in the best of circumstances isolated problems will happen.

While some testimony provided to the Board argued that sealants should only be placed following radiographs of the teeth, school based sealant programs currently operate without the use of dental x-rays. Again, research presented to the Board supports the safety of sealant programs operating in this manner. Research shows that caries that is not clinically detectable or apparent will not progress even if it is inadvertently sealed in teeth.

Dental hygienists, operating under written protocols established by a dentist, can utilize their background and education in oral health to safely assess the appropriateness of sealants for patients in public health settings. They do so in at least 10 other states. Assessment tools are also available to further guide dental hygienists and dentists in developing written protocols for sealant selection and placement. The caries-risk assessment tool (CAT), utilized by dental hygienists working in public health settings and developed using research by the American Academy of Pediatric Dentistry, is one example of an assessment tool that can be incorporated into practice protocols to further guide decision-making.

Dental hygienists are authorized under Board rules to make oral health assessments. The Board's amendment simply extends their ability to apply dental sealants based on the results of the assessment and as further authorized by a dentist according to established written protocols. The Board acknowledges the need for patients to be fully informed that the services being provided by a dental hygienist do not constitute a dental exam nor do they substitute for a dental exam. The proposed amendment requires all patients to be notified of this fact in writing. The Board expects that consent forms for sealants will clearly communicate the need for a dental exam and regular check-ups. As added security, the proposed amendment limits the ability of the dental hygienist to provide certain services to patients who do not follow through by having a dental examination.

Oral and written testimony by Dr. Daniel Venker provides some of the most persuading arguments for allowing dental hygienists to provide sealants prior to a dental exam in public health settings. Dr. Venker is a 1983 graduate from the University of Iowa College of Dentistry who recently completed his Masters degree in dental public health and who completed his thesis research on the area of dental sealants. For the last six years he has also worked in the school-based dental sealant program for Des Moines schools.

According to Dr. Venker's testimony, "Licensed dental hygienists are able to do caries risk assessments and caries detection. Caries detection is part of their education and board examination experiences. Currently, in the sealant program, the dentist performs only a clinical assessment of the tooth structure. A hygienist performing the same clinical assessment, including caries risk assessment, can detect if there is active caries that necessitates the student seeing their regular dentist for definitive diagnosis. Even if enamel caries are sealed into the tooth and the child does not see their dentist for an examination, research supports that there is no harm done…When the public health hygienist is able to perform these assessments and seal the teeth, the time the dentist spends doing the sealants assessments can be better spent providing restorative care."[59]

Dr. Venker further stated that in the Des Moines sealant program the expertise of the dental hygienists, along with their prior education, "…put them in excellent clinical practice to assess students for active caries and making appropriate, timely referrals to the dentist for definitive diagnosis and treatment." [60]

Costs of the Amendments

The next section of this informal regulatory analysis will address costs associated with the Board's proposed amendment. A formal regulatory analysis requires a great deal of focus on the impact of proposed amendments on small business. In this case, such a focus is not appropriate because the Board's proposed amendment does not adversely impact small business and instead focuses on helping a particular class of persons access additional services.

Because the goal of the amendment is to help patients who currently lack access to care achieve greater access, it is also difficult to predict the cost of the amendment. In an ideal situation, all patients who currently lack access to oral health care would achieve greater access. In this respect, the goal of the amendment is to increase expenditures for preventive oral health services. However, the ability to achieve this ultimate goal is obviously hampered by the limitation that the proposed amendment only addresses barriers related to services that can be provided by a dental hygienist and does not directly increase access to restorative dental treatment, which can only be provided by a dentist.

It should also be noted that the proposed amendment will only work if there is consent on the part of both a dentist and a dental hygienist. Public health supervision is a voluntary arrangement: both the dentist and the dental hygienist must agree and comply with the specific requirements of the amendment. There are no specific mandated costs of compliance with the amendment because it is permissive arrangement, rather than an obligatory one.

In addition, the amendments do not change the fundamental concept that dental hygienists cannot work independently, nor can they establish their own business. They must work under the supervision of a licensed dentist. The proposal specifically requires that a dentist be involved in what they are doing, that they communicate and consult regularly, and work off detailed protocols. The amendments do not change the reimbursement structure for Medicaid or

hawk-i dental services. Dental hygienists are not eligible for provider numbers. Reimbursement for services provided by dental hygienists working in public health settings is done through their dental office or employing agencies, most likely Title V clinics.

Finally, it is extremely difficult to predict costs associated with an innovative approach. The Board has no baseline data to utilize or compare to estimate the impact of the proposed amendment. The Board has no way of predicting how widely public health supervision arrangements will be used. The lack of general support for the amendments by the Iowa Dental Association suggests that public health supervision agreements will not be widely utilized. At a minimum, the Board hopes that the 30 dental hygienists who now work in public health settings will be able to take advantage of the opportunities offered by the amendment. In addition, the Board hopes that at least some community health clinics that do not already have an oral health component will be able to add these services.

With these limitations in mind, the following cost data is provided:
There is no overall fiscal impact on dentists or dental hygienists. There may be some minimal costs incurred by certain licensees who agree to work under public health supervision. These costs are related to photocopying the supervision agreement, maintaining regular communication between the supervising dentist and hygienist, and filing a report with the Oral Health Bureau.

The proposed amendment may have some impact on expenditures by the Department of Human Services Medicaid program. Again, it is extremely difficult to predict costs related to the amendment without knowing how widespread use of the amendment will be. Attachment B is a copy of the fiscal impact statement prepared and filed at the time of the Notice of Intended Action. Again, it is difficult to know how accurate these estimates are. Given that there are only 30 dental hygienists working in public health settings, it is likely that a smaller range of estimates may actually be more realistic.

The true fiscal impact of the proposed amendments must be measured in long-term costs and benefits. It is more cost-effective to provide preventive dental services rather than more costly restorative services. As indicated by Eugene Gessow, Iowa's Medicaid Director, "[] the immediate fiscal impact must be evaluated in terms of the offset in savings from restorative dental services. Total estimated savings are impossible to predict."[61] Attachment C is a copy of the letter of support for the Board's amendment from the Department of Human Services.

For example, as discussed earlier, sealants are nearly 100 percent effective in preventing decay in the pit and fissures of molars where 90 percent of decay in children has been found to occur. Data provided by the Medicaid program shows that in fiscal year 2003, Medicaid paid just over $2 million dollars for restorations provided to 13,894 unique Medicaid recipients under 21 years of age. "Assuming that 90% of this expenditure was for restorations on molars, a total $1,869,819 could have been saved had these children received sealants."[62] In addition, it was noted that Medicaid paid over $650,000 to place crowns on the teeth of children that could not be restored with conventional fillings and over $900,000 to extract teeth in children 21 years of age. (ibid) Some of these costs may be saved if dental decay could be prevented in these children.

Exceptional savings can also be realized by preventing cases of early childhood caries. This disease can be prevented through early education and a change in feeding habits. Early intervention by a dental hygienist can help to decrease the rate of early childhood caries. One study found that to treat a single case of early childhood caries with hospital care resulted in an average expenditure of over $2,000.

More importantly, costs must also be assessed against the benefit patients who lack access to oral health care will receive. Poor oral health care contributes to lost school and work hours, patient pain and discomfort, early childhood caries, periodontal disease, which can lead to pre-term labor in pregnant women as well as heart disease and stroke, and other infections. Currently less than one-third of Medicaid recipients in Iowa are seen by a dentist.

States that have embraced a similar strategy of utilizing dental hygienists in a greater capacity in public health settings have shown positive results. For example, a change in the practice act in South Carolina allowed dental hygienists to begin providing cleanings, fluoride treatments, and sealants in South Carolina schools. In the six months that followed, licensed hygienists had screened over 19,000 children and provided cleanings, fluoride treatments, and other services to more than 4,000 children, including nearly 3,000 Medicaid-eligible children.[63]

Finally, cost estimates in the fiscal note have only considered the impact on Medicaid. Estimates have not been provided for how this proposal could affect *hawk-i* participants or other low-income recipients. Without baseline data for comparison, there is simply no way of knowing or predicting the impact of the Board's amendment on these programs. Again, as with the Medicaid program, the goal for all of these patients is to increase access to preventive services, which can result in a long-term savings on restorative dental needs.

Iowa Dental Association Comments

The next section of this regulatory analysis will briefly address each of the concerns and bullets raised by the Iowa Dental Association (IDA) in their memo to the Administrative Rules Review Committee requesting the regulatory analysis.

- *We are concerned that the shortage of dental allied staff, including dental hygienists could be exacerbated due to this proposal.*

There are currently 1,283 licensed dental hygienists working in Iowa. There are four community colleges that offer an Associate's Degree in Dental Hygiene: Des Moines Area Community College in Ankeny, Kirkwood Community College in Cedar Rapids, Hawkeye Community College in Waterloo and Iowa Western Community College in Council Bluffs. According to the Iowa Dental Hygienists' Association, these four schools graduate approximately 80 dental hygienists every year in Iowa and most of these graduates stay in Iowa to practice. The American Dental Hygienists Association also notes that there are more than 120,000 licensed dental hygienists in the U.S. compared to approximately 130,000 dentists. While the number of dental graduates declined by 23 percent from 1985-86 to 1995-96, the number of dental hygiene graduates increased 20 percent.[64]

Distribution data prepared by the Office of Statewide Clinical Education Programs at the University of Iowa on the location of Iowa's licensed dental hygienists shows that like dentists, dental hygienists are more concentrated in Iowa's urban areas. There are currently 10 counties in Iowa that lack dental hygienists: Adams (1 dentist), Audubon (2 dentists), Fremont (1 dentist), Ida (3 dentists), Lyon (4 dentists), Monroe (2 dentists), Palo Alto (2 dentists), Ringgold (1 dentist), Sac (3 dentists), and Worth County (1 dentist).[65] These counties correspond to geographic areas where there is also a low number of dentists.

At the present time, there are currently about 30 dental hygienists working under the general supervision of a dentist in public health settings. Only about 3 of these practitioners work full-time; the vast majority of dental hygienists in public health settings work part-time with the remainder of their work-week spent also working part-time in a private dental office. Dental hygienists are not eligible for provider numbers under the Board's proposed amendment. It is highly unlikely that without a significant change in the reimbursement structure for hygiene services that there would be an adverse affect on the distribution of dental hygienists. The most likely scenario is a slight increase in the number of dental hygienists performing some part-time public health work.

- *We wish to have the Board of Dental Examiners establish a baseline of information including the number of additional Iowans who will be served by this proposal.*

As discussed in the cost section of this analysis, because this is an innovative approach in Iowa, there is no way to establish a baseline of information regarding the number of additional Iowans who could be served by the proposal. A baseline of information cannot be established until the program has operated for at least one year. At that point, the only existing baseline of data that can be used to determine the impact of the proposed amendments is the number of Medicaid recipients who receive any dental services (currently 32.5 percent). Any increase in this percentage can be viewed as a positive development in the dental access crisis.

- *We are hopeful that the Board of Dental Examiners will clearly delineate more detailed information regarding the workings of this proposal.*

The proposed amendment in ARC 2783B provides detailed information regarding the specific requirements to operate under public health supervision. The location where services can be provided is specified and limited to public health settings. Dental hygienists are limited to providing services within their current scope of practice. The responsibilities of each licensee are clearly detailed in proposed rule 650—10.5(153). To achieve a baseline of data and assess the impact of the amendments, each dental hygienist operating under public health supervision must complete a summary report regarding the number of patients seen and services provided. The Board of Dental Examiners will be provided with summary reports on an annual basis.

To help ensure compliance with the rule requirements, the Board will also put a sample public health supervision agreement on its website. The sample agreement will be intended to serve as a general guide for licensees who want to ensure compliance with the rule. Specific practice protocols will not be provided in order to maintain flexibility for each licensee to determine the appropriateness of services based on their unique practice situation.

In fact one of the recurring themes in previous rulemaking comments received by the Iowa Dental Association is the desire of their membership to have flexibility in complying with the rules. The request by the IDA for additional details with respect to how and in what manner dentists would provide public health supervision is puzzling given their previous rulemaking comments which highlighted the need for flexibility.

For example, when commenting on previous rules related to expanded functions for dental assistants, the IDA stated, "Within the statutory limits adopted by the legislature, a dentist should be allowed to train and delegate activities to his/her allied personnel. The dentist is fully responsible and must be allowed to function as the professional that he/she has been educated and trained to be. Over time, without the capability to freely delegate within legislative limitations, the ability of Iowa dentists to continue to provide affordable oral health care will be significantly challenged."[66] In IDA's comments concerning temporary permits, the IDA suggested the Board eliminate a certain provision limiting the number of permits that could be issued, commenting, "The rational for limiting the flexibility of the Iowa Board of Dental Examiners is unclear and the IDA recommends deletion of this proposed limitation."[67] In other comments related to proposed amendments specifying training requirements for dental hygienists monitoring nitrous oxide inhalation analgesia, the IDA commented that they were supportive of the intent to "provide additional flexibility to the licensed dentists to care for their patients through use of allied personnel."[68]

The Board believes that this need for flexibility should extend to public health supervision. It would be inappropriate to mandate specific details that all dentists should follow regarding communication issues and practice protocols. Recognizing that all practitioners operate a little differently, licensees need to have some flexibility within the limits of the rules to adapt requirements to their particular practice situation. For example, concerning the requirement that the dentist and dental hygienist maintain regular communication with each other, it would be inappropriate to mandate a specific number of phone calls or visits because all licensees are different depending on their particular office situation – some may actually visit with the hygienist at a satellite office. In some public health clinics, dentists are on site at specific times. Some licensees may want frequent telephone contact.

Likewise, the Board should not mandate specific protocols for services because dentists need to have flexibility depending on their practice situation. Some dentists, for example, may not want to authorize the placement of sealants by a dental hygienist prior to a dental exam. Other dentists will have different philosophies on caries placement over incipient decay or based on the results of a caries-risk assessment. Recognizing that there is not a single standard that will be appropriate for all public health situations, the Board has placed responsibility for writing protocols with each licensed dentist so that they can respond to the needs of the patients, the education, background, and training of the dental hygienist involved, and their own practice protocols regarding certain services.

- *We expect that the Board of Dental Examiners will clearly establish that the public health is being protected without a dentist exam as contemplated by this proposal.*

The proposed amendments require a number of protections that will help to ensure the public health is being protected under public health supervision:

- A dentist must write detailed protocols for a dental hygienist to follow when providing services.
- Protocols must be age and procedure specific.
- Protocols must address medically compromised patients and dental conditions for which no care can be provided prior to a dental evaluation.
- The dentist and dental hygienist must maintain contact and communication with each other.
- Protocols mandate that if a patient has not been examined by a dentist within 12 months, no additional services beyond education, assessment, and screening can be provided.
- In addition to the education, training, and examinations required for licensure in Iowa, dental hygienists working under public health supervision must have at least three years of clinical practice experience.
- Each patient will be informed that the hygiene services provided do not take the place of a dental exam and must sign a consent form.
- Each patient is provided with a written plan for referral to dentist and assessment of further dental treatment needs.
- Procedures for creating and maintaining dental records must be indicated in the supervision agreement.

- *We wish to know the Board of Dental Examiners' expectation regarding success indicators such as the projected number of dental hygienists and dentists involved in this program after one year, 3 years, and 5 years.*

Without a baseline of data for comparison, it is difficult to predict success indicators for the program. Even a program with limited participation by dentists and dental hygienists will be beneficial to the patients who are able to access oral health services. An increase of one new school-based sealant program would be a success in terms of the number of potential caries prevented in those children. At a minimum, the Board would like to see the following participation rates:

- 1 year success indicators: 10 hygienists working under public health supervision
- 3 year success indicators: 30 hygienists working under public health supervision
- 5 year success indicators: 40 hygienists working under public health supervision

These numbers are intentionally low because there is no way to predict the impact of the proposed amendment. Even if only a small population base is served – *some* prevention to *some* patients who do not otherwise have access to care will help with the overall dental access problem in Iowa.

- *We hope to establish on what basis dental hygienists would apply sealants without the advantage of a dentist's exam, diagnosis, and treatment plan.*

See pages 17 to 20 for a detailed discussion of the sealant issue. To summarize these findings:

- Research provided to the Board supports the safety of sealants, even in cases of incipient decay.
- Sealants will be applied on the basis of a dental hygiene assessment, following age specific protocols written by a dentist to further guide the decision making process.

Alternatives

In their denial of the first petition for rulemaking filed on this issue, the Board stated, "..The main access problem in the state right now appears to be getting dentists involved in providing diagnostic, restorative, and other treatment needs in these underserved areas. Finding a dental home for patients is another significant problem…Overall, the Board believes that the main access problem in Iowa and in other states is how to get more dentists involved in providing care in shortage areas and to underserved populations."[69] The Board still believes these statements accurately reflect the problems faced in Iowa. While the Board now believes, however, that an appropriate alternative may be to allow dental hygienists to provide preventive services, the Board acknowledges there are other alternatives that would do a better job of combating the lack of access to oral health services. However, the vast majority of these alternatives will require on-going and substantial commitments of public funds to achieve success.

The first alternative is to simply do nothing. Inaction will continue to perpetuate the oral health crisis, particularly for Iowa's most vulnerable population group: people of lower socioeconomic status. In this regard, there will continue to be a high unmet need for dental services and a need to perform more costly restorative treatment because prevention needs were not met.

The problem of dental access has been studied and debated in Iowa for a number of years. The most recent efforts in Iowa include a 1996 study, supported in part by the Department of Human Services, which assessed utilization of Medicaid dental services, dentists' attitudes about participation, and provided program recommendations. In 1997, the Iowa Dental Association also issued a report identifying reasons for nonparticipation by dentists in Iowa's Medicaid program. From 1997 to 2000, a Special Committee on Access to Dental Care, formed by the Iowa Department of Public Health (IDPH), met to discuss barriers to access to care and develop specific recommendations to improve access. From 2001 to April 2003, the Director's Dental Advisory Committee of IDPH performed this function. In January 2000 and April 2002, statewide dental summits were held. The departments of Public Health and Human Services have also worked collaboratively for several years in attempts to remedy the access problem.

Although efforts to identify and eliminate barriers to dental access have been on-going for many years, little progress has been made. A brief summary of the various recommendations to improve dental access that have been suggested by these various committees is presented below.

Medicaid reimbursement rates for dental care need to be increased. According to the General Accounting Office, low reimbursement is the number one factor contributing to a low provider participation rate in the Medicaid program. Although attempts to increase the rate in Iowa were made in July 2000, subsequent budget cuts and inflation have returned reimbursement levels to previous low levels. Increasing the reimbursement rates will require a substantial investment of budget funds by the state legislature.

With respect to the barrier concerning the perceived administrative burden in filing Medicaid claims, more can be done to communicate with providers regarding improvements in the process and further improvements could be studied. DHS reports that improvements have been made in the last few years in an attempt to reduce administrative requirements. Medicaid provider enrollment forms for dentists have been simplified to one double-sided page. Electronic billing and claims submission were adopted in 1997. Staff members of Medicaid's fiscal agent, ACS, are available by telephone to assist dental offices with policy, claims, and beneficiary eligibility information during the work week. An automated patient eligibility verification system is available 24 hours a day by toll-free telephone and field representatives are available to make on-site visits to dental offices to provide assistance on claim filing and other problems. The ADA's CDT dental codes and claim forms were adopted in 1998, updated to CDT-3 in 2000 and CDT-4 in 2003. In addition, the dental provider manual fee schedules may be viewed on the Internet.[70]

A large part of this problem may simply be provider perceptions. Data provided by the DHS actually shows that compared to other health providers, dentists have one of the lowest percentages of denied claims submitted to Medicaid. During fiscal year 2003, the Medicaid claims adjudication data shows that 12.69 percent of dental claims were denied. This rate compares to the total denied claims for all health professions of 19 percent.[71]

Although the processing time for dental claims is high compared to the other health professions, overall the rate is still relatively low – about 12 days. Data from other insurance companies was not available to compare processing rates between Medicaid and other insurance companies. However, 12 days does not seem excessive. It is also worth noting that dentists have the lowest rate of electronic billing compared to the other Medicaid providers. Only about 31 percent of dental claims were filed electronically. The rate of electronic dental claims is at least one-third lower than other health providers. The data provided showed that with only one exception, higher rates of electronic claims submission reduced the processing time of submitted claims.[72]

Alternatives that should be considered include further exploring ways to streamline the administrative process of filing claims, exploring ways to increase electronic submission of claims by dentists, and simply communicating program improvements to dentists. Perceptions of administrative requirements seem to have an important influence on the willingness of dentists to participate in Medicaid. More can be done to educate providers about improvements and try to change these negative perceptions.

Other alternatives to improve dental access that have been suggested by various groups, committees, and reports include the following:

- Expand the loan repayment program for dentists and dental hygienists. The Iowa Department of Public Health operates the Primary Care Recruitment and Retention Endeavor (PRIMECARRE) that currently supports the Iowa Loan Repayment Program, with matching federal and state funds. The Loan Repayment Program provides up to $20,000 per year for dentists and $15,000 per year for hygienists who agree to a two-year commitment to practice in a public or non-profit clinic in a dental shortage area.[73] The National Health Service Corps operates a similar federal program. However, both

programs have been hampered by a lack of available funds and a lack of dental applicants.[74]

- Consider "carving out" the dental insurance component of Medicaid and *hawk-i* to an established insurance company in Iowa. This would provide instant access to a very broad network of dentists for all Medicaid enrollees. According to the Dental Advisory Committee, this model is being successfully demonstrated in Michigan and appears to be one of the few successful models for improving access to care for Medicaid enrollees.
- Support legislation to give tax relief to dentists who provide services to Medicaid patients.
- Increase funding to further expand the school-based sealant programs.

Conclusion

The dental access problem has been debated and studied in Iowa and across the nation for many years, with little or no progress in the state of Iowa. Financial barriers seem to be a major limitation – most attempts to resolve the problem will require a substantial on-going commitment of public funds. With the difficult financial situation faced by the state legislature, there is only limited opportunity to fight the dental access problem using approaches that do not require a major commitment of public funds. Many states are seeking innovative approaches to combat dental access, like expanding the role of dental hygienists through public health supervision.

The Board's proposed amendment in ARC 2783B would allow a dentist to provide public health supervision to a dental hygienist who is operating within the scope of practice of dental hygiene in specified public health settings. This Board's proposed amendment was the result of one year of study and debate on this issue. The current amendment represents a compromise of previous rulemaking attempts. The Board's current proposal addresses many of the major concerns previously expressed by the Iowa Dental Association and their members. The Board tried, without success, to have the Iowa Dental Association and Iowa Dental Hygienist's Association resolve more specific concerns to their mutual satisfaction. When those attempts failed, the Board worked to develop a compromise proposal that ensured sufficient patient protections were established while facilitating access to preventive dental services in public health settings.

The Board acknowledges that its proposed amendment has a limited ability to address the dental access problem. However, the Board feels that its proposed amendment does address important barriers to access. By focusing on providing preventive services, access issues will be tackled by trying to reduce the need for more costly restorative dental treatment. The board's rules cannot address the real needs of patients—to find dental providers who are willing to accept new Medicaid patients and attend to their restorative treatment needs. Combating this problem will require action and commitment from the Iowa legislature. Given current budget realities, the Board's approach is a relatively low-cost method of removing some regulatory barriers to positively impact the ability of patients who do not otherwise have access to care to receive preventive oral health services.

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Attachment A: Iowa Dental Health Shortage Designations

Dental Health Care

1) Geographic Area - HPSA with a population to provider ratio of 5,000:1;
2) Special Population Group - HPSA measured by using the income rates of population below 200 percent of poverty and the physicians that participate in the Medicaid program. The ratio must be 4,000:1.

NOTE: Other qualifiers that may be used for eligibility for National Health Service Corps assignment are 50 percent non-fluoridated public water, population below 100 percent of poverty, and distance to the nearest source of care outside the designated area.

Dental Health Care Designations:
There are 73 counties with Dental Health Care designations. 72 are whole county; *1 is a census tract Low-Income Population designation.

01 - Adair	26 - Davis	53 - Jones	78 - Pottawattamie
02 - Adams	27 - Decatur	54 - Keokuk	79 - Poweshiek
03 - Allamakee	28 - Delaware	55 - Kossuth	80 - Ringgold
04 - Appanoose	29 - Des Moines	56 - Lee	81 - Sac
06 - Benton	32 - Emmet	58 - Louisa	82 - Scott
08 - Boone	33 - Fayette	60 - Lyon	83 - Shelby
10 - Buchanan	35 - Franklin	61 - Madison	84 - Sioux
11 - Buena Vista	37 - Greene	62 - Mahaska	86 - Tama
12 - Butler	39 - Guthrie	65 - Mills	87 - Taylor
13 - Calhoun	40 - Hamilton	67 - Monona	88 - Union
15 - Cass	42 - Hardin	69 - Montgomery	89 - Van Buren
16 - Cedar	43 - Harrison	71 - O'Brien	90 - Wapello
18 - Cherokee	44 - Henry	72 - Osceola	92 - Washington
20 - Clarke	45 - Howard	73 - Page	94 - Webster
21 - Clay	46 - Humboldt	74 - Palo Alto	95 - Winnebago
22 - Clayton	47 - Ida	75 - Plymouth	96 - Winneshiek
23 - Clinton	49 - Jackson	76 - Pocahontas	97 - Woodbury
24 - Crawford	51 - Jefferson	*77 - Polk	98 - Worth
			99 - Wright

Source: Iowa Department of Public Health, available at:
http://www.idph.state.ia.us/ch/health_care_access_content/rhpc/dental.htm

Attachment B: Administrative Rule Fiscal Impact Statement

Date: 08/29/2003

Agency: Board of Dental Examiners
IAC Citation: 650—10.5(153) – proposed new rule
Agency Contact: Jennifer Hart 1-0997

Summary of the Rule: Adopts new definition of public health supervision and allows performance of dental hygiene services prior to a dental exam in certain public health settings.

Fill in this box if the impact meets these criteria:

___ No Fiscal Impact to the State.
___ Fiscal Impact of less than $100,000 annually or $500,000 over 5 years.
___ Fiscal Impact cannot be determined.

Brief Explanation:

Fill in the form below if the impact does not fit the criteria above:

_x__ Fiscal Impact of $100,000 annually or $500,000 over 5 years.

* Fill in the rest of the Fiscal Impact Statement form.

Assumptions:

1. There is no way to estimate the impact to local public health programs and to clients who are not Medicaid-eligible, but do not have dental insurance or cannot otherwise access dental services in a private office. The number of these low income clients is unknown. Fiscal impact is provided only for Medicaid clients.
2. Preventive services are cheaper than restorative services, however, it is impossible to estimate the savings realized by preventing future restorative dental needs. For example, sealants may result in caries reduction. It costs Medicaid 19.40 per tooth for a sealant. A one-surface amalgam restoration is reimbursed at $43.65, up to $63.05 for four surfaces.
3. Only about 35% of Medicaid patients currently see a dentist. There were 120,717 Medicaid recipients for which a claim for dental services was paid during FY2003, out of 339,343 total Medicaid eligibles. Of these 172,958 were children and 71,019 were adults (excluding aged and disabled).
4. The proposed rules will not impact the aged Medicaid eligibles (36,872), as there are not currently public health programs operating in nursing homes, or the disabled group (58,494).
5. The rules will only impact hygiene services. It is unknown how many more clients will receive hygiene services and how many successful referrals for dental exams and treatment will result. A modest increase of between a 5 and 10 percent increase in clients for hygiene services is provided. Due to the limited number of hygienists currently providing services in public health settings (about 30), the smaller number of the range may be more realistic.
6. The services that will be impacted include screening assessments for adults and children [Medicaid reimbursement rate $13.19]; oral prophylaxis for adults [rate $33.95] and children [rate $23.28]; fluoride for children [$11.54], and sealants for children [$19.40 per tooth].
7. One screening and one prophy is assumed for each new adult client. One screening, one fluoride application, and one prophy is assumed for each child. It is unknown how many children already have sealants. However, FY2003 data from the Dept. of Public Health school based sealant program, shows that approximately 79% of children examined will need an average of 4.5 sealants placed on their primary teeth. This same rate of sealant placement in children will be assumed.
8. The number of Medicaid eligibles has grown every year. A 5% growth rate in eligibles is assumed.
9. All figures will be rounded to the nearest whole number.
10. The state/federal matching percentage for FY2003 was 63.34% federal funds to 36.66% state funds.
11. The rule will be effective January 1, 2004.

Describe how estimates were derived:

1. (Number of new clients with 5% increase) 172,958x.05 = 8,648 children; 71,019 x .05 = 3,551 adults
   (10% increase) 172,958x.05= 17,296 children; 71,019x.1= 7,102 adults
2. Adult services $13.19+33.95=$47.14 per adult x 3,551 = $167,394 with 5% increase
   Adult services $47.14 x 7,102 = $334,788 with 10% increase
3. Child services $13.19+23.28+11.54=$48.01 per child x 8,648 = $415,190 with 5% increase
   Child services $48.01 x 17,296 = $830,380 with 10% increase
4. Sealants for children – 8,648 x 79% = 6,832 children needing sealants with 5% increase;
   17,296 x 79% = 13,664 children needing sealants with 10% increase
5. Sealants placed $19.40/tooth x 4.5 sealants x 6,832 children=$596,434 sealant cost with 5% increase
   Sealants placed $19.40/tooth x 4.5 sealants x 13,664 children = $1,192,867 sealant cost with 10% inc.
6. Total costs year 1: $167,394+415,190+596,434= $1,179,018 with 5% increase
   Total costs year 1: $334,788+830,380+1,192,867= $2,358,035 with 10% increase
7. State share $1,179,018x36.66% = $432,228; fed share $746,790 with 5% increase
   State share $2,358,035x36.66% = $864,456; fed share $1,493,579 with 10% increase
8. Impact for FY2004 – divide figure above by half to determine impact for 6 months in FY2004.
   (432,228x.5=216,114 state; fed 746,790x.5=373,395 – 5% increase)
   (864,456x.5=432,228 state; fed 1,493,579x.5=746,790 – 10% increase)

9. Year 2 – assume additional 5% increase in Medicaid eligibles for adults and children
10. Costs of additional adult services: $167,394 x 1.05 = $175,764 to [334,788x1.05] $351,572
11. Costs of additional child services: $415,190 x 1.05 = $435,950 to [830,380x1.05] $871,899
12. Costs of additional sealants: $596,434 x 1.05 = $626,256 to [1,192,867x1.05] $1,252,510
13. Total costs year 2: 167,394+415,190+626,256= $1,237,970 to 2,475,981
14. Total state share year 2: $1,237,970 x 36.66% = 4453,840 to $907,695

Estimated Impact to the State by Fiscal Year

	Year 1 (FY 2004)	Year 2 (FY2005)
Revenue by Each Source:		
GENERAL FUND	0	0
FEDERAL FUNDS	0	0
Other (specify)	0	
TOTAL REVENUE	0	0
Expenditures:		
GENERAL FUND	216,114 to 432,228	453,840 - 907,695
FEDERAL FUNDS	373,395 to 746,790	784,130-1,568,286
Other (specify)		
TOTAL EXPENDITURES	589,509 - 1,179,018	1,237,970 to 2,475,981
NET IMPACT	($589,509 to $1,179,018)	($1,237,970 to $2,275,981)

___ This rule is required by State law or Federal mandate.
Please identify the state or federal law:

___ Funding has been provided for the rule change.
Please identify the amount provided and the funding source:

_x_ Funding has not been provided for the rule.
Please explain how the agency will pay for the rule change:
Medicaid funds are derived from a combination of federal and state funds.

Fiscal impact to persons affected by the rule:

The rule allows hygienists working in certain public health settings who have a supervisory agreement with a dentist to provide certain hygiene services prior to a dental exam. This will potentially increase access to services by both Medicaid eligible clients and other low income persons. This can increase access to preventive services in public health settings.

Fiscal impact to Counties or other Local Governments (required by Iowa Code 25B.6):
No impact

* If additional explanation is needed, please attach extra pages.

Agency Representative preparing estimate: Jennifer Hart
Telephone Number: 1-0997

ST. LUKE'S HOSPITAL
IOWA HEALTH SYSTEM

RECEIVED
JUN 3 0 2004
IOWA BOARD OF
DENTAL EXAMINERS

DENTAL HEALTH CENTER
MEDICAL PLAZA BLDG.
SUITE LL 1
855 A AVENUE NE
CEDAR RAPIDS, IA 52402
319 / 369-7730
FAX: 319 / 369-7494

June 25, 2004

Iowa Department of Public Health
Oral Health Bureau, 5th Floor
Attn: Public Health Supervision
321 E 12th St
Des Moines, IA 50319-0075

Dear Oral Health Bureau:

Our three public health dental hygienists have completed their Public Health Supervision Agreements.

Please take note that one agreement is 27 pages, another is 20 pages and the third is 10 pages. This was 57 pages of reporting, plus another 57 pages of copies for our dental public health program in East Central Iowa.

The process required considerable staff time. If this is an annual report, you must consider revising and limiting the agreement and reporting forms.

Sincerely,

Rhys B. Jones DDS

Rhys B. Jones, DDS, MS
Director, Dental Health Center

Cc: Iowa Board of Dental Examiners

RBJ/pb

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

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

Memo

From: Iowa Board of Dental Examiners

Date: October 2006

RE: Public Health Supervision – Providing Access to Oral Health Care

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As you know, access to oral health care is a critical need for the citizens in the state of Iowa. Seventy-two counties in Iowa are designated as dental health professional shortage areas. Public health supervision agreements are one of the innovative ways that the Iowa Department of Public Health and the Board of Dental Examiners are working together to create opportunities to improve the health of Iowans and increase access to oral health care services. Public health supervision agreements allow dental hygienists, working under a written supervision agreement with a dentist, to provide hygiene services to a patient in a public health setting, prior to the patient seeing a dentist for an exam.

The Oral Health Bureau of the Iowa Department of Public Health is responsible for collecting data concerning the services provided by dental hygienists working under public health supervision. The bureau has compiled data from calendar year 2005 showing the amount of services provided under public health supervision. The bureau provides a summary report to the board on an annual basis. A copy of this report is attached. The report shows that there were over 17,000 sealants provided under public health supervision last year. Almost 19,000 assessment/screenings were completed and over 6,000 people received fluoride varnish. Over 6,300 children received referrals to dentists during the year, with over 1,600 of those children needing urgent care. There were about 600 adult referrals and over 90 of those were for urgent care needs.

The report demonstrates that just a few licensees can make a tremendous difference in the oral health care of Iowans. The Board of Dental Examiners would like to draw your attention to the success of this program and ask for your support of public health supervision as an innovative way to increase access to oral health care services in Iowa.

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

Iowa Dental Hygienists' Association

October 15, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo;

This letter constitutes a petition to the Iowa Dental Board, pursuant to Administrative Rule 650-7.1, requesting an amendment to the current administrative rule regarding licensee responsibilities as part of public health supervision of dental hygienists, Administrative Rule 650-10.5(3). Paragraph (a)(3) of this rule requires a dentist to "(s)pecify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement." The proposed amendment would strike this requirement and replace it with a requirement on dental hygienists in paragraph (b) that the dental hygienist refer to a dentist each patient who receives treatment.

This proposed amendment is being submitted for the following reasons: (1) it will remove a barrier to preventive dental services and (2) it would make Iowa's law regarding access to public health services more consistent with other states. As the Dental Board is aware, the public health supervision program for dental hygienists has been very successful in expanding access to quality dental care to Iowans, especially low-income families. According to statistics collected by the Iowa Department of Public Health, nearly 19,000 patients were served by this program in 2005, and by 2007, that figure had grown to nearly 35,000, almost a 100% increase. The number of hygienists providing services in public health settings has also grown, from 21 in 2005 to 56 in 2007; the number of dentists participating in this program has also grown significantly.

Removing a barrier to Preventive Dental Services

However, the current requirement that patients participating by this program be examined by a dentist within no longer than twelve months after receiving treatment serves as a significant barrier to patients receiving the continued benefit of this program. Hygienists

practicing in a public health setting have experienced significant difficulty in determining whether this requirement has been met as they do not provide the examination. Additionally, at a recent dental summit, two school based sealant programs expressed concern that children who would benefit from additional sealants would be denied due to the annual exam requirement. For example, children receiving sealants as a 2nd grader prior to all teeth fully erupting are now ready in third grade have the rest of the teeth sealed, but lacking proof of exam, are not eligible to receive preventive services.

Sealant programs have addressed this by rotating dentists annually to differ sites so all would have an exam at least once a year. However this rotational system does not always work due to the child being absent during the time the dentist was examining or changing schools to a site where the dentist is not in the rotation to perform exams.

Consistency with Laws in other States

Iowa's dental examination requirement is not consistent with laws in other states regarding direct access to dental hygiene services. According to the American Dental Hygiene Association, twenty-eight states, including Iowa, allow for some sort of direct access to hygiene services. Among those twenty-eight states, Iowa currently is one of only five states which place a limit on continuation of preventive services. In contrast, six other states, including Maine, Montana, New Mexico, Oregon, Rhode Island, and Washington, have a referral requirement such as is being proposed in this petition.

At an oral health summit hosted earlier this year by the Iowa Public Health Association, the current exam requirement was identified as a major barrier to access to oral health preventive services, and there was strong support at this summit to replace this requirement with a referral requirement similar to what is proposed in this petition. Additionally, the Oral Health Bureau of the Iowa Department of Public Health has included this change in their policy recommendations for this year. This change is supported, as well, by the Iowa Prevention of Disabilities Council.

As President of the Iowa Dental Hygienists Association, I appreciate the board's consideration of this petition.

Sincerely,

Carol Van Aernam

Carol Van Aernam, President
Iowa Dental Hygienists Association

Hart, Jennifer [IBDE]

From: TOM COPE [tomwcope@msn.com]
Sent: Wednesday, October 22, 2008 8:53 AM
To: Hart, Jennifer [IBDE]
Subject: IDHA petition for Nov. 28 DH Committee meeting
Attachments: direct_access summary.pdf; Oral Health Bureau 1.jpg

Jennifer-

Later this morning, Carol Van Aernam, President of IDHA, will be faxing to you a petition to the DH Committee requesting a change in IDB rules as it relates to public health supervision of DHs. As we have discussed, IDHA would like to initiate consideration of this petition at the Nov. 28 meeting of the DH committee. In addition to Carol's petition, I am attaching a couple of documents that we request be sent to the members of the DH Committee:
(1) A summary compiled by the ADHA of various state laws/rules regarding direct access to patients for DHs
(2) A copy of IDPH's Oral Health Bureau's current policy recommendations--policy change #3 is consistent with Carol's petition.

I will give you a call this morning to discuss this.

Thanks!

Tom

Tom Cope
Avenson, Oakley & Cope
8532 Newbury Court
Johnston, IA 50131
515-278-7074-home
515-975-4590-mobile
tomwcope@msn.com

Iowa Department of Public Health - Oral Health Bureau Update
Tracy Rodgers, Community Health Consultant

I-Smile
Funding from DHS increased this year for the 23 Title V child health contracts. Agencies will receive $1,716,432 for SFY2009. The funding is distributed based on size of service area and Medicaid-enrolled children. Refer to the attachment for examples of activities provided by I-Smile coordinators.

OHB staff is working with Iowa Medicaid Enterprise to evaluate I-Smile. Specific data queries have been requested to review efficacy and impact. Dolores Malvitz, an epidemiologist formerly with CDC, is providing guidance to OHB on the evaluation measures.

School Dental Screening Requirement
This is the first school year that Iowa children are required to have proof of a dental screening prior to enrolling in kindergarten and ninth grade. Information and forms are available on the IDPH Website, trainings are being held, and there has been quite a bit of media coverage.

Local boards of health are responsible for audits – and I-Smile Coordinators are expected to coordinate systems within their service regions to assure completion of audits, reporting to boards of health, and reporting to IDPH. I-Smile Coordinators will also be integral in assisting families in having screenings completed.

Oral Health Bureau Codification
The administrative rules written to codify the Oral Health Bureau have been suspended. The Iowa Dental Association protested the definition of a dental home as written within the rules. The IDA opposes the inclusion of "nondental public and private health care professionals" in the definition. The legislature's Administrative Rules Review Committee agreed to suspend adoption of the rules, asking the IDPH and IDA to come to an agreement on the definition of a dental home.

Oral Health Policy Recommendations
1. Increase funding for the I-Smile dental home project to expand the dental workforce and increase preventive services for underserved children; to double Medicaid's preventive reimbursement for eligible providers; to allow physicians and primary care providers to bill for dental screenings outside of the EPSDT bundled well-child exam rate; and to improve Medicaid dental reimbursement rates or use a 3rd party billing system
2. Reinstate a 4-year bachelor's degree dental hygiene program in Iowa with public health service emphasis
3. Seek rules change by Iowa Dental Board for public health supervision to allow a dental hygienist to refer a patient to see a dentist, but not limit continued treatment if dental visit had not occurred within one year
4. Integrate oral health planning into the medical home initiative

DIRECT ACCESS STATES

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

Alaska 2008

AS 08.32.115

May provide services according to terms of collaborative agreement. No limit on settings. Dentist need not examine, diagnose, or be present.

Special requirements: 4,000 hours experience last 5 years. Board must approve collaborative agreement.

Services: Virtually entire scope of dental hygiene services, as long as agreement provides for them.

Arizona 2006

32-1289B

Dental hygienist working under contract for schools, public health settings and institutions may screen and apply fluoride unsupervised.

Arizona 2004

Sec. 32-1281 H, 3212-89

A dental hygienist with a written affiliated practice agreement with a dentist may assess for and perform dental hygiene services on patients under 18 years who meet certain financial criteria and are enrolled in a federal, state, county or local healthcare program

Special requirements: 5 years practice

Services: Any dental hygiene services specified in the affiliated practice agreement except root planing, local anesthesia, nitrous oxide or placing sutures.

- **Direct Medicaid reimbursement allowed.**

California 2002

Sec 1763 (a) 2002

Any dental hygienist may provide screening, apply fluorides and sealants without supervision in government created or administered public health programs.

California 1998

Sec. 1774, 1775

Dental hygienists endorsed as RDHAPs (registered dental hygienist in alternative practice) may provide services without supervision for homebound persons or at schools, residential facilities, institutions and in dental health professional shortage areas for up to 18 months, and provide further services if the patient obtains a prescription from a dentist or physician. RDHAP'S may own an alternative dental hygiene practice. Currently, there are more than 100 RDHAP's.

Special Requirements: Bachelors degree equivalent, 3 years clinical practice, completion of 150 clock hour special course and exam.
Services: Those services permitted under general supervision (which include oral prophylaxis, root planing, pit and fissure sealants, charting and examination of soft tissue).

- **In 2008, more than 200 RDHAP's registered.**
- **A dental hygienist mobile practice treats 25-35 disabled patients per week.**
- **Direct Medicaid reimbursement allowed.**

Colorado 1987

Sec. 12-35-122.5

Unsupervised practice in all settings for all licensed dental hygienists for the oral prophylaxis and preventive and therapeutic services. The dental hygienist may also own a dental hygiene practice.

Special Requirements: None.

Services: remove deposits, accretions, and stains, curettage without anesthesia, apply fluorides and other recognized preventive agents, oral inspection and charting, topical anesthetic. However, x-rays require general supervision and local anesthesia requires direct supervision.

- **Direct Medicaid reimbursement allowed. In fiscal year 2003-04, 16 independent RDH's provided 199,518 in services to 2,284 Medicaid children.**

Connecticut 1999

Section 20-126l

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

Special Requirements: 2 years experience.

Services: Oral prophylaxis, remove deposits, accretions and stains, root planning, sealants, assessment, and treatment planning.

- **Since 7/1/2003 hygienists have program has provided over 55,000 dental procedures – nearly 7,000 prophys/fluorides, 5,800 sealants and 15,000 exams.**
- **Direct Medicaid reimbursement allowed.**

Idaho 2004

I.C. 54-903 (9) / 54-904

Can provide services in hospitals, long term care facility, public health facility, health or migrant clinic or other board approved setting if dentist affiliated with setting authorizes services.

Special requirements: RDH must be an employee of the facility or obtain extended care permit. ECP requires 1,000 hours experience in last 2 years.

Services: As determined by authorizing dentist.

Iowa 2004

Rule 650-10.5 (153)

Dental hygienists may provide services based on standing orders and a written agreement with a dentist in schools, Head Start settings, FQHCs (Federally Qualified Health Centers), public health vans, free clinics, community centers and public health programs.
Special Requirements: RDH must have 3 years clinical experience and submit annual report on number of patients/services to department of health.

Services: All dental hygiene services (except local anesthesia and nitrous) may be provided once to each patient. To perform repeat services other than assessment, screening and fluoride, dentist must examine.

- **Active Public Health Supervision agreements in place between Iowa dentists and dental hygienists.**
- **Services in 2005: 17,332 clients received sealants, 18,942 received screenings, 6,098 received fluoride applications, over 281 received prophys, and 7,157 received education.**
- **As of 2007, 24 public health RDHs.**

Kansas 2003

Sec. 65-1456

Dental hygienist with an extended care permit I or II to treat patients in schools, head start programs, state correctional institutions, local health departments, indigent care clinics, adult care homes, hospital long term units, or at the home of homebound persons on medical assistance. No prior authorization is needed, but the hygienist must have an agreement with a sponsoring dentist who will monitor his/her practice.

Special requirements: 1,800 hours experience

Services: prophylaxis, application of fluoride, dental hygiene instruction, assessment of the patient's need for further treatment by a dentist and other services if delegated by the sponsoring dentist

- **As of 2007, there were 76 extended care permit dental hygienists.**

Maine 2008

Sec. B-1. 32 MRSA c. 16, sub-c. 3-B

A dental hygienist licensed as an independent practice dental hygienist may practice without supervision by a dentist in all settings.

Special Requirements: Possess a bachelor's degree from a CODA accredited dental hygiene program and 2,000 work hours of clinical practice in a private dental practice during the two years preceding the application or possess an associate degree from a CODA accredited dental hygiene program and 6,000 work hours of clinical practice in a private dental practice during the six years preceding the application. They are also required to provide a referral plan to patients in need of additional care by a dentist.

Services: Interview patients and record complete medical and dental histories; take and record the vital signs of blood pressure, pulse and temperature; perform oral inspections, recording all conditions that should be called to the attention of a dentist; perform complete periodontal and dental restorative charting; perform all procedures necessary for a complete prophylaxis, including root planing; apply fluoride to control caries; apply desensitizing agents to teeth; apply topical anesthetics; apply sealants; smooth and polish amalgam restorations, limited to slow speed application only; cement pontics and facings outside the mouth; take impressions for athletic mouth guards and custom fluoride trays; place and remove rubber dams; place temporary restorations in compliance with the protocol adopted by the board; and apply topical antimicrobials, excluding antibiotics, including fluoride, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The independent practice dental hygienist shall follow current manufacturer's instructions in the use of these medicaments.

Maine 2001
Rule 02 313 Chap. 1. Sec. 4
A dental hygienist may practice in a public or private school, hospital or other non-traditional practice setting under a public health supervision status granted by the dental board on a case-by-case basis. The hygienist may perform all services rendered under general supervision. The dentist should have specific standing orders and procedures to be carried out, although the dentist need not be present when the services have been provided. A written plan for referral or an agreement for follow-up shall be provided by the public health hygienist recording all conditions that should be called to the attention of the dentist. The supervising dentist shall review a summary report at the completion of the program or once a year.

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

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

- **From 3/02 through 10/04, over 5,500 patients were provided care in over 400 clinics. Nearly 30 dental hygienists are involved in this particular program.**
- **Direct Medicaid reimbursement allowed.**

Michigan 1991
Sec. 333.16625
A dental hygienist may administer dental hygiene services for a 2 year period to patients not assigned by a dental through a department of community Health designed "grantee health agency. Grantee health agencies must be a public or nonprofit entity, school, or nursing home that employs or contacts with at least one dentist or dental hygienist and provides care to an underserved population.

Special requirements: Entities seeking a grantee health agency status must submit a comprehensive form outlining how the program will be carried out, providing for oversight and direction, and including information for all dental personnel involved. A dental hygienist operating as a grantee health agency must ensure that the supervising dentist is available for consultation when necessary.

Services: those permitted under general supervision.

Minnesota 2001
Section 150A. 10, subd. 1a
A dental hygienist may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services without the patient first being examined by a licensed dentist if the dental hygienist has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

Health care facility is defined as a hospital, nursing home, home health agency, disabled/juvenile home, federal/state/local public health facility, community clinic, prison, tribal clinic school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.
A collaborative agreement means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services may be performed without the presence of a licensed dentist and may be performed at a setting other than the usual place of practice of the dentist or dental hygienist and without the dentist's diagnosis/treatment plan unless specified in the agreement.

Special Requirements: Has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years. Has documented participation in courses in infection control and medical emergencies within each continuing education cycle and maintains current certification in advanced or basic cardiac life support as recognized by the American Heart Association, the American Red Cross, or another agency that is equivalent to the American Heart Association or the American Red Cross.

Services: Removal of deposits and stains from the surfaces of the teeth, application of topical preventive and prophylactic agents, sealants, fluoride varnishes, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking x-rays and root planing.

- **There are now 2 dental hygienists volunteering in a community dental clinic providing restorative and preventive services to at least 10 patients each day they volunteer.**
- **At least 25 dental hygienists had qualified for collaborative practice in 2006.**
- **Direct Medicaid reimbursement allowed.**

Missouri 2001
Statute 332.311.2
Dental hygienists may provide services without supervision in public health settings to Medicaid eligible children and be directly reimbursed by Medicaid.

Special Requirements: 3 years experience.

Services: Oral prophylaxis, sealants, fluorides.

- **One particular dental hygienist has seen a sealant program grow from one school district to eight. Over 2,500 sealants have been placed on over 700 children.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, were 12 registered providers.**

Montana 2003
Sec. 37-4-405
Dental hygienists may obtain a limited access permit from the board allowing them to practice under public health supervision in a variety of federally funded health centers and clinics, nursing homes, extended care facilities, home health agencies, group homes for the elderly, disabled, and youth, head start programs, migrant work facilities and local and state public health facilities. Public health supervision means the hygienist can provide oral prophylaxis, fluoride, polish restorations, root plane, sealants, oral cancer screening, expose radiographs, and chart without the authorization of a dentist provided he or she follows protocols to be established by the board and refers any patients needing dental treatment.

- **Program took effect in September of '04, 10 permits in '06.**

Nebraska 2007
Sec. 71-193.18
The Department of Health may authorize an unsupervised RDH to provide public health related services in a public health setting or a healthcare or related facility.

Special requirements: 3000 hours experience in at least 4 of last 5 years; professional liability insurance.

Services: Prophylaxis for a health child, pulp vitality testing, preventive measures including fluorides & sealants.

New Hampshire 1993
Rule 302.02(d); 402.01 (c)
Under public health supervision dental hygienists may provide procedures authorized by a dentist in a public or private school, hospital or institution, or residence of a homebound patient provided the dentist reviews patient records once in a 12 month period.

Special Requirements: None.

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

New Mexico 2007
Sec. 61-5-C
No supervision required for any dental hygienist to apply fluorides, and remineralization agents.

New Mexico 1999
Sec. 61-5A-4D
Rule 16.5.17
Collaborative practice permits [based on a written agreement between the dental hygienist and one or more consulting dentist(s)], dental hygienists to treat patients according to a protocol with collaborative dentist. Dental hygienists may own or manage a collaborative dental hygiene practice in any setting. Must refer patient for dental exam yearly.

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

Services: Each collaborative practice agreement must contain protocols for care. Which provide for standing orders allowing the dental hygienist to provide routine services such as preliminary assessment, x- rays, oral prophylaxis and fluoride treatment without prior authorization. Case-by-case authorization required in some procedures (as sealants and root planning).

- **One collaborative practice arrangement that started in 2002, serves a base of 4,000 people-1/3 of which are Medicaid eligible.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, there were 35 collaborative practice RDHs.**

New York 2005
Rules Sec. 61.9
That a supervising dentist be available for consultation, diagnosis and evaluation, has authorized the dental hygienist to perform the services, and exercises that degree of supervision appropriate to the circumstances. A dental hygienist can work in any setting (private or public) and perform dental hygiene duties (listed below) without a dental examination or need to refer a patient to a dentist.

Dental hygiene services allowed include removing calcareous deposits, accretions and stains, including scaling and planning of exposed root surfaces; applying topical agents indicated for a complete dental prophylaxis; removing excess cement from surfaces of the teeth; providing patient education; placing and exposing X-ray films; performing topical anticariogenic agent applications, including but not limited to topical fluoride applications, and performing topical anesthetic applications; polishing teeth, including existing restorations; taking medical history including the measuring and recording of vital signs; charting caries and periodontal conditions

as an aid to diagnosis by the dentist; applying pit and fissure sealants; and applying desensitizing agents to the teeth.

In nursing homes a hygienist can perform a complete oral examination of a resident and then determine treatment priorities; plan for continuing oral hygiene and dental care.

- **In 2005, dental hygienists have screened and provided sealants for over 30,000 children.**
- **About 100,000 children in New York received care in school-based programs overseen by dental hygienists.**

Nevada 1998

Sec. 631.287

Dental hygienists may obtain approval to work as public health dental health hygienists in schools, community centers, hospitals, nursing homes and such other locations as the state dental health officer deems appropriate without supervision.

- **33 RDH's have gained board approval. Nevada Health Centers, Inc. where some RDH's are employed, provides services in eighteen different locations in Nevada. Dental hygienists with Public Health endorsement can also screen and place sealants without a dentist present. Additional locations include Saint Mary's, Huntridge Teen Center & Lyon Co. Healthy Smiles.**
- **Direct Medicaid reimbursement allowed.**

Oklahoma 2003

Sec. 328.34 C

A dentist may authorize in writing a dental hygienist to perform services one time on a patient in a setting outside the office prior to any dentist contact/exam if the hygienist refers the patient back to the authorizing dentist.

Special Requirements: 2 years experience

Oregon 1997

Sec. 680.200

Rule 818-035-0065

Dental hygienists who have obtained a limited access permit (LAP) may initiate services for patients in a variety of limited access settings such as extended care facilities, facilities for the mentally ill or disabled, correctional facilities, schools and pre-schools, and job training centers. RDH must refer the patient annually to a licensed dentist available to treat the patient.
12 hours of CE every two years (in addition to the 24 hours required for all dental hygienists) to renew permit.

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

- **In 2006, there were 70 LAP's.**
- **In the last year, LAP dental hygienists in 3 counties provided over 5,000 preventative procedures for children in Head start, Early Head start, WIC public health settings.**
- **Several LAP hygienists throughout Oregon continue to build practices serving the elderly in foster homes and extended care facilities.**
- **Direct Medicaid reimbursement allowed.**

Pennsylvania 2007

(Act 216) Sec. 2 (Definitions)

Dental hygienists licensed in Pennsylvania can practice as "public health dental hygiene practitioners," providing care in a variety of public health settings without the supervision or prior authorization of a dentist. Public health dental hygiene practitioners are required to take five hours of continuing education dedicated to public health matters during each licensure period.

Special requirements: 3,600 hours expense, liability insurance. Must complete 5 hours of CE in public health during each licensure period.

Services: educational, preventive, therapeutic, and intra-oral services, including complete prophylaxis and sealants, dental hygienists in the state are authorized to provide.

Rhode Island 2006

Sec. 5-31.1-6.1

Dental hygienists working under a dentist's general supervision can initiate dental hygiene treatment to residents of nursing facilities. Dental hygienists working in nursing facilities can treat patients, regardless of whether or not the patient is a patient of record, as long as documentation of services administered is maintained and necessary referrals for follow-up treatment are made.

Special requirements: None.

Services: Initial oral health screening assessments, prophylaxis, fluoride treatments, charting, and other duties delegable under general supervision.

South Carolina 2003

Sec. 40-15-110 (A) (10)

Dental hygienists employed by or contacted through the Department of Health and Environment Control may provide services under general supervision that does not require prior examination by a dentist in settings such as schools or nursing homes.

Special requirements: Dental hygienist must carry professional liability insurance.

Services: Prophylaxis, fluorides, sealants

Texas 2001

Sec. 262.1515

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

Special Requirements: 2 years practice experience.

Services: No limitations.

Vermont 2008

Rule 10.2

Dental hygienists may provide hygiene services in public health settings under the supervision of a dentist via a general supervision agreement. The agreement authorizes the dental hygienist to provide services, agreed to between the dentist and the dental hygienist. The agreement does not require physical presence of the dentist but it stipulates that the supervising dentist review all patient records.

Special Requirements: Three years licensed clinical practice experience and in good standing in Vermont.

Services: Sealants, fluoride varnish, prophylaxis and x-rays. Periodontal maintenance and root planing may be provided on patients with mild periodontitis.

Washington 2001 (Washington has two different provisions for direct access)

Sec. 18.29.220

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

Special Requirements: Sealant/Fluoride Varnish Endorsement from Department of Health.

- **Data obtained through Medicaid indicates that dental hygienists working under these provisions saw 5,653 clients in 2002; 6,799 in 2003, and 4,265 through July of '04. Specifically in terms of sealants, over 19,200 sealants have been placed since Dec. 2003.**
- **Direct Medicaid reimbursement allowed.**

Washington 1984

Sec. 18.29.056

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

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

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

West Virginia 2008

§5-1-8.5

Dental hygienists, who meet specific requirements, may provide dental hygiene services without the supervision of a dentist in hospitals, schools, correctional facilities, jails, community clinics, long term care facilities, nursing homes, home health agencies, group homes, state institutions under the Department of Health and Human Resources, public health facilities, homebound settings and Accredited Dental Hygiene Education programs.

Special requirements: 2 years and 3,000 hours of clinical dental hygiene experience; six additional continuing education hours this must include 3 hours in medical emergencies and 3 hours in general public health content. The dental hygienist and supervising dentist must submit an annual report to the West Virginia Board of Dental Examiners of services rendered.

Services: Dental hygiene education; nutritional counseling; oral screening with referral to dentist; apply fluoride; charting; recording medical history; complete prophylaxis (upon written prescription from a licensed dentist).

Wisconsin 2008

Wisconsin. Sec. 447.06

The statute does not require the presence or general supervision of a dentist in a public or private school, a dental or dental hygiene school or a facility owned by a local health department.

Price, Constance [IBDE]

From: Hart, Jennifer [IBDE]
Sent: Wednesday, November 26, 2008 11:50 AM
To: Larry Carl; jvlegs@hotmail.com; ensey4@yahoo.com
Cc: cvanaernam@aol.com; Price, Constance [IBDE]
Subject: Dental Hygiene Petition - Comments requested
Attachments: DH Petition NewNov08.pdf

Attached is a copy of a petition for rulemaking and supporting documents submitted by the Iowa Dental Hygienists' Association concerning public health supervision. I am forwarding a copy of this information to the associations to give you an opportunity to submit written comments on the petition for board consideration.

The petition will be considered by the Iowa Dental Board at their January 15, 2009, meeting. To give the board time to review your comments, it would be helpful for your to submit them no later than Monday, December 22. Comments may be submitted via mail to the board address or may be e-mailed to my attention. Please note that if the board chooses to grant the petition and initiates rulemaking, a public hearing will be scheduled and there will be an additional opportunity to submit written comments.

Jennifer Hart, Executive Officer
Iowa Dental Board
400 SW 8th St, Suite D
Des Moines, IA 50309
☎Phone (515) 281-0997 ☎Fax (515) 281-7969
http://www.dentalboard.iowa.gov

BE GREEN: Please consider the environment before printing this email.

Iowa Dental Hygienists' Association

November 25, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo;

This letter constitutes a petition to the Iowa Dental Board, pursuant to Administrative Rule 650-7.1, requesting an amendment to the current administrative rule regarding licensee responsibilities as part of public health supervision of dental hygienists, Administrative Rule 650-10.5(3). Paragraph (a)(3) of this rule requires a dentist to "(s)pecify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement." The proposed amendment would strike this requirement.

This proposed amendment is being submitted for the following reasons: (1) it will remove a barrier to preventive dental hygiene services and (2) it would make Iowa's law regarding access to public health services more consistent with other states. As the Dental Board is aware, the public health supervision program for dental hygienists has been very successful in expanding access to quality dental care to Iowans, especially low-income families. According to statistics collected by the Iowa Department of Public Health, nearly 19,000 patients were served by this program in 2005, and by 2007, that figure had grown to nearly 35,000, almost a 100% increase. The number of hygienists providing services in public health settings has also grown, from 21 in 2005 to 56 in 2007; the number of dentists participating in this program has also grown significantly.

A recent study conducted at the Black Hawk County school-based dental sealant program demonstrates how dental hygienists working in a public health setting are making dramatic improvements in the oral health of children in that county. In the four years prior to allowing public health supervision, 1590 screenings were conducted. In the four years since screenings were able to be conducted by dentists and dental hygienists, the

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number of screenings increased to 2046, nearly a 33% increase. Over that same time-period, the number of children receiving dental sealants also increased by nearly 10%.

The study also shows the benefit of additional screenings and sealant applications. Eighth graders who had previously participated in the dental sealant program had 7.6% of their teeth demonstrating a history of caries, compared to 20.3% for those children who did not previously participate.

Removing a barrier to Preventive Dental Services

As shown above, the current dental hygiene public health supervision program is helping expand access to quality dental care. However, the current requirement, that patients participating in this program must be examined by a dentist within no longer than twelve months after receiving treatment, serves as a significant barrier to patients receiving the continued benefit of this program. Hygienists practicing in a public health setting have experienced significant difficulty in determining whether this requirement has been met as they do not provide the examination.

Additionally, at a recent dental summit, two school based sealant programs expressed concern that children who would benefit from additional sealants would be denied due to the annual exam requirement. For example, children receiving sealants as a 2nd grader prior to all teeth fully erupting are now ready in third grade have the rest of the teeth sealed, but lacking proof of exam, are not eligible to receive preventive services.

The study of Black Hawk County schoolchildren again shows the problem of lack of access. When follow-up screenings were conducted on 3rd, 4th, and 5th graders, nearly 47% had not received dental treatment since either their previous screening or sealant application. Under the current administrative rules, those 47% of children would not be able to receive many continuing preventive services from dental hygienists, including the application of additional sealants.

Attached are letters from Jen Badger and Joyce Miller, two dental hygienists who practice in public settings that outline their real world experiences and how adopting this petition would improve access to quality dental care.

Consistency with Laws in other States

Iowa's dental examination requirement is not consistent with laws in other states regarding direct access to dental hygiene services. According to the American Dental Hygiene Association, twenty-eight states, including Iowa, allow for some sort of direct access to hygiene services. Among those twenty-eight states, Iowa currently is one of only five states which place a limit on continuation of preventive services. In contrast, six other states, including Maine, Montana, New Mexico, Oregon, Rhode Island, and Washington, have a referral requirement such as is being proposed in this petition.

At an oral health summit hosted earlier this year by the Iowa Public Health Association, the current exam requirement was identified as a major barrier to access to oral health preventive services, and there was strong support at this summit to replace this

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requirement with a referral requirement similar to what is proposed in this petition. Additionally, the Oral Health Bureau of the Iowa Department of Public Health has included this change in their policy recommendations for this year. This change is supported, as well, by the Iowa Prevention of Disabilities Council.

As President of the Iowa Dental Hygienists Association, I want it understood that dental hygienists believe in and recognize the important role that dentists and dental exams play in providing quality dental health care to Iowans. As is stated in Jen Badger's letter, dental hygienists working in a public health setting work very hard to match up their patients with a dentist who can provide an exam and needed additional care.

However, when an exam is not able to be conducted, which as the Black Hawk County data demonstrates quite often occurs, it is important that barriers to quality dental care be removed. IDHA believes strongly that this petition would accomplish that objective, and we appreciate the board's consideration of this request.

Sincerely,

Carol Van Aernam

Carol Van Aernam, President
Iowa Dental Hygienists Association

IOWA DEPARTMENT OF PUBLIC HEALTH - ORAL HEALTH BUREAU UPDATE
Tracy Rodgers, Community Health Consultant

I-Smile
Funding from DHS increased this year for the 23 Title V child health contracts. Agencies will receive $1,716,432 for SFY2009. The funding is distributed based on size of service area and Medicaid-enrolled children. Refer to the attachment for examples of activities provided by I-Smile coordinators.

OHB staff is working with Iowa Medicaid Enterprise to evaluate I-Smile. Specific data queries have been requested to review efficacy and impact. Dolores Malvitz, an epidemiologist formerly with CDC, is providing guidance to OHB on the evaluation measures.

School Dental Screening Requirement
This is the first school year that Iowa children are required to have proof of a dental screening prior to enrolling in kindergarten and ninth grade. Information and forms are available on the IDPH Website, trainings are being held, and there has been quite a bit of media coverage.

Local boards of health are responsible for audits – and I-Smile Coordinators are expected to coordinate systems within their service regions to assure completion of audits, reporting to boards of health, and reporting to IDPH. I-Smile Coordinators will also be integral in assisting families in having screenings completed.

Oral Health Bureau Codification
The administrative rules written to codify the Oral Health Bureau have been suspended. The Iowa Dental Association protested the definition of a dental home as written within the rules. The IDA opposes the inclusion of "nondental public and private health care professionals" in the definition. The legislature's Administrative Rules Review Committee agreed to suspend adoption of the rules, asking the IDPH and IDA to come to an agreement on the definition of a dental home.

Oral Health Policy Recommendations
1. Increase funding for the I-Smile dental home project to expand the dental workforce and increase preventive services for underserved children; to double Medicaid's preventive reimbursement for eligible providers; to allow physicians and primary care providers to bill for dental screenings outside of the EPSDT bundled well-child exam rate; and to improve Medicaid dental reimbursement rates or use a 3rd party billing system
2. Reinstate a 4-year bachelor's degree dental hygiene program in Iowa with public health service emphasis
3. Seek rules change by Iowa Dental Board for public health supervision to allow a dental hygienist to refer a patient to see a dentist, but not limit continued treatment if dental visit had not occurred within one year
4. Integrate oral health planning into the medical home initiative

DIRECT ACCESS STATES

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

Alaska 2008
AS 08.32.115
May provide services according to terms of collaborative agreement. No limit on settings. Dentist need not examine, diagnose, or be present.

Special requirements: 4,000 hours experience last 5 years. Board must approve collaborative agreement.

Services: Virtually entire scope of dental hygiene services, as long as agreement provides for them.

Arizona 2006
32-1289B
Dental hygienist working under contract for schools, public health settings and institutions may screen and apply fluoride unsupervised.

Arizona 2004
Sec. 32-1281 H, 3212-89
A dental hygienist with a written affiliated practice agreement with a dentist may assess for and perform dental hygiene services on patients under 18 years who meet certain financial criteria and are enrolled in a federal, state, county or local healthcare program

Special requirements: 5 years practice

Services: Any dental hygiene services specified in the affiliated practice agreement except root planing, local anesthesia, nitrous oxide or placing sutures.

- **Direct Medicaid reimbursement allowed.**

California 2002
Sec 1763 (a) 2002
Any dental hygienist may provide screening, apply fluorides and sealants without supervision in government created or administered public health programs.

California 1998
Sec. 1774, 1775
Dental hygienists endorsed as RDHAPs (registered dental hygienist in alternative practice) may provide services without supervision for homebound persons or at schools, residential facilities, institutions and in dental health professional shortage areas for up to 18 months, and provide further services if the patient obtains a prescription from a dentist or physician. RDHAP'S may own an alternative dental hygiene practice. Currently, there are more than 100 RDHAP's.

Special Requirements: Bachelors degree equivalent, 3 years clinical practice, completion of 150 clock hour special course and exam.
Services: Those services permitted under general supervision (which include oral prophylaxis, root planing, pit and fissure sealants, charting and examination of soft tissue).

- **In 2008, more than 200 RDHAP's registered.**
- **A dental hygienist mobile practice treats 25-35 disabled patients per week.**
- **Direct Medicaid reimbursement allowed.**

Colorado 1987

Sec. 12-35-122.5

Unsupervised practice in all settings for all licensed dental hygienists for the oral prophylaxis and preventive and therapeutic services. The dental hygienist may also own a dental hygiene practice.

Special Requirements: None.

Services: remove deposits, accretions, and stains, curettage without anesthesia, apply fluorides and other recognized preventive agents, oral inspection and charting, topical anesthetic. However, x-rays require general supervision and local anesthesia requires direct supervision.

- **Direct Medicaid reimbursement allowed. In fiscal year 2003-04, 16 independent RDH's provided 199,518 in services to 2,284 Medicaid children.**

Connecticut 1999

Section 20-126l

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

Special Requirements: 2 years experience.

Services: Oral prophylaxis, remove deposits, accretions and stains, root planning, sealants, assessment, and treatment planning.

- **Since 7/1/2003 hygienists have program has provided over 55,000 dental procedures – nearly 7,000 prophys/fluorides, 5,800 sealants and 15,000 exams.**
- **Direct Medicaid reimbursement allowed.**

Idaho 2004

I.C. 54-903 (9) / 54-904

Can provide services in hospitals, long term care facility, public health facility, health or migrant clinic or other board approved setting if dentist affiliated with setting authorizes services.

Special requirements: RDH must be an employee of the facility or obtain extended care permit. ECP requires 1,000 hours experience in last 2 years.

Services: As determined by authorizing dentist.

Iowa 2004

Rule 650-10.5 (153)

Dental hygienists may provide services based on standing orders and a written agreement with a dentist in schools, Head Start settings, FQHCs (Federally Qualified Health Centers), public health vans, free clinics, community centers and public health programs.
Special Requirements: RDH must have 3 years clinical experience and submit annual report on number of patients/services to department of health.

Services: All dental hygiene services (except local anesthesia and nitrous) may be provided once to each patient. To perform repeat services other than assessment, screening and fluoride, dentist must examine.

- **Active Public Health Supervision agreements in place between Iowa dentists and dental hygienists.**
- **Services in 2005: 17,332 clients received sealants, 18,942 received screenings, 6,098 received fluoride applications, over 281 received prophys, and 7,157 received education.**
- **As of 2007, 24 public health RDHs.**

Kansas 2003

Sec. 65-1456

Dental hygienist with an extended care permit I or II to treat patients in schools, head start programs, state correctional institutions, local health departments, indigent care clinics, adult care homes, hospital long term units, or at the home of homebound persons on medical assistance. No prior authorization is needed, but the hygienist must have an agreement with a sponsoring dentist who will monitor his/her practice.

Special requirements: 1,800 hours experience

Services: prophylaxis, application of fluoride, dental hygiene instruction, assessment of the patient's need for further treatment by a dentist and other services if delegated by the sponsoring dentist

- **As of 2007, there were 76 extended care permit dental hygienists.**

Maine 2008

Sec. B-1. 32 MRSA c. 16, sub-c. 3-B

A dental hygienist licensed as an independent practice dental hygienist may practice without supervision by a dentist in all settings.

Special Requirements: Possess a bachelor's degree from a CODA accredited dental hygiene program and 2,000 work hours of clinical practice in a private dental practice during the two years preceding the application or possess an associate degree from a CODA accredited dental hygiene program and 6,000 work hours of clinical practice in a private dental practice during the six years preceding the application. They are also required to provide a referral plan to patients in need of additional care by a dentist.

Services: Interview patients and record complete medical and dental histories; take and record the vital signs of blood pressure, pulse and temperature; perform oral inspections, recording all conditions that should be called to the attention of a dentist; perform complete periodontal and dental restorative charting; perform all procedures necessary for a complete prophylaxis, including root planing; apply fluoride to control caries; apply desensitizing agents to teeth; apply topical anesthetics; apply sealants; smooth and polish amalgam restorations, limited to slow speed application only; cement pontics and facings outside the mouth; take impressions for athletic mouth guards and custom fluoride trays; place and remove rubber dams; place temporary restorations in compliance with the protocol adopted by the board; and apply topical antimicrobials, excluding antibiotics, including fluoride, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The independent practice dental hygienist shall follow current manufacturer's instructions in the use of these medicaments.

Maine 2001
Rule 02 313 Chap. 1. Sec. 4
A dental hygienist may practice in a public or private school, hospital or other non-traditional practice setting under a public health supervision status granted by the dental board on a case-by-case basis. The hygienist may perform all services rendered under general supervision. The dentist should have specific standing orders and procedures to be carried out, although the dentist need not be present when the services have been provided. A written plan for referral or an agreement for follow-up shall be provided by the public health hygienist recording all conditions that should be called to the attention of the dentist. The supervising dentist shall review a summary report at the completion of the program or once a year.

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

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

- **From 3/02 through 10/04, over 5,500 patients were provided care in over 400 clinics. Nearly 30 dental hygienists are involved in this particular program.**
- **Direct Medicaid reimbursement allowed.**

Michigan 1991
Sec. 333.16625
A dental hygienist may administer dental hygiene services for a 2 year period to patients not assigned by a dental through a department of community Health designed "grantee health agency. Grantee health agencies must be a public or nonprofit entity, school, or nursing home that employs or contacts with at least one dentist or dental hygienist and provides care to an underserved population.

Special requirements: Entities seeking a grantee health agency status must submit a comprehensive form outlining how the program will be carried out, providing for oversight and direction, and including information for all dental personnel involved. A dental hygienist operating as a grantee health agency must ensure that the supervising dentist is available for consultation when necessary.

Services: those permitted under general supervision.

Minnesota 2001
Section 150A. 10, subd. 1a
A dental hygienist may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services without the patient first being examined by a licensed dentist if the dental hygienist has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

Health care facility is defined as a hospital, nursing home, home health agency, disabled/juvenile home, federal/state/local public health facility, community clinic, prison, tribal clinic school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.
A collaborative agreement means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services may be performed without the presence of a licensed dentist and may be performed at a setting other than the usual place of practice of the dentist or dental hygienist and without the dentist's diagnosis/treatment plan unless specified in the agreement.

Special Requirements: Has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years. Has documented participation in courses in infection control and medical emergencies within each continuing education cycle and maintains current certification in advanced or basic cardiac life support as recognized by the American Heart Association, the American Red Cross, or another agency that is equivalent to the American Heart Association or the American Red Cross.

Services: Removal of deposits and stains from the surfaces of the teeth, application of topical preventive and prophylactic agents, sealants, fluoride varnishes, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking x-rays and root planing.

- **There are now 2 dental hygienists volunteering in a community dental clinic providing restorative and preventive services to at least 10 patients each day they volunteer.**
- **At least 25 dental hygienists had qualified for collaborative practice in 2006.**
- **Direct Medicaid reimbursement allowed.**

Missouri 2001
Statute 332.311.2
Dental hygienists may provide services without supervision in public health settings to Medicaid eligible children and be directly reimbursed by Medicaid.

Special Requirements: 3 years experience.

Services: Oral prophylaxis, sealants, fluorides.

- **One particular dental hygienist has seen a sealant program grow from one school district to eight. Over 2,500 sealants have been placed on over 700 children.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, were 12 registered providers.**

Montana 2003
Sec. 37-4-405
Dental hygienists may obtain a limited access permit from the board allowing them to practice under public health supervision in a variety of federally funded health centers and clinics, nursing homes, extended care facilities, home health agencies, group homes for the elderly, disabled, and youth, head start programs, migrant work facilities and local and state public health facilities. Public health supervision means the hygienist can provide oral prophylaxis, fluoride, polish restorations, root plane, sealants, oral cancer screening, expose radiographs, and chart without the authorization of a dentist provided he or she follows protocols to be established by the board and refers any patients needing dental treatment.

- **Program took effect in September of '04, 10 permits in '06.**

Nebraska 2007
Sec. 71-193.18
The Department of Health may authorize an unsupervised RDH to provide public health related services in a public health setting or a healthcare or related facility.

Special requirements: 3000 hours experience in at least 4 of last 5 years; professional liability insurance.

Services: Prophylaxis for a health child, pulp vitality testing, preventive measures including fluorides & sealants.

New Hampshire 1993
Rule 302.02(d); 402.01 (c)
Under public health supervision dental hygienists may provide procedures authorized by a dentist in a public or private school, hospital or institution, or residence of a homebound patient provided the dentist reviews patient records once in a 12 month period.

Special Requirements: None.

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

New Mexico 2007
Sec. 61-5-C
No supervision required for any dental hygienist to apply fluorides, and remineralization agents.

New Mexico 1999
Sec. 61-5A-4D
Rule 16.5.17
Collaborative practice permits [based on a written agreement between the dental hygienist and one or more consulting dentist(s)], dental hygienists to treat patients according to a protocol with collaborative dentist. Dental hygienists may own or manage a collaborative dental hygiene practice in any setting. Must refer patient for dental exam yearly.

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

Services: Each collaborative practice agreement must contain protocols for care. Which provide for standing orders allowing the dental hygienist to provide routine services such as preliminary assessment, x- rays, oral prophylaxis and fluoride treatment without prior authorization. Case-by-case authorization required in some procedures (as sealants and root planning).

- **One collaborative practice arrangement that started in 2002, serves a base of 4,000 people-1/3 of which are Medicaid eligible.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, there were 35 collaborative practice RDHs.**

New York 2005
Rules Sec. 61.9
That a supervising dentist be available for consultation, diagnosis and evaluation, has authorized the dental hygienist to perform the services, and exercises that degree of supervision appropriate to the circumstances. A dental hygienist can work in any setting (private or public) and perform dental hygiene duties (listed below) without a dental examination or need to refer a patient to a dentist.

Dental hygiene services allowed include removing calcareous deposits, accretions and stains, including scaling and planning of exposed root surfaces; applying topical agents indicated for a complete dental prophylaxis; removing excess cement from surfaces of the teeth; providing patient education; placing and exposing X-ray films; performing topical anticariogenic agent applications, including but not limited to topical fluoride applications, and performing topical anesthetic applications; polishing teeth, including existing restorations; taking medical history including the measuring and recording of vital signs; charting caries and periodontal conditions

as an aid to diagnosis by the dentist; applying pit and fissure sealants; and applying desensitizing agents to the teeth.

In nursing homes a hygienist can perform a complete oral examination of a resident and then determine treatment priorities; plan for continuing oral hygiene and dental care.

- **In 2005, dental hygienists have screened and provided sealants for over 30,000 children.**
- **About 100,000 children in New York received care in school-based programs overseen by dental hygienists.**

Nevada 1998
Sec. 631.287
Dental hygienists may obtain approval to work as public health dental health hygienists in schools, community centers, hospitals, nursing homes and such other locations as the state dental health officer deems appropriate without supervision.

- **33 RDH's have gained board approval. Nevada Health Centers, Inc. where some RDH's are employed, provides services in eighteen different locations in Nevada. Dental hygienists with Public Health endorsement can also screen and place sealants without a dentist present. Additional locations include Saint Mary's, Huntridge Teen Center & Lyon Co. Healthy Smiles.**
- **Direct Medicaid reimbursement allowed.**

Oklahoma 2003
Sec. 328.34 C
A dentist may authorize in writing a dental hygienist to perform services one time on a patient in a setting outside the office prior to any dentist contact/exam if the hygienist refers the patient back to the authorizing dentist.

Special Requirements: 2 years experience

Oregon 1997
Sec. 680.200
Rule 818-035-0065
Dental hygienists who have obtained a limited access permit (LAP) may initiate services for patients in a variety of limited access settings such as extended care facilities, facilities for the mentally ill or disabled, correctional facilities, schools and pre-schools, and job training centers. RDH must refer the patient annually to a licensed dentist available to treat the patient.
12 hours of CE every two years (in addition to the 24 hours required for all dental hygienists) to renew permit.

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

- **In 2006, there were 70 LAP's.**
- **In the last year, LAP dental hygienists in 3 counties provided over 5,000 preventative procedures for children in Head start, Early Head start, WIC public health settings.**
- **Several LAP hygienists throughout Oregon continue to build practices serving the elderly in foster homes and extended care facilities.**
- **Direct Medicaid reimbursement allowed.**

Pennsylvania 2007
(Act 216) Sec. 2 (Definitions)
Dental hygienists licensed in Pennsylvania can practice as "public health dental hygiene practitioners," providing care in a variety of public health settings without the supervision or prior authorization of a dentist. Public health dental hygiene practitioners are required to take five hours of continuing education dedicated to public health matters during each licensure period.

Special requirements: 3,600 hours expense, liability insurance. Must complete 5 hours of CE in public health during each licensure period.

Services: educational, preventive, therapeutic, and intra-oral services, including complete prophylaxis and sealants, dental hygienists in the state are authorized to provide.

Rhode Island 2006
Sec. 5-31.1-6.1
Dental hygienists working under a dentist's general supervision can initiate dental hygiene treatment to residents of nursing facilities. Dental hygienists working in nursing facilities can treat patients, regardless of whether or not the patient is a patient of record, as long as documentation of services administered is maintained and necessary referrals for follow-up treatment are made.

Special requirements: None.

Services: Initial oral health screening assessments, prophylaxis, fluoride treatments, charting, and other duties delegable under general supervision.

South Carolina 2003
Sec. 40-15-110 (A) (10)
Dental hygienists employed by or contacted through the Department of Health and Environment Control may provide services under general supervision that does not require prior examination by a dentist in settings such as schools or nursing homes.

Special requirements: Dental hygienist must carry professional liability insurance.

Services: Prophylaxis, fluorides, sealants

Texas 2001
Sec. 262.1515
A dentist may delegate services without seeing the patient first to a dental hygienist practicing in a nursing facility or school based health center. The hygienist must refer the patient to a dentist following treatment. The hygienist may not perform a second set of services until the patient has been examined by a dentist.

Special Requirements: 2 years practice experience.

Services: No limitations.

Vermont 2008
Rule 10.2
Dental hygienists may provide hygiene services in public health settings under the supervision of a dentist via a general supervision agreement. The agreement authorizes the dental hygienist to provide services, agreed to between the dentist and the dental hygienist. The agreement does not require physical presence of the dentist but it stipulates that the supervising dentist review all patient records.

Special Requirements: Three years licensed clinical practice experience and in good standing in Vermont.

Services: Sealants, fluoride varnish, prophylaxis and x-rays. Periodontal maintenance and root planing may be provided on patients with mild periodontitis.

Washington 2001 (Washington has two different provisions for direct access)
Sec. 18.29.220
Dental hygienists who are school endorsed may assess for and apply sealants and fluoride varnishes in community-based sealant programs carried out in schools.

Special Requirements: Sealant/Fluoride Varnish Endorsement from Department of Health.

- **Data obtained through Medicaid indicates that dental hygienists working under these provisions saw 5,653 clients in 2002; 6,799 in 2003, and 4,265 through July of '04. Specifically in terms of sealants, over 19,200 sealants have been placed since Dec. 2003.**
- **Direct Medicaid reimbursement allowed.**

Washington 1984
Sec. 18.29.056
Unsupervised practice in hospitals, nursing homes, home health agencies, group homes (for the elderly, handicapped or youth), state institutions under department of health and human services, jails, and public health facilities provided the hygienist refers patient to a dentist for dental treatment and needed care.

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

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

West Virginia 2008
§5-1-8.5
Dental hygienists, who meet specific requirements, may provide dental hygiene services without the supervision of a dentist in hospitals, schools, correctional facilities, jails, community clinics, long term care facilities, nursing homes, home health agencies, group homes, state institutions under the Department of Health and Human Resources, public health facilities, homebound settings and Accredited Dental Hygiene Education programs.

Special requirements: 2 years and 3,000 hours of clinical dental hygiene experience; six additional continuing education hours this must include 3 hours in medical emergencies and 3 hours in general public health content. The dental hygienist and supervising dentist must submit an annual report to the West Virginia Board of Dental Examiners of services rendered.

Services: Dental hygiene education; nutritional counseling; oral screening with referral to dentist; apply fluoride; charting; recording medical history; complete prophylaxis (upon written prescription from a licensed dentist).

Wisconsin 2008
Wisconsin. Sec. 447.06
The statute does not require the presence or general supervision of a dentist in a public or private school, a dental or dental hygiene school or a facility owned by a local health department.

SCHOOL-BASED DENTAL SEALANT PROGRAM *

Table 1.[1] Screening Data 2000 - 2004

dds	# screenings	# children with	% children with	number of	average # caries	# sealants
	2nd graders	untreated caries	untreated caries	untx caries	per child	
2000-01	364	104	28.57	271	2.61	1199
2001-02	413	154	37.29	393	2.55	1444
2002-03	404	169	41.83	441	2.61	1296
2003-04	409	138	33.74	368	2.67	1563
TOTALS	**1590**	**565**	**35.53%**	**1473**	**2.61**	**5502**

Table 2.[2] Screening Data 2004 - 2008

dds	# screenings	# children with	% children with	number of	average # caries	# sealants
	2nd graders	untreated caries	untreated caries	untx caries	per child	
2004-05	245	94	38.36	246	2.62	778
2005-06	219	97	44.29	253	2.61	622
2006-07	222	67	30.18	172	2.57	641
2007-08	236	61	25.85	154	2.52	690
TOTALS	**922**	**319**	**34.59%**	**825**	**2.58**	**2731**
rdh						
2004-05	363	118	32.50	316	2.67	1175
2005-06	239	83	34.72	245	2.95	742
2006-07	251	89	35.46	185	2.09	706
2007-08	271	81	29.89	157	1.94	828
TOTALS	**1124**	**371**	**33.00%**	**903**	**2.43**	**3451**

Table 3.[3] Total # Screenings and Sealants

	Screenings	Sealants
	2nd graders	2nd grade
2000-04	1590	5502
2004-08	2046	6182

Table 4.[4] **Treatment Status**

	# of follow-up screenings for 3rd, 4th & 5th graders	# of children who HAVE received tx	# of children who HAVE NOT received tx
2001-02	71	30	41
2002-03	89	46	43
2003-04	79	46	33
2004-05	77	42	35
2005-06	133	88	45
2006-07	140	72	68
2007-08	100	42	58
TOTALS	**689**	**366**	**323**
%		**53.1%**	**46.9%**

Table 5. [5] **Caries Experience of 8th Graders**

Participants in Dental Sealant Program		
# of students	96	
# of first & second permanent molars [1]	695	
# of teeth with caries history	53	
Mean number of caries per student	0.55	(1.014 sd)[2]
Percent of teeth with caries history	**7.6%**	
Non-participants		
# of students	95	
# of first & second permanent molars [1]	684	
# of teeth with caries history	139	
Mean number of caries per student	1.46	(2.004 sd)[2]
Percent of teeth with caries history	**20.3%**	

[1] Does not include missing teeth or questionable caries

[2] *t(189) df = 3.97, p<.001*

Middle Schools 2004

* This data was collected from the Black Hawk County School-based Dental Sealant Program. The program has provided services to 15 elementary and 6 middle schools in 3 counties in Iowa.

[1] Table 1 contains the data collected during the four years that a licensed dentist did all of the screenings.

[2] Table 2 contains the data collected during the four years that both a licensed dentist and a licensed dental hygienist did screenings.
There appears to be no significant difference between the percent of children with untreated caries or the average # of caries per child if the screening was completed by a dentist or a dental hygienist.

[3] Table 3 contains a comparison of the number of screenings and sealants.
During the four years from 2004 -2008 that both a dentist and dental hygienist did screenings there were 456 more screenings and 680 more sealants than the four years that only a dentist did the screenings.

[4] Table 4 contains the data indicating the number of children who were screened in Grades 3,4 & 5 to determine if treatment for dental disease was completed. Almost 47% had not received treatment by a dentist.

[5] Table 5 contains the screening data of eighth graders from 3 middle schools. This outcome data indicates there is a significant difference in the caries experience of 8th graders. The students who did NOT participate in the school-based sealant program were almost 3 times more likely to experience tooth decay in their permanent molars.

Notes: In 2004 the Black Hawk County School-based Dental Sealant program began utilization of the public health supervision ruling in accordance with the requirements of Iowa Code Section 10.5 (153). This ruling has increased access to preventive services for high-risk children and provided significant improvements to the efficiency of the program.

When the dental hygienist does both the screenings and the sealant applications it 1) reduces the amount of time each student is out of the classroom; 2) reduces interruptions to the academic activities in the classroom; 3) reduces the amount of time between the screening and the placement of sealants, 4) reduces the number of clinical supplies needed; and 5) reduces the costs of compensating dentists for time and expenses to perform screenings.

In addition, this format 1) increases the possibility that students who were absent or have not yet returned a consent form will be able to participate in the program; 2) retains the referral process for students in need of dental treatment and 3) retains the ability to do follow-up screenings to determine if children have received the dental treatment they need.

The data collected from this school-based sealant program indicate that the program can be implemented more efficiently in terms of time and cost when a dental hygienist does the screenings and makes referrals to a dentist for dental treatment.

The data from this program also indicate that almost 47% of children who have been identified as having existing caries and are in need of treatment have not received treatment when a follow-up screening was done in subsequent years. Utilization of the time and clinical skills of licensed dentists may be more beneficial to these children if restorative services were provided rather than the time and expenses required to complete screenings in schools.

October 26, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo:

As a registered dental hygienist currently working under public health supervision, I am writing to you to express my support of the Iowa Dental Hygienists' Association's current request for an amendment to the public health supervision rules. I believe that the access-to-care issues we have been aware of are becoming even more evident as more hygienists begin a career in public health. In the 22 months that I have been working as an I-Smile Coordinator, I have had the need demonstrated to me time and again.

This proposed amendment – changing the requirement of a dental exam within 12 months following certain procedures to the requirement of a dental referral following the procedures – will allow myself and the other hygienists employed by our agency to address the access-to-care issues that we are seeing our clients experience. By being able to provide comprehensive dental hygiene services in spite of our clients' inability to be seen by a dentist, we will be a source of ongoing care.

I would like to provide you with two examples of ways in which this change will benefit the patients who are served by our agency.

- In our Child Health clinic in Perry, we are currently applying sealants. Because of the way our public health supervision agreement is set up with our supervising dentist, we can provide sealants after the client has had an exam and has been deemed caries-free. The dentists in the area are not applying sealants on a regular basis, even to children at a high risk for developing caries. After the child has seen a dentist, we apply sealants to the children's teeth. Occasionally, we see a child that has two or three of their molars erupted and ready for sealants so we apply sealants to those teeth. Because of the public health supervision rules, we cannot seal the remaining teeth after they have finished erupting until the child has seen a dentist again. For our children, that will be six to twelve months. With the amendment changed to a referral to the dentist, we could make that referral and then go ahead and seal the remaining teeth in three to four months after they have finished erupting. This would allow us to provide this preventive measure with the hope of decreasing dental caries on these teeth.
- We have recently begun providing dental hygiene services to our Maternal Health clients (pregnant mothers) at our WIC clinics. After a thorough assessment, a decision is

made regarding whether or not we feel we can provide a prophylaxis for the client. If appropriate, an appointment is scheduled for the prophy. We see our clients again in six months and would like to be able to provide a follow-up prophy at that time. Because of the public health supervision rules, we cannot do that unless the client has had an exam. For our clients who are uninsured and cannot afford to pay for a dental visit out-of-pocket, this becomes a serious impediment to ongoing dental care. Our clients who are enrolled in Medicaid also have a difficult time accessing care due to dentists' non-acceptance of Medicaid. If we could refer the client to the dentist and then proceed with the follow up visit, we could provide ongoing, comprehensive dental hygiene care to our clients.

Our programs are expanding and we hope to be able to provide dental hygiene services to clients of our agency's substance abuse treatment program. There is a significant need present in those clients and a change in the rules would allow us to provide ongoing dental hygiene care to these clients as well.

Lastly, I would like to express my continued support and cooperation with the dentists in our area. I always conclude every appointment with any of our clients with a statement of the need to be seen by a dentist. I also make sure all of our clients know that our assessment in no way replaces a dental exam and regular care by a dentist. Unfortunately, due to the shortage of dentists in certain parts of our service area, the shortage of dentists who accept Medicaid, and the inability of some of our clients to pay for out-of-pocket costs associated with dental care, several of our clients are simply unable to access dental care in a dental office. If we could provide ongoing dental hygiene preventive care until they are able to seek care in a dental office, the chances of needing significant dental work will be decreased. This care, along with proper education, will improve the dental health of our clients.

I appreciate your time in reading my letter and your consideration of the request for the amendment to the rules. Our clients are so appreciative of all we do for them because without us they would not be receiving care. Please consider the change to the rules so that we can enhance our services and provide ongoing care to those who need it most.

Sincerely,

Jenifer J. Badger

Jenifer J Badger, RDH
Bagley, Iowa

October 26, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo,

I am writing to support an amendment to Administrative Rule 650-7.1 regarding the need for a dental exam after 12 months of preventive hygiene services and the discontinuation of these services if no dental examination is performed.

My dental hygiene career started about 31 years ago. During this time, I have been in private practice, worked as an adjunct clinical instructor at DMACC and currently have a public health position serving seven counties in Iowa. The majority of my time in the early years was patient education, prophylaxis, fluoride treatments and exposing radiographs. In the 1970s and 1980s, there was a high incidence of rampant decay and nursing caries, especially with the influx of Southeast Asians. It was routine to see "bombed-out" deciduous molars, incisors and first permanent molars. Children required extensive dental treatment, including extractions, crowns, space maintainers, large restorations with pulp caps and some endodontics. Because of the increase in education, preventative treatment, fluoride, sealants, regular recalls and increased third party payments, the extensive treatment we once provided is uncommon. Over the years, there have been many positive changes in dentistry and patients receive improved preventative services.

However, low-income clients, because of their dental insurance or lack of insurance, are unable to receive dental treatment, or receive only minimal treatment at best. This brings me to my current employment. Two months ago, I took a position with New Opportunities, Inc. in Carroll, IA. We provide screenings, fluoride varnishes, dental referrals, etc. as part of the I-Smile Program. If I were to describe the clients' needs in this program, I would have to describe the 1970s and 1980s when I started practicing.

After thirty years in private practice, seeing the well-maintained, disease-free, or successfully treated patients, I thought the dental diseases were decreasing. However, after three weeks with I –Smile Program, I quickly realized was so mistaken. I overestimated the percentage of people who actively seek and receive dental care. In just three days working at the Perry facility, we observed three children with suspected rampant decay, nursing caries and fistulas on deciduous incisors. As part of the screening visit, we provide a referral to a local dentist for an examination. This can be a verbal, a written referral or a call an office to schedule an appointment. Scheduling appointments is not as easy as it would seem, barriers may include:

1) the lack of dentists willing to treat Medicaid clients
2) the office is no longer seeing new Medicaid patients
3) patients dismissal because of missed appointments
4) clients failing scheduled appointments
5) dentists deferring treatment to The University of Iowa because the client is a probable surgery candidate
6) lack of transportation
7) lack of child care when at appointments
8) parents' lack of dental education recognizing dental disease
9) parents' lack of nutrition education
10) decreasing number of child health clinics

I wanted to work in public health to provide preventative care for the underserved, act as a bridge or connection between public health clients and dentists, and bring this group into the 21st century. Please allow public health hygienists to continue providing preventative services including referrals for our clients. If it were not for public health services and referrals, some may never visit a dentist. In addition, making the referral and scheduling an examination appointment does not always a guarantee treatment is provided. It is unfair to suspend all public health services after one year because a dentist did not provide a dental examination. Suspending all preventative therapy in the absence of a dental examination may eliminate the only opportunity the low-income, uninsured and underinsured may have to receive preventative services.

Thank you for your time and consideration.

Sincerely,

Joyce Miller, RDH, BS

IOWA DENTAL ASSOCIATION
A Constituent of the American Dental Association

P.O. Box 31088
Johnston, IA 50131
(515) 986-5605 or (800) 828-2181
(515) 986-5626 (Fax)
info@iowadental.org (e-mail)

December 22, 2008

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

RE: Iowa Dental Hygienists' Association Request for Rulemaking

Jennifer Hart:

On November 25, 2008, the Iowa Dental Hygienists' Association ("IDHA") submitted a request for rulemaking. The IDHA requests that the Iowa Dental Board ("the Board") strike the requirement set forth in Iowa Administrative Rule 650-10.5(3)(a)(3), which states as follows:

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

Iowa Administrative Code r. 650-10.5(3)(a)(3). The Iowa Dental Association ("IDA") believes that the striking of this provision would be inappropriate for the following reasons.

First, the scope of any hygienists' practice is limited by the requirements in Iowa Code section 153.15. That section states as follows:

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

Iowa Code § 153.15 (emphasis added). The Board has further defined the terms and standards utilized in Iowa Code section 153.15 in Iowa Administrative Code sections 650-10.3 and 650-10.5.

Dr. Heather Heddens, President ♦ Dr. Steven Bradley, President-Elect ♦ Dr. William Strohman, Vice-President ♦ Dr. Richard Hettinger, Immediate Past President
Mr. Larry Carl, CAE, Executive Director

IDA believes that deleting the twelve (12) month requirement set forth in Iowa Administrative Code section 650-10.5(3)(a)(3) would be in direct disregard of the statutory supervision requirement. The deletion of the requirement would also allow hygienists to cross the line into the practice of dentistry as diagnosis and analysis, which a dentist is trained to do, is necessary before and after certain types of services are provided.

Second, if the dentist is ultimately responsible for any liability arising from the care provided to the patients in the public health supervision program, few dentists will want to incur that liability if the patient is not required to see a dentist on at least an annual basis. It's hard to imagine any type of professional (i.e.: doctors, attorneys, architects) that would allow his/her own liability coverage be utilized by others without regular oversight.

Third, failure to have dentist oversight of certain procedures would be detrimental to the dental care of the very people the public health supervision program is meant to help. The application of sealants provides a good example and is the issue of most concern for IDA members. Whether and when sealants are appropriate must require an exam and diagnosis at some stage of the treatment regimen. This is an exam and diagnosis that a dentist, not a hygienist, is trained to provide. Furthermore, a dentist is trained to determine at any follow up visit the condition of those sealants and whether re-application is necessary. While IDA has no issue with hygienists applying the sealants, oversight by the dentist is necessary to determine the appropriateness and adequacy of the sealants. The dentist's knowledge and training allow him/her to make that determination to avoid any possible permanent damage to the patient's teeth. The current twelve month requirement is adequate to allow the dentist appropriate oversight to the hygienists' application of sealants and the performance of other hygiene services, while at the same time not prohibiting access to oral hygiene services on a regular basis.

Fourth, while IDA certainly does not question the level of reported success of the public health supervision program in addressing access to dental care in Iowa, the issues and concerns raised in IDHA's request for rulemaking are simply not tenable or could easily be remedied by the specific public health supervision agreements. Each of these assertions will be addressed in turn:

> 1. "Occasionally we see a child that has two or three of their molars erupted and ready for sealants so we apply sealants to those teeth. Because of the public health supervision rules, we cannot seal the remaining teeth after they have finished erupting until the child has seen a dentist again." (Letter from Jennifer J. Badger, RDH, p. 1)
>
> Response: Ms. Badger inaccurately asserts that the rules prevent her from sealing the remaining teeth. The twelve month requirement does not prevent this as the remaining teeth would erupt, as Ms. Badger recognizes, within the next three to four months. Ms. Badger's issue here is not with the rules, but with the particular public health supervision agreement governing the provision of her services. Thus, the asserted problem could be remedied by an amendment or revision to that agreement rather than the rules.
>
> 2. With regard to the services provided to pregnant mothers, Ms. Badger states as follows: "After a thorough assessment, a decision is made regarding whether or not we

feel we can provide a prophylaxis for the client. If appropriate, an appointment is scheduled for the prophy. We see our clients again in six months and would like to be able to provide a follow-up prophy at that time. Because of the public health supervision rules, we cannot do that unless the client has had an exam." (Letter from Jennifer J. Badger, RDH, pp. 1-2)

Response: Again, Ms. Badger seems to be confusing the rules with the public health supervision agreement governing the provision of her services. If she sees the client again within six months, she could provide a follow-up prophy, because it would be within the twelve month period. If the public health supervision agreement governing Ms. Badger provides a shorter period of time, then such issues can be addressed by revising that particular agreement.

3. There is a lack of dentists available to provide the necessary examinations and there is a lack of dentists willing to treat Medicaid clients. (Letter from Jennifer J. Badger, RPH, p. 2; Letter from Joyce Miller, RDH, BS, p. 2)

Response: IDA supports and encourages all dentists to do their part in addressing the oral health needs of all Iowans. While it is true that not every dentist will accept Medicaid patients, there are a significant number who do and will. For example, a statewide claims analysis conducted by Iowa Medicaid Enterprise states that well over 75 percent of Iowa dentists (over 1000) accepted Medicaid patients during the most recent state fiscal year.

IDHA's letter references a specific problem in Black Hawk County regarding access to examinations. After checking with dentists in the Black Hawk County area, it became clear that it was not that these dentists did not want to assist with the program, but that they hadn't been properly informed of the need nor effectively asked to participate. Thus, IDA questions whether the issue is really lack of access or whether it's a lack of knowledge about when and where a dentist's services are needed in the public health setting.

The experience of IDA's members is not that there is little or no access to dental care, but that the patients receiving care in the public health setting often fail to keep appointments for their dental care. The problem is not the lack of access, but the lack of follow through. The argument that dentists are not available, even if accurate, does not mean that this Board should revise its rules to allow hygienists to do the work of dentists. Iowa cannot lower the standard of care to persons in the public health realm on the unsupported claim that dentists are not available.

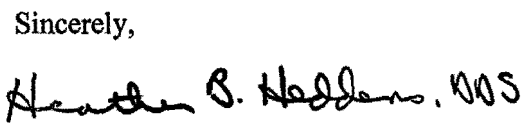
Finally, IDHA's claim that the requested revision would make Iowa more consistent with other states is inaccurate. In assessing the IDHA's comparison, it is important to remember that a particular statute or rule cannot be reviewed in a vacuum. Other statutes and rules in that state related to the matter at issue may not be the same as those in Iowa. For instance, Maine has a category of dental hygienist licensure called "independent practice dental hygienists." "Independent practice dental hygienists" are subject to increased education and training standards and are allowed to practice without certain supervision. Iowa does not have a similar

licensure category. In addition, Iowa Code section 153.15 specifically requires supervision by a dentist and thus, a similar rule in Iowa would not comply with the statutory requirements. Furthermore, IDHA's blanket conclusions regarding what is a "referral" state do not hold up under further scrutiny. In New Mexico, there is a yearly dental referral requirement and a specific exception for dentist authorization of certain procedures, such as sealants and root planning. Thus, New Mexico is not a "referral only" state. In addition, Oregon, contrary to IDHA's assertion, does have a twelve month requirement ("RDH must refer the patient annually to a licensed dentist available to treat the patient."). These corrections and clarifications were found by simply reviewing the "Direct Access States" document provided with IDHA's letter. Accordingly, it is likely that a more thorough review of each state would provide additional evidence that Iowa is not alone in its supervision requirement.

As set forth above, IDA believes that the IDHA's requested rulemaking is unnecessary, unwarranted and unsupported by Iowa law. Accordingly, IDA requests that the Board and the Dental Hygiene Committee deny IDHA's rulemaking request.

If you have questions or desire further discussion with the Iowa Dental Association, please contact Heather Heddens, DDS at (319) 653-5440. Thank you for the opportunity to comment on the request for rulemaking currently before you.

Sincerely,



Heather Heddens, D.D.S.
President, Iowa Dental Association

IOWA DENTAL ASSOCIATION
A Constituent of the American Dental Association

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Johnston, IA 50131
(515) 986-5605 or (800) 828-2181
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December 22, 2008

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

RE: Iowa Dental Hygienists' Association Request for Rulemaking

Jennifer Hart:

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Second, if the dentist is ultimately responsible for any liability arising from the care provided to the patients in the public health supervision program, few dentists will want to incur that liability if the patient is not required to see a dentist on at least an annual basis. It's hard to imagine any type of professional (i.e.: doctors, attorneys, architects) that would allow his/her own liability coverage be utilized by others without regular oversight.

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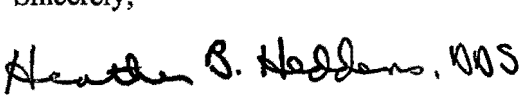
As set forth above, IDA believes that the IDHA's requested rulemaking is unnecessary, unwarranted and unsupported by Iowa law. Accordingly, IDA requests that the Board and the Dental Hygiene Committee deny IDHA's rulemaking request.

If you have questions or desire further discussion with the Iowa Dental Association, please contact Heather Heddens, DDS at (319) 653-5440. Thank you for the opportunity to comment on the request for rulemaking currently before you.

Sincerely,



Heather Heddens, D.D.S.
President, Iowa Dental Association

Iowa Dental Hygienists' Association

November 25, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo;

This letter constitutes a petition to the Iowa Dental Board, pursuant to Administrative Rule 650-7.1, requesting an amendment to the current administrative rule regarding licensee responsibilities as part of public health supervision of dental hygienists, Administrative Rule 650-10.5(3). Paragraph (a)(3) of this rule requires a dentist to "(s)pecify a period of time, no more than 12 months, in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement." The proposed amendment would strike this requirement.

This proposed amendment is being submitted for the following reasons: (1) it will remove a barrier to preventive dental hygiene services and (2) it would make Iowa's law regarding access to public health services more consistent with other states. As the Dental Board is aware, the public health supervision program for dental hygienists has been very successful in expanding access to quality dental care to Iowans, especially low-income families. According to statistics collected by the Iowa Department of Public Health, nearly 19,000 patients were served by this program in 2005, and by 2007, that figure had grown to nearly 35,000, almost a 100% increase. The number of hygienists providing services in public health settings has also grown, from 21 in 2005 to 56 in 2007; the number of dentists participating in this program has also grown significantly.

A recent study conducted at the Black Hawk County school-based dental sealant program demonstrates how dental hygienists working in a public health setting are making dramatic improvements in the oral health of children in that county. In the four years prior to allowing public health supervision, 1590 screenings were conducted. In the four years since screenings were able to be conducted by dentists and dental hygienists, the

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number of screenings increased to 2046, nearly a 33% increase. Over that same time-period, the number of children receiving dental sealants also increased by nearly 10%.

The study also shows the benefit of additional screenings and sealant applications. Eighth graders who had previously participated in the dental sealant program had 7.6% of their teeth demonstrating a history of caries, compared to 20.3% for those children who did not previously participate.

Removing a barrier to Preventive Dental Services

As shown above, the current dental hygiene public health supervision program is helping expand access to quality dental care. However, the current requirement, that patients participating in this program must be examined by a dentist within no longer than twelve months after receiving treatment, serves as a significant barrier to patients receiving the continued benefit of this program. Hygienists practicing in a public health setting have experienced significant difficulty in determining whether this requirement has been met as they do not provide the examination.

Additionally, at a recent dental summit, two school based sealant programs expressed concern that children who would benefit from additional sealants would be denied due to the annual exam requirement. For example, children receiving sealants as a 2nd grader prior to all teeth fully erupting are now ready in third grade have the rest of the teeth sealed, but lacking proof of exam, are not eligible to receive preventive services.

The study of Black Hawk County schoolchildren again shows the problem of lack of access. When follow-up screenings were conducted on 3rd, 4th, and 5th graders, nearly 47% had not received dental treatment since either their previous screening or sealant application. Under the current administrative rules, those 47% of children would not be able to receive many continuing preventive services from dental hygienists, including the application of additional sealants.

Attached are letters from Jen Badger and Joyce Miller, two dental hygienists who practice in public settings that outline their real world experiences and how adopting this petition would improve access to quality dental care.

Consistency with Laws in other States

Iowa's dental examination requirement is not consistent with laws in other states regarding direct access to dental hygiene services. According to the American Dental Hygiene Association, twenty-eight states, including Iowa, allow for some sort of direct access to hygiene services. Among those twenty-eight states, Iowa currently is one of only five states which place a limit on continuation of preventive services. In contrast, six other states, including Maine, Montana, New Mexico, Oregon, Rhode Island, and Washington, have a referral requirement such as is being proposed in this petition.

At an oral health summit hosted earlier this year by the Iowa Public Health Association, the current exam requirement was identified as a major barrier to access to oral health preventive services, and there was strong support at this summit to replace this

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requirement with a referral requirement similar to what is proposed in this petition. Additionally, the Oral Health Bureau of the Iowa Department of Public Health has included this change in their policy recommendations for this year. This change is supported, as well, by the Iowa Prevention of Disabilities Council.

As President of the Iowa Dental Hygienists Association, I want it understood that dental hygienists believe in and recognize the important role that dentists and dental exams play in providing quality dental health care to Iowans. As is stated in Jen Badger's letter, dental hygienists working in a public health setting work very hard to match up their patients with a dentist who can provide an exam and needed additional care.

However, when an exam is not able to be conducted, which as the Black Hawk County data demonstrates quite often occurs, it is important that barriers to quality dental care be removed. IDHA believes strongly that this petition would accomplish that objective, and we appreciate the board's consideration of this request.

Sincerely,

Carol Van Aernam

Carol Van Aernam, President
Iowa Dental Hygienists Association

IOWA DEPARTMENT OF PUBLIC HEALTH - ORAL HEALTH BUREAU UPDATE
Tracy Rodgers, Community Health Consultant

I-Smile
Funding from DHS increased this year for the 23 Title V child health contracts. Agencies will receive $1,716,432 for SFY2009. The funding is distributed based on size of service area and Medicaid-enrolled children. Refer to the attachment for examples of activities provided by I-Smile coordinators.

OHB staff is working with Iowa Medicaid Enterprise to evaluate I-Smile. Specific data queries have been requested to review efficacy and impact. Dolores Malvitz, an epidemiologist formerly with CDC, is providing guidance to OHB on the evaluation measures.

School Dental Screening Requirement
This is the first school year that Iowa children are required to have proof of a dental screening prior to enrolling in kindergarten and ninth grade. Information and forms are available on the IDPH Website, trainings are being held, and there has been quite a bit of media coverage.

Local boards of health are responsible for audits – and I-Smile Coordinators are expected to coordinate systems within their service regions to assure completion of audits, reporting to boards of health, and reporting to IDPH. I-Smile Coordinators will also be integral in assisting families in having screenings completed.

Oral Health Bureau Codification
The administrative rules written to codify the Oral Health Bureau have been suspended. The Iowa Dental Association protested the definition of a dental home as written within the rules. The IDA opposes the inclusion of "nondental public and private health care professionals" in the definition. The legislature's Administrative Rules Review Committee agreed to suspend adoption of the rules, asking the IDPH and IDA to come to an agreement on the definition of a dental home.

Oral Health Policy Recommendations
1. Increase funding for the I-Smile dental home project to expand the dental workforce and increase preventive services for underserved children; to double Medicaid's preventive reimbursement for eligible providers; to allow physicians and primary care providers to bill for dental screenings outside of the EPSDT bundled well-child exam rate; and to improve Medicaid dental reimbursement rates or use a 3rd party billing system
2. Reinstate a 4-year bachelor's degree dental hygiene program in Iowa with public health service emphasis
3. Seek rules change by Iowa Dental Board for public health supervision to allow a dental hygienist to refer a patient to see a dentist, but not limit continued treatment if dental visit had not occurred within one year
4. Integrate oral health planning into the medical home initiative

DIRECT ACCESS STATES

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

Alaska 2008
AS 08.32.115
May provide services according to terms of collaborative agreement. No limit on settings. Dentist need not examine, diagnose, or be present.

Special requirements: 4,000 hours experience last 5 years. Board must approve collaborative agreement.

Services: Virtually entire scope of dental hygiene services, as long as agreement provides for them.

Arizona 2006
32-1289B
Dental hygienist working under contract for schools, public health settings and institutions may screen and apply fluoride unsupervised.

Arizona 2004
Sec. 32-1281 H, 3212-89
A dental hygienist with a written affiliated practice agreement with a dentist may assess for and perform dental hygiene services on patients under 18 years who meet certain financial criteria and are enrolled in a federal, state, county or local healthcare program

Special requirements: 5 years practice

Services: Any dental hygiene services specified in the affiliated practice agreement except root planing, local anesthesia, nitrous oxide or placing sutures.

- **Direct Medicaid reimbursement allowed.**

California 2002
Sec 1763 (a) 2002
Any dental hygienist may provide screening, apply fluorides and sealants without supervision in government created or administered public health programs.

California 1998
Sec. 1774, 1775
Dental hygienists endorsed as RDHAPs (registered dental hygienist in alternative practice) may provide services without supervision for homebound persons or at schools, residential facilities, institutions and in dental health professional shortage areas for up to 18 months, and provide further services if the patient obtains a prescription from a dentist or physician. RDHAP'S may own an alternative dental hygiene practice. Currently, there are more than 100 RDHAP's.

Special Requirements: Bachelors degree equivalent, 3 years clinical practice, completion of 150 clock hour special course and exam.
Services: Those services permitted under general supervision (which include oral prophylaxis, root planing, pit and fissure sealants, charting and examination of soft tissue).

- **In 2008, more than 200 RDHAP's registered.**
- **A dental hygienist mobile practice treats 25-35 disabled patients per week.**
- **Direct Medicaid reimbursement allowed.**

Colorado 1987

Sec. 12-35-122.5

Unsupervised practice in all settings for all licensed dental hygienists for the oral prophylaxis and preventive and therapeutic services. The dental hygienist may also own a dental hygiene practice.

Special Requirements: None.

Services: remove deposits, accretions, and stains, curettage without anesthesia, apply fluorides and other recognized preventive agents, oral inspection and charting, topical anesthetic. However, x-rays require general supervision and local anesthesia requires direct supervision.

- **Direct Medicaid reimbursement allowed. In fiscal year 2003-04, 16 independent RDH's provided 199,518 in services to 2,284 Medicaid children.**

Connecticut 1999

Section 20-126l

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

Special Requirements: 2 years experience.

Services: Oral prophylaxis, remove deposits, accretions and stains, root planning, sealants, assessment, and treatment planning.

- **Since 7/1/2003 hygienists have program has provided over 55,000 dental procedures – nearly 7,000 prophys/fluorides, 5,800 sealants and 15,000 exams.**
- **Direct Medicaid reimbursement allowed.**

Idaho 2004

I.C. 54-903 (9) / 54-904

Can provide services in hospitals, long term care facility, public health facility, health or migrant clinic or other board approved setting if dentist affiliated with setting authorizes services.

Special requirements: RDH must be an employee of the facility or obtain extended care permit. ECP requires 1,000 hours experience in last 2 years.

Services: As determined by authorizing dentist.

Iowa 2004

Rule 650-10.5 (153)

Dental hygienists may provide services based on standing orders and a written agreement with a dentist in schools, Head Start settings, FQHCs (Federally Qualified Health Centers), public health vans, free clinics, community centers and public health programs.
Special Requirements: RDH must have 3 years clinical experience and submit annual report on number of patients/services to department of health.

Services: All dental hygiene services (except local anesthesia and nitrous) may be provided once to each patient. To perform repeat services other than assessment, screening and fluoride, dentist must examine.

- **Active Public Health Supervision agreements in place between Iowa dentists and dental hygienists.**
- **Services in 2005: 17,332 clients received sealants, 18,942 received screenings, 6,098 received fluoride applications, over 281 received prophys, and 7,157 received education.**
- **As of 2007, 24 public health RDHs.**

Kansas 2003

Sec. 65-1456

Dental hygienist with an extended care permit I or II to treat patients in schools, head start programs, state correctional institutions, local health departments, indigent care clinics, adult care homes, hospital long term units, or at the home of homebound persons on medical assistance. No prior authorization is needed, but the hygienist must have an agreement with a sponsoring dentist who will monitor his/her practice.

Special requirements: 1,800 hours experience

Services: prophylaxis, application of fluoride, dental hygiene instruction, assessment of the patient's need for further treatment by a dentist and other services if delegated by the sponsoring dentist

- **As of 2007, there were 76 extended care permit dental hygienists.**

Maine 2008

Sec. B-1. 32 MRSA c. 16, sub-c. 3-B

A dental hygienist licensed as an independent practice dental hygienist may practice without supervision by a dentist in all settings.

Special Requirements: Possess a bachelor's degree from a CODA accredited dental hygiene program and 2,000 work hours of clinical practice in a private dental practice during the two years preceding the application or possess an associate degree from a CODA accredited dental hygiene program and 6,000 work hours of clinical practice in a private dental practice during the six years preceding the application. They are also required to provide a referral plan to patients in need of additional care by a dentist.

Services: Interview patients and record complete medical and dental histories; take and record the vital signs of blood pressure, pulse and temperature; perform oral inspections, recording all conditions that should be called to the attention of a dentist; perform complete periodontal and dental restorative charting; perform all procedures necessary for a complete prophylaxis, including root planing; apply fluoride to control caries; apply desensitizing agents to teeth; apply topical anesthetics; apply sealants; smooth and polish amalgam restorations, limited to slow speed application only; cement pontics and facings outside the mouth; take impressions for athletic mouth guards and custom fluoride trays; place and remove rubber dams; place temporary restorations in compliance with the protocol adopted by the board; and apply topical antimicrobials, excluding antibiotics, including fluoride, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The independent practice dental hygienist shall follow current manufacturer's instructions in the use of these medicaments.

Maine 2001
Rule 02 313 Chap. 1. Sec. 4
A dental hygienist may practice in a public or private school, hospital or other non-traditional practice setting under a public health supervision status granted by the dental board on a case-by-case basis. The hygienist may perform all services rendered under general supervision. The dentist should have specific standing orders and procedures to be carried out, although the dentist need not be present when the services have been provided. A written plan for referral or an agreement for follow-up shall be provided by the public health hygienist recording all conditions that should be called to the attention of the dentist. The supervising dentist shall review a summary report at the completion of the program or once a year.

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

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

- **From 3/02 through 10/04, over 5,500 patients were provided care in over 400 clinics. Nearly 30 dental hygienists are involved in this particular program.**
- **Direct Medicaid reimbursement allowed.**

Michigan 1991
Sec. 333.16625
A dental hygienist may administer dental hygiene services for a 2 year period to patients not assigned by a dental through a department of community Health designed "grantee health agency. Grantee health agencies must be a public or nonprofit entity, school, or nursing home that employs or contacts with at least one dentist or dental hygienist and provides care to an underserved population.

Special requirements: Entities seeking a grantee health agency status must submit a comprehensive form outlining how the program will be carried out, providing for oversight and direction, and including information for all dental personnel involved. A dental hygienist operating as a grantee health agency must ensure that the supervising dentist is available for consultation when necessary.

Services: those permitted under general supervision.

Minnesota 2001
Section 150A. 10, subd. 1a
A dental hygienist may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services without the patient first being examined by a licensed dentist if the dental hygienist has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

Health care facility is defined as a hospital, nursing home, home health agency, disabled/juvenile home, federal/state/local public health facility, community clinic, prison, tribal clinic school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.
A collaborative agreement means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services may be performed without the presence of a licensed dentist and may be performed at a setting other than the usual place of practice of the dentist or dental hygienist and without the dentist's diagnosis/treatment plan unless specified in the agreement.

Special Requirements: Has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years. Has documented participation in courses in infection control and medical emergencies within each continuing education cycle and maintains current certification in advanced or basic cardiac life support as recognized by the American Heart Association, the American Red Cross, or another agency that is equivalent to the American Heart Association or the American Red Cross.

Services: Removal of deposits and stains from the surfaces of the teeth, application of topical preventive and prophylactic agents, sealants, fluoride varnishes, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking x-rays and root planing.

- **There are now 2 dental hygienists volunteering in a community dental clinic providing restorative and preventive services to at least 10 patients each day they volunteer.**
- **At least 25 dental hygienists had qualified for collaborative practice in 2006.**
- **Direct Medicaid reimbursement allowed.**

Missouri 2001
Statute 332.311.2
Dental hygienists may provide services without supervision in public health settings to Medicaid eligible children and be directly reimbursed by Medicaid.

Special Requirements: 3 years experience.

Services: Oral prophylaxis, sealants, fluorides.

- **One particular dental hygienist has seen a sealant program grow from one school district to eight. Over 2,500 sealants have been placed on over 700 children.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, were 12 registered providers.**

Montana 2003
Sec. 37-4-405
Dental hygienists may obtain a limited access permit from the board allowing them to practice under public health supervision in a variety of federally funded health centers and clinics, nursing homes, extended care facilities, home health agencies, group homes for the elderly, disabled, and youth, head start programs, migrant work facilities and local and state public health facilities. Public health supervision means the hygienist can provide oral prophylaxis, fluoride, polish restorations, root plane, sealants, oral cancer screening, expose radiographs, and chart without the authorization of a dentist provided he or she follows protocols to be established by the board and refers any patients needing dental treatment.

- **Program took effect in September of '04, 10 permits in '06.**

Nebraska 2007
Sec. 71-193.18
The Department of Health may authorize an unsupervised RDH to provide public health related services in a public health setting or a healthcare or related facility.

Special requirements: 3000 hours experience in at least 4 of last 5 years; professional liability insurance.

Services: Prophylaxis for a health child, pulp vitality testing, preventive measures including fluorides & sealants.

New Hampshire 1993
Rule 302.02(d); 402.01 (c)
Under public health supervision dental hygienists may provide procedures authorized by a dentist in a public or private school, hospital or institution, or residence of a homebound patient provided the dentist reviews patient records once in a 12 month period.

Special Requirements: None.

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

New Mexico 2007
Sec. 61-5-C
No supervision required for any dental hygienist to apply fluorides, and remineralization agents.

New Mexico 1999
Sec. 61-5A-4D
Rule 16.5.17
Collaborative practice permits [based on a written agreement between the dental hygienist and one or more consulting dentist(s)], dental hygienists to treat patients according to a protocol with collaborative dentist. Dental hygienists may own or manage a collaborative dental hygiene practice in any setting. Must refer patient for dental exam yearly.

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

Services: Each collaborative practice agreement must contain protocols for care. Which provide for standing orders allowing the dental hygienist to provide routine services such as preliminary assessment, x- rays, oral prophylaxis and fluoride treatment without prior authorization. Case-by-case authorization required in some procedures (as sealants and root planning).

- **One collaborative practice arrangement that started in 2002, serves a base of 4,000 people-1/3 of which are Medicaid eligible.**
- **Direct Medicaid reimbursement allowed.**
- **In 2006, there were 35 collaborative practice RDHs.**

New York 2005
Rules Sec. 61.9
That a supervising dentist be available for consultation, diagnosis and evaluation, has authorized the dental hygienist to perform the services, and exercises that degree of supervision appropriate to the circumstances. A dental hygienist can work in any setting (private or public) and perform dental hygiene duties (listed below) without a dental examination or need to refer a patient to a dentist.

Dental hygiene services allowed include removing calcareous deposits, accretions and stains, including scaling and planning of exposed root surfaces; applying topical agents indicated for a complete dental prophylaxis; removing excess cement from surfaces of the teeth; providing patient education; placing and exposing X-ray films; performing topical anticariogenic agent applications, including but not limited to topical fluoride applications, and performing topical anesthetic applications; polishing teeth, including existing restorations; taking medical history including the measuring and recording of vital signs; charting caries and periodontal conditions

as an aid to diagnosis by the dentist; applying pit and fissure sealants; and applying desensitizing agents to the teeth.

In nursing homes a hygienist can perform a complete oral examination of a resident and then determine treatment priorities; plan for continuing oral hygiene and dental care.

- **In 2005, dental hygienists have screened and provided sealants for over 30,000 children.**
- **About 100,000 children in New York received care in school-based programs overseen by dental hygienists.**

Nevada 1998
Sec. 631.287
Dental hygienists may obtain approval to work as public health dental health hygienists in schools, community centers, hospitals, nursing homes and such other locations as the state dental health officer deems appropriate without supervision.

- **33 RDH's have gained board approval. Nevada Health Centers, Inc. where some RDH's are employed, provides services in eighteen different locations in Nevada. Dental hygienists with Public Health endorsement can also screen and place sealants without a dentist present. Additional locations include Saint Mary's, Huntridge Teen Center & Lyon Co. Healthy Smiles.**
- **Direct Medicaid reimbursement allowed.**

Oklahoma 2003
Sec. 328.34 C
A dentist may authorize in writing a dental hygienist to perform services one time on a patient in a setting outside the office prior to any dentist contact/exam if the hygienist refers the patient back to the authorizing dentist.

Special Requirements: 2 years experience

Oregon 1997
Sec. 680.200
Rule 818-035-0065
Dental hygienists who have obtained a limited access permit (LAP) may initiate services for patients in a variety of limited access settings such as extended care facilities, facilities for the mentally ill or disabled, correctional facilities, schools and pre-schools, and job training centers. RDH must refer the patient annually to a licensed dentist available to treat the patient.
12 hours of CE every two years (in addition to the 24 hours required for all dental hygienists) to renew permit.

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

- **In 2006, there were 70 LAP's.**
- **In the last year, LAP dental hygienists in 3 counties provided over 5,000 preventative procedures for children in Head start, Early Head start, WIC public health settings.**
- **Several LAP hygienists throughout Oregon continue to build practices serving the elderly in foster homes and extended care facilities.**
- **Direct Medicaid reimbursement allowed.**

Pennsylvania 2007

(Act 216) Sec. 2 (Definitions)

Dental hygienists licensed in Pennsylvania can practice as "public health dental hygiene practitioners," providing care in a variety of public health settings without the supervision or prior authorization of a dentist. Public health dental hygiene practitioners are required to take five hours of continuing education dedicated to public health matters during each licensure period.

Special requirements: 3,600 hours expense, liability insurance. Must complete 5 hours of CE in public health during each licensure period.

Services: educational, preventive, therapeutic, and intra-oral services, including complete prophylaxis and sealants, dental hygienists in the state are authorized to provide.

Rhode Island 2006

Sec. 5-31.1-6.1

Dental hygienists working under a dentist's general supervision can initiate dental hygiene treatment to residents of nursing facilities. Dental hygienists working in nursing facilities can treat patients, regardless of whether or not the patient is a patient of record, as long as documentation of services administered is maintained and necessary referrals for follow-up treatment are made.

Special requirements: None.

Services: Initial oral health screening assessments, prophylaxis, fluoride treatments, charting, and other duties delegable under general supervision.

South Carolina 2003

Sec. 40-15-110 (A) (10)

Dental hygienists employed by or contacted through the Department of Health and Environment Control may provide services under general supervision that does not require prior examination by a dentist in settings such as schools or nursing homes.

Special requirements: Dental hygienist must carry professional liability insurance.

Services: Prophylaxis, fluorides, sealants

Texas 2001

Sec. 262.1515

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

Special Requirements: 2 years practice experience.

Services: No limitations.

Vermont 2008

Rule 10.2

Dental hygienists may provide hygiene services in public health settings under the supervision of a dentist via a general supervision agreement. The agreement authorizes the dental hygienist to provide services, agreed to between the dentist and the dental hygienist. The agreement does not require physical presence of the dentist but it stipulates that the supervising dentist review all patient records.

Special Requirements: Three years licensed clinical practice experience and in good standing in Vermont.

Services: Sealants, fluoride varnish, prophylaxis and x-rays. Periodontal maintenance and root planing may be provided on patients with mild periodontitis.

Washington 2001 (Washington has two different provisions for direct access)
Sec. 18.29.220
Dental hygienists who are school endorsed may assess for and apply sealants and fluoride varnishes in community-based sealant programs carried out in schools.

Special Requirements: Sealant/Fluoride Varnish Endorsement from Department of Health.

- **Data obtained through Medicaid indicates that dental hygienists working under these provisions saw 5,653 clients in 2002; 6,799 in 2003, and 4,265 through July of '04. Specifically in terms of sealants, over 19,200 sealants have been placed since Dec. 2003.**
- **Direct Medicaid reimbursement allowed.**

Washington 1984
Sec. 18.29.056
Unsupervised practice in hospitals, nursing homes, home health agencies, group homes (for the elderly, handicapped or youth), state institutions under department of health and human services, jails, and public health facilities provided the hygienist refers patient to a dentist for dental treatment and needed care.

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

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

West Virginia 2008
§5-1-8.5
Dental hygienists, who meet specific requirements, may provide dental hygiene services without the supervision of a dentist in hospitals, schools, correctional facilities, jails, community clinics, long term care facilities, nursing homes, home health agencies, group homes, state institutions under the Department of Health and Human Resources, public health facilities, homebound settings and Accredited Dental Hygiene Education programs.

Special requirements: 2 years and 3,000 hours of clinical dental hygiene experience; six additional continuing education hours this must include 3 hours in medical emergencies and 3 hours in general public health content. The dental hygienist and supervising dentist must submit an annual report to the West Virginia Board of Dental Examiners of services rendered.

Services: Dental hygiene education; nutritional counseling; oral screening with referral to dentist; apply fluoride; charting; recording medical history; complete prophylaxis (upon written prescription from a licensed dentist).

Wisconsin 2008
Wisconsin. Sec. 447.06
The statute does not require the presence or general supervision of a dentist in a public or private school, a dental or dental hygiene school or a facility owned by a local health department.

SCHOOL-BASED DENTAL SEALANT PROGRAM *

Table 1.[1] Screening Data 2000 - 2004

dds	# screenings	# children with	% children with	number of	average # caries	# sealants
	2nd graders	untreated caries	untreated caries	untx caries	per child	
2000-01	364	104	28.57	271	2.61	1199
2001-02	413	154	37.29	393	2.55	1444
2002-03	404	169	41.83	441	2.61	1296
2003-04	409	138	33.74	368	2.67	1563
TOTALS	**1590**	**565**	**35.53%**	**1473**	**2.61**	**5502**

Table 2.[2] Screening Data 2004 - 2008

dds	# screenings	# children with	% children with	number of	average # caries	# sealants
	2nd graders	untreated caries	untreated caries	untx caries	per child	
2004-05	245	94	38.36	246	2.62	778
2005-06	219	97	44.29	253	2.61	622
2006-07	222	67	30.18	172	2.57	641
2007-08	236	61	25.85	154	2.52	690
TOTALS	**922**	**319**	**34.59%**	**825**	**2.58**	**2731**
rdh						
2004-05	363	118	32.50	316	2.67	1175
2005-06	239	83	34.72	245	2.95	742
2006-07	251	89	35.46	185	2.09	706
2007-08	271	81	29.89	157	1.94	828
TOTALS	**1124**	**371**	**33.00%**	**903**	**2.43**	**3451**

Table 3.[3] Total # Screenings and Sealants

	Screenings	Sealants
	2nd graders	2nd grade
2000-04	1590	5502
2004-08	2046	6182

Table 4.[4] Treatment Status

	# of follow-up screenings for 3rd, 4th & 5th graders	# of children who HAVE received tx	# of children who HAVE NOT received tx
2001-02	71	30	41
2002-03	89	46	43
2003-04	79	46	33
2004-05	77	42	35
2005-06	133	88	45
2006-07	140	72	68
2007-08	100	42	58
TOTALS	**689**	**366**	**323**
%		**53.1%**	**46.9%**

Table 5.[5] Caries Experience of 8th Graders

Participants in Dental Sealant Program		
# of students	96	
# of first & second permanent molars [1]	695	
# of teeth with caries history	53	
Mean number of caries per student	0.55	(1.014 sd)[2]
Percent of teeth with caries history	**7.6%**	
Non-participants		
# of students	95	
# of first & second permanent molars [1]	684	
# of teeth with caries history	139	
Mean number of caries per student	1.46	(2.004 sd)[2]
Percent of teeth with caries history	**20.3%**	

[1] Does not include missing teeth or questionable caries

[2] *t(189) df = 3.97, p<.001*

Middle Schools 2004

* This data was collected from the Black Hawk County School-based Dental Sealant Program. The program has provided services to 15 elementary and 6 middle schools in 3 counties in Iowa.

[1] Table 1 contains the data collected during the four years that a licensed dentist did all of the screenings.

[2] Table 2 contains the data collected during the four years that both a licensed dentist and a licensed dental hygienist did screenings.
There appears to be no significant difference between the percent of children with untreated caries or the average # of caries per child if the screening was completed by a dentist or a dental hygienist.

[3] Table 3 contains a comparison of the number of screenings and sealants.
During the four years from 2004 -2008 that both a dentist and dental hygienist did screenings there were 456 more screenings and 680 more sealants than the four years that only a dentist did the screenings.

[4] Table 4 contains the data indicating the number of children who were screened in Grades 3,4 & 5 to determine if treatment for dental disease was completed. Almost 47% had not received treatment by a dentist.

[5] Table 5 contains the screening data of eighth graders from 3 middle schools. This outcome data indicates there is a significant difference in the caries experience of 8th graders. The students who did NOT participate in the school-based sealant program were almost 3 times more likely to experience tooth decay in their permanent molars.

Notes: In 2004 the Black Hawk County School-based Dental Sealant program began utilization of the public health supervision ruling in accordance with the requirements of Iowa Code Section 10.5 (153). This ruling has increased access to preventive services for high-risk children and provided significant improvements to the efficiency of the program.

When the dental hygienist does both the screenings and the sealant applications it 1) reduces the amount of time each student is out of the classroom; 2) reduces interruptions to the academic activities in the classroom; 3) reduces the amount of time between the screening and the placement of sealants, 4) reduces the number of clinical supplies needed; and 5) reduces the costs of compensating dentists for time and expenses to perform screenings.

In addition, this format 1) increases the possibility that students who were absent or have not yet returned a consent form will be able to participate in the program; 2) retains the referral process for students in need of dental treatment and 3) retains the ability to do follow-up screenings to determine if children have received the dental treatment they need.

The data collected from this school-based sealant program indicate that the program can be implemented more efficiently in terms of time and cost when a dental hygienist does the screenings and makes referrals to a dentist for dental treatment.

The data from this program also indicate that almost 47% of children who have been identified as having existing caries and are in need of treatment have not received treatment when a follow-up screening was done in subsequent years. Utilization of the time and clinical skills of licensed dentists may be more beneficial to these children if restorative services were provided rather than the time and expenses required to complete screenings in schools.

October 26, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo:

As a registered dental hygienist currently working under public health supervision, I am writing to you to express my support of the Iowa Dental Hygienists' Association's current request for an amendment to the public health supervision rules. I believe that the access-to-care issues we have been aware of are becoming even more evident as more hygienists begin a career in public health. In the 22 months that I have been working as an I-Smile Coordinator, I have had the need demonstrated to me time and again.

This proposed amendment – changing the requirement of a dental exam within 12 months following certain procedures to the requirement of a dental referral following the procedures – will allow myself and the other hygienists employed by our agency to address the access-to-care issues that we are seeing our clients experience. By being able to provide comprehensive dental hygiene services in spite of our clients' inability to be seen by a dentist, we will be a source of ongoing care.

I would like to provide you with two examples of ways in which this change will benefit the patients who are served by our agency.

- In our Child Health clinic in Perry, we are currently applying sealants. Because of the way our public health supervision agreement is set up with our supervising dentist, we can provide sealants after the client has had an exam and has been deemed caries-free. The dentists in the area are not applying sealants on a regular basis, even to children at a high risk for developing caries. After the child has seen a dentist, we apply sealants to the children's teeth. Occasionally, we see a child that has two or three of their molars erupted and ready for sealants so we apply sealants to those teeth. Because of the public health supervision rules, we cannot seal the remaining teeth after they have finished erupting until the child has seen a dentist again. For our children, that will be six to twelve months. With the amendment changed to a referral to the dentist, we could make that referral and then go ahead and seal the remaining teeth in three to four months after they have finished erupting. This would allow us to provide this preventive measure with the hope of decreasing dental caries on these teeth.
- We have recently begun providing dental hygiene services to our Maternal Health clients (pregnant mothers) at our WIC clinics. After a thorough assessment, a decision is

made regarding whether or not we feel we can provide a prophylaxis for the client. If appropriate, an appointment is scheduled for the prophy. We see our clients again in six months and would like to be able to provide a follow-up prophy at that time. Because of the public health supervision rules, we cannot do that unless the client has had an exam. For our clients who are uninsured and cannot afford to pay for a dental visit out-of-pocket, this becomes a serious impediment to ongoing dental care. Our clients who are enrolled in Medicaid also have a difficult time accessing care due to dentists' non-acceptance of Medicaid. If we could refer the client to the dentist and then proceed with the follow up visit, we could provide ongoing, comprehensive dental hygiene care to our clients.

Our programs are expanding and we hope to be able to provide dental hygiene services to clients of our agency's substance abuse treatment program. There is a significant need present in those clients and a change in the rules would allow us to provide ongoing dental hygiene care to these clients as well.

Lastly, I would like to express my continued support and cooperation with the dentists in our area. I always conclude every appointment with any of our clients with a statement of the need to be seen by a dentist. I also make sure all of our clients know that our assessment in no way replaces a dental exam and regular care by a dentist. Unfortunately, due to the shortage of dentists in certain parts of our service area, the shortage of dentists who accept Medicaid, and the inability of some of our clients to pay for out-of-pocket costs associated with dental care, several of our clients are simply unable to access dental care in a dental office. If we could provide ongoing dental hygiene preventive care until they are able to seek care in a dental office, the chances of needing significant dental work will be decreased. This care, along with proper education, will improve the dental health of our clients.

I appreciate your time in reading my letter and your consideration of the request for the amendment to the rules. Our clients are so appreciative of all we do for them because without us they would not be receiving care. Please consider the change to the rules so that we can enhance our services and provide ongoing care to those who need it most.

Sincerely,

Jenifer J. Badger

Jenifer J Badger, RDH
Bagley, Iowa

October 26, 2008

Eileen Cacioppo, RDH
Chair, Dental Hygiene Committee
Iowa Board of Dental Examiners
Attn: Jennifer Hart
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Ms. Cacioppo,

I am writing to support an amendment to Administrative Rule 650-7.1 regarding the need for a dental exam after 12 months of preventive hygiene services and the discontinuation of these services if no dental examination is performed.

My dental hygiene career started about 31 years ago. During this time, I have been in private practice, worked as an adjunct clinical instructor at DMACC and currently have a public health position serving seven counties in Iowa. The majority of my time in the early years was patient education, prophylaxis, fluoride treatments and exposing radiographs. In the 1970s and 1980s, there was a high incidence of rampant decay and nursing caries, especially with the influx of Southeast Asians. It was routine to see "bombed-out" deciduous molars, incisors and first permanent molars. Children required extensive dental treatment, including extractions, crowns, space maintainers, large restorations with pulp caps and some endodontics. Because of the increase in education, preventative treatment, fluoride, sealants, regular recalls and increased third party payments, the extensive treatment we once provided is uncommon. Over the years, there have been many positive changes in dentistry and patients receive improved preventative services.

However, low-income clients, because of their dental insurance or lack of insurance, are unable to receive dental treatment, or receive only minimal treatment at best. This brings me to my current employment. Two months ago, I took a position with New Opportunities, Inc. in Carroll, IA. We provide screenings, fluoride varnishes, dental referrals, etc. as part of the I-Smile Program. If I were to describe the clients' needs in this program, I would have to describe the 1970s and 1980s when I started practicing.

After thirty years in private practice, seeing the well-maintained, disease-free, or successfully treated patients, I thought the dental diseases were decreasing. However, after three weeks with I –Smile Program, I quickly realized was so mistaken. I overestimated the percentage of people who actively seek and receive dental care. In just three days working at the Perry facility, we observed three children with suspected rampant decay, nursing caries and fistulas on deciduous incisors. As part of the screening visit, we provide a referral to a local dentist for an examination. This can be a verbal, a written referral or a call an office to schedule an appointment. Scheduling appointments is not as easy as it would seem, barriers may include:

1) the lack of dentists willing to treat Medicaid clients
2) the office is no longer seeing new Medicaid patients
3) patients dismissal because of missed appointments
4) clients failing scheduled appointments
5) dentists deferring treatment to The University of Iowa because the client is a probable surgery candidate
6) lack of transportation
7) lack of child care when at appointments
8) parents' lack of dental education recognizing dental disease
9) parents' lack of nutrition education
10) decreasing number of child health clinics

I wanted to work in public health to provide preventative care for the underserved, act as a bridge or connection between public health clients and dentists, and bring this group into the 21st century. Please allow public health hygienists to continue providing preventative services including referrals for our clients. If it were not for public health services and referrals, some may never visit a dentist. In addition, making the referral and scheduling an examination appointment does not always a guarantee treatment is provided. It is unfair to suspend all public health services after one year because a dentist did not provide a dental examination. Suspending all preventative therapy in the absence of a dental examination may eliminate the only opportunity the low-income, uninsured and underinsured may have to receive preventative services.

Thank you for your time and consideration.

Sincerely,

Joyce Miller, RDH, BS

Larry Carl

From: Hart, Jennifer [IBDE] [Jennifer.Hart@iowa.gov]
Sent: Wednesday, November 26, 2008 11:50 AM
To: Larry Carl; jvlegs@hotmail.com; ensey4@yahoo.com
Cc: cvanaernam@aol.com; Price, Constance [IBDE]
Subject: Dental Hygiene Petition - Comments requested
Follow Up Flag: Follow up
Due By: Monday, December 08, 2008 12:00 AM
Flag Status: Red
Attachments: DH Petition NewNov08.pdf

Attached is a copy of a petition for rulemaking and supporting documents submitted by the Iowa Dental Hygienists' Association concerning public health supervision. I am forwarding a copy of this information to the associations to give you an opportunity to submit written comments on the petition for board consideration.

The petition will be considered by the Iowa Dental Board at their January 15, 2009, meeting. To give the board time to review your comments, it would be helpful for your to submit them no later than Monday, December 22. Comments may be submitted via mail to the board address or may be e-mailed to my attention. Please note that if the board chooses to grant the petition and initiates rulemaking, a public hearing will be scheduled and there will be an additional opportunity to submit written comments.

Jennifer Hart, Executive Officer
Iowa Dental Board
400 SW 8th St, Suite D
Des Moines, IA 50309
☎Phone (515) 281-0997 ☎Fax (515) 281-7969
http://www.dentalboard.iowa.gov

BE GREEN: Please consider the environment before printing this email.

January 5, 2009

RECEIVED
JAN 08 2009
IOWA DENTAL BOARD

Deena Kuempel, DDS
Chairperson, Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309

Dear Dr. Kuempel

I understand that the Iowa Dental Board will be discussing the public health supervision rules at a meeting in January 2009. While I am not able to attend the meeting I would like the attached information taken into consideration. I have provided clinical coordination of the Black Hawk County school-based dental program since its inception in 1999. For the past four years I have provided services under the public health supervision rules. Although I believe some data from the school-based program has already been forwarded to the Board, I am enclosing a current copy in this correspondence.

As an advocate for high-risk children who have limited access to preventive and operative dental care, I sincerely request that the rules be amended to eliminate the twelve month dental screening requirement. The current requirement reduces the possibility of preventive services being provided to all eligible school children. Eight years of in-school screenings by both dentists and dental hygienists indicate there is no significant difference in the screening outcomes or judgments about which teeth to seal or not to seal. There appears to be no clinical benefit for these children in having a dentist doing the initial screenings or any subsequent screenings. The data also indicate that one of the most serious unmet needs for the children who have been identified with existing disease is getting treatment and follow-up care by a dentist. That is a service we hope more dental clinicians will be willing to provide in the future.

As part of our school-based program we provide in-service programs for the teachers and staff at each of the participating schools. I have enclosed a copy of one of the handouts. It is sometimes difficult to look at all the data and see the individual children the numbers represent. These school-age children are in a critical stage of their dental development. What does or doesn't happen for them during their early development has a serious impact on their future health and well-being. They are impoverished, uninsured or underinsured and in pain. Even when they have toothaches and discomfort they often continue to go to school and struggle through their school hours to pay attention, eat lunch and enjoy recess.

Dr. Kuempel, I would like to take this opportunity to clarify comments that were forwarded to me regarding the availability of dentists to do screenings for our program in Black Hawk County. Since the beginning of the program in 1999 we have had dentists who were willing to help with

the in-school screenings every year. I do not know the origin of the misinformation stating that local dentists were not available or willing to do screenings.

Please share this correspondence and attachments with all of the Board members and extend to each of them an invitation to come and visit our school-based program. They can contact me by phone or email to arrange a visit at any of the schools. Thank you.

Sincerely,

Joan L. Gilpin, RDH, MA
Coordinator, School-Based Dental Program
Black Hawk County Health Department
jlgilpin@cfu.net; ph. 319-277-1843

Cc: Rhonda J. Bottke, MA, ARNP, CPNP
Division Manager, Black Hawk County Health Department

Carol Van Aernam RDH, BA
President, Iowa Dental Hygienists' Association

Robert Russell, DDS, MPH
Public Health Dental Director, Iowa Department of Public Health

5-Jan-09

BLACK HAWK COUNTY HEALTH DEPARTMENT

SCHOOL-BASED DENTAL PROGRAM *

Table 1.[1] Screening Data 2000 - 2004

dds	# screenings 2nd graders	# children with untreated caries	% children with untreated caries	number of untx caries	average # caries per child	# sealants
2000-01	364	104	28.57	271	2.61	1199
2001-02	413	154	37.29	393	2.55	1444
2002-03	404	169	41.83	441	2.61	1296
2003-04	409	138	33.74	368	2.67	1563
TOTALS	**1590**	**565**	**35.53%**	**1473**	**2.61**	**5502**

Table 2.[2] Screening Data 2004 - 2008

dds	# screenings 2nd graders	# children with untreated caries	% children with untreated caries	number of untx caries	average # caries per child	# sealants
2004-05	245	94	38.36	246	2.62	778
2005-06	219	97	44.29	253	2.61	622
2006-07	222	67	30.18	172	2.57	641
2007-08	236	61	25.85	154	2.52	690
TOTALS	**922**	**319**	**34.59%**	**825**	**2.58**	**2731**
rdh						
2004-05	363	118	32.50	316	2.67	1175
2005-06	239	83	34.72	245	2.95	742
2006-07	251	89	35.46	185	2.09	706
2007-08	271	81	29.89	157	1.94	828
TOTALS	**1124**	**371**	**33.00%**	**903**	**2.43**	**3451**

Table 3.[3] Total # Screenings and Sealants

	Screenings 2nd graders	Sealants 2nd grade
2000-04	1590	5502
2004-08	2046	6182

Table 4.[4] **Treatment Status**

	# of follow-up screenings for 3rd, 4th & 5th graders	# of children who HAVE received tx	# of children who HAVE NOT received tx
2001-02	71	30	41
2002-03	89	46	43
2003-04	79	46	33
2004-05	77	42	35
2005-06	133	88	45
2006-07	140	72	68
2007-08	100	42	58
TOTALS	**689**	**366**	**323**
%		**53.1%**	**46.9%**

Table 5.[5] **Caries Experience of 8th Graders**

Participants		
# of students	96	
# of first & second permanent molars [1]	695	
# of teeth with caries history	53	
Mean number of caries per student	0.55	(1.014 sd)[2]
Percent of teeth with caries history	**7.6%**	
Non-participants		
# of students	95	
# of first & second permanent molars [1]	684	
# of teeth with caries history	139	
Mean number of caries per student	1.46	(2.004 sd)[2]
Percent of teeth with caries history	**20.3%**	

[1] Does not include missing teeth or questionable caries

[2] *t(189) df = 3.97, p<.001*

Middle Schools 2004

* The data in Tables 1 - 5 were collected during the implementation of the Black Hawk County School-based Dental Program. Children in 15 elementary and 6 middle schools in 3 counties in Iowa are provided preventive services through this public health program.

[1] Table 1 contains the screening data collected during the four years that a dentist did all of the screenings.

[2] Table 2 contains the screening data collected during the four years that either a dentist or a dental hygienist did the screenings. *There appears to be no significant difference in the clinical judgments of the dentists and the dental hygienists.*

[3] Table 3 contains a comparison of the total number of screenings and sealants for each four year period. During the four years from 2004 -2008 that a dental hygienist did screenings under the public health supervision rules, there were *456 more screenings and 680 more sealants provided to high risk children.*

[4] Table 4 contains the data indicating the number of children who had follow-up screenings in grades 3,4 & 5 to determine if treatment for dental disease was completed. *Almost 47% had not received treatment after referral to a dentist.*

[5] Table 5 contains the screening data of eighth graders from 3 middle schools. The outcome data indicate that students who participated in the school-based program were almost 3 times less likely to have cavities in their permanent molars.

Notes: In 2004 the Black Hawk County School-based Dental Sealant program began utilization of the public health supervision ruling in accordance with the requirements of Iowa Code Section 10.5 (153). This ruling has increased access to preventive services for high-risk children and has provided significant improvements to the efficiency of the program.

When the dental hygienist does both the screening and the sealant application, it 1) reduces the amount of time each student is out of the classroom; 2) reduces interruptions to the academic activities in the classroom; 3) reduces the amount of time between the screening and the placement of sealants, 4) reduces the number of clinical supplies needed; and 5) reduces the costs of compensating dentists for time and expenses to perform screenings.

In addition, this format 1) increases the possibility that students who were absent or have not yet returned a consent form will be able to participate in the program; 2) retains the referral process for students in need of dental treatment and 3) retains the ability to do follow-up screenings to determine if children have received the dental treatment they need.

The data collected from this school-based sealant program indicate that preventive services can be provided to more high-risk children when a dental hygienist does the screenings. The data also indicate that almost 47% of children who have been identified as having existing caries and are in need of treatment have not received treatment when a follow-up screening was done in subsequent years. These children would benefit from the time and unique clinical skills of a dentist.

Respectfully submitted by:
Joan L. Gilpin, RDH, MA
Coordinator, School Based Dental Program
Black Hawk County Health Department
ph 319-277-1843 jlgilpin@cfu.net

ST. LUKE'S HOSPITAL
IOWA HEALTH SYSTEM

RECEIVED
JUN 3 0 2004
IOWA BOARD OF
DENTAL EXAMINERS

DENTAL HEALTH CENTER
MEDICAL PLAZA BLDG.
SUITE LL 1
855 A AVENUE NE
CEDAR RAPIDS, IA 52402
319 / 369-7730
FAX: 319 / 369-7494

June 25, 2004

Iowa Department of Public Health
Oral Health Bureau, 5th Floor
Attn: Public Health Supervision
321 E 12th St
Des Moines, IA 50319-0075

Dear Oral Health Bureau:

Our three public health dental hygienists have completed their Public Health Supervision Agreements.

Please take note that one agreement is 27 pages, another is 20 pages and the third is 10 pages. This was 57 pages of reporting, plus another 57 pages of copies for our dental public health program in East Central Iowa.

The process required considerable staff time. If this is an annual report, you must consider revising and limiting the agreement and reporting forms.

Sincerely,

Rhys B. Jones DDS

Rhys B. Jones, DDS, MS
Director, Dental Health Center

Cc: Iowa Board of Dental Examiners

RBJ/pb

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

IOWA DENTAL BOARD
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

June 2009

Dear Licensee:

Public health supervision of dental hygienists has been an important step in improving access to preventive dental care for many underserved Iowans. Our records indicate that you currently have a public health supervision agreement with a dentist on file with the Oral Health Bureau of the Iowa Department of Public Health.

As you renew your dental hygiene license, we want to remind those of you with public health supervision agreements of the following:

- It is your responsibility – not your employer's – to oversee all aspects of your written supervision agreement and ensure that you are following board rules related to these agreements, including reporting requirements.
- Board rules require you to submit a report concerning the services rendered. These reports must be submitted in a timely manner to the Oral Health Bureau by January 31 of each year.
- Please be sure that the agreement on file is current. If there are changes in public health settings or service locations, a new or amended agreement signed by you and the supervising dentist must be submitted to the Oral Health Bureau.
- Review your agreement with your supervising dentist periodically. If there are any changes, a new or amended agreement signed by you and the supervising dentist must be submitted to the Oral Health Bureau.
- If you are no longer practicing under public health supervision, please advise the Oral Health Bureau in writing.

If you have questions about public health supervision, board rules, or how you can become involved in providing services for underserved Iowans, please contact either the Iowa Dental Board or the Oral Health Bureau of the Iowa Department of Public Health at (866) 528-4020.

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

American Academy of Sleep Medicine

American Academy of Dental Sleep Medicine

RECEIVED
NOV 29 2012
IOWA DENTAL BOARD

November 21, 2012

Melanie Johnson, JD
Executive Director
Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Johnson:

As the leading professional membership societies in the fields of sleep medicine and dental sleep medicine, the American Academy of Sleep Medicine (AASM) and the American Academy of Dental Sleep Medicine (AADSM) are committed to promoting the highest standards of care for patients with obstructive sleep apnea (OSA).

At least 12 to 18 million adults in the U.S. require treatment for OSA, a chronic medical disorder that is associated with deleterious medical conditions such as hypertension, stroke and congestive heart failure. The primary treatment options for adults with OSA are positive airway pressure (PAP) therapy and oral appliance therapy (OAT).

As the number of dentists who have begun to provide OAT has increased rapidly in recent years, both of our societies have received inquiries from members seeking clarification regarding the scope of practice of the physician and dentist in the diagnosis and long-term management of patients with OSA. Therefore, the AASM and AADSM collaboratively developed the attached Joint Policy Statement on the Diagnosis and Treatment of Obstructive Sleep Apnea, which provides the necessary guidance for our members and emphasizes the distinguishing facets of medical and dental licensing laws and practice acts.

The statement clearly assets that the diagnosis of OSA and the prescription of the appropriate treatment must be made by a qualified physician who is trained in sleep medicine. Once OAT has been prescribed by a board-certified sleep medicine physician, then the oral appliance device should be fit by a qualified dentist with training and experience in dental sleep medicine.

This joint policy statement will be made available to the 10,000 members of the AASM and the 3,000 members of the AADSM. Should you have any questions or comments about this statement, please contact Executive Director Jerome A. Barrett at 630-737-9700.

Phone: (630) 737-9705
Fax: (630) 737-9790
www.aadsm.org

2510 North Frontage Road, Darien, IL 60561-1511

Phone: (630) 737-9700
Fax: (630) 737-9790
www.aasmnet.org

It is our hope that your licensing board will find this statement to be useful should you need to respond to inquiries related to this issue.

Sincerely,

B. Gail Demko, DDS
AADSM President

Samuel A. Fleishman, MD
AASM President

Enclosure

cc: Jerome A. Barrett, Executive Director

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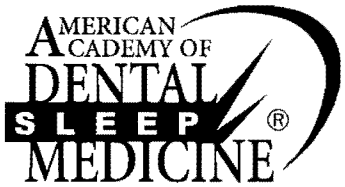
IOWA DENTAL BOARD



American Academy of Sleep Medicine

American Academy of Dental Sleep Medicine

AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE AND AMERICAN ACADEMY OF SLEEP MEDICINE JOINT POLICY STATEMENT ON THE DIAGNOSIS AND TREATMENT OF OBSTRUCTIVE SLEEP APNEA

The American Academy of Sleep Medicine (AASM) and the American Academy of Dental Sleep Medicine (AADSM) are committed to the highest standards for sleep medicine care and ensuring patients receive quality care for obstructive sleep apnea (OSA).

OSA is a highly prevalent syndrome associated with deleterious medical conditions such as hypertension, stroke and congestive heart failure as well as health concerns such as increased motor vehicle accidents and impaired quality of life[i]; it is classified as a medical disorder.

The Diagnosis of Obstructive Sleep Apnea

It is the policy of the AASM and AADSM that patients presenting with symptoms of OSA require a face-to- face evaluation conducted by a qualified physician trained in sleep medicine. The AASM defines a qualified physician trained in sleep medicine as one who is licensed by a state to practice medicine and maintains certification from the American Board of Sleep Medicine or one of the sponsoring sleep medicine boards of the American Board of Medical Specialties.

Treatment Therapies for Obstructive Sleep Apnea

Therapies for OSA, including positive airway pressure (PAP) and oral appliance therapy (OAT), must be prescribed by a qualified physician as described above.

Qualified dentists with training and experience in the overall care of oral health, the temporomandibular joint, dental occlusion and associated oral structures should fit the oral appliance device[ii] as a therapy for OSA. Furthermore, dentists treating patients with OAT must practice within their scope of practice according to dental practice laws in their respective state. The AADSM defines a qualified dentist as one who maintains certification from the American Board of Dental Sleep Medicine[iii], or one who is the director of an AADSM-accredited dental facility and has completed 30 hours of continuing education (ADA CERP recognized or AGD PACE approved) within the past three years. With regard to continuing education, a minimum of 20 credits must be in dental sleep medicine. Additional credits must be sleep medicine related.

All qualified dentists must follow current AASM Practice Parameters and Clinical Guidelines and current AADSM Treatment Protocols.

Medical and Dental Licensing Laws and Practice Acts

The practice of medicine is governed by state licensing laws, which are commonly referred to as enabling laws. Enabling laws have a corresponding practice act, which governs the practice of medicine in the respective state; without this act any individual, regardless of qualifications, can practice medicine without restriction or penalty. The practice act also defines the scope and limits of practice for physicians. Because medicine is an ever-changing field, each practice act

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www.aasmnet.org

expires within a set period of time, which enables the state legislature to ensure that the respective laws are reflective of current medical practice.

Common provisions addressed by a practice act include but are not limited to:

- Provides for the delegation of patient care services to other professionals practicing within the scope of their license
- Outlines requirements for collaboration between physicians or dentists with other professionals
- Prohibits fee splitting
- Specifies limits for advertising
- Specifies requirements for continuing medical education and fitness for licensure
- Outlines terms of each license and conditions for renewal
- Specifies penalties for practicing medicine without a license or beyond the scope of license
- Outlines disciplinary action that can be taken including restriction, suspension or revocation of license

All medical practice acts restrict the diagnosis of a medical disease or disorder to a licensed physician. An individual who is not licensed in medicine yet diagnoses a medical disease or disorder is subject to civil and criminal law.

Medical practice laws and practice acts, however, do not include provisions for the performance of any dental operation.

Similar to medicine, licensing laws and practice acts for dentists include scope of practice and provisions for care.

Dental practice acts specify common provision that the performance of any dental operation upon the oral cavity, teeth or associated structure as well as the construction and fit of any appliance used in the oral cavity is under the purview of a licensed dentist.

Common provisions addressed by a dental practice act include but are not limited to:

- Provides for the delegation of patient care services to other professionals practicing within the scope of their license
- Specifies requirements for continuing medical education and fitness for licensure
- Outlines terms of each license and conditions for renewal
- Specifies penalties for practicing dentistry without a license or beyond the scope of license
- Outlines disciplinary action that can be taken including restriction, suspension or revocation of license
- Outlines the dentist's purview to take dental impressions for patients

Dental licensing laws and practice acts, however, do not include provisions for the diagnosis of medical diseases and disorders or the treatment of diseases by dentists without a prescription from a board certified physician. An individual who is not licensed in dentistry yet provides therapy related to the oral cavity is subject to civil and criminal law.

---

[i] Luyster FS; Strollo PJ; Zee PC; Walsh JK. Sleep: a health imperative. *SLEEP* 2012;35(6):727-734.

[ii] Kushida CA; Morgenthaler TI; Littner MR et al. Practice parameters for the treatment of snoring and obstructive sleep apnea with oral appliances: An Update for 2005. *SLEEP* 2006;29(2): 240-243.

[iii] Certification by the American Board of Dental Sleep Medicine must be achieved on or prior to January 1, 2018.

American Academy of Sleep Medicine

OFFICERS

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September 5, 2012

RECEIVED
SEP 10 REC'D
IOWA DENTAL BOARD

Melanie Johnson, JD
Executive Director
Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines, IA 50309-

Dear Ms. Johnson:

By way of introduction, my name is Sam Fleishman, MD, and I am the President of the American Academy of Sleep Medicine (AASM). The purpose of my letter is to solicit your professional opinion on a scope of practice issue regarding dentists licensed in the state of Iowa.

As context, following is background information on sleep medicine, specifically the diagnosis and treatment of obstructive sleep apnea (OSA), which you may find useful in considering my inquiry. Sleep medicine is recognized as a medical sub-specialty by the American Board of Medical Specialists (ABMS). To this end, there is a board certification examination offered in sleep medicine by the ABMS and fellowship training programs for resident physicians accredited by the Accreditation Council for Graduate Medical Education. As such, sleep medicine physicians are educated, trained and credentialed to treat the full breadth of sleep disorders, including OSA.

OSA is a prevalent medical disease identified in more than 4 percent of men and 2 percent of women. It is often accompanied by one or more co-morbid conditions that impact the patient's overall health. OSA is characterized by repetitive episodes of complete (apnea) or partial (hypopnea) upper airway obstruction during sleep. These events often result in reductions in blood oxygen saturation and are usually terminated by brief arousals from sleep. Most events are 10 to 30 seconds in duration but occasionally persist for one minute or longer. An apnea-hypopnea index (AHI) is the number of apneas plus the number of hypopneas per hour of sleep. OSA is defined as an AHI of greater than five with a complaint of excessive daytime sleepiness.

Sleep apnea is diagnosed by a licensed physician who has interpreted a sleep study that is conducted either by an overnight in-laboratory test known as polysomnography, which monitors 16 independent parameters, or an out-of-center test often referred to as a home sleep test, which monitors 3-4 independent parameters. A physician, using home sleep testing devices, has considerably less information from which to make their diagnosis which increases the need for specific training and patient evaluation. In most cases, the first-line treatment for OSA is Continuous Positive Airway

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Pressure (CPAP), which has been validated extensively through peer-reviewed evidence. Select patients who are intolerant of CPAP or have a mild case of OSA may utilize oral appliance therapy (OAT) for management of OSA. In instances where a patient uses OAT, the sleep medicine physician will conduct the sleep test and interpret its results; diagnose the patient with OSA; and write a prescription for OAT. At this point the physician and dentist work together managing the treatment.

The oral appliance is configured and fitted by a dentist. An oral appliance is considered Durable Medical Equipment (DME) and is reimbursed similar to other types of DME equipment.

We understand that language in Iowa's dental practice act states:
"Practice of dentistry" *as defined in Iowa Code section 153.13 includes the rendering of professional services in this state as an employee or independent contractor or the rendering of any dental decisions, including diagnosing, treatment planning, determining the appropriateness of proposed dental care, or engaging in acts that constitute the practice of dentistry.*
The following classes of persons shall also 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 examinations, 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.
3. Persons who offer to perform, perform, or assist with any phase of any operation incident to tooth whitening, including the instruction or application of tooth whitening materials or procedures at any geographic location. For purposes of this paragraph, "tooth whitening" means any process to whiten or lighten the appearance of human teeth by the application of chemicals, whether or not in conjunction with a light source.

Recently, some dentists who provide patients with OAT, per the written order of a board certified sleep medicine physician, have made claims via advertisements and public forums that dentists are within their scope of practice to diagnose sleep apnea by utilizing home sleep tests. This opinion has in large part been fostered by various marketing companies that sell testing equipment and oral appliances.

It is the position of the AASM that a home sleep test is a diagnostic test conducted for the sole purpose of determining a medical disease and can only be ordered and interpreted by a licensed physician. Further we are of the opinion that a licensed dentist is practicing outside the limits of their license to prescribe, conduct and interpret a medical test. We feel very strongly that this particular practice by dentists is false, misleading and deceptive and frankly dangerous to the public. Further it plays on the vanity and possible fear of the public and promotes a substandard practice model for sleep medicine.

The AASM is also of the opinion that a licensed sleep medicine physician is not within their scope of practice to fit an oral appliance. This is the venue of a licensed dentist.

I am asking that the Iowa Dental Board render an opinion on this issue according to language in the practice act referenced above. It is not our intent to pursue any adverse licensing action against any dentists. Rather, it is our intent to use the opinion of the licensing board for educational awareness purposes among our Board of Directors.

We certainly appreciate your consideration of this request. If there is any additional information you need please feel free to contact me directly or the AASM Executive Director, Mr. Jerry Barrett, at (630) 737-9700 or jbarrett@aasmnet.org.

I look forward to your response.

Sincerely,

Samuel A. Fleishman, MD
President

cc: Jerome A. Barrett, Executive Director

American Academy of Sleep Medicine

American Academy of Dental Sleep Medicine

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IOWA DENTAL BOARD

November 21, 2012

Melanie Johnson, JD
Executive Director
Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

Dear Ms. Johnson:

As the leading professional membership societies in the fields of sleep medicine and dental sleep medicine, the American Academy of Sleep Medicine (AASM) and the American Academy of Dental Sleep Medicine (AADSM) are committed to promoting the highest standards of care for patients with obstructive sleep apnea (OSA).

At least 12 to 18 million adults in the U.S. require treatment for OSA, a chronic medical disorder that is associated with deleterious medical conditions such as hypertension, stroke and congestive heart failure. The primary treatment options for adults with OSA are positive airway pressure (PAP) therapy and oral appliance therapy (OAT).

As the number of dentists who have begun to provide OAT has increased rapidly in recent years, both of our societies have received inquiries from members seeking clarification regarding the scope of practice of the physician and dentist in the diagnosis and long-term management of patients with OSA. Therefore, the AASM and AADSM collaboratively developed the attached Joint Policy Statement on the Diagnosis and Treatment of Obstructive Sleep Apnea, which provides the necessary guidance for our members and emphasizes the distinguishing facets of medical and dental licensing laws and practice acts.

The statement clearly assets that the diagnosis of OSA and the prescription of the appropriate treatment must be made by a qualified physician who is trained in sleep medicine. Once OAT has been prescribed by a board-certified sleep medicine physician, then the oral appliance device should be fit by a qualified dentist with training and experience in dental sleep medicine.

This joint policy statement will be made available to the 10,000 members of the AASM and the 3,000 members of the AADSM. Should you have any questions or comments about this statement, please contact Executive Director Jerome A. Barrett at 630-737-9700.

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Fax: (630) 737-9790
www.aadsm.org

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Phone: (630) 737-9700
Fax: (630) 737-9790
www.aasmnet.org

It is our hope that your licensing board will find this statement to be useful should you need to respond to inquiries related to this issue.

Sincerely,

B. Gail Demko, DDS
AADSM President

Samuel A. Fleishman, MD
AASM President

Enclosure

cc: Jerome A. Barrett, Executive Director

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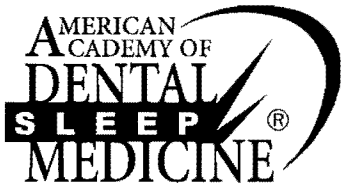
IOWA DENTAL BOARD



American Academy of Sleep Medicine

American Academy of Dental Sleep Medicine

AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE AND AMERICAN ACADEMY OF SLEEP MEDICINE JOINT POLICY STATEMENT ON THE DIAGNOSIS AND TREATMENT OF OBSTRUCTIVE SLEEP APNEA

The American Academy of Sleep Medicine (AASM) and the American Academy of Dental Sleep Medicine (AADSM) are committed to the highest standards for sleep medicine care and ensuring patients receive quality care for obstructive sleep apnea (OSA).

OSA is a highly prevalent syndrome associated with deleterious medical conditions such as hypertension, stroke and congestive heart failure as well as health concerns such as increased motor vehicle accidents and impaired quality of life[i]; it is classified as a medical disorder.

The Diagnosis of Obstructive Sleep Apnea

It is the policy of the AASM and AADSM that patients presenting with symptoms of OSA require a face-to- face evaluation conducted by a qualified physician trained in sleep medicine. The AASM defines a qualified physician trained in sleep medicine as one who is licensed by a state to practice medicine and maintains certification from the American Board of Sleep Medicine or one of the sponsoring sleep medicine boards of the American Board of Medical Specialties.

Treatment Therapies for Obstructive Sleep Apnea

Therapies for OSA, including positive airway pressure (PAP) and oral appliance therapy (OAT), must be prescribed by a qualified physician as described above.

Qualified dentists with training and experience in the overall care of oral health, the temporomandibular joint, dental occlusion and associated oral structures should fit the oral appliance device[ii] as a therapy for OSA. Furthermore, dentists treating patients with OAT must practice within their scope of practice according to dental practice laws in their respective state. The AADSM defines a qualified dentist as one who maintains certification from the American Board of Dental Sleep Medicine[iii], or one who is the director of an AADSM-accredited dental facility and has completed 30 hours of continuing education (ADA CERP recognized or AGD PACE approved) within the past three years. With regard to continuing education, a minimum of 20 credits must be in dental sleep medicine. Additional credits must be sleep medicine related.

All qualified dentists must follow current AASM Practice Parameters and Clinical Guidelines and current AADSM Treatment Protocols.

Medical and Dental Licensing Laws and Practice Acts

The practice of medicine is governed by state licensing laws, which are commonly referred to as enabling laws. Enabling laws have a corresponding practice act, which governs the practice of medicine in the respective state; without this act any individual, regardless of qualifications, can practice medicine without restriction or penalty. The practice act also defines the scope and limits of practice for physicians. Because medicine is an ever-changing field, each practice act

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expires within a set period of time, which enables the state legislature to ensure that the respective laws are reflective of current medical practice.

Common provisions addressed by a practice act include but are not limited to:

- Provides for the delegation of patient care services to other professionals practicing within the scope of their license
- Outlines requirements for collaboration between physicians or dentists with other professionals
- Prohibits fee splitting
- Specifies limits for advertising
- Specifies requirements for continuing medical education and fitness for licensure
- Outlines terms of each license and conditions for renewal
- Specifies penalties for practicing medicine without a license or beyond the scope of license
- Outlines disciplinary action that can be taken including restriction, suspension or revocation of license

All medical practice acts restrict the diagnosis of a medical disease or disorder to a licensed physician. An individual who is not licensed in medicine yet diagnoses a medical disease or disorder is subject to civil and criminal law.

Medical practice laws and practice acts, however, do not include provisions for the performance of any dental operation.

Similar to medicine, licensing laws and practice acts for dentists include scope of practice and provisions for care.

Dental practice acts specify common provision that the performance of any dental operation upon the oral cavity, teeth or associated structure as well as the construction and fit of any appliance used in the oral cavity is under the purview of a licensed dentist.

Common provisions addressed by a dental practice act include but are not limited to:

- Provides for the delegation of patient care services to other professionals practicing within the scope of their license
- Specifies requirements for continuing medical education and fitness for licensure
- Outlines terms of each license and conditions for renewal
- Specifies penalties for practicing dentistry without a license or beyond the scope of license
- Outlines disciplinary action that can be taken including restriction, suspension or revocation of license
- Outlines the dentist's purview to take dental impressions for patients

Dental licensing laws and practice acts, however, do not include provisions for the diagnosis of medical diseases and disorders or the treatment of diseases by dentists without a prescription from a board certified physician. An individual who is not licensed in dentistry yet provides therapy related to the oral cavity is subject to civil and criminal law.

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[i] Luyster FS; Strollo PJ; Zee PC; Walsh JK. Sleep: a health imperative. *SLEEP* 2012;35(6):727-734.

[ii] Kushida CA; Morgenthaler TI; Littner MR et al. Practice parameters for the treatment of snoring and obstructive sleep apnea with oral appliances: An Update for 2005. *SLEEP* 2006;29(2): 240-243.

[iii] Certification by the American Board of Dental Sleep Medicine must be achieved on or prior to January 1, 2018.

1/18/13 Supplemental – Open Session Materials

REPORT TO THE IOWA DENTAL BOARD

FYI ONLY

DATE OF MEETING: January 31, 2013

RE: **List of Registrations Issued Based on Approved Extensions**

SUBMITTED BY: Melanie Johnson, Executive Director

ACTION REQUESTED: None

At the **May 18, 2012** telephonic Board meeting the Board adopted a process for handling future requests for registration in which there is evidence that the applicant believed he/she had been granted an extension of the Trainee Status Expiration Date.

The Board voted to grant authority to issue dental assistant registrations after review by Board staff, the executive director, and the Board's Assistant Attorney(s) General. The Board office was directed to maintain a listing of all applications that have been issued under these circumstances and provide the list to the Board at each regularly scheduled meeting until such time there are no longer any applications involving extensions.

No new applications that involve an extension of the Trainee Status Expiration Date have been processed since the October 25, 2012 Repot to the Board. Attached for review is the list of applications that involved extensions.

DENTAL ASSISTANT APPLICATIONS & EXTENSIONS

AS OF: January 17, 2013

No additional applications & extensions since the October 25, 2012 report at the quarterly Board meeting.

Board action at 4/24-4/25, 2012 meeting:

1. Nicole McGhghy	Application for registration & radiography qualification	Board approved issuance
2. Ashley Backes	Application for registration & radiography qualification	Board approved issuance
3. Katherine Callan	Application for registration & radiography qualification	Board approved issuance
4. Martha Miller	Request for extension of trainee status expiration date	Board denied request; applicant can start over as a trainee
5. Alisha Linville	Request for extension of trainee status expiration date	Board denied request; applicant can start over as a trainee

Action after review by Executive Director, IDB staff, Asst. Attorney General:

6. Hillary Dalton	Application for registration	Issuance approved on 5/4/12

Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
(515) 281-5157

Practitioner Licensed from 10/25/2012 - 01/17/2013

Dental Assistant Trainee

Mitchell, Trecy Jean
86895 590th Ave
Waterbury NE 68785
Date of Birth: 03/19/1968
License Number: T11676
Orig Issue Date: 10/30/2012
Expiration Date:

Cedillo, Lacy Lynn
1314 Irene St
Sioux City IA 51105
Date of Birth: 08/10/1985
License Number: T11673
Orig Issue Date: 10/30/2012
Expiration Date:

Gardiner, Jordan Lee
1770 Larch Ave
Wellman IA 52356
Date of Birth: 03/28/1992
License Number: T11674
Orig Issue Date: 10/30/2012
Expiration Date:

Brown, Elaine Lynn
423 W 8th St
Davenport IA 52803
Date of Birth: 08/04/1979
License Number: T11672
Orig Issue Date: 10/30/2012
Expiration Date:

Weber, Lori Jane
3466 265th Ave
Keokuk IA 52632
Date of Birth: 06/21/1972
License Number: T11675
Orig Issue Date: 10/30/2012
Expiration Date:

Kucera, Mary Elsa
1607 Polk Ave NE
Solon IA 52333
Date of Birth: 08/15/1960
License Number: T11671
Orig Issue Date: 10/30/2012
Expiration Date:

Dental Assistant Trainee

Murillo, Melanie
138 Mae St
Storm Lake IA 50588
Date of Birth: 09/13/1991
License Number: T11670
Orig Issue Date: 10/30/2012
Expiration Date:

Vazquez, Beatriz
4247 Central St
Sioux City IA 51108
Date of Birth: 06/15/1983
License Number: T11678
Orig Issue Date: 11/01/2012
Expiration Date:

Walz, Holly Beth
10765 Golden Oaks Dr
Dubuque IA 52003
Date of Birth: 02/20/1967
License Number: T11677
Orig Issue Date: 11/01/2012
Expiration Date:

Lundahl, Brenda K.
1732 8th Ave
Rock Island IL 61201
Date of Birth: 11/26/1977
License Number: T11679
Orig Issue Date: 11/05/2012
Expiration Date:

Bru, Tessa Talia
5385 NW 89th Court
Johnston IA 50131
Date of Birth: 02/10/1987
License Number: T11680
Orig Issue Date: 11/05/2012
Expiration Date:

Shroyer, Margaret Rose
1550 North 59th Ave West
Newton IA 50208
Date of Birth: 01/14/1991
License Number: T11681
Orig Issue Date: 11/07/2012
Expiration Date:

400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
(515) 281-5157

Practitioner Licensed from 10/25/2012 - 01/17/2013

Dental Assistant Trainee

Rose, Kimberly Suzanne
910 S Division
Boone IA 50036
Date of Birth: 07/23/1974
License Number: T11682
Orig Issue Date: 11/07/2012
Expiration Date:

Johnson, Melissa Joy
715 Pennsylvania
Carlisle IA 50047
Date of Birth: 08/28/1976
License Number: T11683
Orig Issue Date: 11/08/2012
Expiration Date:

Dofner, Jamie Lee
508 Pearl St
Neola IA 51559
Date of Birth: 12/05/1987
License Number: T11684
Orig Issue Date: 11/19/2012
Expiration Date:

Skinner, Nicole Linn
3415 Glover Ave
Des Moines IA 50315
Date of Birth: 10/10/1978
License Number: T11689
Orig Issue Date: 11/27/2012
Expiration Date:

Derrig, Rebecca Sue
1110 S 26 St
Fort Dodge IA 50501
Date of Birth: 05/04/1956
License Number: T11687
Orig Issue Date: 11/27/2012
Expiration Date:

Werner, Kayleen Marie
415 10th St
Murray IA 50174
Date of Birth: 03/01/1993
License Number: T11688
Orig Issue Date: 11/27/2012
Expiration Date:

Dental Assistant Trainee

Niederklein, Kelsie Ann
9667 V Plaza
Apt #39
Omaha NE 68127
Date of Birth: 08/23/1990
License Number: T11686
Orig Issue Date: 11/27/2012
Expiration Date:

Pathikonda, Malathi
530 Frank St
Apt 11
Ottumwa IA 52501
Date of Birth: 08/11/1966
License Number: T11685
Orig Issue Date: 11/27/2012
Expiration Date:

Donat, Anne Marie
245 Haywood Dr
Iowa City IA 52245
Date of Birth: 07/05/1989
License Number: T11690
Orig Issue Date: 11/28/2012
Expiration Date:

Sticklen, Catherine Anne
9204 Huntington Cir
Johnston IA 50131
Date of Birth: 05/19/1986
License Number: T11691
Orig Issue Date: 11/28/2012
Expiration Date:

Esparza, Theresa C.
526 Polk St
Muscatine IA 52761
Date of Birth: 07/17/1981
License Number: T11693
Orig Issue Date: 12/05/2012
Expiration Date:

Engstrand, Tinelle Rose
4 High St
Blanchard IA 51630
Date of Birth: 11/03/1985
License Number: T11697
Orig Issue Date: 12/06/2012
Expiration Date:

Practitioner Licensed from 10/25/2012 - 01/17/2013

Dental Assistant Trainee

Brevoort, Kelli Sides
3390 E Kimberly Rd
Apt 176
Davenport IA 52807
Date of Birth: 01/17/1989
License Number: T11696
Orig Issue Date: 12/06/2012
Expiration Date:

Simpson, Gabrielle Lorraine
104 Sycamore St
Apt B
LaPorte IA 50651
Date of Birth: 07/02/1991
License Number: T11694
Orig Issue Date: 12/06/2012
Expiration Date:

Jukic, Fikreta
5908 Sutton Place
#9
Urbandale IA 50322
Date of Birth: 07/11/1989
License Number: T11695
Orig Issue Date: 12/06/2012
Expiration Date:

Caporelli, Lisa Renee
7409 Dusk Dr
Johnston IA 50131
Date of Birth: 10/11/1974
License Number: T11699
Orig Issue Date: 12/12/2012
Expiration Date:

Velasco, Brandi Marie
2412 E 8th St
Sioux City IA 51105
Date of Birth: 10/25/1982
License Number: T11698
Orig Issue Date: 12/12/2012
Expiration Date:

Knutson, Nicole Ann
18276 Franklin Dr
Houston MN 55943
Date of Birth: 10/22/1978
License Number: T11701
Orig Issue Date: 12/13/2012
Expiration Date:

Dental Assistant Trainee

Claussen, Theresa Lee
622 McCoy Dr
Carroll IA 51401
Date of Birth: 07/06/1962
License Number: T11705
Orig Issue Date: 12/17/2012
Expiration Date:

Danford, Grace Leigh
5250 21st Ave
Marion IA 52302
Date of Birth: 08/14/1991
License Number: T11707
Orig Issue Date: 12/17/2012
Expiration Date:

Ross, India Leigh
822 E Williams St
Ottumwa IA 52501
Date of Birth: 04/27/1994
License Number: T11706
Orig Issue Date: 12/17/2012
Expiration Date:

Lozano, Cheri M.
3101 Harrison St
Bellevue NE 68147
Date of Birth: 07/30/1963
License Number: T11710
Orig Issue Date: 12/18/2012
Expiration Date:

Carver, Kla Lou
PO Box 444
Andalusia IL 61232
Date of Birth: 08/22/1990
License Number: T11715
Orig Issue Date: 12/20/2012
Expiration Date:

Markley, Courtney Olivia
PO Box 317
Badger IA 50516
Date of Birth: 11/09/1987
License Number: T11719
Orig Issue Date: 12/26/2012
Expiration Date:

Practitioner Licensed from 10/25/2012 - 01/17/2013

Dental Assistant Trainee

Butler, Kirsten Marie
10948 Thrush Ave
Mason City IA 50401
Date of Birth: 12/08/1990
License Number: T11725
Orig Issue Date: 12/27/2012
Expiration Date:

Meusburger, Kari Ann
1314 Navaho CR
Sioux City IA 51104
Date of Birth: 02/15/1981
License Number: T11720
Orig Issue Date: 12/27/2012
Expiration Date:

Kniffen, Sara Christine
707 S 8th St
Burlington IA 52601
Date of Birth: 10/30/1978
License Number: T11722
Orig Issue Date: 12/27/2012
Expiration Date:

Evenson, Diane Carol
214 3rd Ave E
Cresco IA 52136
Date of Birth: 11/20/1960
License Number: T11721
Orig Issue Date: 12/27/2012
Expiration Date:

Evans, Katelyn Elizabeth
213 W 7th St
Madrid IA 50156
Date of Birth: 12/21/1990
License Number: T11727
Orig Issue Date: 01/07/2013
Expiration Date:

Clemons, Rebecca Lynn
2534 7th Ave
Rock Island IL 61201
Date of Birth: 12/24/1973
License Number: T11729
Orig Issue Date: 01/09/2013
Expiration Date:

Dental Assistant Trainee

Gillam, Angela Kay
201 S Locust St
Richland IA 52585
Date of Birth: 03/03/1972
License Number: T11730
Orig Issue Date: 01/10/2013
Expiration Date:

Larsen, Sidney Taylor
351 Lindsay Lane SE
Cedar Rapids IA 52403
Date of Birth: 03/16/1995
License Number: T11731
Orig Issue Date: 01/15/2013
Expiration Date:

Wittrock, Mark Thomas
204 S Mulberry
PO Box 321
Richland IA 52585
Date of Birth: 05/19/1967
License Number: T11733
Orig Issue Date: 01/15/2013
Expiration Date:

Crane, Sam Michael
340 Sumac Rd
Mason City IA 50401
Date of Birth: 09/11/1989
License Number: T11732
Orig Issue Date: 01/15/2013
Expiration Date:

Carlson, Melissa Marie
926 S 16th St
Sac City IA 50583
Date of Birth: 07/26/1976
License Number: T11734
Orig Issue Date: 01/16/2013
Expiration Date:

Larsen, Courtney Sue
4100 SW 5th St
Des Moines IA 50315
Date of Birth: 06/06/1982
License Number: T11735
Orig Issue Date: 01/17/2013
Expiration Date:

Practitioner Licensed from 10/25/2012 - 01/17/2013

Dental Hygienist

Fenton, Amanda Lynn, D.H.
17058 524th St.
Centerville IA 52544
Date of Birth: 02/20/1988
License Number: 04179
Orig Issue Date: 10/26/2012
Expiration Date: 08/31/2013

Irish, Bridget Catherine, D.H.
153 Crest View Dr.
Potosi WI 53820
Date of Birth: 09/02/1989
License Number: 04178
Orig Issue Date: 10/26/2012
Expiration Date: 08/31/2013

Benbow, Ashley Lauren, D.H.
15 24th St.
Fort Madison IA 52627
Date of Birth: 07/01/1981
License Number: 04180
Orig Issue Date: 10/30/2012
Expiration Date: 08/31/2013

Hawkinson, Tracie Nicole, D.H.
112 Kestrel Ct.
Council Bluffs IA 51501
Date of Birth: 08/31/1972
License Number: 04181
Orig Issue Date: 10/30/2012
Expiration Date: 08/31/2013

Sutton, Julie Darden, D.H.
264 Derbyshire Rd.
Waterloo IA 50701
Date of Birth: 01/01/1901
License Number: 04182
Orig Issue Date: 11/02/2012
Expiration Date: 08/31/2013

Ellison, Alyssa Lynn, D.H.
10581 E 100th St.
Lynn Center IL 61262
Date of Birth: 03/13/1991
License Number: 04184
Orig Issue Date: 11/05/2012
Expiration Date: 08/31/2013

Dental Hygienist

Krzemecki, Marnie Sue, D.H.
3599 Sheridan
Emmett MI 48022
Date of Birth: 09/25/1980
License Number: 04183
Orig Issue Date: 11/05/2012
Expiration Date: 08/31/2013

Maliszewski, Kelly Michelle, D.H.
2323 Hanscom Blvd.
Omaha NE 68105
Date of Birth: 04/01/1979
License Number: 04185
Orig Issue Date: 11/13/2012
Expiration Date: 08/31/2013

Qualia, Lori Ann, D.H.
1408 S Friendswood Dr.
#902
Friendswood TX 77546
Date of Birth: 08/05/1958
License Number: 04186
Orig Issue Date: 11/15/2012
Expiration Date: 08/31/2013

Hartz, Aubrey Katherine, D.H.
1020 6th St.
DeWitt IA 52742
Date of Birth: 05/20/1987
License Number: 04187
Orig Issue Date: 11/26/2012
Expiration Date: 08/31/2013

van Vliet, Joan, D.H.
PO Box 78
Sioux Center IA 51250
Date of Birth: 05/25/1955
License Number: 04188
Orig Issue Date: 12/19/2012
Expiration Date: 08/31/2013

Habenicht, Holly Lynette, D.H.
581 Squaw Creek Cir.
Marion IA 52302
Date of Birth: 07/26/1978
License Number: 04192
Orig Issue Date: 01/07/2013
Expiration Date: 08/31/2013

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Des Moines, IA 50309-4687
(515) 281-5157

Practitioner Licensed from 10/25/2012 - 01/17/2013

Dental Hygienist

Reiland, Kelly Anne, D.H.
21588 161st Ave.
Spring Valley MN 55975
Date of Birth: 05/29/1969
License Number: 04191
Orig Issue Date: 01/07/2013
Expiration Date: 08/31/2013

Cary, Angela Marie, D.H.
1140 S 16th St.
Adel IA 50003
Date of Birth: 01/09/1984
License Number: 04189
Orig Issue Date: 01/07/2013
Expiration Date: 08/31/2013

Kain, Julie Renee, D.H.
34 Longfellow St.
Hartsdale NY 10530
Date of Birth: 01/07/1973
License Number: 04190
Orig Issue Date: 01/07/2013
Expiration Date: 08/31/2013

Dentist

Skoumal, Thomas Edward, D.D.S.
405 47th
West Des Moines IA 50265
Date of Birth: 01/06/1986
License Number: 08978
Orig Issue Date: 11/13/2012
Expiration Date: 08/31/2014

Gonzales, Laurel Rose, D.D.S.
740 Foster Rd.
Iowa City IA 52245
Date of Birth: 03/18/1985
License Number: 08979
Orig Issue Date: 11/15/2012
Expiration Date: 08/31/2014

Livingston, Jeffrey James, D.D.S.
4200 Pioneers Blvd.
Lincoln NE 68506
Date of Birth: 06/16/1982
License Number: 08980
Orig Issue Date: 12/19/2012
Expiration Date: 08/31/2014

Dentist

Fuller, Jessica Kay, D.D.S.
4917 NW 163rd St.
Edmond OK 73013
Date of Birth: 01/21/1982
License Number: 08981
Orig Issue Date: 01/07/2013
Expiration Date: 08/31/2014

Faculty

Handoo, Nidhi Qasba, B.D.S.
UofIA College Dentistry
S337-1 DSB
Iowa City IA 52242
Date of Birth: 09/09/1972
License Number: 40132
Orig Issue Date: 11/13/2012
Expiration Date: 08/31/2014

Thalji, Ghadeer, B.D.S.
UIA College of Dentistry
200 Hawkins Dr.
Iowa City IA 52242
Date of Birth: 12/21/1981
License Number: 40133
Orig Issue Date: 11/15/2012
Expiration Date: 08/31/2014

Local Anesthesia Permit

Fenton, Amanda Lynn, D.H.
17058 524th St.
Centerville IA 52544
Date of Birth: 02/20/1988
License Number: 2862
Orig Issue Date: 10/26/2012
Expiration Date: 08/31/2013

Irish, Bridget Catherine, D.H.
153 Crest View Dr.
Potosi WI 53820
Date of Birth: 09/02/1989
License Number: 2861
Orig Issue Date: 10/26/2012
Expiration Date: 08/31/2013

Benbow, Ashley Lauren, D.H.
15 24th St.
Fort Madison IA 52627
Date of Birth: 07/01/1981
License Number: 2863
Orig Issue Date: 10/30/2012
Expiration Date: 08/31/2013

400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
(515) 281-5157

Practitioner Licensed from 10/25/2012 - 01/17/2013

Local Anesthesia Permit

Ellison, Alyssa Lynn, D.H.
10581 E 100th St.
Lynn Center IL 61262
Date of Birth: 03/13/1991
License Number: 2864
Orig Issue Date: 11/05/2012
Expiration Date: 08/31/2013

Hirsch, Melissa Sue, D.H.
41797 Cottage Rd.
Mabel MN 55954
Date of Birth: 04/27/1991
License Number: 2865
Orig Issue Date: 11/13/2012
Expiration Date: 08/31/2013

Maliszewski, Kelly Michelle, D.H.
2323 Hanscom Blvd.
Omaha NE 68105
Date of Birth: 04/01/1979
License Number: 2866
Orig Issue Date: 11/13/2012
Expiration Date: 08/31/2013

Hartz, Aubrey Katherine, D.H.
1020 6th St.
DeWitt IA 52742
Date of Birth: 05/20/1987
License Number: 2867
Orig Issue Date: 11/26/2012
Expiration Date: 08/31/2013

Arthur, Joan M Clemens, DH
1297 Dunleith Ct.
Dubuque IA 52001
Date of Birth: 04/25/1959
License Number: 2868
Orig Issue Date: 01/07/2013
Expiration Date: 08/31/2013

Cary, Angela Marie, D.H.
1140 S 16th St.
Adel IA 50003
Date of Birth: 01/09/1984
License Number: 2869
Orig Issue Date: 01/07/2013
Expiration Date: 08/31/2013

Local Anesthesia Permit

Reiland, Kelly Anne, D.H.
21588 161st Ave.
Spring Valley MN 55975
Date of Birth: 05/29/1969
License Number: 2870
Orig Issue Date: 01/07/2013
Expiration Date: 08/31/2013

Qual/Reg Dental Asst

Seurey, Alicia Kay
2211 E Park Ave
#101
Des Moines IA 50320
Date of Birth: 08/03/1983
License Number: Q11669
Orig Issue Date: 10/30/2012
Expiration Date: 08/31/2013

Cleghorn, Ashlie Brooke
511 S 16th St
Adel IA 50003
Date of Birth: 09/17/1988
License Number: Q11692
Orig Issue Date: 12/03/2012
Expiration Date: 08/31/2013

Kauffman, Djuna Kaye
825 William St
Webster City IA 50595
Date of Birth: 04/21/1964
License Number: Q11700
Orig Issue Date: 12/13/2012
Expiration Date: 08/31/2013

Frederick, Nicole Denise
504 S Davis St
Keota IA 52248
Date of Birth: 05/13/1993
License Number: Q11704
Orig Issue Date: 12/17/2012
Expiration Date: 08/31/2013

Middendorf, Brooke Elizabeth
1325 2nd St
Coralville IA 52241
Date of Birth: 07/29/1991
License Number: Q11708
Orig Issue Date: 12/17/2012
Expiration Date: 08/31/2013

Practitioner Licensed from 10/25/2012 - 01/17/2013

Qual/Reg Dental Asst

Shelquist, Molly Elizabeth
320 South 5th St
Albia IA 52531
Date of Birth: 04/10/1989
License Number: Q11703
Orig Issue Date: 12/17/2012
Expiration Date: 08/31/2013

Winders, Stephanie Ann
6800 Deer Horn Trail NE
Cedar Rapids IA 52411
Date of Birth: 04/13/1993
License Number: Q11702
Orig Issue Date: 12/17/2012
Expiration Date: 08/31/2013

Clubb, Jessica Dawn
17307 295th St
Hedrick IA 52563
Date of Birth: 05/19/1993
License Number: Q11709
Orig Issue Date: 12/18/2012
Expiration Date: 08/31/2013

Suchomel, Amanda Rachelle
300 8th Street #9
Van Horne IA 52346
Date of Birth: 09/19/1987
License Number: Q11713
Orig Issue Date: 12/20/2012
Expiration Date: 08/31/2013

Freese, Lisa Lynn
813 Westwood Dr NW
Cedar Rapids IA 52405
Date of Birth: 03/27/1986
License Number: Q11712
Orig Issue Date: 12/20/2012
Expiration Date: 08/31/2013

Cole, Tiffany Ann
5673 Observatory St SW
Riverside IA 52327
Date of Birth: 01/10/1993
License Number: Q11714
Orig Issue Date: 12/20/2012
Expiration Date: 08/31/2013

Qual/Reg Dental Asst

Bland, Donna Marie
8506 Linn Johnson Rd
Fairfax IA 52228
Date of Birth: 10/29/1978
License Number: Q11711
Orig Issue Date: 12/20/2012
Expiration Date: 08/31/2013

Way, Shanice Shantrece
603 Hwy T-14
Apt 11
Pella IA 50219
Date of Birth: 10/31/1990
License Number: Q11718
Orig Issue Date: 12/26/2012
Expiration Date: 08/31/2013

Booth, Christine Irene
21590 140th St
Iowa Falls IA 50126
Date of Birth: 10/10/1990
License Number: Q11716
Orig Issue Date: 12/26/2012
Expiration Date: 08/31/2013

Delp, Sydney Marie
120 Maple Circle
Annandale MN 55302
Date of Birth: 07/06/1993
License Number: Q11717
Orig Issue Date: 12/26/2012
Expiration Date: 08/31/2013

Kurth, Carlee Jo
1547 4th Ave SE
Cedar Rapids IA 52403
Date of Birth: 03/21/1993
License Number: Q11723
Orig Issue Date: 12/27/2012
Expiration Date: 08/31/2013

Droz, Derrick David
835 Blue Sky Drive
#303
North Liberty IA 52317
Date of Birth: 03/16/1986
License Number: Q11724
Orig Issue Date: 12/27/2012
Expiration Date: 08/31/2013

Practitioner Licensed from 10/25/2012 - 01/17/2013

Qual/Reg Dental Asst

Summers, Frances Marie Ann
2610 Friendship St
Iowa City IA 52245
Date of Birth: 11/16/1987

License Number: Q11726
Orig Issue Date: 12/27/2012
Expiration Date: 08/31/2013

Bechen, Anna Fu-You
5426 Klinger Street SW
Cedar Rapids IA 52404
Date of Birth: 06/01/1989

License Number: Q11728
Orig Issue Date: 01/08/2013
Expiration Date: 08/31/2013

Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
(515) 281-5157

Practitioner Profession Change Report from 10/25/2012 - 01/17/2013

Qual/Nreg Dental Asst

Johnson, Kristin Rachael
1158 Columbine Court
Norwalk IA 50211
Date of Birth: 05/10/1974

License Number: X11290
Orig Issue Date: 12/02/2011
Expiration Date: 08/31/2013

Qual/Reg Dental Asst

Berkland, Beverly A.
Dr. James Pollard
2606 17th St
Spirit Lake IA 51360
Date of Birth: 03/11/1960

License Number: Q01300
Orig Issue Date: 07/01/1982
Expiration Date: 08/31/2013

Trumbo, Terri Lynn
4621 Valdez Drive
Des Moines IA 50310
Date of Birth: 07/13/1972

License Number: Q05668
Orig Issue Date: 11/13/1998
Expiration Date: 08/31/2013

Fina, Katie Elizabeth
5000 Lyndale Drive
Des Moines IA 50310
Date of Birth: 01/21/1977

License Number: Q08258
Orig Issue Date: 01/13/2004
Expiration Date: 08/31/2013

Scott, Kelly Lynn
405 10th St.
Ames IA 50010
Date of Birth: 05/04/1981

License Number: Q09318
Orig Issue Date: 09/22/2006
Expiration Date: 08/31/2013

Edwards, Tracie L.
400 Cass St
Adair IA 50002
Date of Birth: 07/17/1987

License Number: Q11230
Orig Issue Date: 10/05/2011
Expiration Date: 08/31/2013

Qual/Reg Dental Asst

Turner, Crystal Shavon
3430 Oakland Rd NE
Cedar Rapids IA 52402
Date of Birth: 08/06/1982

License Number: Q11268
Orig Issue Date: 11/10/2011
Expiration Date: 08/31/2013

Petersen, Erika Anne
19157 152 Ave
Sperry IA 52650
Date of Birth: 12/05/1983

License Number: Q11271
Orig Issue Date: 11/15/2011
Expiration Date: 08/31/2013

Pasa, Kelsey Lynn
PO Box 414
Fairfax IA 52228
Date of Birth: 08/13/1988

License Number: Q11274
Orig Issue Date: 11/18/2011
Expiration Date: 08/31/2013

Petersen, Ashley Elizabeth
1604 Robeson Ave
Bettendorf IA 52722
Date of Birth: 09/18/1988

License Number: Q11282
Orig Issue Date: 11/28/2011
Expiration Date: 08/31/2013

Hubbell, Rachel Lyn
402 Orchard Lane
Clear Lake IA 50428
Date of Birth: 03/22/1983

License Number: Q11284
Orig Issue Date: 11/29/2011
Expiration Date: 08/31/2013

Weets, Christina Marie
3704 Little Soap Rd
Ottumwa IA 52501
Date of Birth: 01/24/1983

License Number: Q11283
Orig Issue Date: 11/29/2011
Expiration Date: 08/31/2013

Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
(515) 281-5157

Practitioner Profession Change Report from 10/25/2012 - 01/17/2013

Qual/Reg Dental Asst

Blau, Regina Marie
PO Box 742
Latimer IA 50452
Date of Birth: 02/12/1972
License Number: Q11294
Orig Issue Date: 12/07/2011
Expiration Date: 08/31/2013

Olsen, Rebecca Carolyn
11182 650th Ave
McCallsburg IA 50154
Date of Birth: 08/05/1993
License Number: Q11293
Orig Issue Date: 12/07/2011
Expiration Date: 08/31/2013

Smith, Josselyn Elizabeth
1098 Bridgeview Pl
Le Claire IA 52753
Date of Birth: 04/20/1971
License Number: Q11335
Orig Issue Date: 01/20/2012
Expiration Date: 08/31/2013

Hua, Min
1063 Goldenrod Dr
Iowa City IA 52246
Date of Birth: 06/25/1972
License Number: Q11334
Orig Issue Date: 01/20/2012
Expiration Date: 08/31/2013

Shontz, Lindsey Nichole
307 S Fairmount St
Davenport IA 52802
Date of Birth: 08/18/1990
License Number: Q11340
Orig Issue Date: 01/25/2012
Expiration Date: 08/31/2013

Stephens, Shiloh Louise
5023 S Avenue
Winfield IA 52659
Date of Birth: 01/25/1991
License Number: Q11345
Orig Issue Date: 02/02/2012
Expiration Date: 08/31/2013

Qual/Reg Dental Asst

Olivares, Jessica Ann
3211 11th Ave
Apt B
Council Bluffs IA 51501
Date of Birth: 01/31/1982
License Number: Q11354
Orig Issue Date: 02/09/2012
Expiration Date: 08/31/2013

Smithart, Amanda M.
3301 SE 22nd St
Apt 17
Des Moines IA 50320
Date of Birth: 09/11/1981
License Number: Q11364
Orig Issue Date: 02/20/2012
Expiration Date: 08/31/2013

Van Zante, Laura Ann
565 320th Ave
Grinnell IA 50112
Date of Birth: 11/14/1979
License Number: Q11375
Orig Issue Date: 03/08/2012
Expiration Date: 08/31/2013

Hailey, Kori K.
1837-4th St
Moline IL 61265
Date of Birth: 04/20/1971
License Number: Q11379
Orig Issue Date: 03/21/2012
Expiration Date: 08/31/2013

Breitbach, Jeffry Donald
11009 Oakland Farms Rd
Dubuque IA 52003
Date of Birth: 02/28/1992
License Number: Q11384
Orig Issue Date: 03/23/2012
Expiration Date: 08/31/2013

Redd, Teisha LaShae
5515 SE 14th
Apt 2106
Des Moines IA 50320
Date of Birth: 10/31/1983
License Number: Q11405
Orig Issue Date: 04/18/2012
Expiration Date: 08/31/2013

400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
(515) 281-5157

Practitioner Profession Change Report from 10/25/2012 - 01/17/2013

Qual/Reg Dental Asst

Viers, Lita Elaine
1839 130th Street
Packwood IA 52580
Date of Birth: 06/13/1971
License Number: Q11423
Orig Issue Date: 06/06/2012
Expiration Date: 08/31/2013

Gonzalez, Keli Veronica
1322 South Alice St
Sioux City IA 51106
Date of Birth: 06/22/1981
License Number: Q11444
Orig Issue Date: 06/21/2012
Expiration Date: 08/31/2013

Anderson, Christina Renee
1211 N 8th St
Red Oak IA 51566
Date of Birth: 08/21/1979
License Number: Q11449
Orig Issue Date: 06/22/2012
Expiration Date: 08/31/2013

Harshbarger, Tiffany Lea
113 NE Grant St
Ankeny IA 50021
Date of Birth: 08/04/1992
License Number: Q11459
Orig Issue Date: 06/26/2012
Expiration Date: 08/31/2013

Anderson, Ashley Lynne
615 W Nishna St
Clarinda IA 51632
Date of Birth: 11/05/1988
License Number: Q11496
Orig Issue Date: 07/12/2012
Expiration Date: 08/31/2013

Clark, Ashtin Marie
905 Harrison St
Council Bluffs IA 51503
Date of Birth: 04/12/1992
License Number: Q11510
Orig Issue Date: 07/17/2012
Expiration Date: 08/31/2013

Qual/Reg Dental Asst

Flowers, Cheri Nicole
14399 Ray Lane
Apt #108
Council Bluffs IA 51503
Date of Birth: 01/28/1992
License Number: Q11533
Orig Issue Date: 07/24/2012
Expiration Date: 08/31/2013

Moreno, Trista Rosemary
2814 Ordway Ave
Sioux City IA 51106
Date of Birth: 08/12/1990
License Number: Q11534
Orig Issue Date: 07/26/2012
Expiration Date: 08/31/2013

Dahl, Breelynn Ellen
3761 Locust Rd
Decorah IA 52101
Date of Birth: 06/07/1989
License Number: Q11567
Orig Issue Date: 08/14/2012
Expiration Date: 08/31/2013

Macauley, Meredith Ashley
860 Collins Drive
Waukee IA 50263
Date of Birth: 07/06/1990
License Number: Q11608
Orig Issue Date: 08/23/2012
Expiration Date: 08/31/2013

Danner, Kelli Ann
705 S Spruce Street
Knoxville IA 50138
Date of Birth: 01/08/1992
License Number: Q11613
Orig Issue Date: 08/29/2012
Expiration Date: 08/31/2013

Porter-Brown, Mechelle Sheree
352 3rd Ave
Marion IA 52302
Date of Birth: 12/17/1969
License Number: Q11638
Orig Issue Date: 09/19/2012
Expiration Date: 08/31/2013

Iowa Board of Dental Examiners
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
(515) 281-5157

Practitioner Profession Change Report from 10/25/2012 - 01/17/2013

Qual/Reg Dental Asst

Seurey, Alicia Kay
2211 E Park Ave
#101
Des Moines IA 50320
Date of Birth: 08/03/1983

License Number: Q11669
Orig Issue Date: 10/30/2012
Expiration Date: 08/31/2013

Summers, Frances Marie Ann
2610 Friendship St
Iowa City IA 52245
Date of Birth: 11/16/1987

License Number: Q11726
Orig Issue Date: 12/27/2012
Expiration Date: 08/31/2013

Registered Dental Asst

Roszell, Briana Paige
407 15th St NW
Mason City IA 50401
Date of Birth: 05/13/1990

License Number: R11246
Orig Issue Date: 10/20/2011
Expiration Date: 08/31/2013

Judge, Maggie Anne
508 26th St SE
Altoona IA 50009
Date of Birth: 09/06/1991

License Number: R11260
Orig Issue Date: 11/04/2011
Expiration Date: 08/31/2013

Poggis-Weber, Laura Anne
300 Valley St
Glenwood IA 51534
Date of Birth: 02/08/1965

License Number: R11291
Orig Issue Date: 12/05/2011
Expiration Date: 08/31/2013

Ekstrom, Heather Kay
3069 Jentz Baker Dr
Platteville WI 53818
Date of Birth: 08/06/1986

License Number: R11358
Orig Issue Date: 02/10/2012
Expiration Date: 08/31/2013

1/18/13 Supplemental

REPORT TO THE IOWA DENTAL BOARD

ACTION

DATE OF MEETING: February 1, 2013

RE: **April Strong – Application for Registration and Radiography Qualification**

SUBMITTED BY: Licensure/Registration Committee (Rovner, McCullough, Meier)

ACTION REQUESTED: Board Action on Committee Recommendation

Committee Recommendation:

The Committee recommends the issuance of a Stipulated Registration with the stipulation that Ms. Strong disclose to all future employers information regarding her criminal history and overall behavior pattern.

Background:

Applicant's Criminal History

December 19, 1998	OWI 1st Offense
2001 (no date provided)	"Theft paid a fine"
August 31, 2002	Criminal Mischief in the 4th Degree
2002 (no date provided)	Driving under suspension
2004 (no date provided)	Criminal Mischief ("Broke a window got a ticket paid a fine.")
August 12, 2005	Theft of Services ("Stealing basic cable less than $200")
2007 (specific date not provided by applicant, no history on file with the state of NE where this occurred)	Ms. Strong was arrested for Negligence of Minor Care. According to Ms. Strong, she was arrested for "negligence of minor care. This happened at my home. I left my children with a babysitter who left them alone. The neighbors called the cops, the kids were taken into custody until I was notified. I was ticketed and requested to take a parenting classes. Charges were then dismissed."
March 1, 2006	Shoplifting (HyVee, was ticketed and fined) (under $50)
May 2, 2007	Received unlaw taken property (under $100)
July 24, 2007	Ms. Strong was arrested and charged with Interference with Official Acts, a Simple Misdemeanor.
September 17, 2008	Ms. Strong arrested and charged with 2nd OWI, an Aggravated Misdemeanor. a) Ms. Strong lost her driver's license for 6 months. b) Completed a drunk driving course. c) Paid $3000 in fines. d) Required to have an alcohol evaluation. e) Driver's license was reinstated upon compliance with all conditions required by the court.
September 17, 2008	Ms. Strong charged with Operating Without a Valid Driver's License, a Serious Misdemeanor.

September 30, 2008	Ms. Strong arrested for Theft 5, a Simple Misdemeanor.
2010 (no date provided)	Driving under suspension

Attached for Review:

- 10/5/12 Application for Iowa Dental Assistant Registration & Dental Radiography Qualification
- 11/30/12 Email to Licensure/Registration Committee w/application materials

APPLICATION FOR IOWA DENTAL ASSISTANT REGISTRATION & DENTAL RADIOGRAPHY QUALIFICATION

RECEIVED
OCT 5 2012
IOWA DENTAL BOARD

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Ph. (515) 281-5157 http://www.dentalboard.iowa.gov

This form must be completed and returned to the Iowa Dental Board. Include the ***non-refundable*** application fee. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle) Strong, April, Marie			
Other Names Used: (e.g. Maiden Name)			
Home Address: 3209 Renner Dr. Apt. 29			
City: Council Bluffs	**County:** Pott.	**State:** Iowa	**Zip:** 51501
Home Phone: (712) 256-4004 Cell (712) 314-1458		**Home E-mail:** aprilstrong479@yahoo.com	
Work Address:			
City: Council Bluffs	**County:** Pott.	**State:** Iowa	**Zip:** 51501
Work Phone: (712) 323-8402	**Work Fax:** (712) 323-8811	**Work E-mail:**	

BASIS FOR APPLICATION

1. I have worked in a dental office for a minimum of six month as a dental assistant trainee, within 12 months of my first date of employment in Iowa. Trainee Number: T 11326 (*Complete the Affidavit of Employment.)	Yes ☑ No ☐
2. I have at least 6 months of prior dental assisting experience under the supervision of a licensed dentist within the past two years. (*Complete the Affidavit of Employment.)	Yes ☑ No ☐
3. I am a graduate of an ADA-accredited postsecondary dental assisting program. (*Complete the Certification of Education.)	Yes ☑ No ☐
4. I have completed Board-approved training in dental radiography with the past 2 years, passed an examination in dental radiography, and am also applying for a qualification in dental radiography.	Yes ☑ No ☐

For office use only:	**Registration #:**	**Date Issued:**

#1305
$40

APPLICATION FOR IOWA DENTAL ASSISTANT REGISTRATION & DENTAL RADIOGRAPHY QUALIFICATION

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Ph. (515) 281-5157 http://www.dentalboard.iowa.gov

RECEIVED
OCT 5 2012
IOWA DENTAL BOARD

This form must be completed and returned to the Iowa Dental Board. Include the ***non-refundable*** application fee. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle) Strong, April, Marie			
Other Names Used: (e.g. Maiden Name) ~~Brown~~ same			
Home Address: 3209 Renner Dr. Apt 29			
City: Council Bluffs	County: Pott.	State: Iowa	Zip: 51501
Home Phone: (712) 256-4004 Cell (712) 314-1458		Home E-mail: aprilstrong479@yahoo.com	
Work Address: Dr. Eischeid 427 E Kansville Suite 200			
City: Council Bluffs	County: Pott.	State: Iowa	Zip: 51501
Work Phone: (712) 323-8402	Work Fax: (712) 323-8811	Work E-mail: NA	

Applebees 3000 Dial Dr. CB, IA 51503

BASIS FOR APPLICATION

1. I have worked in a dental office for a minimum of six month as a dental assistant trainee, within 12 months of my first date of employment in Iowa. Trainee Number: T11326 (*Complete the Affidavit of Employment.)	Yes ☑ No ☐
2. I have at least 6 months of prior dental assisting experience under the supervision of a licensed dentist within the past two years. (*Complete the Affidavit of Employment.)	Yes ☑ No ☐
3. I am a graduate of an ADA-accredited postsecondary dental assisting program. (*Complete the Certification of Education.)	Yes ☑ No ☐
4. I have completed Board-approved training in dental radiography with the past 2 years, passed an examination in dental radiography, and am also applying for a qualification in dental radiography.	Yes ☑ No ☐

For office use only:	Registration #:	Date Issued:

#1305
$40

Received Time Oct. 8. 2012 4:02PM No. 0402

Name of Applicant: April Strong

QUALIFICATIONS & EXPERIENCE

1. Do you currently take dental x-rays in Iowa?	Yes ☑ No ☐
2. Do you now hold, or have you ever held, a certificate of qualification in dental radiography issued by the Iowa Dental Board? If yes, what is the qualification number? _____	Yes ☐ No ☑
3. Did you complete a course of study using the dental assistant trainee manual, or other course approved by the Board in the area of dental radiography within the past 2 years?	Yes ☑ No ☐
4. Did you complete clinical (i.e. on-the job) dental radiography training under the supervision of a dentist? If yes, the supervising dentist must verify this training on the Affidavit of Employment. (If training was completed outside of Iowa, the training dentist must certify training in all competencies prior-approved by the Board. Contact the Board for further details.)	Yes ☑ No ☐
5. Did you complete a course of study approved by the Board in the areas of infection control/hazardous materials and jurisprudence using the study manual or at an ADA-accredited post secondary school (i.e. community college)?	Yes ☑ No ☐
6. Are you currently certified in CPR by nationally-recognized provider? Online certification is not accepted. (Attach copy of CPR card.)	Yes ☑ No ☐
7. Are you registered, certified or qualified as a dental assistant in another state? If yes, which states: Nebraska (Provide written verification from each state in which you are registered, certified or qualified.)	Yes ☑ No ☐

8. Provide a chronological listing of all dental-related employment in the last 5 years. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you.

Employer Dentist Name & Location	Type of Work (e.g. chairside, lab, office)	From (Mo/Yr):	To (Mo/Yr):	Avg. Hours per Week
1411 J F Kennedy Dr Bllv Neb. Dr. Jamar Anderson	Dental assisant chairside	4/10	8/10	40
Dr. Jim Becker 178th Pacific Omaha Neb	Dental assisant chairside	10/10	1/11	25
Dr. Ray E. Scheid 427 E Kansville CB, IA	Dental assistant chairside	10/11	Current	36

REGISTRATION INFORMATION

List all state/countries in which you are or have ever been registered, certified or qualified.
Please note: you will be required to request written certifications of all registrations.

State/Country	Registration No.	Date Issued	Registration Type	Basis for Registration
Neb./Omaha			Certified	

Name of Applicant: April Strong

QUALIFICATIONS & EXPERIENCE

1. Do you currently take dental x-rays in Iowa?	Yes ☑ No ☐
2. Do you now hold, or have you ever held, a certificate of qualification in dental radiography issued by the Iowa Dental Board? If yes, what is the qualification number? _____	Yes ☐ No ☑
3. Did you complete a course of study using the dental assistant trainee manual, or other course approved by the Board in the area of dental radiography within the past 2 years?	Yes ☑ No ☐
4. Did you complete clinical (i.e. on-the job) dental radiography training under the supervision of a dentist? If yes, the supervising dentist must verify this training on the Affidavit of Employment. (If training was completed outside of Iowa, the training dentist must certify training in all competencies prior-approved by the Board. Contact the Board for further details.)	Yes ☑ No ☐
5. Did you complete a course of study approved by the Board in the areas of infection control/hazardous materials and jurisprudence using the study manual or at an ADA-accredited post secondary school (i.e. community college)?	Yes ☑ No ☐
6. Are you currently certified in CPR by nationally-recognized provider? Online certification is not accepted. (Attach copy of CPR card.)	Yes ☑ No ☐
7. Are you registered, certified or qualified as a dental assistant in another state? If yes, which states: Nebraska certified (Provide written verification from each state in which you are registered, certified or qualified.)	Yes ☐ No ☑

8. Provide a chronological listing of all dental-related employment in the last 5 years. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you.

Employer Dentist Name & Location	Type of Work (e.g. chairside, lab, office)	From (Mo/Yr):	To (Mo/Yr):	Avg. Hours per Week
Kennedy Dental / Samar Anderson 1411 JF Kennedy Dr	chairside	03/10	8/10	40
Pacific Spring Dental / Jim Becker 17775 Mason St	chairside	08-10	1/11	40
Dr. Eischeid 427 E Kanesville Blvd.	chairside	10/11	Current	36

REGISTRATION INFORMATION

List all state/countries in which you are or have ever been registered, certified or qualified.
Please note: you will be required to request written certifications of all registrations.

State/Country	Registration No.	Date Issued	Registration Type	Basis for Registration

04-99 Thomas Jefferson Diploma

American Red Cross

This recognizes that
April Strong
has completed the requirements for
CPR/AED for Professional Rescuers and Health Care Providers
conducted by
YMCA Council Bluffs
Date completed: **04/15/2012**
The American Red Cross recognizes this certificate is valid from completion date for: 2 Years

[redacted]

Name of Applicant: April Strong

PERSONAL & CONFIDENTIAL DATA

[redacted]

EXAMINATION INFORMATION

[redacted]

DEFINITIONS

Important! Read these definitions before completing the following questions.

"Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

"Improper use of drugs or other chemical substances" means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

Name of Applicant: April Strong

PERSONAL & CONFIDENTIAL DATA

[redacted]

If you answered yes to any of the questions above, please provide a statement below providing the details as requested in the instructions above. Please add a separate sheet of paper if necessary.

_____

_____

_____

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_____

_____ _____

Signature **Date**

Name of Applicant: April Strong

PERSONAL & CONFIDENTIAL DATA

[redacted]

If you answered yes to any of the questions above, please provide a statement below providing the details as requested in the instructions above. Please add a separate sheet of paper if necessary.

[redacted]

Received Time Oct. 8. 2012 4:02PM No. 0402

Name of Applicant: April Strong

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 15, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

Yes ☑	No ☐	5. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?
Yes ☐	No ☑	6. Have you ever been terminated or requested to withdraw from any dental assisting school or training program?
Yes ☐	No ☑	7. Have you ever been requested to repeat a portion of any dental assisting training program/school?
Yes ☐	No ☑	8. Have you ever received a warning, reprimand, or been placed on probation during a dental assisting training program/school?
Yes ☐	No ☑	9. Have you ever been denied a registration/certificate to practice dental assisting?
Yes ☐	No ☑	10. Have you ever voluntarily surrendered a registration/certification issued to you by any professional licensing agency?
Yes ☐	No ☑	11. If yes, was license/registration disciplinary action pending against you, or were you under investigation by a licensing agency at the time the voluntary surrender of license/registration was tendered?
Yes ☐	No ☑	12. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dental assisting?
Yes ☐	No ☑	13. Are charges or an investigation currently pending relative to your license/registration in any other state?
Yes ☐	No ☑	14. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license/registration you held?
Yes ☐	No ☑	15. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?
Yes ☑	No ☐	**16.** Do you understand that if registration is granted by this Board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the registration?

T 11326

STATE OF IOWA
Criminal History Record Check Request Form

DCI Account Number: _____ (If applicable)

To: Iowa Division of Criminal Investigation
Support Operations Bureau, 1st Floor
215 E. 7th Street
Des Moines, Iowa 50319
(515) 725-6066
(515) 725-6080 Fax

From: April Marie Strong
3204 Renner Dr. Apt 29
Council Bluffs, IA 51501
Phone: 712 314-1458
Fax: 515-281-7969

I am requesting an Iowa Criminal History Record Check on:

Last Name (mandatory)	First Name (mandatory)	Middle Name (recommended)
Strong	April	Marie
Date of Birth (mandatory)	**Gender (mandatory)**	**Social Security Number (recommended)**
4-19-1979	☐ Male ☑ Female	[redacted]

Waiver Information: Without a signed waiver from the subject of the request, a complete criminal history record may not be releasable, per Code of Iowa, Chapter 692.2. For complete criminal history record information, as allowed by law, always obtain a waiver signature from the subject of the request.

Waiver Release: I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation (DCI). Any criminal history data concerning me that is maintained by the DCI may be released as allowed by law.

Waiver Signature: April Strong

Iowa Criminal History Record Check Results

(DCI use only)

As of 10-30-12, a search of the provided name and date of birth revealed:

☐ No Iowa Criminal History Record found with DCI

☒ Iowa Criminal History Record attached, DCI # 589299

DCI initials JO

DCI-77 (08/25/10)

IOWA CRIMINAL HISTORY
MISDEMEANOR CONVICTIONS ONLY

DCI 00589299
PAGE 1 OF 2
DATE PRINTED-
2012/10/30

DCI:00589299

NAME: STRONG,APRIL MARIE

DOB	SEX	RAC	HGT	WGT	EYE	HAIR	SKN	POB
19790419	F	W	503	150	BLU	BRO	FAR	IA

ADDITIONAL IDENTIFIERS PHOTO AVAILABLE: Y
TAT BACK
TAT L SHLD
TAT R ANKL

CCH RECORD ***

01 ARRESTED 19981219
AGENCY: IA0780100 COUNCIL BLUFFS PD
CHARGE NO- 01 IA STATUTE IA321J-2
OWI 1ST OFFENSE
TRK#: 044481201

COURT DISPOSITION
AGENCY: IA078015J POTT CO DIST COURT
COUNT NO- 01 IA STATUTE IA321J-2A
OWI 1ST OFFENSE
CHARGE CLASS: NON CONVICTION
TRK#: 044481201

SENTENCE		DISP EFF DAT
PLEAD GUILTY		19990609
DEFERRED JUDGEMENT		19990609
PROBATION	1Y	19990609
COMMUNITY SERVICE	50H	19990609
DISCHARGED FROM DEFERRED JUDGEMENT		20001018

02 ARRESTED 20020831
AGENCY: IA0780100 COUNCIL BLUFFS PD
CHARGE NO- 01 IA STATUTE IA716-6
CRIMINAL MISCHIEF 4TH
TRK#: 801817301

COURT DISPOSITION
AGENCY: IA078015J POTT CO DIST COURT
COUNT NO- 01 IA STATUTE IA716.6(1)
CRIMINAL MISCHIEF 4TH DEGREE
COURT CASE ID: 04781 SRCR123889
CHARGE CLASS: NON CONVICTION
TRK#: 801817301
RESTITUTION

SENTENCE		DISP EFF DAT
DEFERRED JUDGEMENT		20030225
UNSUPERVISED PROBATION	1Y	20030225
COMMUNITY SERVICE	20H	20030225
DISCHARGED FROM		20040816

DEFERRED JUDGEMENT

03 ARRESTED 20080917
AGENCY: IA0780100 COUNCIL BLUFFS PD
CHARGE NO- 01 IA STATUTE IA321J.2(B)
OPER VEH WH INT (OWI) / 2ND OFF
TRK#: 8A003H001

COURT DISPOSITION
AGENCY: IA078015J POTT CO DIST COURT
COUNT NO- 01 IA STATUTE IA321J.2(B)
OPER VEH WH INT (OWI) / 2ND OFF
COURT CASE ID: 04781 OWMG124997
CHARGE CLASS: MISDEMEANOR CONVICTION
TRK#: 8A003H001
DRUNK DRIVING SCHOOL
SUBSTANCE ABUSE EVALUATION

SENTENCE		DISP EFF DAT
SUSPENDED JAIL	23D	20090309
JAIL	30D	20090309
FINE	$1875	20090309
UNSUPERVISED PROBATION		20090309

AN ARREST WITHOUT DISPOSITION IS NOT AN INDICATION OF GUILT. THIS RECORD MAINTAINED BY THE IOWA DIVISION OF CRIMINAL INVESTIGATION, BUREAU OF IDENTIFICATION IS A PUBLIC RECORD BUT CAN ONLY BE RELEASED TO NON-LAW ENFORCEMENT AGENCIES BY THE DCI.
IN THE ABSENCE OF FINGERPRINTS FOR POSITIVE IDENTIFICATION THIS RECORD IS BASED ON INFORMATION FURNISHED. WE CANNOT CONFIRM OR DENY THAT THE RECORD COVERS THE SUBJECT OF YOUR INQUIRY.
DIVISION OF CRIMINAL INVESTIGATION

April Strong

T 11326

Criminal charges in the last 5 years.

1. DWI - driving while intoxicated 2008
I lost my license for 6 months. Had to take a drunk driving Couse a IWCC which I completed. Paid like 3000 dollars in fines and was required to have an alcohal evaluation and follow any recommondations they Had. I did that and no further treatment was recommended. After I did all this. I got my license back and haven't gotten a ticket since.

2. DUS Driving under suspension got a ticket paid a fine

April Strong

Received Time Oct. 26. 2012 11:23AM No. 0570

IOWA DENTAL BOARD
400 S.W. 8TH Street, Suite D
Des Moines, IA 50309-4687

Dear Iowa Dental Board

This letter is to inform you about my criminal history report for state of Nebraska. The report that I sent you from the Douglas County Sherriff Department is the report they give you on a person criminal history besides the one that you can get from the State trooper office in Lincoln, Nebraska, Which I drove all the way there to get and paid 15 dollars to receive. On this report tough it came up that I didn't have a criminal history. I told the clerk that this couldn't be right because I do have a criminal history in Omaha, Ne. He then said that unless you where fingerprinted and found guilty of a charge that it wouldn't be in the State records. I told him there was one time in 2005 that I was tickets for theft of services less than 200 dollars missed court and went to jail for failure to appear and was finger printed then and found guilty and he said that far back he wouldn't be surprise it didn't get in get into the states system and that Omaha was good for doing that. He told me that the only other thing I could do was to go to the Sherriff's office and get a report from them, which you already have. I also asked him about the charge that was dismissed and why it wasn't on the criminal history report and he said that that if you where just given a ticket and not fingerprinted and taken to jail and was not found guilty and all charges were dismissed that Nebraska will not will not disclose such charge on your criminal history report because you where not found guilty. Also Nebraska does not have a DCI report. I am faxing with this letter the Nebraska State Patrol record and on it is the number you can call if you have any more questions.

I now hope that you have everything you need to complete the registration process so that a decision can be made and I may be able to return to work soon.

Sincerely
April Strong
10-24-12

Received Time Oct. 25. 2012 8:59AM No. 0565

CRIMINAL HISTORY RECORD CHECK RECEIPT

RECEIPT NUMBER: 2012N0023790 RECEIPT DATE: 24 October 2012

REQUESTED BY:

NAME: APRIL STRONG
CONTACT:
ADDRESS 1: 3209 RENNER DRIVE APT 29
ADDRESS 2:
CITY/ST/ZIP: COUNCIL BLUFFS, IA 51501
WORK PHONE:
CELL PHONE:
HOME PHONE: (712) 314-1458
FAX #:

SENT TO:

NAME: APRIL STRONG
CONTACT:
ADDRESS 1: 3209 RENNER DRIVE APT 29
ADDRESS 2:
CITY/ST/ZIP: COUNCIL BLUFFS,IA 51501
WORK PHONE:
CELL PHONE:
HOME PHONE: (712) 314-1458
FAX #:

PAYMENT INFORMATION:

PMT TYPE	REFERENCE NUMBER	PMT AMOUNT
CHECK	1307	$15.00
	TOTAL:	$15.00

REFERENCE:

LAST NAME	FIRST NAME	MI	SUFFIX
STRONG	APRIL	M	

NEBRASKA STATE PATROL - CRIMINAL IDENTIFICATION DIVISION
3800 NW 12TH SUITE A
LINCOLN, NE 68521
PHONE: (402) 479-4971

NEBRASKA STATE PATROL

Criminal History Record

Dissemination Form

Receipt Number: 2012N0023790 Completed Date: 24 October 2012 Mailed Out: 24 October 2012

Requesting Agency/Individual		Dissemination Agency/Individual	
Requestor:	APRIL STRONG	Company:	APRIL STRONG
Contact:		Contact:	
Address:	3209 RENNER DRIVE APT 29	Address:	3209 RENNER DRIVE APT 29
City, State Zip	COUNCIL BLUFFS, IA 51501	City, State Zip	COUNCIL BLUFFS, IA 51501

NO CRIMINAL RECORD-NEBRASKA

Person of Interest

Name	Date of Birth
STRONG, APRIL M	April 19 1979

Name Check Only: Positive Identification cannot be effective without the support of finger prints. NEBRASKA STATE PATROL	No record in our files as of complete date. CRIMINAL IDENTIFICATION DIVISION NEBRASKA STATE PATROL		

NOTE: Traffic infraction data available from:
NEBRASKA STATE DEPARTMENT OF MOTOR VEHICLES
P.O.Box 94789 402-471-2281
Lincoln, NE 68509

NEBRASKA STATE PATROL
CRIMINAL RECORDS & IDENTIFICATION DIVISION
3800 NW 12th Suite A
Lincoln, NE 68521
by

Captain Kevin Knorr
Nebraska State Patrol Employee Signature

Iowa Dental Board
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

To: Iowa Dental Board

I am writing this letter in reference to my criminal history records from the Council Bluffs Police Department and Douglas County, Nebraska. I regret to say that I am not proud of what I've done, but I am proud of what I've accomplished these last four years to turn my life around.

I moved to Nebraska in 2002 struggling to raise 3 children by myself away from family. In 2008 I hit rock bottom and moved back to Iowa with my family. I then got a job at Applebee's where I still work two days a week. So through the Grace of God and the support of my family I've finally got my life together.

Today I now have a valid Driver's license without restrictions. I also have a degree in Dental Assisting from Kaplan University which I graduated on the President's list for having a GPA 3.8 or better. I also had perfect attendance. I'm currently working in Iowa as a Dental Assistant and have passed all my Iowa Dental Boards. Now I am asking for the opportunity and the chance to become a registered Dental Assistant and not lose the job that I've worked so hard to get.

If you have any further questions or information you might want or need before making you decision please contact me at (712)314-1458.

Sincerely,

April Strong

Criminal History

- These acts of crime took place in Council Bluffs, Iowa.

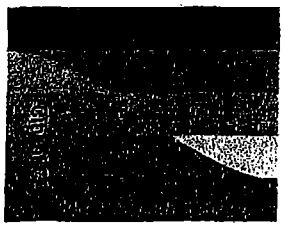
1998 DWI Driving ~~under suspension~~ while intoxicated I went to jail and ost my Drivers Lisence for 6 months. 1998 child endangerment for child not being in a car seat. got a ticket charges was dissmissed.
1999 got a traffic ticket paid a fine. 2001 theft paid a fine
2002 tresspassing paid a fine. 2002 Driving under suspension I didn't have a licence ~~paid~~ got a ticket paid a fine
2004 Criminal mischeif broke a window got a ticket paid a fine.
2007 interfer w/ offical acts wouldnt give friend name later I coroperated and was let go.
2007 Driving while intoxicated ~~a~~ went to jail for 7 days Had to take a Drunk driving class at Iwce which I completed. I also had an alcohol evaluation and at which time no treatment was recommened. I no longer drink and drive and I now have a vaild Drivers License in Iowa without restriction as of 2010. ~~[illegible]~~ I do not break the law any more. ~~[illegible]~~ I am a law abiding Citizen and would never jeopardice my Career as a Dental Assisant.

Sincerely
April Stroney
10-17-12

Charges Listed happened in Omaha, Neb. where I was Living from 2002 until 2008. First charge was 8-12-05 Theft of services which was stealing basic cable less than 200 dollars. I was ticketed then I missed court and went to jail for failure to appear. When I went to court I pled not guilty and went to jail with a bond of 10,000 So I sat in jail for 15 days before I pled guilty time served.
In 2007 I got cought shoplifting at Hyvee I was ticketed and fined. Also in 2007 I recieve stolen property fined $100 pellin
2007 Driving while under suspion ticketed and fined.
2010 Driving under suspension for the last time because I had got my License back at this time.

2007 neg of minor care. This happened at my home in Omaha, Neb. I left my children in the care of a babysitter who left them alone. The neighbors called the cops the kids were taken into custody until I was notified. I was ticketed and requested I taken parenting class charges where then Dissmissed.

Signature Date
April Strong 10-17-12



OFFICE OF:
POLICE DEPARTMENT
(712) 328-4701

REQUEST FOR CRIMINAL HISTORY RECORD

Please Print Last: Strong First: April Middle: Marie

Other Names Used

Social Security # [redacted] Date of Birth 4 / 19 / 79

I request a copy of my Criminal History Record which may be on file with the Council Bluffs Police Department, and authorize its release.

Dated this 20 (Day) Day of Sept. (Month), 2012 (Year).

Signed April Strong
(Signature of Above Person Requesting Search)

ALONG WITH THIS FORM YOU MUST PRESENT VALID GOVERNMENT IDENTIFICATION.

A Criminal History Records search was conducted on the above named Individual on, Date Sept 20, 2012, Time 1311.

By and for the Records Section of the Council Bluffs Police Department ONLY,

And it was found that:

_____ NO RECORD ON FILE

✓ RECORD ATTACHED

Signed Stacia 959
(Employee Conducting Search)

5 pages total

Information is for above agency use only. Council Bluffs Police Department is not responsible for any further dissemination of information.

CITY OF COUNCIL BLUFFS, IOWA - 227 SOUTH 6TH STREET - 51501-4294
FAX: (712) 328-4723
"An Equal Opportunity Employer"

COUNCIL BLUFFS POLICE D[illegible]T
9/20/12

Jacket Activity

PS1191S1
Jacket #: 000066956 A

ORI# . . : IA0780100
Name . . : STRONG,APRIL,MARIE,
Address. : 3209 RENNER DR 29
Ct/St/Zp : COUNCIL BLUFFS IA 51501
DOB . . : 04/19/1979 Age: 33 Race : W Sex : F Hgt : 503 Wgt : 150
DL# . . : 946RR7759 State: IA Hair : BRO Eyes : BLU

Phone: 712-323-3550
Cell :
Work : 712-366-1250
SS# : [redacted]

Type options, press Enter.
2=Change 5=Display 10=Close 11=Delayed Close 12=Open

Opt	Date	Description			Number	Type
	09/30/2008	Summoned	App Ticket	2008-00037941	000000018645	ARREST
		THEFT 5-ALL OTHER		001 C Sim Misde		ARRST CHG
	09/17/2008	On-View	Held	2008-00037942	000000018453	ARREST
		OPER W/O VALID DRIVERS		001 C Traffic		ARRST CHG
		OWI - 2ND		001 C Agg Misde		ARRST CHG
	07/24/2007	On-View	Held	2007-00031602	000000013081	ARREST
				001 C Agg Misde		ARRST CHG
		INTERF W OFFICIAL ACTS/		001 C Sim Misde		ARRST CHG

More...

F3=Exit F9=Date/Activity Order F12=Cancel F17=Profile Sheet

1979
18
1997 - 18 y.of age

Last charge 2008

****
********** CID HISTORY ********** Page: 01 ***
****

Name: STRONG,APRIL MARIE DOB: 04/19/1979 SSN: [redacted] Sex: F Race: W
Addr: 4958 S 37 ST Apt#: Tel:
City: OMAHA NB 68107

Agency: C COUNCIL BLUFFS PD CID #: 0000065750

05/16/2004 TAKEN INTO FAILURE TO APPEAR - ARR-ADULT ARS C 04025577 01

04/22/2004 CRMNL MISDM CRIM MISC 4TH S WAR C 00000CR123889

02/20/2004 TAKEN INTO CRIMINAL MISCHIEF 4 ARR-ADULT ARS C 04009169 01

08/31/2002 TAKEN INTO CRIMINAL MISCHIEF 4 ARR-ADULT ARS C 02043896 01

08/12/2002 ON-VIEW ARR DRIVING UNDER SUSPE ARR-ADULT ARS C 02049112 01

06/10/2002 SUMMONED/CI TRESPASS ARR-ADULT ARS C 02034586 01

02/04/2001 ON-VIEW ARR THEFT 3RD ARR-ADULT ARS C 01005820 01

[redacted]

09/19/2000 TAKEN INTO OPERATION WHILE INT ARR-ADULT ARS C 00053024 01

07/27/2000 TAKEN INTO CONTEMPT OF COURT ARR-ADULT ARS C 00041928 01

03/18/2000 SUMMONED/CI MINOR IN POSSESSION ARR-ADULT ARS C 00014233 01

08/17/1999 ON-VIEW ARR TRAFFIC VIOLATION - ARR-ADULT ARS C 99046313 01

[redacted]

12/19/1998 ON-VIEW ARR OPERATION WHILE INT ARR-ADULT ARS C 98076525 01

[redacted]

Child Endangerment - ARR-Adult

TRAFFIC VIOLATION - ARR-ADULT ACH 0103

TRAFFIC VIOLATION - ARR-ADULT ACH 0104

TRAFFIC VIOLATION - ARR-ADULT ACH 0105

TRAFFIC VIOLATION - ARR-ADULT ACH 0106

TRAFFIC VIOLATION - ARR-ADULT ACH 0107

11/04/1998	ON-VIEW ARR	DRIVING UNDER SUSPE ARR-ADULT	ARS C 98067383	01
		TRAFFIC VIOLATION - ARR-ADULT	ACH	0102
		TRAFFIC VIOLATION - ARR-ADULT	ACH	0103
		TRAFFIC VIOLATION - ARR-ADULT	ACH	0104

Timothy F. Dunning – Douglas County Sheriff

COURT SERVICES BUREAU
1616 Leavenworth Street
Omaha, NE 68102

Civil Process Division	599-2600
Civil Proceeds Division	599-2601
Fugitive Warrants Division	599-2633
Records Division	599-2608

APRIL M. STRONG
3209 RENNER DR. #29
COUNCIL BLUFFS, IA 51501

DATE: 09/25/12
PROCESSED BY: S840

CRIMINAL HISTORY

*** ALIAS NAME ***

D.O.B.
04/19/1979

LAST/FIRST/M.I.: STRONG APRIL M
LAST KNOWN ADDRESS: 03209 RENNER DR 29
COUNCIL BLUFFS, IA

	DATE	CLASS	ARREST/CHARGE		DISPOSITION
8-12-05	042805	M2	THEFT OF SERVICES	$200/LESS	CONFINED - JAIL
2-20-07	030106	M2	THEFT BY SHOPLIFTING	UNDER $50	FINE, SUSPENSION OF EXECUTION
	052306	M	FAIL TO APPEAR - CITATION	-MISDEMEANOR	CONFINED - JAIL
7-13-07	050207	M	RECEIVE UNLAW TAKEN PRPTY	UNDER $100	FINE, SUSPENSION OF EXECUTION
5-27-10	061407	TM	OPER VEH DURING REV/SUSP -	2/MORE OFF	FINE AND COURT COSTS
	071907	M	FAIL TO APPEAR - CITATION	-MISDEMEANOR	FINE AND COURT COSTS

2007 Neg Minor Care Dismissed ~~[illegible]~~ Misdemeanor

Last charge 2010 Driving under susp

the rest 2007 and before

****
* THIS DATA IS FROM LOCAL COMPUTERIZED FILES INCLUDING FELONY AND MISDEMEANOR OFFENSE. *
* MISDEMEANOR DATA OVER TEN YEARS OLD MAY HAVE BEEN PURGED. OTHER DATA MAY OR MAY NOT EXIST *
* IN NON-COMPUTERIZED FILES REQUIRING AN ADMINISTRATIVE SEARCH AT ADDITIONAL COST. *
* TRAFFIC INFRACTION DATA IS AVAILABLE FROM THE NEBRASKA DEPARTMENT OF MOTOR VEHICLES. *
****

POSSIBLE OTHER AGENCIES TO CONTACT:

PAID BY CHECK NUMBER 001302 FOR $10.00

Name of Applicant: _____

AFFIDAVIT OF APPLICANT

IN STATE OF Iowa COUNTY OF Polk

I, April Strong, hereby declare under penalty of perjury that I am the person described and identified in this application and that the attached photograph is a true likeness of myself. I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

If registration is issued to me, I understand that if I violate state law, my registration may be revoked as provided by law. I declare under penalty of perjury that my answers and all statements made by me on this application are true and correct. Should I furnish any false information or have substantial omission in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my registration.

I hereby authorize the Iowa Dental Board and/or its agents to verify any information including, but not limited to, criminal history and motor vehicle driving records. I authorize all colleges or universities, employers and law enforcement agencies to release any information concerning my background to the Iowa Dental Board for registration purposes. I do hereby release said person(s) from any and all liability that may be incurred as a result of furnishing such information. A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

Signature of Applicant April Strong

Sworn to before me this 26 day of Sept, 2012

Signature of Notary Public Sarah L Wendt

NOTARY SEAL: NOTARIAL SEAL IOWA | SARAH L. WENDT Commission Number 742619 MY COMMISSION EXPIRES 6-5-15

Johnson, Melanie [IDB]

From: Braness, Christel [IDB]
Sent: Friday, November 30, 2012 4:26 PM
To: Diane Meier; matt@ankenydentist.com; Mike Rovner
Cc: Johnson, Melanie [IDB]; Arjes, Janet [IDB]; Davidson, Angela [IDB]
Subject: Licensure/Registration Committee - Application for Registration/Qualification - APRIL STRONG
Attachments: Board Guidelines w- Enforcement Flowcharts 11 30 12.pdf; Strong_April_DAApp.pdf

Importance: High

RE: Licensure/Registration Committee

ACTION REQUESTED: Review and Recommendation re: Application for Iowa Dental Assistant Registration & Dental Radiography Qualification– **April Strong**

Attached is a copy of applicant's registration and dental radiography application and corresponding materials for your review.

Note: Emails are subject to the open records law. Unless information is deemed confidential (e.g. medical information), your responses will become part of the public record.

After review of these materials, please place an "X" in the box below next to your recommendation when responding to this email.

Committee Member's Recommendation:

_____	Approve.
_____	Approve, pending receipt of: _____
_____	Approve, with these restrictions: _____
_____	Deny. Reason(s):_____
_____	Refer to full Board without a Committee recommendation.

Issue(s) for Committee Review: This is an application for Iowa Dental Assistant Registration & Dental Radiography Qualification. The applicant graduated from Kaplan University, Omaha, Nebraska, in April 2010. Ms. Strong has worked under trainee status for Dr. Raymond Eischeid, Council Bluffs, from 10/10/11 through 10/10/12.

This application is being referred to the Committee for review of her reported criminal history, which indicates a pattern of behavior (e.g. 2 OWIs, multiple theft/shoplifting charges, etc).

Questions for the Committee:

1) Does the Licensure/Registration Committee have any concerns issuing registration and radiography qualification given her history of alcohol usage?
2) Does the Licensure/Registration Committee have any concerns about Ms. Strong's criminal history? Does the Committee want to make a recommendation to the Board concerning her prior history (e.g. Letter of Warning or Stipulated Registration)?

Board Rule(s)/ Board Enforcement Guidelines:
There are no Board rules that establish when an application from an applicant with a criminal history must be reviewed by the Committee or the Board.

However, the Board has adopted guidelines for staff to follow to determine when an application must be referred to the Committee and the Board. At the October 25, 2012, meeting the Board revised these guidelines, "Enforcement Criteria – Dental Assistants," [redacted] If the criminal history includes a [redacted] the application must be referred to the Committee and/or Board for review.

Background:

Applicant's Criminal History

In the past five years, Ms. Strong has had the following arrests and charges. Previously, Ms. Strong has numerous charges ranging back to 1998. Those arrests and charges are attached.

December 19, 1998	OWI 1st Offense
2001 (no date provided)	"Theft paid a fine"
August 31, 2002	Criminal Mischief in the 4th Degree
2002 (no date provided)	Driving under suspension
2004 (no date provided)	Criminal Mischief ("Broke a window got a ticket paid a fine.")
August 12, 2005	Theft of Services ("Stealing basic cable less than $200")
2007 (specific date not provided by applicant, no history on file with the state of NE where this occurred.	Ms. Strong was arrested for Negligence of Minor Care. According to Ms. Strong, she was arrested for "negligence of minor care. This happened at my home. I left my children with a babysitter who left them alone. The neighbors called the cops, the kids were taken into custody until I was notified. I was ticketed and requested to take a parenting classes. Charges were then dismissed."
March 1, 2006	Shoplifting (HyVee, was ticketed and fined) (under $50)
May 2, 2007	Received unlaw taken property (under $100)
July 24, 2007	Ms. Strong was arrested and charged with Interference with Official Acts, a Simple Misdemeanor.
September 17, 2008	Ms. Strong arrested and charged with 2nd OWI, an Aggravated Misdemeanor. a) Ms. Strong lost her driver's license for 6 months. b) Completed a drunk driving course. c) Paid $3000 in fines. d) Required to have an alcohol evaluation. e) Driver's license was reinstated upon compliance with all conditions required by the court.

September 17, 2008	Ms. Strong charged with Operating Without a Valid Driver's License, a Serious Misdemeanor.
September 30, 2008	Ms. Strong arrested for Theft 5, a Simple Misdemeanor.
2010 (no date provided)	Driving under suspension

Applicant History:

October 10, 2011-October 10, 2012	Ms. Strong worked as a dental assistant trainee for Dr. Raymond Eischeid, Council Bluffs.
August 21, 2012	Ms. Strong successfully passed the Dental Radiography Examination.
September 11, 2012	Ms. Strong successfully passed the Jurisprudence Examination.
September 18, 2012	Ms. Strong successfully passed the Infection Control Examination.
October 5, 2012	Ms. Strong made Application for Iowa Dental Assistant Registration and Dental Radiography Qualification.

Prior Disciplinary Actions:

None. This applicant has been in trainee status during 2011-2012. The Board office became aware of her criminal history when Ms. Strong made application for registration.

Historical Treatment of Similar Situations:

Staff is not aware of any similar dental assistant cases.

Staff Recommendations:

The licensure/registration team offers the following viewpoints for your consideration:

Janet: Since Ms. Strong's arrests and charges are 4-5 years old, I recommend that the committee issue the registration and a Letter of Warning. The Letter of Warning would state that any further criminal sanctions may result in formal disciplinary action.

Christel and Angie: Given the separate charges related to theft, shoplifting and receiving stolen property, we would recommend that the Board issue a Stipulated Registration Agreement wherein Ms. Strong would be required to report that history to future employers.

Christel Braness, Program Planner
Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

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ACTION

REPORT TO THE DENTAL HYGIENE COMMITTEE

DATE OF MEETING:	January 31, 2013
RE:	**Application for License – Jessica Koster, D.H.**
SUBMITTED BY:	Christel Braness, Program Planner
ACTION REQUESTED:	Dental Hygiene Committee Recommendation to Board

Topic(s) for Committee Review

Ms. Koster has reported a lengthy criminal history. Should a dental hygiene license be issued? If yes, should it be issued as a stipulated license?

Background

1/19/98	Operating under suspension in Webster County. • Guilty - 5 days in jail and a fine.
9/29/99	Minor in possession of alcohol in Webster County. • Guilty – fine
6/9/00	Possession of paraphernalia (marijuana pipe) in Webster County. • Guilty – fine
6/9/00	Arrested for OWI, but was not charged
7/21/00	Contempt of Court in Webster County • Guilty – fine
1/8/01	Possession to manufacture paraphernalia (rolling papers) in Polk County • Guilty – fine
3/30/01	OWI – 1st Offense, Polk County • Guilty – fine, drinking drivers course, probation.
4/10/01	Possession of a controlled substance (marijuana) in Polk County • Charge dismissed.
1/11/02	Possession of drug paraphernalia (marijuana pipe) in Polk County. • Charge dismissed in exchange for pleading guilty to possession of marijuana.
1/11/02	Possession of marijuana under 1 gram in Polk County. • Guilty – deferred judgment, fine, probation
7/22/03	Driving under suspension – adjudicated to driving with expired license in Polk County. • Guilty – fine
8/7/03	Driving under suspension – adjudicated to driving with expired license in Polk County. • Guilty – fine
1/28/04	Driving under suspension in Calhoun County • Guilty – fine
8/14/04	OWI – 2nd offense, adjudicated to public intoxification because of the margin of error of the breathalyzer in Marion County. • Guilty – fine
8/14/04	Unlawful operation of a golf cart due to no flag in Marion County • Guilty – fine
5/05	Arrested for domestic abuse causing injury. Adjudicated to assault causing injury in Polk County. Bit boyfriend's cheek.

	• Deferred and expunged upon completion of 30 day inpatient substance abuse treatment, aftercare treatment, probation, fine.
3/1/08	Domestic abuse causing injury. Adjudicated down to simple assault. Slapped boyfriend, which left a red mark. • Guilty – 1 day in jail, 16 weeks of assaultive behavior classes, probation, fine
11/23/08	OWI – 2nd offense in Boone County. • Guilty – 7 days in jail, probation, fine
8/10-5/12	Attended the dental hygiene program at DMACC.
9/19/12	Applied for a dental hygiene license in Iowa.
10/25/2012	DHC reviewed application. Requested additional information.

Prior Disciplinary Actions

Ms. Koster has not been licensed previously. Therefore, there is no disciplinary action on file.

Historical Treatment of Similar Situations

There are prior cases involving alcohol and/or substance abuse; however, we do not have another case, which is comparable in terms of the volume of charges.

Attached for Review

- Application for dental hygiene license
- Written explanation for criminal history
- Statement regarding any diagnosis related to alcohol/substance abuse
- DCI results regarding state background check

APPLICATION FOR IOWA DENTAL HYGIENE LICENSE

SEP 19 REC'D

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Ph. (515) 281-5157 http://www.dentalboard.iowa.gov

☒ **Application by Examination** ☐ **Application by Credentials**

This form must be completed and returned to the Iowa Dental Board. Include the ***non-refundable*** application fee. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

IDENTIFYING INFORMATION

Full Legal Name: (Last, First, Middle) Koster, Jessica, Marie			
Other Names Used: (e.g. Maiden Name) none			
Home Address: 117 SE Booth Avenue			
City: Waukee	**County:** Dallas	**State:** Ia	**Zip:** 50263
Home Phone: 515-257-3577		**Home E-mail:** jmkoster11@gmail.com	
Work Address: 1215 Plaza Drive			
City: Carroll	**County:** Carroll	**State:** Ia	**Zip:** 51401
Work Phone: 712-792-9102	**Work Fax:** none	**Work E-mail:** none	

DENTAL HYGIENE EDUCATION

	Institution	City, State, Country	From (Mo/Yr)	To (Mo/Yr)
Year 1	DMACC	Ankeny, Ia, U.S.	8/10	5/11
Year 2	DMACC	Ankeny, Ia U.S.	8/11	5/12
Year 3				
Year 4				

Degree Received: associates in applied science dental Hygiene	**Date of Degree:** 5-2-12

For office use only:	**License #**	**Date Issued:**	**Fees (App/Fprint):** $216 #1000098019

Fprint Rcvd. 9-19-12

Name of Applicant: Jessica Koster

POST-GRADUATE DENTAL HYGIENE TRAINING

Institution: N/A	Specialty:	From (Mo/Yr):	To (Mo/Yr):
Address:	City:	State:	

CHRONOLOGY OF ACTIVITIES

Provide a chronological listing of all dental hygiene and non-dental hygiene activities from the date of your graduation from dental hygiene school to the present date, with no more than a three (3) month gap in time. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you.

Activity & Location	From (Mo/Yr):	To (Mo/Yr):
Pinahanna Clubs / ossys Carroll Ia	6-06	current

LICENSE INFORMATION

List all state/countries in which you are or have ever been licensed. Please note: you will be required to request written certifications of all licenses.

State/Country	License No.	Date Issued	License Type (e.g. Resident, Faculty, Permanent)	How Obtained (e.g. Credentials, Exam)

Name of Applicant: Jessica Koster

PERSONAL & CONFIDENTIAL DATA

Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13), Iowa Code §§ 272J.8(1) and 261.126(1), and Iowa Code § 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

Social Security Number: [redacted]	**Gender:** ☐ Male ☒ Female	**U.S. citizen:** ☒ Yes ☐ No

If no, visa type or alien registration number: ☐ Student Visa ☐ Work Visa ☐ Alien Registration
Provide visa or alien registration number: **If visa, provide expiration date of current visa:**

Date of birth:	**City of Birth:**	**State of birth:**	**Country of birth:**
10-13-78	Sioux City	Iowa	Calhoun

EXAMINATION INFORMATION

List all national, regional, or state licensure exams you have taken. Include the date and indicate if you passed or failed. Add additional sheets if necessary.

1. CRDTS - clinical exam	Date: 4-28-12	[redacted]
2. NBDHE - written exam	Date: 5-16-12	[redacted]

DEFINITIONS

Important! Read these definitions before completing the following questions.

"Ability to practice dental hygiene with reasonable skill and safety" means ALL of the following:

1. The cognitive capacity to make reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental hygiene examinations and dental hygiene procedures.

"Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

"Improper use of drugs or other chemical substances" means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

Name of Applicant: Jessica M. Koster

PERSONAL & CONFIDENTIAL DATA

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 18, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

Yes ☐	**No** ☒	1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dental hygiene with reasonable skill and safety?
Yes ☐	**No** ☒	2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
Yes ☐	**No** ☒	3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dental hygiene with reasonable skill and safety?
Yes ☐	**No** ☐	4. If YES to any of the above, are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
Yes ☐	**No** ☐	5. If YES to any of the above, does your field of practice, the setting, or the manner in which you have chosen to practice dental hygiene, reduce or eliminate the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?

If you answered yes to any of the questions above, please provide a statement below providing the details as requested in the instructions above. Please add a separate sheet of paper if necessary.

Signature _____ 9-14-12 **Date**

Name of Applicant: Jessica Koster

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 18, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

Yes ☒	No ☐	6. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?
Yes ☐	No ☒	7. Have you ever been terminated or requested to withdraw from any dental hygiene school or training program?
Yes ☐	No ☒	8. Have you ever been requested to repeat a portion of any professional training program/school?
Yes ☐	No ☒	9. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?
Yes ☐	No ☒	10. Have you ever been denied a license to practice dental hygiene?
Yes ☐	No ☒	11. Have you ever voluntarily surrendered a license issued to you by any professional licensing agency?
Yes ☐	No ☐	11a. If yes, was a license disciplinary action pending against you, or were you under investigation by a licensing agency at that time the voluntary surrender of license was tendered?
Yes ☐	No ☒	12. Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?
Yes ☐	No ☒	13. Are any malpractice claims or complaints in process/pending against you?
Yes ☐	No ☒	14. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dental hygiene?
Yes ☐	No ☒	15. Are charges or an investigation currently pending relative to your dental hygiene license in any other state?
Yes ☐	No ☒	16. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license you held?
Yes ☐	No ☒	17. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the United States or other nation?
Yes ☐	No ☒	18. Have any judgments or settlements been paid on your behalf as a result of a professional liability case(s)?
Yes ☒	No ☐	**19. Do you understand that if a license is granted by this board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the license?**

List of arrests, convictions and judgments

1. 1-19-98 Operating vehicle under suspension. Webster Co. Adjudicated to failure to have valid permit Guilty
   Sentence: 5 days in jail, Fine

2. 9-29-99 Minor in possession of alcohol. Webster co. Guilty
   Sentence: fine

3. 6-9-00 possession of paraphernalia, marijuana pipe. Webster Co, Guilty
   Sentence: fine

4. 6-9-00 arrested for OWI but was not charged

5. 7-21-00 Contempt of court. Webster Co. Guilty
   Sentence: fine

6. 1-8-01 possession to manufacture paraphernalia, rolling papers. Polk Co. Guilty
   Sentence: fine

7. 3-30-01 OWI 1st offense. Polk Co. Guilty
   Sentence: fine, drinking drivers course, probation

8. 4-10-01 Possession of controlled substance, Marijuana, Polk Co. Charge dismissed

9. 1-11-02 possession of drug paraphernalia, marijuana pipe. Polk Co. Dismissed in exchange for pleading guilty of possession of marijuana

10. 1-11-02 Possession of marijuana under 1 gram. Polk Co. Guilty
    Sentence: Deferred Judgment, fine, probation

11. 7-22-03 driving under suspension- adjudicated to driving with expired license. Polk Co, guilty
    Sentence: fine

12. 8-7-03 driving under suspension. Adjudicated down to driving with expired license. Polk Co. Guilty
    Sentence: fine

13. 1-28-04 driving under suspension. Calhoun Co. Guilty
    Sentence: Fine

14.8-14-04 OWI 2nd offense, adjudicated to public intoxication because of the margin of error of the breathalyzer put my test below .08 blood alcohol. Marion Co. Guilty

Sentence: fine

15. 8-14-04 Unlawful operation of a golf cart due to no flag. Marion Co. Guilty

Sentence: fine

16. 5-05 Arrested for domestic abuse causing injury. Adjudicated down to assault causing injury. Polk Co. Guilty. I Bit my boyfriend's cheek

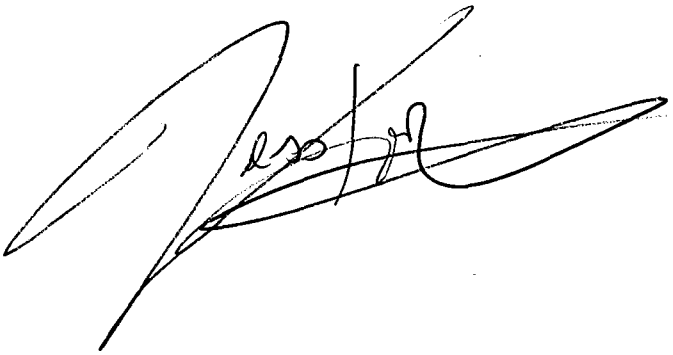
Sentence: deferred and expunged upon completion of 30 day inpatient substance abuse treatment, aftercare treatment, probation, fine

17. 3-1-08 Domestic abuse causing injury. Adjudicated down to simple assault. I slapped my boyfriend and left a red mark.

Sentence: I day in jail, 16 weeks of assaultive behavior classes, probation, fine

18. 11-23-08 OWI 2nd offense. Boone Co, Guilty

Sentence: fine, 7 days in jail, probation



IOWA CRIMINAL HISTORY
MISDEMEANOR CONVICTIONS ONLY

DCI 00641393
PAGE 1 OF 3
DATE PRINTED-
2012/09/27

DCI:00641393

NAME: **KOSTER,JESS**
KOSTER,JESSICA MARIE

DOB	SEX	RAC	HGT	WGT	EYE	HAIR	SKN	POB
19781013	F	W	506	135	BLU	BLN	LGT	IA

ADDITIONAL IDENTIFIERS PHOTO AVAILABLE: Y
TAT ABDOM
TAT NECK

CCH RECORD ***

✓ 01 **ARRESTED 20010330**
AGENCY: IA0770400 URBANDALE PD
CHARGE NO- 01 IA STATUTE IA321J-2
OWI 1ST OFFENSE
TRK#: 052739401

COURT DISPOSITION
AGENCY: IA077015J POLK CO DIST COURT
COUNT NO- 01 IA STATUTE IA321J.2(A)
OPER VEH WH INT (OWI) / 1ST OFFENSE
COURT CASE ID: 05771 OWOM052892
CHARGE CLASS: MISDEMEANOR CONVICTION
TRK#: 052739401
SUBSTANCE ABUSE EVALUATION

SENTENCE		DISP EFF DAT
SUSPENDED JAIL	363D	20010608
JAIL	365D	20010608
FINE	$1000	20010608
PROBATION	1Y	20010608
CREDIT W/TIME SERVED		20010608
PROBATION EXTENDED	1Y	20020628
COMMUNITY SERVICE	70H	20020628

✓ 02 **ARRESTED 20020111**
AGENCY: IA0770500 WEST DES MOINES PD
CHARGE NO- 01 IA STATUTE IA124-401-5
POSSESS MARIJUANA
TRK#: 058617201

COURT DISPOSITION
AGENCY: IA077015J POLK CO DIST COURT
COUNT NO- 01 IA STATUTE IA124.401(5)
POSSESSION OF A CONTROLLED SUBSTANCE
COURT CASE ID: 05771 SRCR162359
TRK#: 058617201
SUBSTANCE ABUSE EVALUATION

SENTENCE		DISP EFF DAT
DEFERRED JUDGEMENT		20020328
PROBATION	1Y	20020328

03 **ARRESTED 20040813**

AGENCY: IA0630000 MARION CO SO
CHARGE NO- 01 IA STATUTE IA321J-2
OWI
TRK#: 070056801

COURT DISPOSITION
AGENCY: IA063015J MARION CO DIST COURT
COUNT NO- 01 IA STATUTE IA123.46
CONSUMPTION / INTOXICATION
COURT CASE ID: 05631 OWCR020886
CHARGE CLASS: MISDEMEANOR CONVICTION
TRK#: 070056801

SENTENCE		DISP EFF DAT
FINE	$100	20041110

04 ARRESTED 20050627
AGENCY: IA0770200 CLIVE PD
CHARGE NO- 01 IA STATUTE IA708.2-2
ASSAULT/CAUSE INJURY
TRK#: 068037101

COURT DISPOSITION
AGENCY: IA077015J POLK CO DIST COURT
COUNT NO- 01 IA STATUTE IA708.2(2)
ASSAULT CAUSING BODILY INJURY
COURT CASE ID: 05771 SRCR194111
CHARGE CLASS: NON CONVICTION
TRK#: 068037101
SUBSTANCE ABUSE EVALUATION
RESTITUTION

SENTENCE		DISP EFF DAT
DEFERRED JUDGEMENT		20050906
FINE	$250	20050906
PROBATION	12M	20050906
DISCHARGED FROM DEFERRED JUDGEMENT		20060920

05 ARRESTED 20080302
AGENCY: IA0770500 WEST DES MOINES PD
CHARGE NO- 01 IA STATUTE IA708.2A(2)(B)
DOMESTIC ABUSE ASSAULT WITHOUT INTENT CAUSING INJURY
TRK#: 081972401

COURT DISPOSITION
AGENCY: IA025015J DALLAS CO DIST COURT
COUNT NO- 01 IA STATUTE IA708.2(6)
ASSAULT
COURT CASE ID: 05251 SRCR031404
CHARGE CLASS: MISDEMEANOR CONVICTION
TRK#: 081972401
RESTITUTION

SENTENCE		DISP EFF DAT

SUSPENDED JAIL	29D	20080508
JAIL	30D	20080508
FINE	$65	20080508
COURT COSTS		20080508
PROBATION	1Y	20080508
NO CONTACT ORDER		20080508

06 ARRESTED 20081123
AGENCY: IA0080200 OGDEN PD
CHARGE NO- 01 IA STATUTE IA321J.2(A)
OPER VEH WH INT (OWI) / 1ST OFFENSE
TRK#: EG000X401

COURT DISPOSITION
AGENCY: IA008015J BOONE CO DIST COURT
COUNT NO- 01 IA STATUTE IA321J.2(B)
OPER VEH WH INT (OWI) / 2ND OFFENSE
COURT CASE ID: 02081 OWCR016385
CHARGE CLASS: MISDEMEANOR CONVICTION
TRK#: EG000X401
DRUNK DRIVING SCHOOL
SUBSTANCE ABUSE EVALUATION

SENTENCE		DISP EFF DAT
SUSPENDED JAIL	113D	20090310
	FEES	
JAIL	120D	20090310
FINE	$1875	20090310
PROBATION	1Y	20090310

AN ARREST WITHOUT DISPOSITION IS NOT AN INDICATION OF GUILT. THIS RECORD MAINTAINED BY THE IOWA DIVISION OF CRIMINAL INVESTIGATION, BUREAU OF IDENTIFICATION IS A PUBLIC RECORD BUT CAN ONLY BE RELEASED TO NON-LAW ENFORCEMENT AGENCIES BY THE DCI.
IN THE ABSENCE OF FINGERPRINTS FOR POSITIVE IDENTIFICATION THIS RECORD IS BASED ON INFORMATION FURNISHED. WE CANNOT CONFIRM OR DENY THAT THE RECORD COVERS THE SUBJECT OF YOUR INQUIRY.
DIVISION OF CRIMINAL INVESTIGATION

1/30/13 Supplemental

REPORT TO THE IOWA DENTAL BOARD

ACTION

DATE OF MEETING: February 1, 2013

RE: **Tracy Lawler – Application for Registration and Radiography Qualification**

SUBMITTED BY: Licensure/Registration Committee (Rovner, McCullough, Meier)

ACTION REQUESTED: Board Action on Committee Recommendation

[redacted]

Background:

Criminal History:

In the past five years, Ms. Lawler had the following arrest.

Date	Charge, Disposition
May 1, 2012	Ms. Lawler was arrested for Domestic Abuse Assault Causing Bodily Injury/Mental Illness. Ms. Lawler's received: • Deferred Judgment of 1 year • 1 year probation • Paid $315 in civil penalty/no contact order for 5 years.

Applicant History:

June 1, 1995	Successfully completed the Dental Assisting National Board (DANB) in Dental Radiation Health and Safety Examination.
September 29, 1995	Submitted Application for Qualification in Dental Radiography.
October 1, 1995	Reinstated Qualification in Dental Radiography .
November 1, 1995	Successfully completed the DANB Infection Control Examination.
August 18, 2000	Ms. Lawler successfully completed the Radiation Safety Examination.
September 18, 2000	Ms. Lawler reinstated the qualification in dental radiography.
June 30, 2001	Ms. Lawler's qualification in dental radiography expired.
September 1, 2001	Ms. Lawler's qualification in dental radiography lapsed.
June 20, 2012	Board office received Application for Dental Assistant Trainee Status.
July 13, 2012	DANB certifications in Infection Control and Radiation Health & Safety Examinations.
August 24, 2012	Passed the Dental Assistant Jurisprudence Examination.
June 18, 2012-present	Working under dental assistant trainee status for Dr. Richard Rips, Chariton.
November 15, 2012	Submitted Iowa Dental Assistant Registration and Dental Radiography

	Qualification Application.
November 28, 2012	Board office received Iowa Criminal History Check.
November 30, 2012	Successfully completed the Dental Assistant Radiography Examination. Submitted Application for Reinstatement of an Iowa Dental Radiography Qualification.

Attached for Review:

- 11/15/12 Application for Iowa Dental Assistant Registration & Dental Radiography Qualification
- 1/29/13 Email to Licensure/Registration Committee w/application materials

From:	Arjes, Janet [IDB]
To:	"Michael"; "Diane Meier"; "Matt McCullough"
Cc:	Johnson, Melanie [IDB]; Davidson, Angela [IDB]; Braness, Christel [IDB]
Subject:	Licensure/Registration Committee-Tracy Lawler
Date:	Tuesday, January 29, 2013 4:50:00 PM
Attachments:	tracy lawler reinst app.pdf
Importance:	High

Dr. Rovner, Diane and Dr. McCullough-

Thank you for your review and consideration.

Janet Arjes

Executive Officer

Iowa Dental Board

515-281-3248

visit us on the web http://www.dentalboard.iowa.gov/

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RE: Licensure/Registration Committee

ACTION REQUESTED: Review and Recommendation re: Application for Registration and Qualification in Dental Radiography: **Tracy Lawler**

Attached is a copy of applicant's registration and dental radiography application and corresponding materials for your review.

Note: Emails are subject to the open records law. Unless information is deemed confidential (e.g. medical information), your responses will become part of the public record.

After review of these materials, please place an "X" in the box below next to your recommendation when responding to this email.

Committee Member's Recommendation:

_____	Approve.
_____	Approve, pending receipt of: _____
_____	Approve, with these restrictions: _____
_____	Deny. Reason(s):_____
_____	Refer to full Board without a Committee recommendation.

-

Issue(s) for Committee Review: This is an Application for Iowa Dental Assistant Registration and Radiography Qualification. The applicant is a graduate of a school accredited by the ADA Commission on Dental Accreditation, Des Moines Area Community College. Ms. Lawler has worked under trainee status for Dr. Richard Rips, Chariton, as a dental assistant trainee from 6/18/12 through present.

This application is being referred to the Committee for review of her criminal history, a charge of Domestic Assault Causing Bodily Injury/Mental Illness, a Serious Misdemeanor.

Questions for the Committee:

1) Does the Licensure/Registration Committee have any concerns issuing registration and radiography qualification given the prior assault charge?
2) Does the Licensure/Registration Committee have any concerns about Ms. Lawler's criminal history? Does the Committee want to make a recommendation to the Board concerning her prior history [redacted]?

Board Rule(s)/ Board Enforcement Guidelines

There are no Board rules that establish when an application from an applicant with a criminal history must be reviewed by the Committee or the Board.

[redacted] If the criminal history includes a felony, the application must be referred to the Committee and/or Board for review.

Background:

Criminal History:

In the past five years, Ms. Lawler had the following arrest.

Date	**Charge, Disposition**
May 1, 2012	Ms. Lawler was arrested for Domestic Abuse Assault Causing Bodily Injury/Mental Illness. Ms. Lawler's received: • Deferred Judgement of 1 year • 1 year probation • Paid $315 in civil penalty/no contact order for 5 years.

Applicant History:

June 1, 1995	Successfully completed the Dental Assisting National Board (DANB) in Dental Radiation Health and Safety Examination.
September 29, 1995	Submitted Application for Qualification in Dental Radiography.
October 1, 1995	Reinstated Qualification in Dental Radiography .
November 1, 1995	Successfully completed the DANB Infection Control Examination.
August 18, 2000	Ms. Lawler successfully completed the Radiation Safety Examination.
September 18, 2000	Ms. Lawler reinstated the qualification in dental radiography.
June 30, 2001	Ms. Lawler's qualification in dental radiography expired.
September 1, 2001	Ms. Lawler's qualification in dental radiography lapsed.
June 20, 2012	Board office received Application for Dental Assistant Trainee Status.
July 13, 2012	DANB certifications in Infection Control and Radiation Health & Safety Examinations.
August 24, 2012	Passed the Dental Assistant Jurisprudence Examination.
June 18, 2012-present	Working under dental assistant trainee status for Dr. Richard Rips, Chariton.

November 15, 2012	Submitted Iowa Dental Assistant Registration and Dental Radiography Qualification Application.
November 28, 2012	Board office received Iowa Criminal History Check.
November 30, 2012	Successfully completed the Dental Assistant Radiography Examination. Submitted Application for Reinstatement of an Iowa Dental Radiography Qualification.

Prior Disciplinary Actions

This applicant is currently in good standing and has not received any disciplinary action in Iowa.

Historical Treatment of Similar Situations:

(6/11/12) Telisha Young. Ms. Young is a May 2011 graduate of a school accredited by the ADA Commission on Dental Accreditation, Des Moines Area Community College. According to her registration application, Ms. Young had been arrested for Assault Use/Display of a Weapon in September 26, 2001. Ms. Young was arrested again in March 2005 for Domestic Assault Without Injury. Ms. Young's signed statement was in conflict with the criminal history reports. Even though the assault charges were similar, the issue brought forth to the Licensure/Registration Committee addressed a separate issue of failing to disclose all past criminal history on the signed statement. [redacted] At the July 12, 2012 closed Board meeting, the Board voted to issue the Registration/Qualification with no further action.
Registration/Qualification **Approved.**

(11/30/12) Trista Moreno. Ms. Moreno graduated in May 2012 graduate of a school accredited by the ADA Commission on Dental Accreditation, Western Iowa Tech Community College. According to the registration application, Ms. Moreno was arrested on October 18, 2008, and charged with Assault Causing Bodily Injury, a Serious Assault. Ms. Moreno had an altercation with an acquaintance just over four years ago. Ms. Moreno stated that she made changes in her life and learned from the past mistakes. The Licensure/Registration Committee voted to issue her registration and qualification with no further action.
Registration/Qualification **Approved.**

[redacted]

APPLICATION FOR IOWA DENTAL ASSISTANT REGISTRATION & DENTAL RADIOGRAPHY QUALIFICATION

RECEIVED
NOV 15 2012
IOWA DENTAL BOARD

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Ph. (515) 281-5157 http://www.dentalboard.iowa.gov

This form must be completed and returned to the Iowa Dental Board. Include the ***non-refundable*** application fee. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle) Lawler, Tracy, Ann			
Other Names Used: (e.g. Maiden Name) Harms			
Home Address: 420 N Washington Ave			
City: Lacona	**County:** Warren	**State:** Iowa	**Zip:** 50139
Home Phone: 515-975-7810		**Home E-mail:** lawlertracy94@gmail.com	
Work Address: 117 N Main			
City: Chariton	**County:** Lucas	**State:** Iowa	**Zip:** 50049
Work Phone: 641-774-2312	**Work Fax:** 641-774-4055	**Work E-mail:** rrdds@iowatelecom.net	

BASIS FOR APPLICATION

1. I have worked in a dental office for a minimum of six month as a dental assistant trainee, within 12 months of my first date of employment in Iowa. Trainee Number: TD5004 (*Complete the Affidavit of Employment.)	Yes ☒	No ☐
2. I have at least 6 months of prior dental assisting experience under the supervision of a licensed dentist within the past two years. (*Complete the Affidavit of Employment.)	Yes ☐	No ☒
3. I am a graduate of an ADA-accredited postsecondary dental assisting program. (*Complete the Certification of Education.)	Yes ☒	No ☐
4. I have completed Board-approved training in dental radiography with the past 2 years, passed an examination in dental radiography, and am also applying for a qualification in dental radiography.	Yes ☒	No ☐

For office use only:	**Registration #:**	**Date Issued:**

#2229
#40

Name of Applicant: Tracy A Lawler

QUALIFICATIONS & EXPERIENCE

1. Do you currently take dental x-rays in Iowa?	Yes ☒ No ☐
2. Do you now hold, or have you ever held, a certificate of qualification in dental radiography issued by the Iowa Dental Board? If yes, what is the qualification number? 05004	Yes ☒ No ☐
3. Did you complete a course of study using the dental assistant trainee manual, or other course approved by the Board in the area of dental radiography within the past 2 years?	Yes ☒ No ☐
4. Did you complete clinical (i.e. on-the job) dental radiography training under the supervision of a dentist? If yes, the supervising dentist must verify this training on the Affidavit of Employment. (If training was completed outside of Iowa, the training dentist must certify training in all competencies prior-approved by the Board. Contact the Board for further details.)	Yes ☒ No ☐
5. Did you complete a course of study approved by the Board in the areas of infection control/hazardous materials and jurisprudence using the study manual or at an ADA-accredited post secondary school (i.e. community college)?	Yes ☒ No ☐
6. Are you currently certified in CPR by nationally-recognized provider? Online certification is not accepted. (Attach copy of CPR card.)	Yes ☒ No ☐
7. Are you registered, certified or qualified as a dental assistant in another state? If yes, which states: _____ (Provide written verification from each state in which you are registered, certified or qualified.)	Yes ☐ No ☒

8. Provide a chronological listing of all dental-related employment in the last 5 years. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you.

Employer Dentist Name & Location	Type of Work (e.g. chairside, lab, office)	From (Mo/Yr):	To (Mo/Yr):	Avg. Hours per Week

REGISTRATION INFORMATION

List all state/countries in which you are or have ever been registered, certified or qualified.
Please note: you will be required to request written certifications of all registrations.

State/Country	Registration No.	Date Issued	Registration Type	Basis for Registration

Name of Applicant: Tracy A Lawler

QUALIFICATIONS & EXPERIENCE

1. Do you currently take dental x-rays in Iowa?	Yes ☒ No ☐
2. Do you now hold, or have you ever held, a certificate of qualification in dental radiography issued by the Iowa Dental Board? If yes, what is the qualification number? 05004	Yes ☒ No ☐
3. Did you complete a course of study using the dental assistant trainee manual, or other course approved by the Board in the area of dental radiography within the past 2 years?	Yes ☒ No ☐
4. Did you complete clinical (i.e. on-the job) dental radiography training under the supervision of a dentist? If yes, the supervising dentist must verify this training on the Affidavit of Employment. (If training was completed outside of Iowa, the training dentist must certify training in all competencies prior-approved by the Board. Contact the Board for further details.)	Yes ☒ No ☐
5. Did you complete a course of study approved by the Board in the areas of infection control/hazardous materials and jurisprudence using the study manual or at an ADA-accredited post secondary school (i.e. community college)?	Yes ☒ No ☐
6. Are you currently certified in CPR by nationally-recognized provider? Online certification is not accepted. (Attach copy of CPR card.)	Yes ☒ No ☐
7. Are you registered, certified or qualified as a dental assistant in another state? If yes, which states: _____ (Provide written verification from each state in which you are registered, certified or qualified.)	Yes ☐ No ☒

8. Provide a chronological listing of all dental-related employment in the last 5 years. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you.

Employer Dentist Name & Location	Type of Work (e.g. chairside, lab, office)	From (Mo/Yr):	To (Mo/Yr):	Avg. Hours per Week
n/A				

REGISTRATION INFORMATION

List all state/countries in which you are or have ever been registered, certified or qualified.
Please note: you will be required to request written certifications of all registrations.

State/Country	Registration No.	Date Issued	Registration Type	Basis for Registration

Received Time Nov. 26. 2012 12:47PM No. 0782

Yes answer to question # 5 – I was arrested and charged with Domestic Assault on May 01, 2012. I was not convicted, but took a plea bargain and I am currently on probation, and have a deferred judgment. I am currently following all the rules set up and attending Moving On class as stated in the agreement. If any additional information is needed please let me know.

This came about as the result of an argument with my daughter. She is the one that filed the charges. There is a no contact order in affect and have been following all the rules of the agreement.

Tracy A Lawler

Tracy received a deferred judgment so this will be expundged from her record once she completes probation.

Carmen Estrada
Attorney for Tracy

Yes answer to question # 5 – I was arrested and charged with Domestic Assault on May 01, 2012. I was not convicted, but took a plea bargain and I am currently on probation, and have a deferred judgment. I am currently following all the rules set up and attending Moving On class as stated in the agreement. If any additional information is needed please let me know.

This came about as the result of an argument with my daughter. She is the one that filed the charges. There is a no contact order in affect and have been following all the rules of the agreement.

Tracy A Lawler

Tracy A Lawler

Tracy received a deferred judgment so this will be expundged from her record once she completes probation.

Carmen Estrada
Attorney for Tracy

it was a serious misdemeanor per the plea that I took..

Tracy A Lawler
11-26-2012.

Received Time Nov. 26. 2012 12:47PM No. 0782

IOWA CRIMINAL HISTORY
COURT DISPOSITION PENDING STATUS UNKNOWN
PRINTER FRIENDLY VERSION

DCI :00955507Request Id:20121128C303460F

NAME:LAWLER, TRACY ANN

DOB	SEX	RAC	HGT	WGT	EYE	HAIR	SKN	POB
1972-05-02	F	W	507	210	BRO	BLN	FAR	ND

ALIAS NOTICE:
ADDITIONAL IDENTIFIERS
TAT L FOOT
TAT R ANKL
TAT BACK
TAT R BUTK

CCH RECORD **

1 ARRESTED 2012-05-01
AGENCY: IA0910000 WARREN CO SO
CHARGE NO-01 IA STATUTE 708.2A(2)(B)
DOMESTIC ABUSE ASSAULT CAUSE BODILY INJURY/MENTL ILLNSS
TRK#:X0002LO01
COURT DISPOSITION
AGENCY: IA091015J WARREN CO DIST COURT
COUNT NO-01 IA STATUTE 708.2A(2)(B)
DOMESTIC ABUSE ASSAULT CAUSE BODILY INJURY/MENTL ILLNSS
(SRMS
COURT CASE ID: 05911 SRCR026943

TRK#: X0002LO01

SENTENCE		DISP EFF DATE
DEFERRED JUDGEMENT	1Y	2012-06-29
PROBATION	1Y	2012-06-29
	FORMAL	
		2012-06-29
	$315 CIVIL PENALTY/NO CONTACT ORDER 5 YRS	

An arrest without disposition is not an indication of guilt. This record maintained by the Iowa Division of Criminal Investigation, Bureau of Identification is a public record but can only be released to non-law enforcement agencies by the DCI. In the absence of fingerprints for positive indentification, the record listed is based on information furnished. DCI cannot confirm or deny the record covers the subject of your inquiry.

Your session will end after 15 minutes of inactivity.

Home **Search Again**

Version 1.0.2.7

Name of Applicant: Tracy A Lauder

PERSONAL & CONFIDENTIAL DATA

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 15, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

[redacted]

If you answered yes to any of the questions above, please provide a statement below providing the details as requested in the instructions above. Please add a separate sheet of paper if necessary.

Signature **Date**

Name of Applicant: Tracy A Lauder

PERSONAL & CONFIDENTIAL DATA

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 15, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

[redacted]

If you answered yes to any of the questions above, please provide a statement below providing the details as requested in the instructions above. Please add a separate sheet of paper if necessary.

[redacted]

Received Time Nov. 26. 2012 12:47PM No. 0782

Healthcare Provider

PEEL HERE

Tracy Lawler

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association BLS for Healthcare Providers (CPR and AED) Program.

06-20-2012
Issue Date

06-2014
Recommended Renewal Date

Training Center Name: Mercy College TC — TC ID #

TC Info: City, State: Des Moines, IA 50309 — ZIP — Phone

Course Location: Lacona Fire Department

Instructor Name: Eric L. Wallace — Inst. ID #

Holder's Signature: Tracy Lawler

© 2011 American Heart Association Tampering with this card will alter its appearance. 90-1801

This card contains unique security features to protect against forgery.

90-1801 3/11

Name of Applicant: Tracy A Lawler

PERSONAL & CONFIDENTIAL DATA

[redacted]

EXAMINATION INFORMATION

[redacted]

DEFINITIONS

Important! Read these definitions before completing the following questions.

"Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

"Improper use of drugs or other chemical substances" means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

Name of Applicant: Tracy A Lawler

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 15, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

Yes ☒	No ☐	5. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment? see attached.
Yes ☐	No ☒	6. Have you ever been terminated or requested to withdraw from any dental assisting school or training program?
Yes ☐	No ☒	7. Have you ever been requested to repeat a portion of any dental assisting training program/school?
Yes ☐	No ☒	8. Have you ever received a warning, reprimand, or been placed on probation during a dental assisting training program/school?
Yes ☐	No ☒	9. Have you ever been denied a registration/certificate to practice dental assisting?
Yes ☐	No ☒	10. Have you ever voluntarily surrendered a registration/certification issued to you by any professional licensing agency?
Yes ☐	No ☒	11. If yes, was license/registration disciplinary action pending against you, or were you under investigation by a licensing agency at the time the voluntary surrender of license/registration was tendered?
Yes ☐	No ☒	12. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dental assisting?
Yes ☐	No ☒	13. Are charges or an investigation currently pending relative to your license/registration in any other state?
Yes ☐	No ☒	14. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license/registration you held?
Yes ☐	No ☒	15. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?
Yes ☒	No ☐	**16.** Do you understand that if registration is granted by this Board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the registration?

Name of Applicant: Tracy Lawler

AFFIDAVIT OF APPLICANT

IN STATE OF Iowa COUNTY OF Warren

I, Tracy A Lawler, hereby declare under penalty of perjury that I am the person described and identified in this application and that the attached photograph is a true likeness of myself. I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

If registration is issued to me, I understand that if I violate state law, my registration may be revoked as provided by law. I declare under penalty of perjury that my answers and all statements made by me on this application are true and correct. Should I furnish any false information or have substantial omission in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my registration.

I hereby authorize the Iowa Dental Board and/or its agents to verify any information including, but not limited to, criminal history and motor vehicle driving records. I authorize all colleges or universities, employers and law enforcement agencies to release any information concerning my background to the Iowa Dental Board for registration purposes. I do hereby release said person(s) from any and all liability that may be incurred as a result of furnishing such information. A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

Signature of Applicant Tracy A Lawler

Sworn to before me this 14 day of November, 2012

Signature of Notary Public Cami Eslick

NOTARY SEAL:

NOTARIAL SEAL IOWA
CAMI ESLICK
Commission Number 752672
My Commission Expires
06/03/2014

AFFADAVIT OF EMPLOYMENT

The dental assistant's supervising dentist should complete this form.

Applicants for dental assistant registration who are not graduates of a ADA-accredited postsecondary dental assisting program must either (1) work in a dental office for a minimum of six months as a dental assistant trainee, within 12 months of the first date of employment, or (2) have had at least six months of prior dental assisting experience under the supervision of a licensed dentist within the past two years. To verify that the dental assistant meets one of these requirements, the supervising dentist must complete and sign the following form.

I hereby certify that the applicant, Tracy Lawler, has successfully completed didactic and clinical training and has worked as a dental assistant under my supervision on the following dates at the following locations:

Date:	Location:
6/18/12 - 10/3/12	Richard Rios DDS 117 N Main Chariton, IA 50049

YES ☑ **NO** ☐ I further certify that the applicant has received Board-approved clinical training in dental radiography and has exhibited clinical proficiency in the area of dental radiography.

Richard A Rios DDS
Printed Name of Dentist

7754
License #

Richard A Rios DDS
Dentist's Signature

10/3/12
Date

Return Completed Form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157

APPLICATION FOR REINSTATEMENT OF AN IOWA DENTAL RADIOGRAPHY QUALIFICATION

RECEIVED
NOV 30 2012
IOWA DENTAL BOARD

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Ph. (515) 281-5157 http://www.dentalboard.iowa.gov

This form must be completed and returned to the Iowa Dental Board. Include the ***non-refundable*** application fee. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle) Lawler, Tracy, Ann			
Other Names Used: (e.g. Maiden Name) Harms			
Home Address: 420 N Washington Ave			
City: Lacona	**County:** Warren	**State:** Iowa	**Zip:** 50139
Home Phone: 515 975-7810		**Home E-mail:** lawlertracy94@gmail.com	
Work Address: 117 N Main			
City: Chariton	**County:** Lucas	**State:** Iowa	**Zip:** 50049
Work Phone: 641-774-2312	**Work Fax:** 641-774-4055	**Work E-mail:** rrdds@iowatelecom.net * see reg. reinst.	

REINSTATMENT INFORMATION

1. Qualification #: 5004 Original Issue Date: 10-1-95 Expiration Date: 6-30-01	
2. Are you currently registered as a dental assistant or on trainee status? If yes, provide registration or trainee number. Trainee/Registration #: TD5004	Yes ☒ No ☐
3. Are you currently licensed by the Iowa Board of Nursing? License #: _____ Attach proof of current licensure.	Yes ☐ No ☒
4. Are you currently registered, certified or qualified as a dental assistant in another state? If yes, list the state(s) and type(s) of qualification: _____	Yes ☐ No ☒
5. Have you completed 2 hours of continuing education in the area of dental radiography? Date of course: _____ Course sponsor: _____ Attach proof of continuing education. (Required if qualification lapsed less than 4 years ago.)	Yes ☐ No ☒

#12366
$100

Name of Applicant: Tracy A Lawler

PERSONAL & CONFIDENTIAL DATA

[redacted]

EXAMINATION INFORMATION

[redacted]

DEFINITIONS

Important! Read these definitions before completing the following questions.

"Medical Condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical Substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past (2) two years.

"Improper use of drugs or other chemical substances" means ALL of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, or use of any chemical substance prohibited by law.

Name of Applicant: Tracy Lawler

PERSONAL & CONFIDENTIAL DATA

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 14, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

[redacted]

If you answered yes to any of the questions above, please provide a statement below providing the details as requested in the instructions above. Please add a separate sheet of paper if necessary.

[redacted]

Signature **Date**

Name of Applicant: Tracy Lawler

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 15, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

Yes ☒	No ☐	5. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?
Yes ☐	No ☒	6. Have you ever been terminated or requested to withdraw from any dental assisting school or training program?
Yes ☐	No ☒	7. Have you ever received a warning, reprimand, or been placed on probation during a dental assisting training program or school?
Yes ☐	No ☒	8. Have you ever been denied a certificate/registration to practice dental radiography or dental assisting?
Yes ☐	No ☒	9. Have you ever voluntarily surrendered a certificate/registration issued to you by any professional licensing agency?
Yes ☐	No ☒	10. If yes, was disciplinary action pending against you, or were you under investigation by a licensing agency at the time the voluntary surrender of certificate/registration was tendered?
Yes ☐	No ☒	11. Have any judgments been entered against you resulting from your practice of dental radiography?
Yes ☐	No ☒	12. Are charges or an investigation currently pending relative to your dental radiography or dental assisting certificate/registration in any other state?
Yes ☐	No ☒	13. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a certificate/registration you held?
Yes ☐	No ☒	14. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency or any jurisdiction of the U.S. or other nation?
Yes ☒	No ☐	15. Do you understand that if a qualification is granted by this Board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the qualification?

Yes answer to question # 5 – I was arrested and charged with Domestic Assault on May 01, 2012. I was not convicted, but took a plea bargain and I am currently on probation, and have a deferred judgment. I am currently following all the rules set up and attending Moving On class as stated in the agreement. If any additional information is needed please let me know.

This came about as the result of an argument with my daughter. She is the one that filed the charges. There is a no contact order in affect and have been following all the rules of the agreement.

Tracy A Lawler

Tracy A Lawler

Tracy received a deferred judgment so this will be expundged from her record once she completes probation.

Cam Eslick
Attorney for Tracy

it was a serious misdemeanor per the plea that I took.

Tracy A Lawler
11-26-2012.

IOWA CRIMINAL HISTORY
COURT DISPOSITION PENDING STATUS UNKNOWN
PRINTER FRIENDLY VERSION

DCI :00955507Request Id:20121128C303460F

NAME:LAWLER, TRACY ANN

DOB	SEX	RAC	HGT	WGT	EYE	HAIR	SKN	POB
1972-05-02	F	W	507	210	BRO	BLN	FAR	ND

ALIAS NOTICE:
ADDITIONAL IDENTIFIERS
TAT L FOOT
TAT R ANKL
TAT BACK
TAT R BUTK

CCH RECORD **

1 ARRESTED 2012-05-01
AGENCY: IA0910000 WARREN CO SO
CHARGE NO-01 IA STATUTE 708.2A(2)(B)
DOMESTIC ABUSE ASSAULT CAUSE BODILY INJURY/MENTL ILLNSS
TRK#:X0002LO01
COURT DISPOSITION
AGENCY: IA091015J WARREN CO DIST COURT
COUNT NO-01 IA STATUTE 708.2A(2)(B)
DOMESTIC ABUSE ASSAULT CAUSE BODILY INJURY/MENTL ILLNSS
(SRMS
COURT CASE ID: 05911 SRCR026943

TRK#: X0002LO01

SENTENCE		DISP EFF DATE
DEFERRED JUDGEMENT	1Y	2012-06-29
PROBATION	1Y	2012-06-29
	FORMAL	
		2012-06-29
	$315 CIVIL PENALTY/NO CONTACT ORDER 5 YRS	

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Version 1.0.2.7

Name of Applicant: Tracy A Lawler

AFFIDAVIT OF APPLICANT

IN STATE OF Iowa COUNTY OF Warren

I, Tracy A Lawler, hereby declare under penalty of perjury that I am the person described and identified in this application. I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

If dental radiography qualification is issued to me, I understand that if I violate rules or regulations, my qualification may be revoked as provided by law. I declare under penalty of perjury that my answers and all statements made by me on this application are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my registration and/or radiography qualification.

I hereby authorize the Iowa Dental Board and/or its agents to verify any information including, but not limited to, criminal history and motor vehicle driving records. I authorize all colleges or universities, employers and law enforcement agencies to release any information concerning my background to the Iowa Dental Board for radiography qualification purposes. I do hereby release said person(s) from any and all liability that may be incurred as a result of furnishing such information. A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

Signature of Applicant Tracy Lawler

Sworn to before me this 30th day of November, 2012

Signature of Notary Public Wendy Frame

NOTARY SEAL:

NOTARIAL SEAL IOWA
WENDY FRAME
Commission Number 763541
My Commission Expires
6/18/13