Report on Services Provided by Virginia Department of Health (VDH) Dental Hygienists Pursuant to a Practice Protocol in Lenowisco, Cumberland Plateau, and Southside Health Districts for FY 2012

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Executive Summary

In 2009, the Virginia General Assembly passed legislation to revise § 54.1-2722 "License; application; qualifications; practice of dental hygiene" in Chapter 27 of Title 54.1 of the Code of Virginia. The changes to the practice of dental hygiene pertain specifically to those hygienists employed by the Virginia Department of Health (VDH) who work in the Cumberland Plateau, Lenowisco, and Southside Health Districts, all dentally underserved areas. These practice changes were in effect through July 1, 2012, due to additional legislation in the 2011 Session. As of July1, 2012, Virginia Code as amended by Senate Bill146 and passed in 2012, permits any VDH dental hygienist throughout the commonwealth to practice under the "remote supervision" protocol.

In July 2009, a committee was formed to develop the new practice protocol comprised of representatives from VDH, the Virginia Board of Dentistry, the Virginia Dental Association, and the Virginia Dental Hygienists' Association. Definitions and guidelines for the new remote supervision practice protocol were drafted by the committee, approved by the State Health Commissioner, and provided to the Virginia Board of Dentistry in 2009 and again in 2010 after minor revisions. This protocol was adopted in the language of Senate Bill 146 by the 2012 General Assembly, as the practice standard now in the Code of Virginia for "remote supervision" practice.

This legislative action has enabled a small cohort of dental hygienists to provide preventive dental services in selected settings without the general or direct supervision of a dentist. This effort has improved access to preventive dental services for those at highest risk of dental disease, as well as reduced barriers and costs for dental care for low-income individuals. This report documents the services provided in FY 12 by the hygienists and assistants employed in the pilot Districts identified above.

Funding received in 2009 from a U.S. Health Resources and Services Administration Oral Health Workforce Grant was used to support the majority of the dental hygiene positions in the three pilot project districts. Therefore, the majority of prevention services provided by VDH using the remote supervision protocol are through relatively newly established school-based dental sealant programs and keep with grant objectives. A dental sealant is a plastic material that is applied to the chewing surfaces of the back teeth (molars) to act as a barrier to bacteria and to prevent cavities. Dental sealant programs are evidence-based and cost-effective means to reduce the dental disease burden of a population. The hygienists were also able to provide additional preventive services for the individuals in these communities under existing practice protocols, including screenings, fluoride varnish applications, education, and referrals.

During FY 12, forty-seven elementary and middle schools participated in the school-based sealant programs specifically targeted to children enrolled in the National School Lunch Program. Over 1,200 children returned a permission form and were screened by a dental hygienist; 746 received sealants. A total of 819 children were identified as having other oral health needs and referred to providers for comprehensive care.

In addition to the sealant programs provided under remote supervision protocol, preventive services provided under existing practice protocols in the target health districts were also significant. The fluoride varnish program, operated in Special Supplemental Nutrition Program for Women, Infants and Children (WIC) clinics and in three Care Connection for Children clinics, provided screenings and fluoride varnish applications to over 500 infants and young children; 296 of whom were referred to a dentist to establish a dental home. WIC eligible children are too young to have permanent molar teeth appropriate for sealants. However, topical fluoride varnishes benefit all teeth and are the primary direct preventive service appropriate for the very young, WIC eligible child. Fluoride varnish is an evidence-based application for the primary (baby) teeth that reduces decay from 40% to 60%. The dental hygienists also provided dental education programs on topics including proper oral hygiene, oral fads, nutrition, oral health for overall wellbeing and oral care for persons with special health care needs; these educational programs were provided to 7187 individuals in targeted health districts. Referral and care coordination for individuals without a dental home was the focus of the dental referral program. The program initially used specially trained home visitors to provide care coordination for families that included assistance with obtaining a dental home, making and keeping dental appointments, and oral health education. As this program evolved, home visitors and specially trained dental assistants provided these services.

As this and previous reports indicate, the remote supervision model offers the potential of an alternative method of delivery for safety net dental program services and increased access for underserved populations. Increasing availability to preventive services such as sealants and fluoride has been proven to significantly reduce the dental disease burden, which is a priority need for those populations at highest risk. With a national shift from individual clinical care to population based preventive services, an aging public health workforce, and difficulties in recruiting dentists into safety net positions, the remote supervision model could offer an alternative for VDH programs as public health dentists retire and cannot be replaced. Preventive services could be provided to more individuals, over a wider geographic area, at a lower overall cost, with referrals to dentists primarily for treatment services and to establish a dental home. The potential for program sustainability improves as costs for delivering services are reduced with this model compared to those provided under general supervision. The remote supervision protocol has also proven successful in increasing the ability of VDH to successfully compete for federal grant funding for staff to work under this model.

Therefore, the recommendations regarding the future of the now codified “remote supervision” practice protocol for VDH dental hygienists are as follows:

- VDH should optimize the opportunity this new practice protocol creates to provide needed services to the most people at the lowest cost to taxpayers.

- VDH, utilizing dental hygienists under the new protocol, should continue to emphasize preventive efforts in the state to reduce the burden of oral disease in the population over time.

- Stakeholders should work with legislators and the Virginia Board of Dentistry to refine the language of the legislation codifying "remote supervision", such that the protocol can be amended as needed based on continued VDH experience with the practice model and evolving standards of care and practice.

- VDH should periodically consult with stakeholders in the dental care access community to evaluate the effectiveness of the new protocol practice model.

Overview

Language was passed in the 2009 Virginia General Assembly Session to revise § 54.1-2722 "License; application; qualifications; practice of dental hygiene" in Chapter 27 of Title 54.1 of the Code of Virginia. This legislation pertained to those hygienists employed by the Virginia Department of Health (VDH) who work in selected dentally underserved areas. An initial report was submitted to the General Assembly in 2010 as "RD327 – Report of Services Provided by Virginia Department of Health Dental Hygienists Pursuant to a Practice Protocol in the Cumberland Plateau, Lenowisco, and Southside Health Districts"[1]. "RD299 – Final Report on Services Provided by Virginia Department of Health (VDH) Dental Hygienists Pursuant to a Practice Protocol in Lenowisco, Cumberland Plateau, and Southside Health Districts"[2] was submitted to the General Assembly in 2011. The 2011 General Assembly passed legislation that extended the practice provision until July 1, 2012 (Appendix A).

As a result of the successful implementation of the pilot project and the improved access provided over the trial period, Senate Bill 146 was submitted to the 2012 Virginia General Assembly session, passed by the General Assembly and signed into law by the governor effective July 1, 2012 (Appendix B). This legislation revised § 54.1-2722 "License; application; qualifications; practice of dental hygiene" in Chapter 27 of Title 54.1 of the Code of Virginia to permit a dental hygienist employed by VDH to practice in all areas of the Commonwealth under the protocol established for the pilot program. This effectively removed the restriction limiting "remote supervision" practice to the Districts previously identified in 2009, and enabled VDH to plan expanded use of "remote supervision" hygienists as appropriate throughout the Commonwealth.

Although tremendous strides have been made in the reduction of tooth decay among many Virginians over the past fifty years, primarily due to water fluoridation, the decline in disease prevalence and severity has not been distributed uniformly across all segments of the population. Race and socioeconomic disparities continue to be predictors of tooth decay, and geographic considerations affect access to care in many parts of the state. Racial and ethnic minorities, persons with low-income and individuals with special health care needs are all less likely to have access to regular dental care and resources, further compounding their disease problems.

Workforce capacity in both the public and private sectors is also challenged to meet the oral health needs of these populations. Safety net providers including local health departments, community health centers, and free clinics have traditionally provided

access to dental services for individuals in need. The oldest dental safety net provider is VDH's dental program working with a traditional model of a dentist and dental assistant. More recently, some localities have employed dental hygienists to provide preventive services augmenting treatment services. In FY 12, there were 27 full- and part-time VDH dentist positions in 17 of the 35 health districts, providing 130,323 services to 18,169 individual patients. Of these services, 46% were preventive, including cleanings, fluoride applications, education and sealants. According to the Virginia Health Care Foundation, there are also currently 34 community health center sites and 28 free clinics providing dental services across the state. Volunteer programs such as the Virginia Dental Association Mission of Mercy have grown in an effort to meet the increasing need for dental services, a continual sign of the demand for dental care for underserved segments of the population.

Because the Commonwealth of Virginia continues to face challenges in improving access to dental services for its most vulnerable citizens in underserved areas of the state, in FY 12 the pilot program was continued using the new practice provision as an alternate model of service delivery. This pilot has continued to enable a small cohort of dental hygienists to provide preventive dental services in selected settings without the general or direct supervision of a dentist. The goals of the extended pilot programs continue to be to improve access to preventive dental services for those populations at highest risk of dental disease and reduce barriers for low-income individuals in underserved areas of the state. This report takes a comprehensive look at progress towards these goals and details services provided during FY 12 pursuant to the extended legislative authority.

Practice Protocol for VDH Dental Hygienists

Based on the legislative guidance, VDH established and convened a committee in 2009 to develop the dental hygiene practice protocol. The committee had representation from the agencies outlined in the legislation, which included the VDH Dental Health Program, the VDH District Health Directors and Community Health Services, the Virginia Board of Dentistry, the Virginia Dental Hygienists' Association, and the Virginia Dental Association (Appendix C). The protocol, deemed "remote supervision," was designed as a less restrictive oversight requirement for VDH dental hygienists in three health districts. Currently, 4,381 licensed dental hygienists with addresses in Virginia practice under general or direct supervision of a dentist. General supervision means that a dentist has examined the patient and authorized a dental hygienist to perform procedures, but the dentist need not be present in the treatment facility during the delivery of care. In comparison, the committee defined remote supervision to mean that "a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but who has not done an initial examination of the patients who are to be seen and treated by the dental hygienist, and who is not necessarily on site with the dental hygienist when dental hygiene services are delivered."

In addition to defining remote supervision for VDH hygienists, the committee developed guidelines for the management and oversight required by VDH dentists and the requirements for a licensed dental hygienist to practice under this protocol. In July 2009,

the State Health Commissioner signed the remote supervision guidelines, which were subsequently provided to the Virginia Board of Dentistry. At a follow-up meeting, based on the discussion of the existing programs and services, several changes were proposed to amend the original protocol in order to document VDH dentist oversight and management. The final revised protocol was approved by the State Health Commissioner and provided to the Board of Dentistry in September 2010 (Appendix D). This protocol was adopted in the language of Senate Bill 146 by the 2012 General Assembly, as the practice standard now in the Code of Virginia for "remote supervision" practice.

Implementation of the Pilot Protocol

To fund new dental hygienist positions to work under the new practice protocol in the three targeted health districts, VDH applied for and received a federal Oral Health Workforce Grant from the U.S. Health Resources and Services Administration (HRSA). One of the primary grant requirements was to establish school-based dental sealant programs, thus, providing an ideal opportunity to pilot the remote supervision protocol. Additional efforts were made to establish and recruit a position funded locally by the Lenowisco Health District during the same period. This report documents the services provided by dental hygienists who have worked under remote supervision in these three districts. Because of staff changes, the hygienists have not all worked continuously during the reporting period. However, this report includes all services provided during FY 12.

The VDH Dental Health Program developed and provided orientation and a training plan for dentists to use with the hygienists practicing under remote supervision. VDH dentists were responsible for providing initial on-site training for all the hygienists according to the new remote supervision protocol requirements. VDH dentists also provide ongoing technical assistance to the "remote supervision" hygienists as well as performing quality assurance functions.

School-based sealant programs targeting low-income children who did not have a family dentist were started in the three districts. A dental sealant is a plastic material that is applied to the chewing surfaces of the back teeth (molars) to act as a barrier to bacteria and to prevent cavities. Sealant programs typically include oral health education, dental screening, referral for dental treatment, and dental sealant and fluoride application. The Centers for Disease Control and Prevention Task Force on Community Preventive Services found strong evidence that school-based and school-linked sealant programs are effective in reducing tooth decay, with a median decrease in tooth decay of 60%.[3] The dental hygienists spent substantial effort working with school administration and staff in the schools in all three districts to provide information about the dental sealant program and encourage participation. The hygienists also met with local private dentists and safety net providers to introduce the program, gain acceptance, and facilitate referral of children with treatment needs.

Public programs that support the placement of dental sealants are quite successful, and in many states, dental hygienists are the primary providers in school-based sealant

programs. A dental hygienist is widely accepted as equally skilled in applying dental sealants as a dentist. A 10-year retrospective study comparing the longevity of sealants placed by dentists, dental hygienists, and dental assistants found that all operators are effective in applying sealants.[4]

Report of Services Provided

The Centers for Disease Control and Prevention has implemented computer software, titled Sealant Efficiency Assessment for Locals and States (SEALS), as an evaluation and benchmarking tool for administrators of community sealant programs.[5] This tool was modified and used to collect and report the data for this report.

Services Provided Under Remote Supervision

The primary services provided under remote supervision are school-based dental sealant programs. However, in FY 12 when dental manpower capacity was available and schools were supportive, application of topical fluoride varnishes was added to the services offered in schools. In some schools, children in pre kindergarten through first grade, who are not age appropriate for sealants and are unlikely to have fully erupted 6 year molars for sealing, were offered oral assessments and fluoride varnish applications when indicated. This provided an opportunity for more oral hygiene education, increased interaction with children to acclimate them dental care and earlier identification of oral health needs and referrals to dental homes.

During FY 12, 47 of the 67 targeted elementary and middle schools in the three districts (70%) participated in the school-based sealant program. Staff turnover and vacancies impacted the production and outreach efforts of the program this year. Forty-one of these schools participated in FY 10, and 64 participated in FY 11. The school-based sealant program specifically targeted children enrolled in the National School Lunch Program in these schools. On average, 25% of eligible children returned a permission form to receive a sealant screening by a dental hygienist.

Of the 1,274 children screened, 59% received dental sealants on permanent molar teeth (Table 1). A total of 2,281 permanent molar teeth were sealed for an average of three sealants per child. A child could be screened and not be a candidate for a dental sealant due to the status of the permanent molar teeth, including filled, decayed, or not fully erupted into the mouth. In FY 12, the dental hygienists also referred 819 (64%) of children from the sealant program to a dentist for evaluation or treatment for fillings, root canals, and/or extractions.

The program protocol included evaluating the sealants placed during the prior year. Additionally, new sealants were placed on teeth previously unable to be sealed because the teeth were not present at the first appointment. The one year retention rate for individual sealants was acceptable, averaging 86% for the children who received sealants. The retention rate calculated in FY 12 and based on sealants placed in FY 11 would

ideally exceed 90%. Provider skill and training may have been an issue but this is likely to improve in FY 13 with staffing changes that have occurred.

Table 1. Sealant Program Summary Data Provided Under Remote Supervision, All Grades, By Health District, FY12

Health District	Number of Children Screened (response rate)*	Number of Children Referred	Number of Children Sealed	Number of Teeth Sealed	Number of Teeth Sealed/Child (Average)
Cumberland Plateau	484 (28 %)	212	290	831	2.9
Lenowisco	277 (15 %)	243	88	290	3.3
Southside	513 (33 %)	364	368	1160	3.1
Total	**1274 (25%)**	**819**	**746**	**2281**	**3.0**

*****Based on free and reduced lunch program enrollment.

Cost Comparison of Services Provided Under Remote vs. General Supervision

Because VDH had dental sealant programs operating in other districts under the general supervision of a public health dentist, cost comparison data were available for the remote supervision model. The ability to provide services to children, as well as the cost-effectiveness of a sealant program depend, in part, on whether a dentist must examine children before sealants can be placed.

Costs were calculated for the two models using fixed and variable costs including staff salaries for clinic and administrative time, travel to the school, dental materials, clinic supplies, and equipment depreciation, and were based on an overall average of 3.6 sealants placed per child, extracted from historical data. Using these data and appropriate assumptions, the cost per child to apply sealants was calculated to be 22% more under general supervision than under remote supervision ($96.19 vs. $78.78). On average, the cost per sealant was calculated to be $26.71 under general supervision and $21.88 under remote supervision. This variation in cost per child was anticipated based on the resource requirements to deliver the services. Specifically, the general supervision model required an examining dentist and assistant for the screening and treatment plan and a follow-up visit by the hygienist and assistant team to apply the sealants. In contrast, under the remote supervision model, the screening and sealants were conducted at the same visit utilizing a hygienist and assistant only. Over the three year pilot study, there have been minimal changes in the fixed and variable costs required to deliver services, but based on our experience, the average number of children anticipated to be sealed per day has been adjusted downward from twelve to ten. This has resulted from more accurate assessments of the time required to provide services and program support functions in the schools and has slightly increased the calculated cost per sealant.

The cost for providing a sealant is still very favorable. According to the American Dental Association Fee Schedule for the South Atlantic Region, the average charge in private dental offices is $46.00 for placing a dental sealant on one tooth.[6]

Services Provided Under Other Existing Supervision Protocols

In addition to the sealant programs provided under the pilot remote supervision protocol, preventive services were provided under existing practice protocols by the dental hygienists. Therefore, to provide a comprehensive picture of preventive services provided by all VDH dental hygienists in Cumberland Plateau, Lenowisco, and Southside Health Districts, the following data are provided for each health district.

Fluoride Varnish Program: Under existing regulations and a standing order from a dentist or physician, VDH dental hygienists can provide screening, education, and fluoride varnish. Fluoride varnish is an evidence-based application for the primary (baby) teeth that reduces decay from 40% to 60%. VDH "Bright Smiles for Babies" program has partnered with the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) as a way to provide low-income children and their parents with these services. VDH also partners with the Care Connection for Children network to provide these services to children with special health care needs and with some Head Start programs. Screenings and fluoride varnish application have been provided for over 483 children in the three districts; 296 of these children were referred to a dentist to establish a dental home (Table 2).

Table 2. Services Provided Through "Bright Smiles for Babies" Fluoride Varnish Program by VDH Dental Hygienists in Three Health Districts, FY 12

Health District	Number of Children Screened*	Number of Children Treated with Fluoride Varnish	Number of Children Referred to a Dental Home
Cumberland Plateau	105	84	31
Lenowisco	119	118	57
Southside	284	281	208
Total	508	483	296

**The number of children screened is greater than those treated with varnish because some children who are screened do not have teeth.*

Dental Health Education: Dental hygienists provided dental health education to a variety of customers in the programs operating under all practice protocols. For example, education of teachers, parents, and students was conducted in many schools to increase knowledge of, and participation in, the school-based sealant programs. Other venues included the Bright Smiles for Babies program in WIC clinics, preschool programs such as Head Start, and professional trainings for nurses and other health providers.

In total, 7,187 individuals were provided dental health education or training during FY 12 (Table 3).

Table 3. Education and Training Provided by VDH Dental Hygienists in Three Health Districts, FY 12

Health District	Number of Preschool and School Age Children Educated	Number of Parents and Citizens Educated	Number of Teachers Trained	Number of Professionals Trained
Cumberland Plateau	1653	1298	78	4
Lenowisco	1020	399	20	25
Southside	708	1946	34	2
Total	**3381**	**3643**	**132**	**31**

Dental Referrals: Dental hygienists can serve as an efficient pipeline for identifying and referring patients in need of care by a dentist. In addition to the 819 children referred to a dentist for treatment through the dental sealant program and 296 children referred to a dental home through the fluoride varnish program, the dental hygienists in the targeted health districts worked with local home visiting programs. In past years, pregnant women were also referred to a dental home; none of the pregnant women seen reported not having a dental home in FY 12.

Home visiting programs offer a mechanism for providing at-risk families with ongoing health education and linkage with public and private community services, including assistance with making and keeping dental appointments. To support the project, the hygienists maintain communication with the home visitors regarding patients they have referred, provide technical support, and record tracking information. Additionally, the dental hygienists have contacted all pediatric and general dentists in their districts to inform them about the project and to ask for their assistance in providing dental care for the children. Most dentists responded favorably; by locality, from 60% to 100% agreed to be on a referral list developed by the hygienists. The dental hygienists also contacted the dental offices to make sure appointments had been kept, treatment had been completed, and a routine follow-up dental visit had been scheduled. Funding for home visitors to provide dental education and care coordination was from the HRSA workforce grant.

As shown in Table 4 below, a total of 315 children have been referred to a home visitor for education and care coordination.

Table 4. Referrals to Home Visitors by Dental Hygienists in Three Targeted Health Districts, FY 12

Health District	Number of Pregnant Women Referred to Home Visitor (HV)	Number of Children Referred to HV (Aged 0-4 years)	Number of School-Age Children Referred to HV (Aged 5-14 years)
Cumberland Plateau	0	12	63
Lenowisco	0	24	22
Southside	0	27	167
Total	**0**	**63**	**252**

Recommendations

Our experience to date indicates the remote supervision model offers the potential of an alternative method of delivery for safety net dental program services and increased access for underserved populations. Increasing availability to preventive services such as sealants and fluoride has been proven to significantly reduce the dental disease burden, which is a priority need for those populations at highest risk. With an aging public health workforce and difficulties in recruiting dentists into safety net positions, the remote supervision model could offer an alternative for VDH programs as dentists retire and cannot be replaced. Preventive services could be provided to more individuals, over a wider geographic are, at a lower personnel cost, with referrals to dentists primarily for treatment services and to establish a dental home. The potential for program sustainability improves as costs for delivering services are reduced with this model compared to those provided under general supervision. The remote supervision protocol has also proven successful in increasing the ability for VDH to successfully compete for federal grant funding for staff to work under this model. In 2012, the consensus of the dental access stakeholder community was to support expansion of the "remote supervision" model of care as a means of improving access to dental care and disease prevention, particularly for low income populations. With passage of Senate Bill 146, the recommendations regarding the future of the remote supervision practice protocol for VDH dental hygienists are as follows:

- VDH should optimize the opportunity this new practice protocol provides to provide needed services to the most people at the lowest cost to taxpayers.

- VDH, utilizing dental hygienists under the new protocol should continue to emphasize preventive efforts in the State to reduce the burden of oral disease in the population over time

- Stake holders should work with legislators and the Virginia Board of Dentistry to refine the language of the legislation codifying “remote supervision”, such that the protocol can be amended as needed based on continued VDH experience with the practice model and evolving standards of care and practice.

- VDH should periodically consult with stakeholders in the dental care access community to evaluate the effectiveness of the new protocol practice model and apply lessons learned from schools and parent participants to strengthen partnerships and improve outcomes.

References

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2. RD327 – Report of Services Provided by Virginia Department of Health Dental Hygienists Pursuant to a Practice Protocol in the Cumberland Plateau, Lenowisco, and Southside Health Districts. Available at: http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2992011/$file/RD299.pdf

3. Centers for Disease Control and Prevention. Promoting Oral health: Interventions for Preventing Dental Caries, Oral and Pharyngeal Cancers, and Sports-Related Craniofacial Injuries—A Report on Recommendations of the Task Force on Community Preventive Services. MMWR Recomm Rep 2001;50(RR-21):1-13.

4. Folke BD, Walton JL, Feigal RJ. Occlusal Sealants Success Over Ten Years in a Private Practice: Comparing longevity of sealants placed by dentists, hygienists and assistants. Pediatr Dent. 2004: 26: 426-432.

5. Sealant Efficiency Assessment for Locals and States (SEALS). CDC website. 2007. Available at: http://www.cdc.gov/ORALHEALTH/state_programs/infrastructure/seals.htm.

6. American Dental Association (ADA). 2011 Survey of Dental Fees. ADA Survey Center, December 2011.

Appendix A: Section 54.1-2722 of the Code of Virginia Relating to the Protocol
(Subsequently amended effective July 1, 2012.

§ 54.1-2722 "License; application; qualifications; practice of dental hygiene" in Chapter 27 of Title 54.1 of the Code of Virginia as follows:

E. ~~(Expires July 1, 2011)~~ Notwithstanding any provision of law or regulation to the contrary, a dental hygienist employed by the Virginia Department of Health who holds a license issued by the Board of Dentistry may provide educational and preventative dental care in the Cumberland Plateau, Southside, and Lenowisco Health Districts, which are designated as Virginia Dental Health Professional Shortage Areas by the Virginia Department of Health. A dental hygienist providing such services shall practice pursuant to a protocol developed jointly by the medical directors of each of the districts, dental hygienists employed by the Department of Health, the Director of the Dental Health Division of the Department of Health, one representative of the Virginia Dental Association, and one representative of the Virginia Dental Hygienists' Association. A report of services provided by dental hygienists pursuant to such protocol, including their impact upon the oral health of the citizens of these districts, shall be prepared and submitted by the medical directors of the three health districts to the Virginia Secretary of Health and Human Resources by ~~November 1, 2010~~ January 1, 2012. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene.

2. That the third enactment of Chapter 99 of the Acts of Assembly of 2009 is amended and reenacted as follows:

3. That the provisions of this act shall expire on July 1, ~~2011~~ 2012.

3. That the third enactment of Chapter 561 of the Acts of Assembly of 2009 is amended and reenacted as follows:

3. That the provisions of this act shall expire on July 1, ~~2011~~ 2012.

Appendix B: Senate Bill 146

CHAPTER 102

An Act to amend and reenact § 54.1-2722 of the Code of Virginia and to repeal the third enactments of Chapters 99 and 561 of the Acts of Assembly of 2009, as amended by Chapter 289 of the Acts of Assembly of 2011, relating to dental hygienists' scope of practice.

[S 146]

Approved March 6, 2012

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2722 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2722. License; application; qualifications; practice of dental hygiene.

A. No person shall practice dental hygiene unless he possesses a current, active, and valid license from the Board of Dentistry. The licensee shall have the right to practice dental hygiene in the Commonwealth for the period of his license as set by the Board, under the direction of any licensed dentist.

B. An application for such license shall be made to the Board in writing, and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character, (ii) is a graduate of an accredited dental hygiene program offered by an accredited institution of higher education, (iii) has passed the dental hygiene examination given by the Joint Commission on Dental Examinations, and (iv) has successfully completed a clinical examination acceptable to the Board.

C. The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B ~~of this section~~; (ii) holds a current, unrestricted license to practice dental hygiene in another jurisdiction in the United States; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) meets other qualifications as determined in regulations promulgated by the Board.

D. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection V of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.

A dentist may also authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. In its regulations, the Board of Dentistry shall establish the

education and training requirements for dental hygienists to administer such controlled substances under a dentist's direction.

For the purposes of this section, "general supervision" means that a dentist has evaluated the patient and prescribed authorized services to be provided by a dental hygienist; however, the dentist need not be present in the facility while the authorized services are being provided.

For the purposes of this section, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have done an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.

The Board shall provide for an inactive license for those dental hygienists who hold a current, unrestricted license to practice in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

E. (Expires July 1, 2012) (Date to be corrected in final publication) Notwithstanding any provision of law ~~or regulation to the contrary~~, a dental hygienist employed by the Virginia Department of Health who holds a license issued by the Board of Dentistry may provide educational and preventative dental care in the ~~Cumberland Plateau, Southside, and Lenowisco Health Districts, which are designated as Virginia Dental Health Professional Shortage Areas by the Virginia Department of Health~~ *Commonwealth under the remote supervision of a dentist employed by the Department of Health.* A dental hygienist providing such services shall practice pursuant to a protocol *adopted by the Commissioner of Health on September 23, 2010, having been* developed jointly by *(i)* the medical directors of ~~each of the districts,~~ *the Cumberland Plateau, Southside, and Lenowisco Health Districts; (ii)* dental hygienists employed by the Department of Health~~,~~*; (iii)* the Director of the Dental Health Division of the Department of Health~~,~~*; (iv)* one representative of the Virginia Dental Association~~,~~*;* and *(v)* one representative of the Virginia Dental Hygienists' Association. *Such protocol shall be adopted by the Board as regulations.*

F. A report of services provided by dental hygienists pursuant to such protocol, including their impact upon the oral health of the citizens of ~~these districts~~ *the Commonwealth,* shall be prepared and submitted by ~~the medical directors of the three health districts~~ *the Department of Health* to the Virginia Secretary of Health and Human Resources ~~by January 1, 2012~~ *annually*. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene.

2. That the third enactments of Chapters 99 and 561 of the Acts of Assembly of 2009, as amended by Chapter 289 of the Acts of Assembly of 2011, are repealed .

Appendix C: Virginia Department of Health (VDH) Dental Hygienist Protocol Committee

Name	Title	Agency
Dr. Terry Dickinson	Executive Director	Virginia Dental Association
Kelly T. Williams, RDH, MS	Past President	Virginia Dental Hygienist's Association
Sandra Reen	Executive Director	Virginia Board of Dentistry
Dr. John Dreyzehner	District Director Cumberland Plateau Health District	Virginia Department of Health
Dr. E. Sue Cantrell	District Director Lenowisco Health District	Virginia Department of Health
Dr. Charles Devine	District Director Southside Health District	Virginia Department of Health
Norma Marrin	Executive Advisor Community Health Services	Virginia Department of Health
Dr. Karen Day	Dental Health Program Manager Office of Family Health Services	Virginia Department of Health
Dr. Lynn Browder	Dental Health Program Quality Assurance Manager Office of Family Health Services	Virginia Department of Health
Susan Pharr, RDH	Program Coordinator Office of Family Health Services	Virginia Department of Health

Appendix D: Protocol for Virginia Department of Health Dental Hygienists to Practice in an Expanded Capacity under Remote Supervision by Public Health Dentists

As authorized by law, the Virginia Department of Health is conducting a pilot program in three health districts, Cumberland Plateau, Lenowisco and Southside, to assess the use of dental hygienists employed by VDH in an expanded capacity as a viable means to increase access to dental health care for underserved populations. This protocol shall guide the pilot program.

Definitions:

- *"Expanded capacity"* means that a VDH dental hygienist provides education, assessment, prevention and clinical services as authorized in this protocol under the remote supervision of a VDH dentist.

- *"Remote supervision"* means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but who has not done an initial examination of the patients who are to be seen and treated by the dental hygienist, and who is not necessarily onsite with the dental hygienist when dental hygiene services are delivered.

Management:

- Program guidance and quality assurance shall be provided by the Dental Health Program in the Division of Child and Family Health at VDH for the public health dentists providing supervision under this protocol. Guidance for all VDH dental hygienists providing services through remote supervision is outlined below:

    - VDH compliance includes a review of the remote supervision protocol with the dental hygienist. The hygienist will sign an agreement consenting to remote supervision according to the protocol. The hygienist will update the remote agreement annually attaching a copy of their current dental hygiene license, and maintain a copy of the agreement on-site while providing services under this protocol.

    - VDH training by the public health dentist will include didactic and on-site components utilizing evidence based protocols, procedures and standards from the American Dental Association, the American Dental Hygienists' Association, the Centers for Disease Control and Prevention, the Association of State and Territorial Dental Directors, as well as VDH Occupational Safety and Health Administration (OSHA), Hazard Communication and Blood Borne Pathogen Control Plans.

Management (cont'd):

- VDH monitoring by the public health dentist during remote supervision activities shall include tracking the locations of planned service delivery and review of daily reports of the services provided. Phone or personal communication between the public health dentist and the dental hygienist working under remote supervision will occur at a minimum of every 14 days.

- VDH on-site review to include a sampling of the patients seen by the dental hygienist under remote supervision will be completed annually by the supervising public health dentist. During the on-site review, areas of program and clinical oversight will include appropriate patient documentation for preventive services (consent completed, assessment of conditions, forms completed accurately), clinical quality of preventive services (technique and sealant retention), patient management and referral, compliance with evidence-based program guidance, adherence to general emergency guidelines, and OSHA and Infection Control compliance.

- The protocol may be revised as necessary during the trial period through agreement of the committee composed of medical directors of the three health districts, staff from the Division of Dental Health and Community Health Services, and representatives from the Virginia Dental Hygienists' Association, Virginia Dental Association and Virginia Board of Dentistry. This committee shall meet and discuss program progress and any necessary revisions to the protocol at periodic intervals beginning July 1, 2009. The protocol and any revisions will be approved by the State Health Commissioner of VDH.

- No limit shall be placed on the number of full or part time VDH dental hygienists that may practice under the *remote supervision* of a public health dentist(s) in the three targeted health districts.

- The dental hygienist may use and supervise assistants under this protocol but shall not permit assistants to provide direct clinical services to patients.

- The patient or responsible adult should be advised that services provided under the remote supervision protocol do not replace a complete dental examination and that they should take their child to a dentist for regular dental appointments.

Remote Supervision Practice Requirements:

- The dental hygienist shall have graduated from an accredited dental hygiene school, be licensed in Virginia, and employed by the Virginia Department of Health in a full or part time position and have a minimum of two years of dental hygiene practice experience.

Remote Supervision Practice Requirements (cont'd):

- The dental hygienist shall annually consent in writing to providing services under remote supervision.

- The patient or a responsible adult shall be informed prior to the appointment that no dentist will be present, that no anesthesia can be administered, and that only limited described services will be provided.

- Written basic emergency procedures shall be established and in place, and the hygienist shall be capable of implementing those procedures.

Expanded Capacity Scope of Services:

Public health dental hygienists may perform the following duties under *remote supervision:*

- Performing an initial examination or assessment of teeth and surrounding tissues, including charting existing conditions including carious lesions, periodontal pockets or other abnormal conditions for further evaluation by a dentist, as required.
- Prophylaxis of natural and restored teeth.
- Scaling of natural and restored teeth using hand instruments, and ultrasonic devices.
- Assessing patients to determine the appropriateness of sealant placement according to VDH Dental Program guidelines and applying sealants as indicated. Providing dental sealant, assessment, maintenance and repair.
- Application of topical fluorides.
- Providing educational services, assessment, screening or data collection for the preparation of preliminary written records for evaluation by a licensed dentist.

Required Referrals:

- Public health dental hygienists will refer patients without a dental provider to a public or private dentist with the goal to establish a dental home.

- When the dental hygienist determines at a subsequent appointment that there are conditions present which require evaluation for treatment, and the patient has not seen a dentist as referred, the dental hygienist will make every practical or reasonable effort to schedule the patient with a VDH dentist or local private dentist volunteer for an examination, treatment plan and follow up care.

Approved July, 2009; Revised September, 2010, Signed by the State Health Commissioner September 2010