2019 Report to the General Assembly

Services Provided by Virginia Department of Health Dental Hygienists Pursuant to a "Remote Supervision" Protocol

VDH VIRGINIA DEPARTMENT OF HEALTH
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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 3rd Grade Basic Screening Survey (BSS) and documents the services provided in FY19 by the dental hygienists and dental assistants employed by VDH under the remote supervision protocol.

In FY19, 8,380 children returned a permission form and were screened by a dental hygienist in a school-based setting; 2,274 received sealants, and 7,179 fluoride varnish applications were provided in initial and follow-up visits. A total of 1,774 children were identified as having other oral health needs and referred to community providers. Additionally, over 6,000 dental prophylaxes (cleanings) were provided. In clinic settings, through the VDH "Bright Smiles for Babies" (BSB) Program, 2,988 infants and children were screened, and 2,728 fluoride varnish applications were provided. In FY19, the combined remote supervision hygienist workforce provided clinical services with a market value of $2.6 million in 14 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 disparities continue to be predictors of tooth decay, and geographic considerations affect 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 VDH remote supervision protocol.

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 facilitated development of the "remote supervision" model of care for dental hygienists. 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 additional preventive services for the individuals in these communities under existing practice protocols, including screenings, education, and referrals.

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. Effective 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 presents 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.

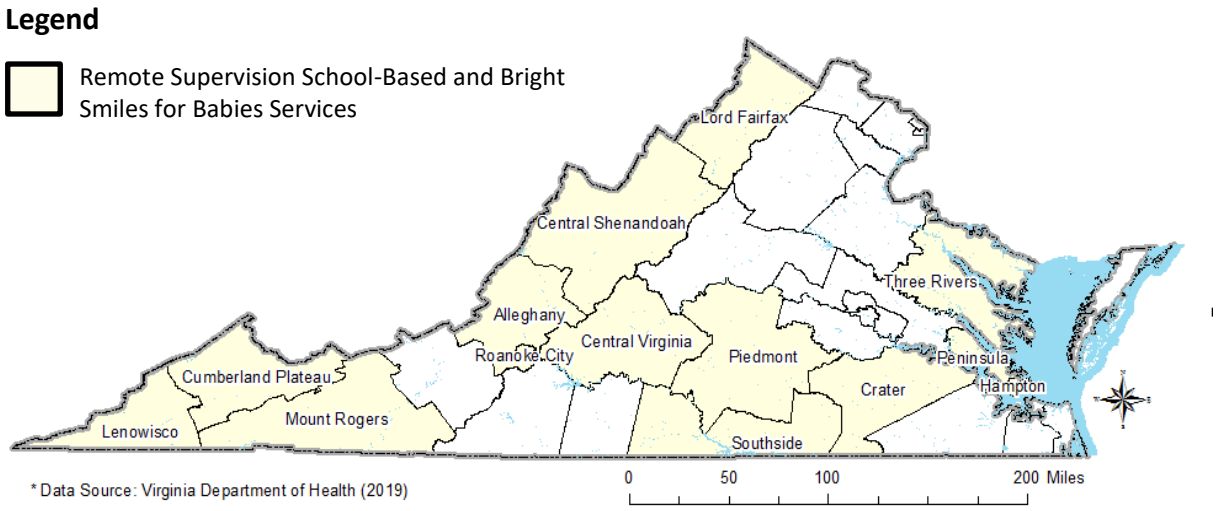
In August 2015, the recruitment and selection process for expansion of the VDH remote supervision programs, as proposed in the VDH Dental Transition Plan, was completed. In the 2015-2016 school-year, four additional full-time community-based dental hygienists and part-time dental assistants began providing services. In FY19, 10 remotely supervised hygienists were providing services in 14 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 functions.

Legislation passed in the 2019 General Assembly Session (Appendix A) provided an opportunity for VDH to update the language of the existing 2012 protocol. The revised protocol, approved by the Board of Dentistry on 6/21/2019 (Appendix B), did not create any substantive changes to the protocol but simply updated regulatory language, revised references to the VDH organization and clarified some terms.

Having now reached the ten-year anniversary of the initial remote supervision protocol approval, it is interesting to note the prescience of this decision. Over the past decade, there has been a growing awareness of the social determinants of health in communities. The remote supervision model that brings preventive oral health services to children beyond dental clinics, to some degree, addresses the challenges of low- income households, limited transportation options, and unequal access to health insurance. These are all recognized community factors that determine

access to oral health care.[1] The availability of school-based healthcare centers and services has grown dramatically over this period as well. Increasingly, oral health services are being combined with school-based primary care, as efforts to address health inequities are becoming more comprehensive in scope.[2] All of these initiatives, including the VDH school-based oral health preventive program, have responded to the current public health science confirming children's oral health status is strongly linked to their academic outcomes.[3]

Figure 1: Map of VDH Preventive Dental Services in Virginia



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[4], 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,

[1] Chazin S and Glover J. A Community Framework for Addressing Social Determinants of Oral Health for Low-Income Populations. Technical Assistance Brief. *Center for Healthcare Strategies, Inc*. Jan. 2017.
[2] Love H, Schlitt J, Soleimanpour S, Panchal N and Behr C. Twenty Years of School Based Health Care Growth and Expansion. *Health Affairs,* May 2019*:* 755-764.
[3]Hereno C, Lyu L, Wehby G. Children's Oral Health and Academic Performance: Evidence of a Persisting relationship Over the Last Decade in the United States. *The Journal of Pediatrics*, June 2019, vol. 209:183-189.
[4] Gift H, Reisine S, Larach D. The social impact of dental problems and visits. *Am J Public Health*. 1992; 82(12):1663–1668.

according to data from the National Health and Nutrition Examination Survey (NHANES)[5]. For children aged 6-9 years, the prevalence of dental caries was 57.7%, and for adolescents 13-15 years, the prevalence of caries experience was 53.4%.

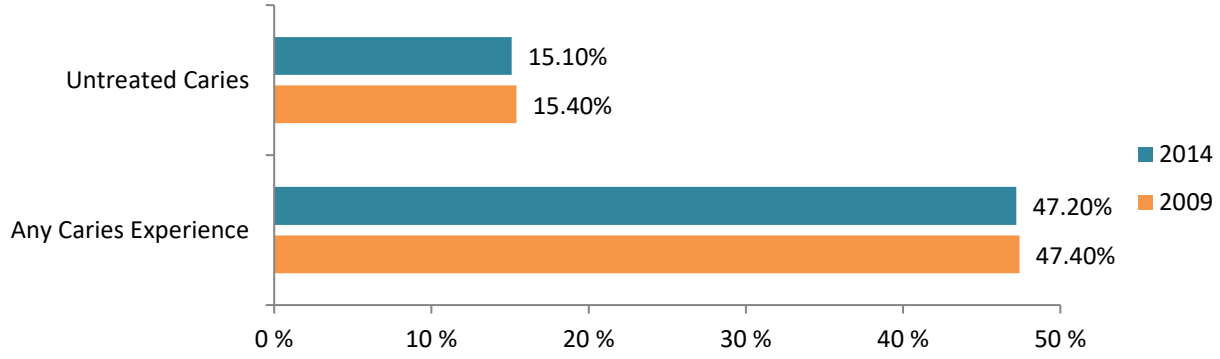
Healthy People 2020 (an initiative of the U.S. Department of Health and Human Services) includes two objectives related to dental caries experience and untreated decay in children that VDH is currently able to monitor at the population level with available data systems:

- OH-1.2: Reduce the proportion of children aged 6 to 9 years with dental caries experience in their primary and permanent teeth.
- OH-2.2: Reduce the proportion of children aged 6 to 9 years with untreated decay in their primary and permanent teeth.

Virginia monitors these indicators through the Virginia 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 3rd 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 3rd graders in Virginia. Following the frequency recommended by the ASTDD, the next Virginia BSS will be conducted in January 2020. The impact of the 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 3rd Graders, Basic Screening Survey, Virginia 2009, 2014



The prevalence of caries varies by region, ethnicity and race. In 2014, Southwest Virginia had the highest rates of untreated caries. Black, Non-Hispanic children also had the highest rates of untreated caries. Unlike any other racial group, there was a large decline in untreated caries among Hispanic children. 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.

[5] US Department of Health and Human Services. Oral health. *Healthy people 2020*. Available at: http://www.healthypeople.gov/2020/. Accessed August 30, 2013.

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

	Untreated Caries (%)		Any Caries Experience (%)	
Region	**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
Race				
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 3rd 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 3rd 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 3rd graders will begin in 2019.

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 most commonly 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. Additionally, the American Dental Association (ADA) has recently confirmed the therapeutic benefit of sealants and fluoride varnish placed on non-cavitated lesions, to arrest and reverse the destruction of enamel by dental caries.[6] 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%.[7] 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 and can effectively reduce the cost of delivering the service. 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.[8]

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 in the 2011-2012 survey period.[9] 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%)[10]. 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.

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[6] Evidence-based clinical practice guideline on nonrestorative treatments for carious lesions- A report from the American Dental Association. JADA 2018:149(10) 837-844.

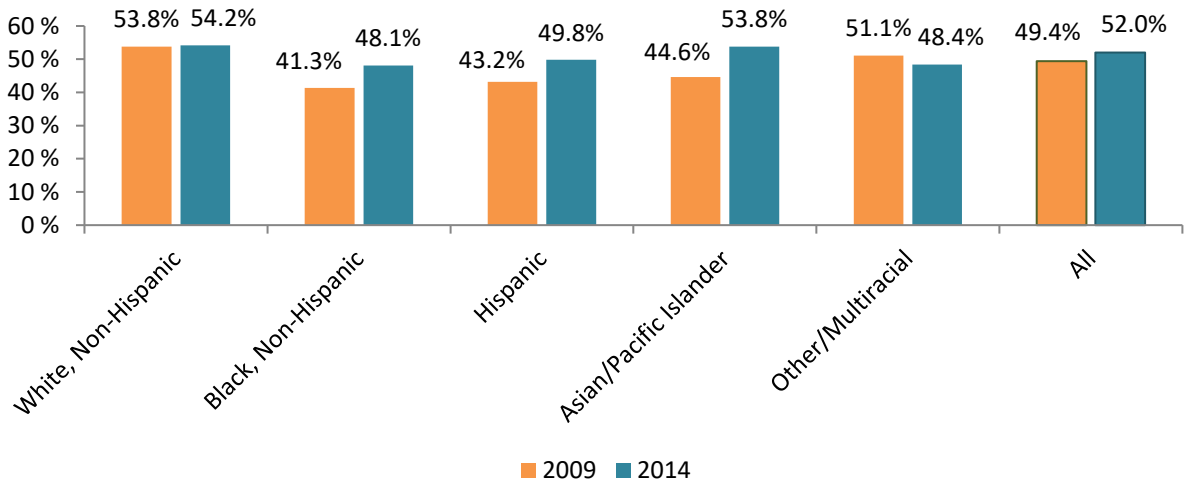
[7] Centers for Disease Control and Prevention. Promoting Oral health: Interventions for Preventing Dental Caries, Oral and Pharyngeal Cancers, and Sports-Related Craniofacial Injuries—A Report on Recommendations of the Task Force on Community Preventive Services. MMWR Recommendations and Reports 2001;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

[8] 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.

[9] 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.

[10] 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, 3rd Graders, Basic Screening Survey, Virginia 2009, 2014



Topical Fluorides and Varnishes

Topical fluorides (gels, varnishes, pastes, and mouth rinse) are 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.[11] Fluoride varnishes are a topical fluoride delivery vehicle that instantly "stick" to tooth surfaces where applied, which 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.[12] 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.

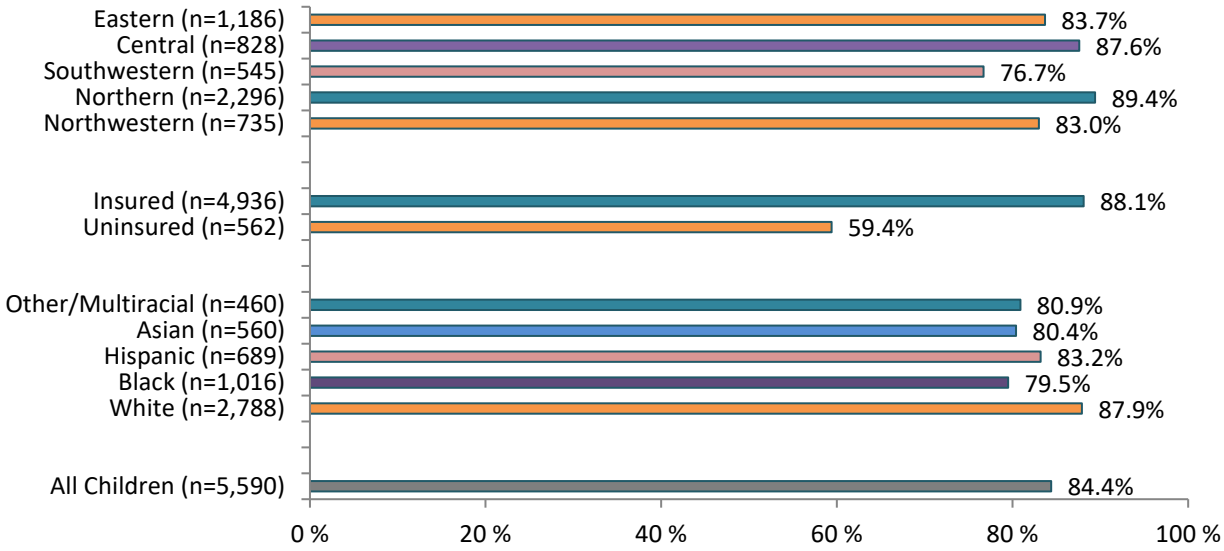
A summary of dental visit status in the past year is provided in Figure 4. The most notable population characteristic associated with whether a child had a dental visit in the past year was dental insurance status. In 2014, 88% of insured children reported a visit in the past year versus

[11] 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

[12]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

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 3rd grade BSS, that nearly 80% of visits were for preventive services.

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



Program Production and Impact on Oral Health

School-based Preventive Services

VDH RSDHs provide preventive care visits in a school-based setting to deliver dental assessment, sealants, fluoride varnish applications, oral health education and, in most health districts as of FY19, prophylaxis (cleanings). Children in qualified schools who do not have a dental home are referred to dental providers. VDH makes an effort to focus services specifically on those children without a regular source of dental care. 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. In spring 2019, utilizing Preventive Health and Health Services Block Grant funds, VDH purchased dental intraoral cameras and supporting tablets for hygienists working in the field. With some basic training and support, several of the hygienists have already incorporated the vivid clinical images captured to motivate children and educate school nurses. For the FY20 school year, it is expected that image use will be expanded. Ideally, intraoral

photographs can be employed to inform parents of children's needs, with the goal of better compliance with follow-up care recommendations. Developing a comfort level with onsite tablet use will smooth the transition for VDH staff from paper forms to real time electronic data entry planned in the future.

In FY19, 8,380 school children returned a permission form and were assessed by a dental hygienist in a school-based setting. A total of 2,274 children received 6,684 sealants, and 7,179 fluoride varnish applications were provided. Over 6,000 prophylaxes were provided to children whose parents elected this relatively new VDH service for their child. Providing a prophylaxis is not only a significant expansion of the services available in schools, but also represents a very significant time commitment per child from the hygienists. This service is provided in addition to those listed in Table 2, which was designed to reflect original data indicators required to be reported to the CDC.

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 or from a different dental experience. 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 during each school year, regardless of sealant status, continue to receive updated assessments, oral care education, fluoride varnish applications and prophylaxis. VDH, having operated in schools for 10 years, is now routinely providing regular preventive services to a large cohort of returning students needing access through VDH. Consequently, 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 who were 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, the number of participating children has trended upwards. In FY19, 1,774 children were also identified as having other oral health needs and were referred to community providers to establish dental homes.

In any given year, there are generally periods of position vacancies, which can impact clinic production. A combined total of six months of family leave was granted to hygienists in FY19, and several assistant positions were vacated and had to be filled. However, the remote supervision staff are also very involved in expanding the program's reach, participation, and scope in communities and improving efficiency in delivery of services. Hygienists and assistants continue these activities in their community even during times when clinical teams are not whole. VDH experienced fewer hygienist absences in FY19 than in FY18, and yet more children were assessed in FY19 than in any previous year to date.

Across all dental preventive program venues, VDH provided clinical services in FY19 to a child population that was 57% insured with Medicaid and 43% uninsured. VDH identifies schools as

eligible by NSLP 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 3rd 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 ongoing 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 and FY19 with the same goals of increasing school program acceptance and child participation. With the exception of Lord Fairfax, prophylaxis services were provided in all health districts. Initial reports confirm that this was a very popular modification to the program.

Having provided thousands of fluoride varnish treatments in schools as well as clinical settings, it is possible that VDH programs contributed to the slight reduction in 3rd grader caries experience from 2009 to 2014 as noted in Figure 2. Oral health surveillance data collection during school-based encounters has continued through FY19 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 – FY19

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
FY19	14	37	8380	1774	2274	6684	2.9	7179

** 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, number 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 or 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. The sealant retention data sample for FY19 was extracted from the evaluation of 6,948 sealants.

In FY19, the aggregate retention rate calculated statewide for all sealants evaluated during "follow-up" visits was 96%. 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. With one exception, the observed one-year retention rates for individual providers reviewed in FY19 were all within the desired 90-100% range. The exception was an 83% retention rate recorded for a cohort of patients with sealants in place for greater than two years, which was included in the evaluation visit due to scheduling constraints, which resulted from staff being on extended leave. These rates are consistent with, or exceed, other state programs with a long history of success, including the long-running Ohio School-Based Dental Sealant Program, and the National Maternal and Oral Health Resource

Center's stated expectation that one year retention rates of properly applied dental sealants should average between 80-90%.[13]

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 FY19, the cost per sealant application for VDH remote supervision programs was calculated through modeling to be fairly consistent with FY18 costs at $23.32 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 school children's participation, cost calculations will likely continue to evolve over time with more and better data collection becoming available. Current calculations have been enhanced for accuracy over the past few years with newly available tracking of costs associated with travel time, vehicle expenses and input from the CDC. Actual travel expenses were lower than previously modeled projections and resulted in the lower calculated cost per sealant in FY18 and FY19 than prior years. According to the 2018 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 $57.22.[14] "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. The CDC emphasizes there are societal savings from "caries averted" (cavities avoided). These include the savings realized by avoiding expensive dental restorative work over a lifetime and a reduction in parent productivity loss when school programs reduce appointment obligations for children.[15]

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 to children with special health care needs. Although services as described in this report are categorized primarily by age of recipients as "School-based" or "Bright Smiles for Babies" programs, in most cases the same area VDH hygienists are now providing services in both settings.

[13] Carter NL, Lowe EA, with the American Association for Community Dental Programs and the National Maternal and Child Oral Health Resource Center. 2016. *Seal America: The Prevention Invention* (3rd ed.). Washington, DC: National Maternal and Child Oral Health Resource Center.

[14] American Dental Association (ADA) Health Policy Institute. 2018 Survey of Dental Fees.

[15] Guide to Community Preventive Services. Improving oral health: dental caries.www.thecommunityguide.org/oral/caries.html (caries.html). Last updated May18, 2016.

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 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 3rd grade children in 2014, an uninsured 3rd 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 Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The data collected from these surveillance activities supports planning and assessment not just for VDH, but also 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. In FY19, hygienists screened over 700 people through BSS programs for individuals with special healthcare needs and pregnant women in 20 sites across the state.

An added benefit of engaging WIC-enrolled pregnant women, if insured under the new Medicaid/FAMIS expansion program 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 60th 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 individuals 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 Commonwealth to provide 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 private medical providers to integrate the BSB protocol into their practices. Through this fiscal year, the Dental Health Program's 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 level of BSB clinic services reported for FY19 declined. The magnitude of the reduction was an anticipated outcome of staffing changes, 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 supplanted by VDH hygienists providing a wider variety of remote supervision protocol services in communities and by medical partner providers. In FY19, a part-time BSB-focused position in Crater Health District was vacated, and the workload was distributed to an existing hygiene position that had extensive school-based commitments. Additionally, the full impact of converting a previous BSB-focused position in Rappahannock Health District to a more comprehensive school-based program in Three Rivers Health District was realized this fiscal year. In FY19, hygienists providing clinical services through the BSB Program as a component of their clinical responsibilities screened 2,988 infants and children, provided 2,728 fluoride varnish applications, and referred 1,562 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 - FY19

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
FY18	13	4861	4420	1885
FY19	14	2988	2728	1562

Note: The program was initiated very late in FY10 with few participating schools. FY10 and FY11 data were combined due to the late start.

Combined Preventive Services Impact

In FY19, the remote supervision hygienist workforce provided clinical services with a current market value of $2.6 million.[16] This is consistent with the production average over the past five years of $2.4 million annually. Service value calculations, as determined by Current Dental Terminology Codes from the ADA, 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. Assigned dollar values for services from the ADA survey are adjusted every two years.

[16] American Dental Association (ADA) Health Policy Institute. 2018 Survey of Dental Fees.

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 18,007 individuals in FY19.

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. 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 2018, VDH conducted a school staff satisfaction survey in client schools with 85 principals and school nurses participating. All (100%) school nurses and principals agreed that 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 continuous expansion of prophylaxis services in schools to motivate parents through the offering of more familiar services. In FY20, all remote supervision hygienists will offer prophylaxis as an option in at least some of their participating schools.

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. In FY19, 132 medical health personnel, including 17 physicians, were trained by VDH staff to apply fluoride varnish in non-dental settings.

Over the past several General Assembly sessions, Code of Virginia language has been revised in support of other oral health safety-net stakeholders utilizing remote supervision to improve effectiveness and efficiency in the delivery of services. Although the legal requirements for practice have been refined over time, there still appear to be some implementation challenges in the care community due to the cumbersome dental oversight requirements. Utilizing a HRSA workforce grant, VDH has worked to develop a theoretical teledentistry model which may potentially resolve some of the issues. However, technology and physical constraints within VDH have challenged operational implementation in clinic sites. Partnerships are now being developed to support teledentistry use in an alternative setting utilizing VDH's resources and experience to date, with the same original goal of demonstrating that technology may be able to facilitate practice within the existing remote supervision protocols.

Although the 2019 legislative amendments to the Code of Virginia did not result in substantive changes for VDH, they did create a new remote supervision protocol development opportunity for the Department of Behavioral Health and Developmental Services (DBHDS) based on the VDH model. VDH collaborated with DBHDS in the successful development of their protocol by sharing institutional knowledge and over ten years of experience gained from existing program operation. This additional expansion of remote supervision, which should improve access for a particularly challenged population, again validates the General Assembly's support of an innovative "pilot" program for VDH in 2009 that continues to benefit so many residents of Virginia in ways that are still evolving in 2019.

Going forward, VDH, in collaboration with its many oral health partners, will continue work to increase access to care for those facing barriers, promote the importance of good oral health for everyone in all stages of life and innovate when possible to solve challenges. A remotely supervised workforce continues to be a critical resource in accomplishing these goals in the most cost effective manner. The remote supervision historical perspective and experience that can be shared is clearly valued in the expanding environment of dental safety net providers working to create improved access models. This enables VDH to contribute to the community far beyond its capacity to provide preventive services directly. Additionally, by continuing to identify oral health needs in vulnerable populations through hygienist-supported statewide surveillance and keeping partners informed of oral health status in Virginia, VDH will continue to lead the oral healthcare community towards the goal of optimal oral health for all in the Commonwealth.

Appendix A: Code of Virginia effective July 1, 2019

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

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

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 or the Department of Behavioral Health and Developmental Services 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 or the Department of Behavioral Health and Developmental Services. A dental hygienist providing such services shall practice pursuant to protocols developed jointly by the Department of Health and the Department of Behavioral Health and Developmental Services for each agency, in consultation with the Virginia Dental Association and the Virginia Dental Hygienists' Association. Such protocols shall be adopted by the Board as regulations.

A report of services provided by dental hygienists employed by the Virginia Department of Health pursuant to such protocol, including their impact upon the oral health of the citizens of the Commonwealth, shall be prepared and submitted annually to the Secretary of Health and Human Resources by the Department of Health, and a report of services provided by dental hygienists employed by the Department of Behavioral Health and Developmental Services shall be prepared and submitted annually to the Secretary of Health and Human Resources by the Department of Behavioral Health and Developmental Services. 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; mobile dentistry program for adults with developmental disabilities operated by the Department of Behavioral Health and Developmental Services' Office of Integrated Health; 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, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, and any other Schedule VI topical drug approved by the Board of Dentistry 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; 2019, cc. 86, 431.

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

Unpublished (as of 8/1/2019) Protocol Revisions approved by Board of Dentistry 6/21/2019

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, Revised XX, 2019

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 *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, 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, *video*, *email*, 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~~ *shall* be advised that services provided under the remote supervision protocol do not replace a complete dental examination and that he/she ~~should~~ *shall* 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 *Health* Program guidelines and applying sealants as indicated.
- Providing dental sealant, assessment, maintenance and repair.
- ~~Application of topical fluorides.~~ Administration of Schedule VI topical drugs.
- 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.