Report on Services Provided by Virginia Department of Health Dental Hygienists Pursuant to a “Remote Supervision” Practice Protocol 2013

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 pertained 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. The practice changes were in effect through July 1, 2012, due to additional legislation in the 2011 Session. As of July 1, 2012, Virginia Code, as amended by Senate Bill146 and passed in 2012 (Appendix A,B), permits any VDH dental hygienist throughout the Commonwealth to practice under the "remote supervision" protocol previously created by a committee of dental advisors and approved by the VDH Commissioner of Health (Appendix C).

This legislative action has enabled VDH dental hygienists to provide preventive dental services 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 FY13 by the hygienists and assistants employed by VDH.

Over 3,000 children returned a permission form and were screened by a dental hygienist in a school-based setting; 831 received sealants and 1794 received a fluoride varnish application. A total of 1,094 children were identified as having other oral health needs and referred to providers. In clinic settings through the VDH "Bright Smiles for Babies" program 5,828 infants and children were screened. School and clinic programs combined to provide 7,476 fluoride varnish applications.

As this and previous reports indicate, the remote supervision model offers an alternative method of delivery for safety net dental program services with increased access for underserved populations. 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.

Introduction

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. The need for creative solutions to dental care access challenges have led to the development of alternative practice models for dental hygienists in the Commonwealth.

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 reduced the dentist oversight requirement for those dental hygienists employed by the Virginia Department of Health (VDH) in selected dentally underserved areas, by allowing what is termed a "remote supervision" model of practice for hygienists. VDH developed and implemented a dental preventive services program pilot utilizing remote supervision hygienists with portable equipment primarily focused on elementary schools in the select Districts. An initial report, 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], documents this process in detail. "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 and summarized the continued evolution of the program and the services impact. Based on the initial successes of the pilot program, the 2011 General Assembly passed legislation that extended the practice provision until July 1, 2012 for additional study. General Assembly report RD318 "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" [3] submitted in October 2012, detailed the continued progress of the remote supervision hygienists in the final year of the pilot project.

In the Spring of 2012, Senate Bill 146 was submitted, passed by the General Assembly and signed into law by the governor effective July 1, 2012 (Appendix A, 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 throughout the Commonwealth under the protocol established for the pilot program (Appendix C). This enabled VDH to plan and implement expanded use of remote supervision hygienists as appropriate Statewide.

In FY 13 VDH enrolled all existing VDH hygienists providing patient care services into the remote supervision protocol. This expanded the service capabilities of hygienists that had previously been working under more restrictive supervision and improved efficiency in professional oversight. To fund dental hygienist positions working under the new practice protocol, 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, which continues to be the primary focus of current community dental preventive services programs for VDH. Additionally, some local VDH Districts have contributed funding to support hygienists practicing in their areas. Federal Maternal and Child Health Block Grant funds have also supported hygienists, primarily serving infants and young children in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) clinics. The VDH Dental Health Program (DHP) provides practice guidelines, orientation and training to hygienists practicing under remote supervision. VDH dentists provide ongoing technical assistance, as well as performing clinical oversight and quality assurance functions to remote supervision hygienists.

In FY13, the expanded VDH remote supervision hygienist workforce provided services in fourteen Health Districts. Services provided varied by location and included oral assessments, dental sealants, child and parent education, topical fluoride varnish applications, community education, and training to allied healthcare professionals. To this point, in these relatively new prevention programs, there is a great deal of variation in the dental hygiene preventive services delivered in individual Districts. In some cases a single hygienist covers multiple areas while in others the hygienist is full time in a District. School programs vary in their elected participation in the programs and some newer programs do not have the school cooperation that is enjoyed by Districts with long term Health Department /school relationships. VDH recognizes the challenges that face any new program such as this in a community and is working with the hygiene staff to share “lessons learned” and “best practices” to grow acceptance and participation. A consistent presence in the community over time has generally resulted in increased school and parent support for these programs. VDH intends now to move from a “pilot program” status to an ongoing commitment to prevention services in targeted areas, with the goals of increasing staff resources, continuing to grow local participation and establishing stable school relationships.

As directed in the 2012 General Assembly Budget Item 296, VDH has been working closely with a diverse group of community stakeholders to plan a comprehensive transition of VDH dental services to a more preventive focused model utilizing dental hygienists. The initial planning for this transition is detailed in a report to the General assembly titled RD 257 “Virginia Department of Health Oral Health Plan October 2012”[4]. A follow up report with plan specifics will be delivered by VDH to the General Assembly in October 2013. The 2013 report, as drafted, identifies a proposed expanded hygienist workforce to be deployed across the Commonwealth beginning in FY 14, utilizing the remote supervision model of practice. The service areas will be widely distributed and programs will provide dental preventive services in targeted schools with

>50% participation rates in the National School Lunch Program (NSLP), as well as in other community-based settings.

Dental Sealant Services Provided by Remote Supervision Hygienists

A dental sealant is a plastic coating that is applied to the chewing surfaces of the back teeth (molars) to prevent cavities by forming a barrier to plaque and bacteria. It is generally accepted that sealants are most effective when applied to newly erupted first and second permanent (adult) molars. Typically, school-based sealant programs focus on second and sixth grade children to maximize the opportunity to seal the targeted teeth, based on normal eruption patterns. 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 of 60%.[5] Nationally, school-based sealant programs targeting low-income children have been in place now for many years. 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.[6]

The VDH sealant program component of the dental preventive services program uses hygienists in a school-based setting to provide dental screening, dental sealants, fluoride applications, oral health education, and referral for dental treatment to low income children that do not have a dental home. In addition to providing clinical services, VDH hygienists are responsible for program development in their area. Hygienists spend substantial effort working with school administration, staff in schools, and with parent groups, to provide information about the dental sealant program and to encourage participation. The hygienists also meet with local private dentists and safety net providers to introduce the program, gain acceptance, and facilitate referral of children with treatment needs. Staff turnover impacted school based sealant production in FY13 in some areas, but statewide, the program has continued to grow through the outreach efforts of VDH hygienists and the relationships developed with the community.

In FY13, of the 3,011 children screened, 831 received dental sealants on permanent molar teeth (Table 1). A total of 3,186 permanent molar teeth were sealed for an average of 3.8 sealants per child. A child could be screened and not be a candidate for a dental sealant due to the identified status of the permanent molar teeth, including filled, decayed, or not fully erupted into the mouth. In FY13, the dental hygienists also referred 1,094 (36%) of children from the sealant program to a dentist for evaluation or treatment for fillings, root canals, and/or extractions. As noted above, there are differences within districts, in terms of the resources available and the participation of local school districts. This accounts for significant differences in the numbers of children screened in each of the health districts.

Table 1. School-Based Sealant Program Summary Data for Remote Supervision Hygienists in Health Districts FY13

Health District	Number of Children Screened for Sealants or Varnish	Number of Children Referred for Treatment	Number of Children Sealed	Number of Teeth Sealed	Number of Teeth Sealed per Child (Average)	Fluoride Varnish Applied
Cumberland Plateau	366	72	117	367	3.1	378
Lenowisco	2189	835	469	1917	4.1	1102
Piedmont	154	45	110	381	3.5	69
Crater	16	3	7	19	2.7	4
Central Va.	286	139	128	502	3.9	241
Total	**3011**	**1094**	**831**	**3186**	**3.8**	**1794**

Sealant programs are only effective if the sealants that are placed are retained. VDH is committed to assuring a quality service is being delivered using the most effective techniques, supported by current science, to assure retention. Sealant retention is evaluated in two ways. The program protocol requires annual follow up assessments by hygienists to evaluate retention of sealants placed during the prior year. This statistically yields retention rate data and provides the opportunity to place new sealants on teeth previously unable to be sealed because they were not erupted at the first appointment. In FY13, based on the one year evaluation of more than 1,000 sealants placed in four Districts with sealant programs, the aggregate retention rate was 98%. Additionally, the VDH dentist providing clinical supervision performs an annual onsite quality assurance evaluation, and directly observes a sample of patients to assess retention. The observed one year retention rate ranged from 95-100% for programs reviewed in FY13. This is well in line with other state programs with a long history of success. The long-running Ohio School Based Dental Sealant Program and others, use the performance standard rate of >90% for long term (one year minimum) retention as acceptable. VDH considers this a reasonable expectation as well.

Under the remote supervision model, screening and sealants are conducted at the same visit utilizing a hygienist and assistant only. As expected, this is a more efficient and cost effective modality for providing preventive services than alternative protocols requiring an initial examination by a dentist, followed by a separate visit for a child to receive preventive services. In FY13, for VDH remote supervision programs, the cost per sealant application was calculated through modeling to be $20.73 per sealant. Over the years, 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 projected to be sealed per day has been adjusted down to ten per day. This has resulted from more accurate assessments of the time required to provide services and program support functions in the schools and the addition of adjunct preventive services during the visit.

For ideal sealant placement efficiency, many programs focus on grades two and six, based on the goal of sealing newly erupted permanent molars. The VDH program was initially limited in this way but due to a large number of children with unsealed teeth, has now evolved to include all grades in elementary schools until such time that most children are sealed in a school. Resuming the grade two and six protocol may be possible in the future as the program "catches up" unsealed children and only program maintenance is required. At present, some targeted children are presenting with a need for as many as eight sealants to cover both first and second molars. A large number of children without early sealant application creates a temporary financial efficiency for our program, lowering the cost per sealant since many teeth are sealed at one visit on a single child. VDH's cost for providing each sealant is very favorable. According to the American Dental Association Fee Schedule for the South Atlantic Region 2011, the average charge in private dental offices for placing a dental sealant on one tooth is $46.00.[7] As the number of children with sealants increases, the cost per sealant may increase, as a greater number of children will need to be seen to deliver the same number of sealants.

Additional Services Provided Under Remote Supervision

Fluoride Varnish: The primary school-based services provided under remote supervision are dental sealants although VDH dental hygienists can provide screening, education, and fluoride varnish. In a 2013 systematic review of dental literature, a 43% reduction in decayed, missing, and filled tooth surfaces was attributed to the use of fluoride varnish.[8] In FY12 and continuing in FY13, 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 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 to dental care, and earlier identification of oral health needs and referrals to dental homes. Additionally, VDH hygienists with the "Bright Smiles for Babies" program have partnered with the WIC clinics as a way to provide low-income children and their parents with these services (see Table 2). 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. In FY13, a total of 7476 infants and children received fluoride varnish applications through the combined efforts of hygienists in the BSB and school based programs (as noted in Tables 1 and 2).

Table 2. "Bright Smiles for Babies" Summary Program Data for Remote Supervision Dental Hygienists in Health Districts FY 13

Health District	Number of Children Screened*	Number of Children Treated with Fluoride Varnish	Number of Children Referred to a Dental Home
Cumberland Plateau	80	64	52
Lenowisco	67	67	49
Southside	198	193	107
Piedmont	271	271	41
Crater	209	156	116
Central Va.	228	223	167
Chickahominy	151	150	103
Peninsula	1001	964	494
Rappahannock	1312	1306	1311
Richmond	166	164	46
Chesterfield	209	208	97
Lord Fairfax	378	375	244
Rappahannock-Rapidan	1261	1244	1280
Henrico	297	297	251
Total	**5828**	**5682**	**4358**

**The number of children screened is greater than those treated with varnish because some children who are screened do not have teeth. The number of children screened is greater than those referred to a dental home because some have a family dentist affiliation.*

Dental Health Education: Dental hygienists provided dental health education to a variety of customers in programs across the Commonwealth. Teacher, parent, and student education sessions were conducted in many schools to increase knowledge of the dental preventive services program, and to motivate participation in the school-based programs. Other venues included WIC clinics, preschool programs such as Head Start, and professional trainings for nurses and other health providers. Oral health education was provided to 4,360 individuals and training was provided for 688 health professionals in FY13 (Table 3).

Table 3. Education and Training Summary Program Data for Remote Supervision Dental Hygienists in Health Districts FY 13

Health District	Number of Preschool and School Age Children Educated	Number of Parents, Teachers, and Citizens Educated	Number of Professionals Trained
Cumberland Plateau	2,875	911	67
Lenowisco	1189	40	0
Southside	52	200	0
Piedmont, Chesterfield, Richmond	128	1276	474
Crater	0	518	0
Central Va.	72	285	126
Chickahominy, Rappahannock, Henrico	0	2,160	4
Peninsula	3	2,014	17
Lord Fairfax	41	397	0
Rappahannock-Rapidan	0	120	0
Total	**4,360**	**7,921**	**688**

Dental Referrals: Hygienists in the VDH program serve as an effective conduit for identifying and referring patients in need of care by a dentist. Beyond clinical services, communicating with parents and recruiting local dentists to link low income children to a dental home is a program priority. Often parents are not aware of the dental needs of their children or the availability of services to them. Each child encounter with a remote supervision hygienist includes communication with a parent to identify the additional needs of their child. In the school based sealant program 1,094 children were specifically referred to a dentist when additional treatment needs were identified. The BSB program referred 4,358 infants and children for the purposes of establishing a "dental home" early in life regardless of whether any specific need was identified. Even in the absence of specific treatment needs requiring referral, all children and parents are advised through the VDH programs to access regular dental care and preventive services and to practice good oral health hygiene at home. In the event that a child has urgent needs, requiring immediate care, hygienists and assistants work with school nurses, parents, and local providers to secure an initial visit with a dental provider to address the urgent need. Because of the strong working relationships the VDH dental teams build with dentists in the communities, they are very successful at securing care for children with urgent needs.

Conclusions

As expected, the employment of hygienists under the remote supervision protocol for practice continues to benefit many areas of the Commonwealth. Across the State remote supervision hygienists are making a significant contribution to the oral health of their communities, not only through direct services, but through education, raising awareness of local dental challenges, partnering with providers and linking children to the services they need.

The change in practice protocol increased the eligible target populations for several programs and created cost and operations efficiencies by reducing the dentist involvement in delivery of preventive services, but, to date, meaningful comparisons of year-to-year data are hard to make due to the consolidation of general supervision and remote supervision projects, vacancies and staffing variations, and unique program elements in individual communities. While it is known that the remote supervision program continues to expand and reach new communities in need of preventive dental care and provide a more productive means of care, the changing dynamics of the program make it difficult to appropriately quantify the data for comparison from year to year. From this point forward, reports of remote supervision protocol services delivered will represent the vast majority of VDH dental hygienists' efforts and aggregate data will show the substantial and growing contribution to preventive services anticipated utilizing the new protocol. A VDH transition plan to a preventive dental services program utilizing remote supervision hygienists has been drafted for submission to the General Assembly in October 2013 and will be available on the web under "Reports to the General Assembly" http://leg2.state.va.us/DLS/H&SDocs.NSF/Search%20options?OpenForm . This document details the proposed operations, staffing additions and targeted service areas for a preventive program expansion across the State.

VDH and stakeholders have embraced the potential for remote supervision to expand population based services. Expanded access models for preventive services present a potential opportunity to have a greater impact on the oral health of more Virginians than has been possible with other clinical models in place in the past. In addition to facilitating innovative services programs, the remote supervision protocol has also enhanced the ability of VDH to successfully compete for federal grant funding for staff, enabling more sophisticated program development and monitoring. With these resources and opportunities available, in FY14, the DHP in the Office of Family Health Services will be able to creatively expand development and implementation of preventive strategies for remote supervision dental hygienists, to optimize community oral health in Virginia.

References

1. 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/RD3272010/$file/RD327.pdf

2. RD299 – 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. RD318- 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/RD3182012/$file/RD318.pdf

4. RD257 Virginia Department of Health Oral Health Plan October 2012. Available at:
http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2572012/$file/RD257.pdf

5. 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 Recommendations and Reports 2001; 50(RR-21):1-13.

6. 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. Pediatric Dentistry. 2004: 26: 426-432.

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

8. Marinho VCC, Worthington HV, Walsh T, Clarkson JE. 2013 Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Summaries. July 2013.
http://summaries.cochrane.org/CD002279/fluoride-varnishes-for-preventing-dental-caries-in-children-and-adolescents

Appendix A: 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 B: **Code of Virginia** effective July 1, 2012

§ 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 a dental hygiene program accredited by the Commission on Dental Accreditation and 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; (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. Notwithstanding any provision of law, 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 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 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 the Commonwealth, shall be prepared and submitted by the Department of Health to the Virginia Secretary of Health and Human Resources annually. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene.

(1950, pp. 983-985, §§ 54-200.2, 54-200.4, 54-200.7 through 54-200.9, 54-200.11; 1968, c. 604; 1970, c. 639; 1972, cc. 805, 824; 1973, c. 391; 1975, c. 479; 1976, c. 327; 1986, c. 178; 1988, c. 765; 1990, c. 441; 1997, c. 855; 2002, c. 170; 2005, cc. 505, 587; 2006, c. 858; 2007, c. 702; 2009, cc. 99, 506, 561; 2011, c. 289; 2012, c. 102; 2013, c. 240.)

Appendix C: 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