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## ADHA's Response to ADA Study: *The Economic Impact of Unsupervised Dental Hygiene Practice and its Impact on Access to Care in the State of Colorado*

We read with interest the study of *The Economic Impact of Unsupervised Dental Hygiene Practice and its Impact on Access to Care in the State of Colorado*. It is clear many resources in both time and money were spent on the report. As ADHA has mentioned publicly and at ADA's council meetings in the past, we've extended an offer to work with the ADA on this project and were disappointed that we were not contacted for input or involvement. A dental hygiene practice study without the perspective from the profession itself raises questions about the study's depth and breadth, as well as the efficacy of its overall findings.

The primary goal of ADHA and its state constituents is to increase the public's access to the preventive and therapeutic services provided by dental hygienists. Several models exist that may accomplish this goal. Independent dental hygiene practice is just one example. As ADHA has also stated, independent dental hygiene practice is a modest part of a greater solution to a much larger and more complicated access to oral health care crisis.

To provide a historical perspective, the *Sunset Review* report published by the Colorado Department of Regulatory Affairs in July 1985 stated that not only is the unsupervised practice of dental hygienists safe for consumers, but it also provides the public with the option to visit with a dental hygienist exclusively for preventive oral care and recognizes that dental hygienists are educated to refer patients to a qualified dentist as needed. Additionally, the report reinforces that unsupervised practice should be all-inclusive in all settings, as otherwise this would violate the equal protection clause in both the U.S. and Colorado constitutions stating that similarly situated people must be treated equally.

As dental hygiene practice settings increase along with changes to supervision requirements, underserved populations may now benefit from services provided by dental hygienists. A limited number of dental hygienists may have begun to practice independently and many of them choose not to publicly identify themselves as independent practitioners due to the negative political pressure by influential segments of organized dentistry. In addition, independent dental hygiene practitioners often face basic entrepreneurial challenges similar to new dentists related to starting a new practice.

Representing the dental hygiene profession and our members, we feel it is important to point out inaccuracies within the document.

First, the study repeatedly confuses "independent practice" with "unsupervised practice." These terms are not synonymous. In fact, on page 6 of the study it states "If a dentist was not available and a separate visit would have to be scheduled, then that practice was determined to be unsupervised." That definition describes **general supervision**, which is legal in over 40 states. The separation of the dental hygiene appointment from the dentist appointment occurs in countless dental offices across this country every day in those states where general supervision is legally authorized. Therefore, the economic theory of combining services does not hold true under a general supervision model. It also is interesting to note that the conceptual framework for unsupervised practice (described on page 2) was not used in the collection of data from dental hygienists as described on page 6.

Second, Colorado is not the only state to allow dental hygienists to practice unsupervised. The citation on page 2 of the study identifies the Colorado State Dental Practice Act as the source for this information. The Colorado State Dental Practice Act does not identify Colorado as the only state to allow dental hygienists to practice unsupervised. ADHA recognizes 19 states having "varying forms of unsupervised practice or less restrictive supervision."

Unfortunately, a significant deficient outcome of the time and money spent on this study is that the data did not provide information on the care the patients received from the Colorado dental hygienists, nor did it include dental hygienists practicing in settings such as community health centers or other public health settings as identified on page 2. These omissions reduce the validity of the study and its conclusions. From ADHA's perspective, patients who have not received preventive oral care at all or regularly who became patients of the independent dental hygienists was a significant contribution to the access issue.

Excluded from the Colorado study findings was the fact that 64 dental hygienists are participating Medicaid providers. In addition, these dental hygienists served over 2,000 children from February 2003 to January 2004. This was more than double the number of children seen from February 2002 to January 2003.

From a research perspective and in addition to the omissions outlined above, there are other serious limitations in the study methods and conclusions. The sample size (n=17) is too small and the

descriptive methods used do not allow the findings to be generalized to the whole of the unsupervised dental hygiene practice community, especially since this was not the sample population surveyed. Even though the authors indicate that the response rate of the study is 71.4%, the 71.4% is of those who could be contacted in one state, which was only a little over half (53%) of the total 2702. A substantial number of dental hygienists (1259) were not included in the study due to unavailable phone numbers (385), incorrect phone numbers and addresses (294) and one was deceased. From the total of 1,443 completed screening interviews an additional 105 hygienists refused to answer the questions and 474 could not be contacted after repeated phone calls. The confusion of general practice, unsupervised practice and independent practice also calls into question the validity of the study.

The impact that the existing states with less restrictive practice acts can be demonstrated by the information below, which details just a sample of how dental hygienists are making headway on providing care to underserved populations. ADHA believes that these numbers reflect the measured effect on access to care, not the measurement of a small subset of supposed "independent" practitioners in one state out of fifty.

In CT: dental hygienists can practice "without supervision" in certain settings, nearly 55,000 procedures were performed during one year's time, including over 7,000 prophylaxis, 5,800 sealants and 15,000 oral exams.

In ME: dental hygienists can practice under "public health supervision" status and with referrals to dentists written in the practice act - nearly 5,500 patients were examined by dental hygienists in over 400 clinics.

In MO: dental hygienists may practice "without supervision" in public health settings—one dental hygienist has seen a sealant program grow from one school district to eight and over 2,500 sealants have been placed on over 700 children.

In NM: dental hygienists practice under "collaborative practice" with consulting dentists—a particular collaborative practice arrangement serves a patient base of 4,000 people—1/3 of which are on Medicaid.

In NV: dental hygienists may work as "public health dental hygienists"—dental hygienists provide services in eighteen different locations in the state—an undeniably rural state—in schools, community health centers and other settings.

In WA: dental hygienists can practice "unsupervised" in hospitals, nursing homes and other settings—data obtained from Medicaid indicates that dental hygienists working under these provisions examined over 17,000 patients in two year's time, including placement of over 19,000 sealants.

We've been further encouraged by recent bill passages in states over the past couple years that have enacted language similar to the states cited above. In fact, organized dentistry and state dental hygiene associations have worked in a bi-partisan fashion on agreed bills that have been signed by state governors in Arizona, Illinois, Oklahoma, Maryland, Montana, Kentucky and others over the past few years.

We all benefit by working in a collaborative partnership with respect to the access issue and we again appeal to the ADA to work with ADHA constructively on issues of mutual interest, such as workforce models, education issues and practice challenges.

**To read ADA's study:** <http://www.ada.org/prof/resources/topics/reports.asp#hygiene>

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