

## **2018 Report to the General Assembly**

### **Services Provided by Virginia Department of Health Dental Hygienists Pursuant to a “Remote Supervision” Protocol**

## TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY .....</b>	<b>2</b>
<b>HISTORY AND OVERVIEW OF REMOTE SUPERVISION.....</b>	<b>3</b>
<b>BURDEN OF DENTAL DISEASE AMONG CHILDREN .....</b>	<b>5</b>
<b>ORAL HEALTH SERVICES PROVIDED BY VDH .....</b>	<b>8</b>
DENTAL SEALANTS	
TOPICAL FLUORIDES, FLUORIDE SUPPLEMENTS, AND VARNISHES	
DENTAL VISITS	
<b>PROGRAM PRODUCTION AND IMPACT ON ORAL HEALTH .....</b>	<b>10</b>
SCHOOL-BASED PREVENTIVE SERVICES	
BRIGHT SMILES FOR BABIES PREVENTIVE SERVICES	
COMBINED PREVENTIVE SERVICES IMPACT	
<b>SUMMARY AND FUTURE PLANS .....</b>	<b>16</b>
<b>APPENDIX A: CODE OF VIRGINIA EFFECTIVE JULY 1, 2017.....</b>	<b>18</b>
<b>APPENDIX B: PROTOCOL FOR VIRGINIA DEPARTMENT OF HEALTH DENTAL HYGIENISTS TO PRACTICE IN AN EXPANDED CAPACITY UNDER REMOTE SUPERVISION BY PUBLIC HEALTH DENTIST .....</b>	<b>20</b>

## FIGURES

<b>FIGURE 1</b>	<b>MAP OF VDH PREVENTIVE DENTAL SERVICES IN VIRGINIA....</b>	<b>5</b>
<b>FIGURE 2</b>	<b>PREVALENCE OF UNTREATED CARIES AND ANY CARIES EXPERIENCE AMONG 3RD GRADERS, BASIC SCREENING SURVEY, VIRGINIA 2009, 2014 .....</b>	<b>6</b>
<b>FIGURE 3</b>	<b>PREVALENCE OF DENTAL SEALANTS ON PERMANENT MOLARS, 3RD GRADERS, BASIC SCREENING SURVEY, VIRGINIA 2009, 2014 .....</b>	<b>9</b>
<b>FIGURE 4</b>	<b>PERCENT OF VIRGINIA 3RD GRADE CHILDREN WITH A DENTAL VISIT IN THE LAST YEAR, BASIC SCREENING SURVEY, VIRGINIA 2014.....</b>	<b>10</b>

## TABLES

<b>TABLE 1</b>	<b>PREVALENCE OF UNTREATED CARIES AND ANY CARIES EXPERIENCE AMONG 3RD GRADERS BY REGION AND RACE ETHNICITY, BASIC SCREENING SURVEY, VIRGINIA 2009, 2014....</b>	<b>7</b>
<b>TABLE 2</b>	<b>SCHOOL-BASED PROGRAM SUMMARY DATA PROVIDED UNDER REMOTE SUPERVISION, ALL GRADES, FY10 - FY18.....</b>	<b>12</b>
<b>TABLE 3</b>	<b>SERVICES PROVIDED THROUGH BRIGHT SMILES FOR BABIES FLUORIDE VARNISH PROGRAM, BY VDH DENTAL HYGIENISTS, FY10 - FY18 .....</b>	<b>15</b>

## **Executive Summary**

The program for Virginia Department of Health (VDH) dental hygienist services provided under a remote supervision protocol was first established in 2009. The evolution of the remote supervision protocol from pilot to established program is detailed in prior VDH annual reports on the [General Assembly's Legislative Information System website](#).

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 summarizes the burden of relevant oral disease statewide as updated by the 2014 Virginia 3<sup>rd</sup> Grade Basic Screening Survey (BSS) and documents the services provided in FY18 by the dental hygienists and dental assistants employed by VDH under the remote supervision protocol.

In FY18, 7,864 children returned a permission form and were screened by a dental hygienist in a school-based setting; 2,518 received sealants, and 7,090 fluoride varnish applications were provided in initial and follow-up visits. A total of 2,031 children were identified as having other oral health needs and referred to community providers. In clinic settings, through the VDH “Bright Smiles for Babies” (BSB) Program, 4,861 infants and children were screened, and 4,420 fluoride varnish applications were provided. In FY18, the combined remote supervision hygienist workforce provided clinical services with a market value exceeding \$ 2.4 million in 19 VDH health districts. As this and previous reports indicate, the remote supervision model offers an effective alternative method of delivery for safety net dental program services that increases access for underserved populations.

## **History and Overview of Remote Supervision Program**

Although tremendous strides have been made in the reduction of tooth decay among many Virginians over the past fifty years, primarily due to community water fluoridation, the decline in disease prevalence and severity has not been distributed uniformly across all segments of the population. Race and socioeconomic status continue to be predictors of tooth decay, and geography affects access to care in many parts of the Commonwealth. 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 the impact of oral disease. 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, such as the remote supervision protocol in the Virginia Department of Health.

In 2009, the Virginia General Assembly passed legislation to revise § 54.1-2722 of the Code of Virginia “License; application; qualifications; practice of dental hygiene” to allow dental hygienists employed by VDH, and working in the Cumberland Plateau, Lenowisco, and Southside Health Districts, to provide preventive dental services in selected settings without the general or direct supervision of a dentist. This legislation aimed to improve access to preventive dental services for those at highest risk of dental disease, as well as reduce barriers and costs for dental care for low-income individuals. The legislation also had potential for significant changes to the practice of public health dentistry in the Commonwealth, a model that had not changed since the state dental program was established in 1921.

When the legislation passed, there were only two VDH dental hygienists (one full-time and one part-time) located in priority health districts. Therefore, efforts were made to secure funds through grants and other opportunities to increase staff that could work under this new protocol. As a result, by early 2010 there were six full or part-time VDH dental hygienists practicing under remote supervision in Lenowisco, Cumberland Plateau and Southside Health Districts, and one part-time hygienist working exclusively with the fluoride varnish program. The primary prevention services provided by VDH using the remote supervision protocol were school-based dental sealant and fluoride varnish programs in the targeted health districts. Dental sealant and fluoride varnish programs are evidence-based and cost-effective means to reduce the dental disease burden of a population. The hygienists were also able to provide many other additional preventive services for the individuals in these communities under existing practice protocols, including screenings, education, and referrals.

In addition to the sealant programs provided under the pilot remote supervision protocol, preventive services were provided under existing practice protocols in the target health districts. These included 1) a fluoride varnish program in Special Supplemental Nutrition Program for Women, Infants and Children (WIC) clinics and Care Connection for Children (CCC) clinics; 2) dental education programs; 3) oral health screenings and referrals; and 4) a program that involved home visits (this program ended after the first year).

The pilot program was originally slated to last until July 1, 2011. However, due to the program’s success, it was extended during the 2011 General Assembly Session for another year – until July

1, 2012. On July 1, 2012, the Code of Virginia was amended to permit any VDH dental hygienist throughout the Commonwealth to practice under the remote supervision protocol, not just those practicing in one of the three designated health districts.

With support of the new legislation, VDH enrolled all existing VDH hygienists providing patient care services into the remote supervision protocol in FY13. This expanded the service capabilities of hygienists who 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). Additionally, some VDH local health districts contributed funding to support hygienists practicing in their areas.

In FY14, VDH initiated implementation of the VDH Dental Transition Plan to emphasize more community-based prevention services. Resources previously committed to VDH local health districts were identified for redirection to add new remote supervision hygienist programs in targeted areas of the Commonwealth. The transition plan identified localities based on applied metrics of greatest need for placement of additional hygienists to expand the “Dental Preventive Services Program.”



Also in FY14, VDH expanded the eligibility rules for the dental sealant program. Schools are now selected for participation in the sealant program based on having a National School Lunch Program (NSLP) participation rate of 50% or greater. Prior to 2014, individual students had to be identified as participants in the NSLP in order to be eligible for sealant services through VDH. VDH identified concerns that the requirement for parents to disclose a child’s NSLP status is potentially stigmatizing and poses administrative burdens. The disclosure requirement presented a barrier to participation in the program. Therefore, in FY14, eligibility was expanded to all students in the qualifying schools, thus avoiding the need to identify the status of individuals. This has increased the service population, reach and impact of the program in high-need areas.

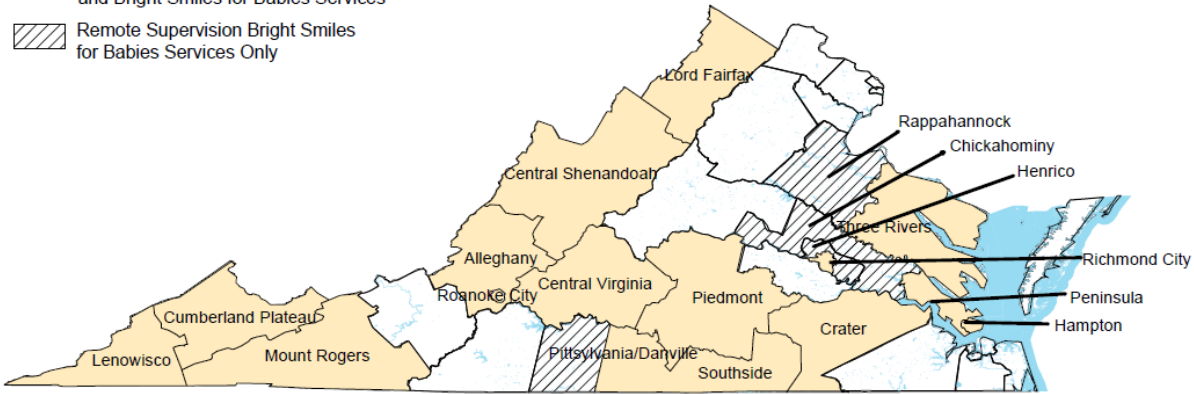
In August 2015, the recruitment and selection process for expansion of the VDH remote supervision programs, as proposed in the VDH Dental Transition Plan, was completed. In the 2015-2016 schoolyear, four additional full-time community-based dental hygienists and part-time dental assistants began providing services. By FY18, eleven remotely supervised hygienists were providing services in nineteen VDH health districts (Figure 1). The VDH dentist in the Office of Family Health Services (OFHS) continues to provide professional support to all of these remote supervision programs including ongoing technical assistance, clinical oversight, and quality assurance.

**Figure 1: Map of VDH Preventive Dental Services in Virginia**

**VIRGINIA DEPARTMENT OF HEALTH - DENTAL PREVENTIVE SERVICES PROGRAM**

**Legend**

-  Remote Supervision School - Based and Bright Smiles for Babies Services
-  Remote Supervision Bright Smiles for Babies Services Only



\* Data Source: Virginia Department of Health, 2018

0 50 100 200 Miles

## Burden of Dental Disease among Children

Tooth decay is estimated to be five times more common than asthma and seven times more common than hay fever in children. Dental issues among children have been demonstrated to contribute significantly to lost school and activity time<sup>1</sup>, and lack of dental insurance and access to care complicate dental treatment for those most at risk. Nationally, 28% of children aged 3-5 years were estimated to have some dental caries experience in the 2011-2012 time period, according to data from the National Health and Nutrition Examination Survey (NHANES)<sup>2</sup>. For children aged 6-9 years, the prevalence of dental caries was 57.7%; for adolescents 13-15 years, the prevalence of caries experience was 53.4%.

Healthy People 2020 (an initiative of the U.S. Department of Health and Human Services) includes two objectives related to dental caries experience and untreated decay in children that VDH is currently able to monitor at the population level with available data systems:

- OH-1.2: Reduce the proportion of children aged 6 to 9 years with dental caries experience in their primary or permanent teeth.

<sup>1</sup> Gift H, Reisine S, Larach D. The social impact of dental problems and visits. *Am J Public Health*. 1992;82(12):1663–1668.

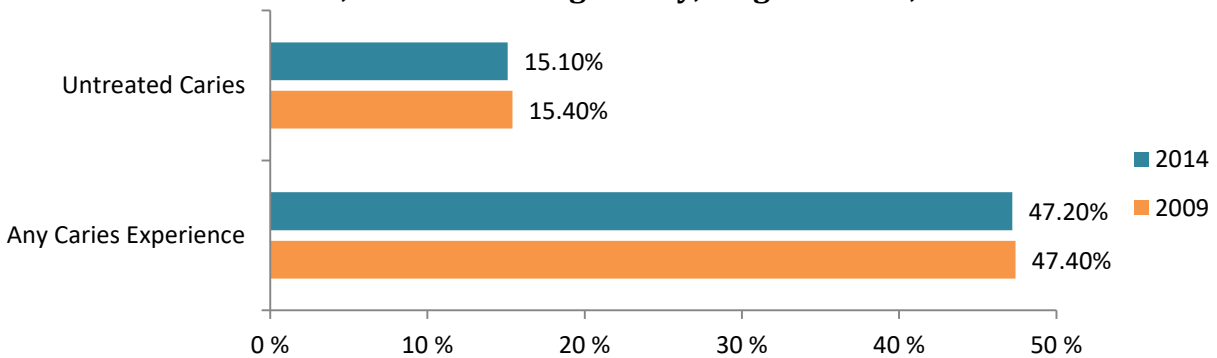
<sup>2</sup> US Department of Health and Human Services. Oral health. *Healthy people 2020*. Available at: <http://www.healthypeople.gov/2020/>. Accessed August 30, 2013.

- OH-2.2: Reduce the proportion of children aged 6 to 9 years with untreated decay in their primary or permanent teeth.

Virginia monitors these indicators through the Virginia Basic Screening Survey (BSS). Conducted every five years and based on guidelines developed by the Association of State and Territorial Dental Directors (ASTDD), the Virginia BSS includes an open-mouth survey of a representative sample of 3<sup>rd</sup> grade school children in Virginia to assess statewide progress in pediatric oral health indicators. Data are weighted to the population level and are thus representative of all 3<sup>rd</sup> graders in Virginia. Following the frequency recommended by the ASTDD, the next Virginia BSS will be conducted in 2019. The impact of the Bright Smiles for Babies (BSB) and school-based fluoride varnish programs initiated in 2010 may be evident at that time. Future third graders screened in some areas could potentially have benefited from VDH preventive services for most of their lives.

Findings from the 2009 and 2014 BSS on the prevalence of untreated caries and dental caries experience are presented in Figure 2.

**Figure 2: Prevalence of Untreated Caries and Any Caries Experience among 3<sup>rd</sup> Graders, Basic Screening Survey, Virginia 2009, 2014**



The prevalence of caries varies by region, ethnicity and race. In 2014, Southwest Virginia and Black, Non-Hispanic children had the highest rate of untreated caries. This represents a slight shift in racial characteristics for untreated caries since the 2009 BSS. Comprehensive caries data for the 2009 and 2014 BSS are presented in Table 1.

**Table 1: Prevalence of Untreated Caries and Any Caries Experience among 3<sup>rd</sup> Graders, by Region and Race/Ethnicity, Basic Screening Survey, Virginia 2009, 2014**

Region	Untreated Caries (%)		Any Caries Experience (%)	
	2009	2014	2009	2014
Northwest	14.3	16.1	45.4	62.6*
Northern	11.5	9.7	40.5	38.0
Southwest	25.3	23.0	59.6	54.9
Central	13.6	16.8	48.3	50.1
Eastern	15.4	16.2	47.7	43.4
<b>Race</b>				
White, Non-Hispanic	13.4	13.1	45.2	44.2
Black, Non-Hispanic	18.2	19.8	50.3	51.8
Hispanic	22.4	14.4	54.0	51.0
Asian/ Pacific Islander	15.5	14.7	51.8	46.4
Other / Multiracial	15.0	16.5	44.5	48.1

\*The 2014 sample in NW was significantly smaller compared to 2009. Future BSS data will be needed to inform existence of a meaningful trend.

According to the BSS, most 3<sup>rd</sup> graders in Virginia in 2009 and 2014 had no obvious dental problems requiring care. Only a very small percentage (1.1%) needed urgent (within 24 hours) dental care in 2009 and this remained relatively unchanged in 2014 (0.9%). It is also important to note that when the presence of insurance is considered, an uninsured 3<sup>rd</sup> grade child is not only less likely to have sealants, but is also more likely to have at least one tooth with untreated decay, than an insured child.

Progress on these indicators will be tracked periodically through the school-based BSS and findings from subsequent BSS statewide administrations will be evaluated to determine changing patterns of caries experience in the school population over time. The next statewide BSS of 3<sup>rd</sup> graders will begin in FY19.

Remotely supervised dental hygienists (RSDHs) provide special dental programs for Head Start enrollees and support them in accessing care. In FY17 and FY18, VDH expanded its oral health surveillance utilizing RSDHs to conduct a BSS survey of children participating in Virginia's Head Start Program. These data will help inform VDH and its partners in directing preventive and educational services for an even earlier target age group. Preliminary survey results indicate that over 90% of Head Start children were covered by dental insurance but only about 50% of the children had seen a dentist by age one. Even at this young age, 28% of the children had experienced dental decay and almost 20% of the children had active, untreated decay.



# Oral Health Services Provided by VDH through Remote Supervision

## Dental Sealants

A dental sealant is a plastic coating applied to the chewing surfaces of the back teeth (molars) to prevent the initiation and progression of dental caries 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. The Centers for Disease Control and Prevention (CDC) 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%.<sup>3</sup> Nationally, school-based sealant programs targeting low-income children have been in place now for many years. A dental hygienist is widely accepted as equally skilled as a dentist in applying dental sealants. 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.<sup>4</sup>

According to NHANES, 31% of children aged 6-8, 49% of children aged 9-11, and 43% of adolescents aged 12-19 had at least one dental sealant on a permanent tooth<sup>5</sup> in the 2011-2012 survey period. Dental sealant prevalence is known to vary by socio-demographic factors. According to an analysis of NHANES data from 2009 and 2010, children aged 6-9 years living below the federal poverty level were less likely to have sealants on permanent molars than children of that age living above the federal poverty level (26% vs. 34%)<sup>6</sup>. Additionally, this analysis found that sealant prevalence was lower among black adolescents (32%) than white adolescents (56%). Recent survey data for Virginia suggest the sealant prevalence disparity is not as great as the national findings.

VDH currently monitors the following Healthy People 2020 objective on dental sealants:

- OH-12.2 Increase the proportion of children aged 6 to 9 years who have received dental sealants on one or more of their permanent first molar teeth.

Sealant prevalence is tracked by VDH through the BSS. Virginia 2009 and 2014 BSS data on dental sealant prevalence by race and ethnicity are presented in Figure 3. There was a slight improvement noted in 2014 over 2009 for sealant prevalence on “All” children.

---

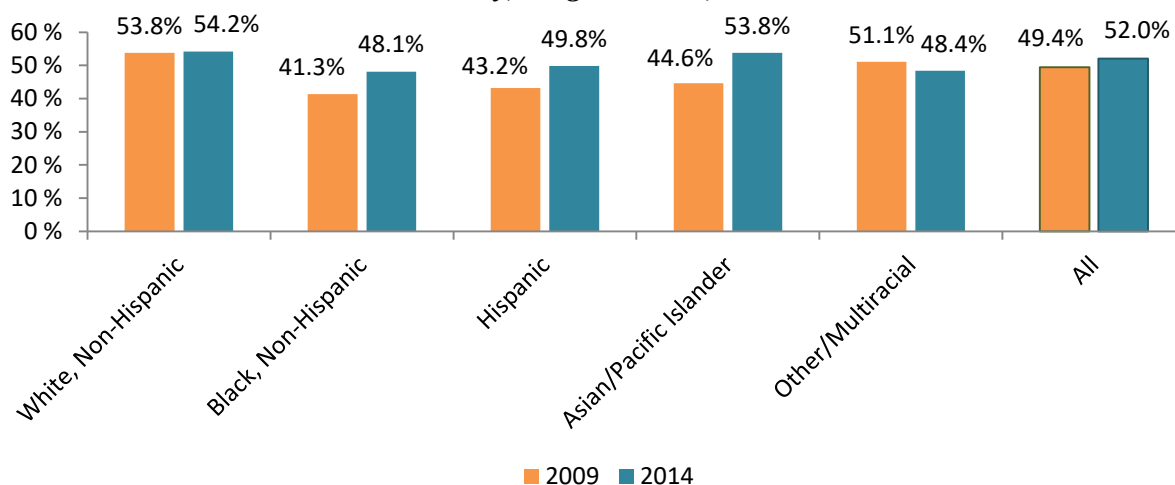
<sup>3</sup> Centers for Disease Control and Prevention. Promoting Oral health: Interventions for Preventing Dental Caries, Oral and Pharyngeal Cancers, and Sports-Related Craniofacial Injuries—A Report on Recommendations of the Task Force on Community Preventive Services. *MMWR Recommendations and Reports*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

<sup>4</sup> 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.

<sup>5</sup> Dye BA, Thornton-Evans G, Li X, Iafolla TJ. Dental caries and sealant prevalence in children and adolescents in the United States, 2011–2012. *NCHS data brief*, no 191. Hyattsville, MD: National Center for Health Statistics. 2015.

<sup>6</sup> Dye B, Xianfen L, Thornton-Evans G. Oral health disparities as determined by selected Healthy People 2020 oral health objectives for the United States, 2009-2010. 2012. Available at: <http://www.cdc.gov/nchs/data/databriefs/db104.htm>. Accessed October 4, 2013.

**Figure 3: Prevalence of Dental Sealants on Permanent Molars, 3<sup>rd</sup> Graders, Basic Screening Survey, Virginia 2009, 2014**



### Topical Fluorides, Fluoride Supplements and Varnishes

Topical fluorides (gels, varnishes, pastes, and mouth rinse) and fluoride supplements are all interventions proven effective in reducing the risk of dental decay. In a 2013 systematic review of dental literature, the authors attributed a 43% reduction in decayed, missing, and filled tooth surfaces to the use of fluoride varnish alone.<sup>7</sup> Fluoride varnishes are a topical fluoride delivery vehicle that instantly “stick” to tooth surfaces where applied and eliminates the risk of significant patient ingestion. This facilitates the use of topical fluorides on infants and children of all ages in a variety of settings.

### Dental Visits

Dental visits are an important component of good oral health. Routine preventive dental visits, particularly, provide opportunities for oral health education, professional cleaning, fluoride applications, and oral cancer screenings. Delivery models for school-based preventive services significantly reduce many of the typical barriers to accessing preventive care visits facing some families<sup>8</sup>. Healthy People 2020 includes the following related objective that VDH tracks through BSS and the Behavioral Risk Factor Surveillance System (BRFSS):

- OH-7: Increase the proportion of children, adolescents and adults who used the oral health care system in the past year.

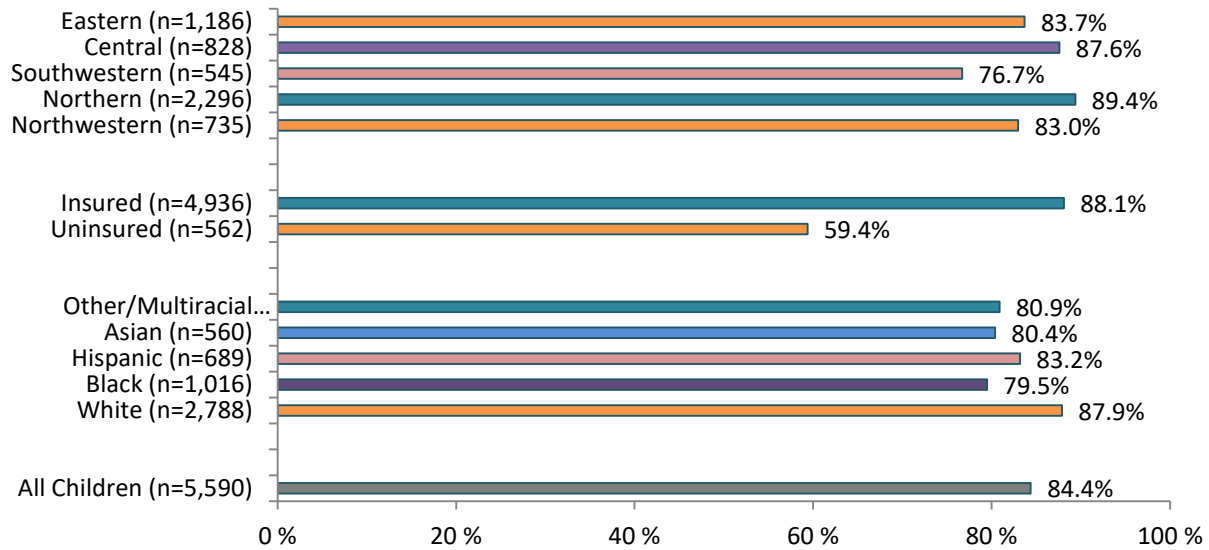
A summary of dental visit status in the past year is provided in Figure 4. The most notable population characteristic associated with whether a child had a dental visit in the past year was dental insurance status. In 2014, 88% of insured children reported a visit in the past year versus

<sup>7</sup> Marinho VCC, Worthington HV, Walsh T, Clarkson JE. 2013 Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Summaries. July 2013. Available at <http://summaries.cochrane.org/CD002279/fluoride-varnishes-for-preventing-dental-caries-in-children-and-adolescents>

<sup>8</sup>Gooch, B et al. 2009. Preventing Dental Caries through school based dental sealant programs. JADA. 140;11:1356-65. November 2009. Available at [http://jada.ada.org/article/S0002-8177\(14\)64584-0/fulltext](http://jada.ada.org/article/S0002-8177(14)64584-0/fulltext)

59% for those identifying themselves as uninsured. This was virtually unchanged from 2009. The 2014 BSS instrument did not distinguish the purpose of the dental visit in the data collection. The 2014 BSS identified a child as having had a visit in the past year, for any reason, which is more in line with the language of Healthy People 2020 OH-7. However, it was determined by the 2009 3<sup>rd</sup> grade BSS, that nearly 80% of visits were for preventive services.

**Figure 4: Prevalence of Dental Visit in Past Year by Selected Demographic Characteristics, 3<sup>rd</sup> Grade Children, Basic Screening Survey, 2014**



## Program Production and Impact on Oral Health

### School-based Preventive Services

VDH remote supervision hygienists provide preventive care visits in a school-based setting to deliver dental assessment, sealants, fluoride varnish applications, oral health education and, in some settings, prophylaxis (cleanings). Children in qualified schools who do not have a dental home are referred to dental providers. In addition to providing clinical preventive services, VDH hygienists are responsible for program development in their geographic area. Hygienists spend substantial effort working with school administration, school staff, 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. Although services as described in this report are categorized as "school-based" or "Bright Smiles for Babies" programs, in most cases the same area VDH hygienists are now providing the services in both settings.

In FY18, 7,864 school children returned a permission form and were assessed by a dental hygienist in a school-based setting; 2,518 received sealants; and 7,090 fluoride varnish applications were provided. A child could be assessed and not be a candidate for a dental sealant

due to the identified status of the permanent molar teeth including “filled”, “decayed”, “previously sealed”, or those molars “missing” or not fully erupted into the mouth. Over the years, ongoing VDH programs are increasingly identifying children at the older age ranges with previously sealed teeth from earlier program participation. New sealant application is now primarily limited to the younger grades in schools that hygienists have returned to or schools new to the program. However, all participating children, regardless of sealant status, continue to receive updated assessments, oral care education, and fluoride varnish applications during each school year. Recognizing that the VDH program, having operated in schools for nine years, is now routinely providing regular preventive services to a large cohort of returning students needing access through VDH, the counting metric applied for "Number of Children Screened" was edited in FY18. To accurately capture the hygienists' labor and the actual number of individual children receiving VDH care annually, children participation counts now include each individual child assessed/screened in a school year. Previously, only children new to ongoing programs were included in reported counts and returning children were not represented in the totals. Going forward, this will better represent the activity and success of a more mature program. Over the life of the program, even when adjustments in counting metrics are considered, production has trended upwards in the number of children receiving assessments, sealants and fluoride varnish. In FY18, 2,031 children (the highest count to date) were also identified as having other oral health needs and were referred to community providers to establish dental homes. Encouragingly, there continues to be a year-over-year increasing trend in the number of school divisions participating in the prevention programs.

In any given year, there are generally periods of position vacancies. FY18 was particularly challenging. Four VDH programs had to recruit and hire dental assistants during the school year. Fortunately, the pool of applicants was strong and each position was filled with an experienced candidate before the end of the school year. The remote supervision staff continues initiatives to expand the program's reach, participation, and scope in communities and to improve efficiency in delivery of services. However, the FY18 total school services production was adversely impacted by these vacancies, as well as hygienists absent due to extended medical disability leave and maternity leave.

Across all dental preventive program venues, VDH provided clinical services in FY18 to a child population that was 54% insured with Medicaid and 46% uninsured. VDH identifies schools as eligible by National School Lunch Program participation status and then provides services to all attending children with parental consent, regardless of insurance status. Medicaid revenue is collected, when available, to help sustain the program; however, a large number of children are provided critical preventive services without reimbursement. In the absence of these VDH programs, it is very likely many children would go without the benefit of dental sealants to prevent future disease. According to the VDH BSS of 3<sup>rd</sup> grade children in 2014, children with insurance were significantly more likely than uninsured children to have at least one dental sealant. The VDH program attempts to mitigate this disparity.

School programs vary in their elected participation, with some of the newer VDH programs not yet having the school engagement that is enjoyed by districts with long-term health department/school relationships. As VDH expands preventive services programs across the Commonwealth, few challenges are encountered and community support is generally

outstanding. VDH maintains engagement with the hygiene staff to share “lessons learned” and “best practices” to facilitate program acceptance and participation. Past experience has shown that a continuous presence in the schools and community, over time, results in increased school and parent support for these programs. Additionally, programs are monitored and adapted to best serve the targeted population while remaining consistent with public health science recommendations. For example, in FY13 routine application of fluoride varnish was initiated in conjunction with screening appointments to increase program impact. A trial addition of prophylaxis services for school-based programs in Hampton and Cumberland Plateau, implemented in FY17, was expanded in FY18 to the Southside Health District with the same goals of increasing school program acceptance and child participation. Initial reports confirm this was a very popular modification to the program. Future program evaluation efforts will target school decision makers for feedback to assess the value of this added service more definitively.

Having provided thousands of fluoride varnish treatments in schools as well as clinical settings, it is possible that VDH programs contributed to the very slight reduction in 3<sup>rd</sup> grade student caries experience from 2009 to 2014 as noted in Figure 2. Oral health surveillance data collection during school-based encounters has continued through FY18 in support of a national CDC effort to capture additional data on the current dental status of children. This will complement oral disease status assessments such as the BSS in the future, with the goal of accurately determining Virginia trends for all children to better guide program efforts.

VDH school-based services production is summarized in Table 2.

**Table 2: School-based Program Summary Data Provided under Remote Supervision, All Grades FY10 – FY18**

Year	Number of Participating Health Districts	Number of Participating School Divisions	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 Varnishes Applied
FY10	3	8	485	248	346	1277	3.7	N.A.
FY11	3	9	1029	474	543	1909	3.5	N.A.
FY12	3	10	1274	819	746	2281	3.0	N.A.
FY13	5	16	3011	1094	831	3186	3.8	1794
FY14	7	23	3982	1220	1746	6109	3.5	3754
FY15	6	21	4955	1181	1993	6918	3.5	5445
FY16	12	31	4363*	1386	2583	8328	3.2	6272
FY17	12	34	4123	1519	2863	8635	3.0	8851
FY18	15	38	7864**	2031	2518	7081	2.8	7090

\* In order to maintain consistency with other reporting obligations, beginning in FY16 “Number of Children Screened for Sealants and Varnish” represents a count of unique individuals only. Previously some children may have been screened twice during the data collection period.

\*\*In FY18, # of children screened included any child receiving a screening service in the school year regardless of prior program participation

Sealant programs are only effective if the sealants placed are retained. Sealant retention is evaluated in two ways, follow-up assessments and quality assurance evaluations. The program protocol requires annual follow-up assessments and reporting by hygienists to evaluate retention of sealants placed during the prior year. This yields retention rate data and provides the opportunity to place new sealants on teeth previously unable to be sealed at the first appointment and to replace lost sealants. Follow-up is dependent on children returning to the same school in consecutive years, parents continuing to sign children up for services, and schools participating in the program consistently. Still, the sealant retention data sample for FY18 was extracted from the evaluation of over 5,000 sealants.

In FY18, the aggregate retention rate calculated statewide for all sealants evaluated during “follow-up” visits was 95%. The VDH Dental Quality Assurance Manager performs the annual onsite quality assurance evaluation of each program and directly observes a sample of patients to evaluate and corroborate calculated retention rates. The observed one-year retention rates for individual providers reviewed in FY18 were all within the desired 90-100% range. These rates are consistent with other state programs with a long history of success, including the long-running Ohio School-Based Dental Sealant Program and others, which use the performance standard rate of >90% for long-term (one year minimum) retention.

Under the remote supervision model, assessments are conducted and sealants are applied at the same visit utilizing a hygienist and assistant. As expected, this is a more efficient and cost effective modality for providing preventive services than alternative protocols from the past requiring an initial examination by a dentist followed by a separate visit for a child to receive preventive services. In FY18, the cost per sealant application for VDH remote supervision programs was calculated through modeling to be \$24.15 per sealant. In FY17, in an effort to include the total program cost of delivering a sealant beyond the administrative time and fixed and variable costs associated with each provider, an adjustment was added per sealant to reflect the “distributed costs” per sealant of managing the program and the funding streams. An additional 13% cost was attributed to each sealant following typical grant valuation metrics for program support. As with the metric applied to measure schoolchildren participation, costing calculations will likely continue to evolve over time with more and better data collection becoming available. The FY18 calculations were enhanced for accuracy with newly available tracking of costs associated with travel time and vehicle expenses. "Actual" travel expenses were lower than previously modeled projections and resulted in the lower calculated cost per sealant for FY18 than the FY17 value of \$26.35. According to the 2016 American Dental Association Fee Schedule for the South Atlantic Region, the average charge in private dental offices for placing a dental sealant on one tooth was \$53.00.<sup>9</sup> Smiles for Children Virginia Medicaid reimbursement per sealant is \$32.28. The VDH remote supervision sealant delivery model continues to be cost effective relative to most alternative provider resources. It is also important to recognize two less tangible impacts from school-based dental sealant programs. There are societal savings from caries averted and thus the “savings” realized from avoided expensive

---

<sup>9</sup> American Dental Association (ADA). 2016 Survey of Dental Fees. ADA Survey Center, December 2016.

dental restorative work over a lifetime and there is a reduction in parent production loss when school programs reduce parent appointment obligations for children.<sup>10</sup>

### **Bright Smiles for Babies Preventive Services**

In addition to preventive services offered through schools, VDH dental hygienists practicing under remote supervision in the BSB Program provide services through WIC clinics, Head Start, Care Connection for Children medical specialty clinics, and some unique settings where young children are provided other services. This affords opportunities to provide preventive and educational services and fluoride varnish, when appropriate, to low-income children and their parents and children with special health care needs. The BSB Program utilizes non-dental settings as a means of accessing children aged five and under who otherwise may not receive early preventive dental services. Early preventive care can positively impact dental caries experience throughout childhood. With 46% of the VDH programs' target population being uninsured, there are significant concerns that many children may not otherwise receive preventive services. According to the VDH BSS of 3<sup>rd</sup> grade children in 2014, an uninsured 3<sup>rd</sup> grade child is 1.5 times more likely to have at least one tooth with untreated decay than an insured child.

Increasingly, Dental Health Program staff in OFHS are engaged in oral health surveillance activities. In addition to the oral disease data captured during school-based clinical assessments and the Head Start BSS, remote hygienists are conducting oral health surveys in a variety of population cohorts. In FY18, VDH hygienists, utilizing standardized practices developed by the ASTDD, continued conducting a survey and screening of pregnant women in the Women, Infant and Children Supplemental Nutrition Program (WIC). The data collected from these surveillance activities supports planning and assessment not just for VDH, but increasingly for individual statewide oral health partners and collectively through the Virginia Oral Health Coalition. Both the school-based and BSB provider workforce will continue to contribute their collective knowledge of the local communities, existing collaborative partnerships, and clinical expertise as patient examiners in support of surveillance activities in the future.

An additional benefit of engaging WIC-enrolled pregnant women, if they are determined to be insured under the new Medicaid/FAMIS expansion for pregnant women, is to inform and educate them regarding the value of utilizing this opportunity. The dental services benefit for pregnant women has very strict time constraints limiting services to the first trimester through the end of the month following the 60<sup>th</sup> day after delivery. To assure effectiveness of the program, eligible women frequently require information and assistance to promptly access services. VDH hygienists have been effectively identifying a variety of opportunities to communicate with and assist this target group.

Additionally, as an extension of the BSB Program, some VDH dental hygienists provide oral health preventive services to children with special health care needs in medical specialty clinics and in some Head Start settings. The remote hygienists are also actively expanding the integration of oral care into non-dental settings by training physicians and nurses across the

---

<sup>10</sup> Guide to Community Preventive Services. Improving oral health:dental caries.[www.thecommunityguide.org/oral/caries.html\(caries.html\)](http://www.thecommunityguide.org/oral/caries.html(caries.html)) . Last updated May18, 2016.

Commonwealth to provide the BSB Program services during well-child visits. Available Medicaid reimbursement for physician office varnish application, initiated several years ago with VDH support, appears to be an incentive to the private medical providers to integrate the BSB protocol into their practices. Most recently, the Dental Health Program’s receipt of the Perinatal and Infant Oral Health Quality Improvement Expansion Grant (PIOHQIE) has supported a variety of partnerships and outreach efforts to expand fluoride varnish availability in non-dental settings.

The BSB clinic services reported for FY18 declined to some extent. The magnitude of the reductions are an anticipated outcome of staff vacancies, the increasing time committed to the VDH goal of expanded community surveillance utilizing hygienists, and some reconfigurations of positions. Dedicated BSB hygiene positions have gradually been replaced by VDH hygienists that provide a wider variety of remote supervision protocol services in communities and by medical partner providers. In FY18, hygienists providing clinical services through the BSB Program as a component of their clinical responsibilities screened 4,861 infants and children, provided 4,420 fluoride varnish applications, and referred 1,885 young children to a dental home (see Table 3 below).

**Table 3: Services Provided Through “Bright Smiles for Babies” Fluoride Varnish Program, by VDH Dental Hygienists, FY10 - FY18**

Year	Number of Health Districts	Number of Children Screened	Fluoride Varnishes Applied	Number of Children Referred to a Dental Home
FY10 - FY11	3	1822	1607	1351
FY12	3	508	483	296
FY13	14	5828	5682	4358
FY14	13	6527	6088	3552
FY15	13	5408	4995	2865
FY16	16	7074	6692	3613
FY17	16	6649	5602	2840
FY 18	13	4861	4420	1885

**Combined Preventive Services Impact**

In FY18, the remote supervision hygienist workforce provided clinical services with a market value exceeding \$2.4 million. This is in line with production over the past five years with the exception of a slight reduction from the peak production of \$2.7 million in FY17. Service value calculations, as determined by Current Dental Terminology Codes from the American Dental Association, include oral screenings (D0190) and assessments (D0191); dental sealants (D1351); education (D1330); topical fluoride varnish applications (D1206); and a limited number of child (D1120) and adult (D1110, >age 12) prophylaxis services.



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, to motivate participation in the school-based programs, and to stress the importance of accessing preventive services in the community when available. Other venues included WIC clinics, preschool programs such as Head Start, and professional trainings for nurses and other health providers. Through group and chairside activities, VDH remote supervision hygienists provided oral health education to 24,857 individuals in FY18.

## **Summary and Future Plans**

The remote supervision program, in its current iteration, reflects the successful transition from VDH dental clinical services as the primary focus, to dental preventive services as a more cost effective and sustainable effort to improve long term oral health trends across the Commonwealth. As this report indicates, the remote supervision model has provided an alternative method of delivery for safety net dental program services that has increased access for underserved populations. Preventive services are provided to more individuals at a lower cost compared to those requiring a licensed dentist to examine a patient. The resulting referrals to private community dentists for comprehensive diagnosis and treatment services also encourage care-seeking behavior by parents and the desirable establishment of a “dental home” for children in the private provider community.

As the program matures, the lessons learned and best practices identified are informing a continually improving model for the remote hygienists’ role in the community. In 2016, VDH conducted a staff satisfaction survey in client schools. A total of 122 school staff members were contacted, of which 62 responded; 98.4% stated they were very satisfied (82.3%) or satisfied (16.1%) with the VDH dental services program in the schools. The majority of school nurses and principals, 97%, agreed they would recommend the program to other schools. Survey participants were also given the opportunity to provide specific suggestions. The need for greater promotion of the program and enhanced efforts to improve child participation were consistently emphasized. This has driven the recent addition of prophylaxis services in select schools to motivate parents through the offering of more familiar services. Currently, participation in VDH school-based preventive services is voluntary for schools. Therefore, it will continue to be the mission of VDH staff to educate schools and communities about the prevention resources VDH offers and the opportunities provided in school settings. VDH continually faces the challenge of clarifying for education decision makers the differences between VDH school-based programs and other options available to schools, which often focus only on insured children.

Although BSB specific care sites have been reduced over the years, this is consistent with VDH goals of integrating care into non-dental settings and expanding the contribution of allied healthcare personnel. Specifically, VDH will continue to train private providers and VDH nurses in preventive dentistry, assessment, and fluoride varnish applications. Experienced remote supervision dental hygienists are now being utilized in the field to provide local training to medical personnel with the goal of increasing the use of fluoride varnish while reducing community dependence on VDH dental staff.

The VDH Dental Transition Plan noted that stakeholders, with VDH support, promoted the value of extending remote supervision to other providers serving underserved and challenged populations, such as hospitals and nursing homes, charitable safety net facilities, and community health centers. During the 2016 General Assembly session, SB 712 was passed to revise § 54.1-2722 of the Code of Virginia “License; application; qualifications; practice of dental hygiene”. The new legislation provided, in subsection “F”, a protocol for remote supervision practice for hygienists not employed by VDH. The passage of this legislation was a natural evolution from VDH’s success in the Commonwealth with remote supervision as reported to the Board of Dentistry. This legislation, which was signed into law subject to the development of regulations to be finalized in September 2016, was intended to further expand access to care, particularly in public and charitable settings, as well as long term care facilities. When it was determined the language in SB712 created some barriers to functional implementation of programs, the legislative language was amended in the 2017 General Assembly Session. HB1474 modified the Code of Virginia, effective July 1<sup>st</sup> 2017, and in 2018 regulations were adopted by the Department of Health Professions to clarify the education requirements for the new remote supervision model. Although the legal requirements for practice have been refined over time, there still appears to be some implementation challenges in the care community. Utilizing a Health Resources Services Administration workforce grant renewed in 2018, VDH is working with the Office of Information Management to develop an operational teledentistry model for use in the field. This will ideally lead to replication by safety net entities if remote treatment efficacy and cost effectiveness can be demonstrated. This is intended to facilitate expanded adoption of the remote supervision protocols by other dental safety net providers to expand access in challenged areas.

VDH shares with all Virginia oral health stakeholders the desire to most efficiently optimize access to prevention services in order to address dental challenges over the long term. To assure effectiveness, VDH will continue to assess population oral health status and available community services in a newly evolving provider environment to assure that programs assist those without alternative resources. VDH strategies will include utilizing remote supervision hygienists to bring preventive services to targeted schools and communities, developing and expanding child and infant interventions with a focus on fluoride varnish, and increasing establishment of dental homes for all ages in local communities. By identifying oral health needs in communities, developing programs, and informing partners, VDH will continue to pursue the goal of leading the oral healthcare community in serving the Commonwealth across all demographics in the achievement of optimum oral health.

## **Appendix A: Code of Virginia effective July 1, 2017**

Code of Virginia Title 54.1. Professions and Occupations Chapter 27. Dentistry

### **§ 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. 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. For the purposes of this subsection, "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 conducted 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.

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.

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.

F. For the purposes of this subsection, remote supervision means that a supervising dentist is accessible and available for communication and consultation with a dental hygienist during the delivery of dental hygiene services, but such dentist may not have conducted 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.

Notwithstanding any other provision of law, a dental hygienist may practice dental hygiene under the remote supervision of a dentist who holds an active license by the Board and who has a dental practice physically located in the Commonwealth. No dental hygienist shall practice under remote supervision unless he has (i) completed a continuing education course designed to develop the competencies needed to provide care under remote supervision offered by an accredited dental education program or from a continuing education provider approved by the Board and (ii) at least two years of clinical experience, consisting of at least 2,500 hours of clinical experience. A dental hygienist practicing under remote supervision shall have professional liability insurance with policy limits acceptable to the supervising dentist. A dental hygienist shall only practice under remote supervision at a federally qualified health center; charitable safety net facility; free clinic; long-term care facility; elementary or secondary school; Head Start program; or women, infants, and children (WIC) program.

A dental hygienist practicing under remote supervision may (a) obtain a patient's treatment history and consent, (b) perform an oral assessment, (c) perform scaling and polishing, (d) perform all educational and preventative services, (e) take X-rays as ordered by the supervising dentist or consistent with a standing order, (f) maintain appropriate documentation in the patient's chart, (g) 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 pursuant to

subsection V of § 54.1-3408, and (h) perform any other service ordered by the supervising dentist or required by statute or Board regulation. No dental hygienist practicing under remote supervision shall administer local anesthetic or nitrous oxide.

Prior to providing a patient dental hygiene services, a dental hygienist practicing under remote supervision shall obtain (1) the patient's or the patient's legal representative's signature on a statement disclosing that the delivery of dental hygiene services under remote supervision is not a substitute for the need for regular dental examinations by a dentist and (2) verbal confirmation from the patient that he does not have a dentist of record whom he is seeing regularly.

After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision may provide further dental hygiene services following a written practice protocol developed and provided by the supervising dentist. Such written practice protocol shall consider, at a minimum, the medical complexity of the patient and the presenting signs and symptoms of oral disease.

A dental hygienist practicing under remote supervision shall inform the supervising dentist of all findings for a patient. A dental hygienist practicing under remote supervision may continue to treat a patient for 90 days. After such 90-day period, the supervising dentist, absent emergent circumstances, shall either conduct an examination of the patient or refer the patient to another dentist to conduct an examination. The supervising dentist shall develop a diagnosis and treatment plan for the patient, and either the supervising dentist or the dental hygienist shall provide the treatment plan to the patient. The supervising dentist shall review a patient's records at least once every 10 months.

Nothing in this subsection shall prevent a dental hygienist from practicing dental hygiene under general supervision whether as an employee or as a volunteer.

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; 2016, c. 497; 2017, c. 410.

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

**Title of document: Protocol adopted by Virginia Department of Health (VDH) for Dental Hygienists to Practice in an Expanded Capacity under Remote Supervision by Public Health Dentists**

**Reference to 18VAC60-20-220: Regulations Governing Dental Practice – Dental Hygienists**

**Filed by: Virginia Board of Dentistry**

**Date filed: September 7, 2012**

**Document available from:**

**Board of Dentistry**

**9960 Mayland Drive, Suite 300**

**Henrico, VA 23233**

### **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 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, Association of State and Territorial Dental Directors, as well as VDH OSHA, Hazard Communication and Blood Borne Pathogen Control Plan.
  - VDH monitoring during remote supervision activities by the public health dentist 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.

- 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)
- 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 he/she should take his/her 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 VDH in a full or part time position and have a minimum of two years of dental hygiene practice experience.
- 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.