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On behalf of the
Ohio Dental Hygienists' Association
House Health Committee
House Bill 184 amendment opponent testimony
December 12, 2018

Chairman Huffman, Vice Chairman Gavarone, Ranking Member Antonio, and members of the committee I am Matt Whitehead and I am the legislative agent for the Ohio Dental Hygienists' Association. I appreciate the opportunity to testify on behalf of my client and present brief comments on House Bill 184, as it is proposed as an amendment to Senate Bill 259.

My client and I have testified before on this bill in this committee in full opposition to the bill. The bill that left this committee over a year ago has only had 2 hearings in the Senate Health Committee, neither of which included opponent testimony. There were no amendments offered to the committee.

As the bill stands today, the sponsor has provided two amendments that in one instance punts authority to the Dental Board to decide what "informed consent" looks like relating to silver diamine fluoride (SDF) and interim therapeutic restorations (ITRs). Ironically, with the General Assembly working to pass SB 255 it is taking on power from the Executive by heavily reviewing boards/departments, so it is interesting that the House would yield power away in this instance. We suggested to the sponsor that an Illinois model of informed consent be used, and we advocated that this be achieved in statute, instead of leaving it to a small group of decision makers. An example is provided to you of their policy. Additionally, the amendment on the application of silver diamine (SDF) does improve the situation from the current bill by requiring a prior dental exam, but it is counter to what the State Dental Board is contemplating currently, which is application of SDF by only a DDS and a hygienist, similar to Illinois. The bill still contemplates EFDAs applying SDF. The amendment does close loopholes in application that we did point out.

Our major concern is that the bill still allows an expanded function dental auxiliary (EFDA), who is unlicensed and not degreed to practice in the mouth of a patient in a teledentistry setting. As I indicated in previous statements no other state, except California, can an

auxiliary practice in the mouth and in California it is under the supervision of a hygienist and can be in an independent setting of the dentist. Washington allows EFDAs, but they are licensed, and they also have limited use of dental therapists. Ohio would have the most dramatic use of teledentistry in the nation.

We still maintain that if the EFDA, except one that is also a hygienist, should not be allowed to work in a teledentistry setting. The EFDA scope of practice and training is specifically geared to assist dentists in providing restorative procedures for patients. The approximately 6-month programs are clinical in nature and focused on supporting the dentist following their preparation of the tooth for restoration. As defined by Ohio law, the EFDA curriculum does not focus on preventive dental therapies. Evaluating a patient's medical history and medical emergencies is not a part of the EFDA training. The curriculum is completed part-time for about 200 hours, typically one day a week, in comparison to the over 2500 hours of full-time dental hygiene education, these dental auxiliaries, if allowed to practice without supervision they would be offering a lower standard of dental care to Ohio patients.

Under House Bill 184, EFDAs are proposed to get an expansion in their scope of practice, but also receive a relaxation of supervision. House Bill 184 seeks to allow EFDAs to perform new duties in the office under general supervision (without a dentist present in the office) and to place sealants in programs like the school-based sealant program operated by the Ohio Department of Health without a prior examination of a dentist for disease diagnosis or an RDH trained to recognize suspicious areas of potential disease. EFDA curriculum envisions a system of <u>direct dentist supervision</u> for dental sealants and certainly not to perform the duties outlined in the bill prior to a dentists' examination. EFDAs also are not trained to evaluate a patient's health history. In this bill, the dentist would not have to evaluate a medical history within the past year in certain circumstances. EFDAs are simply not trained to practice without supervision as the bill proposes.

As we state above the EFDA curriculum does not support many of the duties that are sought in the bill. However, ODHA compromised in 2014 to a list of the duties that we believe make sense for an EFDA to perform and to which we agreed to allow with the guardrail that a trained, degreed, and licensed accountable practitioner like a dentist or hygienist be physically present at the location where the services are being provided. The guardrail did not get added in 2014 and now House Bill 184 is further seeking to allow an EFDA to work with reduced experience requirements and without a patient's dental exam. The only way we can agree to this change is if this auxiliary also holds an RDH license.

The essential point is that an individual with a degree in dental hygiene and licensed by the state is an individual that has the education it takes to care for a patient in need of cleanings or preventative services. Hygienists have the knowledge to educate the patient.

Hygienists know the disease process and know what to look for on x-rays and in the mouth for oral cancer, tooth decay, bone loss, and other abnormalities that require attention. Hygienists know how to avoid and what to do in emergency situations.

In the two states that enacted teledentistry bills in 2016 (Missouri and Tennessee), neither state used any auxiliary to perform these duties except for licensed hygienists. EFDAs appropriately work in the office providing services for which they are trained, mainly filling cavities. Presumably, a dentist would want to see x-rays and view the mouth through the intraoral camera to initially determine the course of treatment. EFDAs are only qualified to take x-rays if they maintain a dental x-ray machine operator certificate. RDHs have radiography as a standard practice in their license and performing this function will ensure that proper care is provided. Additionally, in the definition of "interim therapeutic restoration" they would be authorized to remove debris from a tooth, again an expansion of their scope of practice. Because of their education and training an EFDAs potential to treat patients is limited; Ohio should follow Missouri and Tennessee and limit teledentistry services to only RDHs.

Not mentioned in the House process, the bill contains an insurance mandate requiring the same amount of insurance coverage in the teledentistry setting as in an office. The Chamber of Commerce and NFIB determine this to be an insurance mandate. In conferring with the sponsor of SB 259 he was unaware of the mandate in HB 184 that would be placed in his bill and he was especially concerned.

The process on this bill is being scuttled. ODHA has not been afforded the opportunity to provide opponent testimony on this bill in the Senate Health Committee. At that time, we would have shared the information that Senator Manning challenged us to provide, including which states allow EFDA to practice in teledentistry? Which states allow SDF application? Please see the chart prepared on who can practice ITRs, use SDF, or practice in teledentistry in each of the 50 states.

By allowing this amendment to be added to SB 259, you would also be complicit in allowing a practitioner without the proper education and training to be on the other side of a camera and deal with emergencies. Furthermore, an EFDA does not currently and will not be required under this bill to have professional liability coverage. A disservice to the patient would occur because an EFDA would not be able to provide the full, comprehensive oral health treatment that a dental hygienist can provide.

Teledentistry, as envisioned by the proponents, is designed to perform two specific procedures to address dental decay in a patient: perform an interim therapeutic restoration and apply SDF. What is truly needed in these communities for these patients are full oral health care services, including prophylaxis (cleanings). This procedure can be accomplished remotely using this technology, but can be performed only by a dental

hygienist. EFDAs do not have the educational background to perform this function. A dental hygienist is able to accomplish all of the desired duties proposed by the proponents of the bill. Other states that have passed laws implementing teledentistry have limited the practice to only licensed personnel, dentists and hygienists. This bill is a disservice to underserved dental patients and needs further work.

We are requesting that the amendment effort be abandoned so that these issues may be worked out in the next session. Our client has provided to the sponsor a pathway to support; we hope that we are given that opportunity.