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Ohio Dental Hygienists' Association
House Health Committee
House Bill 184 Opponent Testimony
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Chairman Huffman, Vice Chairman Gavarone, Ranking Member Antonio, and members of the committee my name is Nichole Oocumma and I am a Past President of the Ohio Dental Hygienists' Association. I appreciate the opportunity to testify on behalf of my colleagues and to share some perspective on teledentistry and related provisions in House Bill 184.

Allow me to begin with the portions of the bill with which ODHA has no issue. These sections include those addressing:

- insurance coverage parity requirements, including Medicaid;
- Choose Ohio First Scholarships;
- Dental Loan Repayment Program changes (although the budget will address this before passage of this bill);
- Changes to dental exams and anesthesia permits for dentists;
- Teledentistry permits for dentists.

However, my Association has a few serious concerns with this bill.
If I may, I will drill down to examine our issues with the bill. A question was asked about dental hygienists' level of education. Registered Dental Hygienists (RDHs) are the only degreed dental professionals aside from the dentist in the dental office. There are 12 community colleges or universities with dental hygiene programs in Ohio, the Commission on Dental Accreditation (CODA), an arm of the American Dental Association, accredits all programs (A list of schools is added to the end of my testimony). Over 8000 dental hygienists are licensed in the state of Ohio, with over 250 new grads becoming licensed each year in Ohio. We agree completely that there is a dentist geographic distribution issue in the state contributing to the access issues we currently find in Ohio and across the nation. Like other states, we believe part of the solution is the deployment of the ready workforce of licensed, degreed dental hygienists in Ohio, not the promotion of less educated auxiliaries.

Hygienists are educated at a national standard, required by CODA, the same body that accredits dental schools, and tested through an examination accepted in Ohio and across the nation. Upon

completion of the degree and granting of a state license, dental hygienists should be able to practice to the highest level of their training. A case in point are the restrictions that continue to be placed on hygienists working in offices and under a dentist with a teledentistry permit in this bill. An RDH must have one year and a minimum of 1,500 hours of experience to work prior to being able to provide care when a dentist is not present (during a dentist's vacation, etc.).

It should be noted that Michigan, just miles from the Vice Chairwoman's district, there is no restriction in its practice act of this type and an Ohio graduate, licensed in Michigan can begin to practice with this reduced restriction upon hire. In Michigan, dentists entrust that their licensed hygienists are ready to serve patients without this similar restriction in the dental office on the day of hire. We believe that reducing the supervision restrictions in Ohio may cause more degreed graduates to be hired in offices as supervising dentists would be able to utilize personnel immediately instead of waiting for a minimum period in the law, especially with the change a few years ago to allow a dentist to supervise 4 RDHs. This change, as always, would be at the discretion of the dentist. We urge discussion of this limitation in context of this bill. We support the duties expansion for RDHs to be allowed when a DDS is not present and prior to a dental examination.

EFDAs

Expanded Function Dental Auxiliaries (EFDAs) are trained 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 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 auxiliary, 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 direct dentist supervision for dental sealants and certainly not to perform the duties outlined in the bill (lines 1567-1575) 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. We have the knowledge to educate the patient. We know the disease process and we 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. We 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. I will also explain during discussion of silver diamine why EFDAs should not be permitted to participate in teledentistry. 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.

Certified Dental Assistants

Of significant concern with the bill is the intention to allow a certified dental assistant to operate with reduced supervision or without a dentist present. In previous proponent testimony, there was no mention of this auxiliary and the need to lower years/hours of experience, relax supervision requirements, and the urgent need to remove a restriction that a dentist examine a patient and get the patient's medical dental history prior to allowing services to be provided in dental offices or in the field.

We ask that you please consider who you are allowing to work in these scenarios. Certified dental assistants in this state can take a few different pathways to this job in Ohio, the most common of which offers no clear standard. Certified dental assistants can be trained in a high school career-technical program and as a high school graduate, if 18 years of age, could then take the Ohio, not national, certification examination. There are also post high school training programs offered through for-profit colleges and community colleges, with only one of which is accredited in Ohio. These training programs are not college level courses even though they are provided at a college campus.

Additionally, a dental assistant can learn on the job in a dental practice "chair side" under a dentist' authority (OAC 4715-11-02) without a set training period determined or defined education curriculum. In all cases they are not required to register with the Dental Board after they obtain a certificate. Unsupervised care provided by an inconsistently and minimally trained auxiliary is not what we should strive for as a standard of dental care in Ohio for those at greatest need affected by our dental access issue. We view this training and standard as inconsistent among practitioners and a disservice to the patient. Consider the passage rate for the Ohio Dental Assistant Exam. In October 2016-199 took the exam with 114 passing, in April 2017-381 took the exam and 228 passed, in May 2017 79 took the exam and only 39 passed. Without a standard of education, degree, license, or registration process with the state **we, therefore, advocate that all references to a CDAs relaxation of supervision be stricken from the bill.**

Teledentistry

ODHA is encouraged by the prospect of teledentistry. California and Arizona began covering teledentistry in 2015. Other states, including West Virginia, Hawaii, Oregon, and Colorado, have considered teledentistry bills; states that with progressive dental hygiene practice acts. Utilizing technology and the hygiene workforce could prove to be very beneficial to the access to care problem. House Bill 184 addresses many of the areas of discussion that we believe would need to be tackled to create the program. These areas include: other state practices/credentialing (should we allow interstate practice?), communication (Dr. /patient, Dr. /RDH, and RDH/patient), scope of practice, and technology (should this be limited to just synchronous, real time communication?).

However, there are a few practical application issues we must raise.

Supervision

A dentist using a teledentistry permit can supervise 3 RDHs and EFDAs at any time. Since the stated goal is to create an extension of a dentist working from a hospital clinic setting or a private dental office in Columbus because there are too few dentists in Appalachia, we question how a dentist can supervise up to 4 RDHs in their office, potentially 3 RDHs working under an OHASP permit and now 3 RDHs and 3 EFDAs in a teledentistry scenario. *We must also point out that under current law a DDS shall not have more than 2 EFDAs practicing under the same dentist.*

Are we trying to expect too much of the dentist involved in these different supervision types? If a dentist used all the authority granted by the state, they could be supervising 15 people at the same time, 6 of which are in synchronous, real time. Are we compromising patient care and not protecting the citizens of Ohio?

Patient/service site reporting

The bill requires the dentist to verify where services are provided by RDHs and EFDAs in order to receive or renew a permit with the State Dental Board (OSDB) (Lines 1496-1499). However, in authority provided to the OSDB (lines 1506-1514), they may ask the authorizing dentist, RDH, or EFDA for the list of locations where services were provided or are expected to be provided. Since there is no requirement for a hygienist or an EFDA to have contact with the OSDB to practice in teledentistry, **we suggest references for this type of reporting be limited to a dentist only**.

OSDB rule making authority

The Board is given authority to promulgate rules related to the dentists' permits, courses for application of silver diamine and rules to specify procedures that RDHs are not permitted to perform. Our ultimate request is to not include EFDAs in teledentistry, but if EFDAs are involved, language should be added to limit their services as well. Additionally, we believe that this specific rule authority is not necessary at all as we believe that this should be an individual decision of the authorizing dentist.

Silver diamine fluoride

There was just brief discussion of silver diamine fluoride (SDF) in proponent testimony that we believe the committee should know more about this topic. We applaud the ODA for bringing forth a dental practice that has been used extensively for decades in Japan, Argentina, and Australia. We support a legislative solution that has also been used for decades with wide success in Australia and many other countries; the dental therapist and dental hygiene therapist could be substantial additions to the dental team and compliment the efforts sought by House Bill 184. We encourage you to review Senate Bill 98 sponsored by Senators Lehner and Thomas.

In 2014, the U.S. Food and Drug Administration (FDA) cleared SDF as a **desensitizing agent**. The SDF is intended to be applied multiple times for greatest efficacy in arresting dental caries. We have seen the data suggesting that reapplication appears to provide additional benefits; after 12 months, the caries arrest rate plummeted without reapplication, but benefits increased with reapplication.

Because of the Ohio Dental Association's past concerns, executed in law, in allowing a hygienist with an Oral Health Access Supervision Permit (OHASP) to limit a patient to only one visit and no subsequent care until a dental exam is performed, we find it refreshing that they advance use of a product that requires multiple applications to be completely useful to the patient and make no pretense to require the patient to be seen again by a dentist prior to further treatment or other services to ensure arrest is occurring.

Research by Jeremy Horst, DDS, pediatric dentist at University of California San Francisco and funded by National Institute of Health, shows a 90% decrease in caries(decay) in 2 years. 1 drop of silver diamine fluoride covers 5-8 teeth. The cost is 52 cents for 1 drop and the CDT insurance Code: D 1354 Carries Arrest.

Use of SDF does have side effects including blackening of the treated lesion, a short-lived bitter metallic taste, and temporary staining of soft tissues. This agent also has been shown to stain clinical surfaces and leave residual stains on treatment trays. As a result, reasonable caution is advised to avoid touching patients' soft tissues, as well as clinical surfaces. In addition, patients should be told to expect the lesion to darken substantially over a week's time. We believe that given these side effects a more robust warning in statute must be provided prior to application of silver diamine to the patient and their parent/guardian (lines 1368-1372).

Since the FDA cleared this solution as a desensitizing agent, we urge the committee to review the practice acts of RDHs, EFDAs and CDAs because each has varying degrees of scope of practice abilities to apply desensitizing agents, some prior to a dental exam and/or when a dentist is not present. House Bill 184 may unintentionally allow any of these dental team members to apply SDF without the guardrails envisioned by this bill.

In a presentation by Dr. Scott L. Tomar, DMD, DrPH of the University of Florida College of Dentistry he outlines the following steps as a protocol to use silver diamine fluoride. The steps include prophylaxis, Vaseline application next to the adjacent soft tissue, relative isolation using gauze or cotton, suction/drying, application with a microbrush for 2-3 minutes, washing with water and no specification on the number of applications. Using Dr. Tomar's protocol, an EFDA cannot work under authorization of a dentist's teledentistry permit because they are not authorized to perform prophylaxis for a patient. Again, because this may be the only dental care a patient receives prophylaxis is an important component to this distance care, we urge removal of references to EFDAs operating under this authority under this bill.

Mr. Chairman and members of the committee I apologize for the length of this testimony, but this is a large bill, an evolving technology, a new dental product, and a major attempt to weaken the dental hygienists practice act while advancing lesser trained and lesser skilled auxiliaries. We hope to work with the sponsors to improve the bill and address some of the unintended issues in the bill and advance this effort for our underserved patients. Thank you for the opportunity to testify. I will be happy to answer any questions.

Dental Hygiene Programs in Ohio

Columbus State Community College
Cuyahoga Community College
Lakeland Community College
James A. Rhodes State College
University of Cincinnati-Blue Ash
The Ohio State University
Owens State Community College
Shawnee State Community College
Sinclair Community College
Stark State College of Technology
Lorain County Community College
Youngstown State University
Hocking Technical College (approved for creation in 2016 state capital budget)