

## THE EFFECTS OF STATE DENTAL PRACTICE LAWS ALLOWING ALTERNATIVE MODELS OF PREVENTIVE ORAL HEALTH CARE DELIVERY TO LOW-INCOME CHILDREN

### EXECUTIVE SUMMARY

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### BACKGROUND

Although the incidence of tooth decay has decreased considerably over the past two decades, the prevalence of caries among children and adolescents remains high. Minorities and low-income populations experience more dental decay than those with higher incomes, and they are also more likely to have a higher proportion of untreated decayed teeth.<sup>2</sup> Low oral health care utilization is the primary reason for higher tooth decay among low-income and minority populations. Low use of

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<sup>2</sup> U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, page 63.

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dental services among low-income and minority children is related to several factors that reduce their access to such services, which include low dentist Medicaid participation, shortage of dentists, mal-distribution of dentists, restrictive state laws, patients' lack of health insurance, and families' lack of understanding and awareness of the need for preventive oral health care.

## **PROJECT OVERVIEW**

### **Project Purpose**

The purpose of this project was to examine state dental practice laws and the extent to which they encourage alternative models of delivering preventive oral health care. This project encompassed two distinct study components: 1) an analysis of existing state dental statutes and regulations; and 2) case studies to examine the enactment of public health-oriented provisions encouraging alternative models of delivering preventive oral health care to low-income children; and the development and implementation of such alternative models.

## **METHODS**

### **Review State Dental and Medical Practice Laws**

We reviewed state dental practice acts for the 50 states and the District of Columbia to determine how they address the delivery of preventive oral health care services by dentists and dental hygienists.<sup>3</sup> We also examined any applicable exemptions for physicians and nurses to deliver oral health care. In addition, we reviewed the statutes for supervision requirements for dental hygienists, consultation between dentists and hygienists when delivery of oral health services is unsupervised or independent, and the educational and competency requirements for dental hygienists.

### **Case Studies**

We opted to study six states that had: 1) enacted a statute that permitted/encouraged an alternative model; and/or 2) had or had not yet implemented the alternative model. We chose to examine two types of

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<sup>3</sup> We reviewed state dental and medical practice laws during 2000-2001. The full report contains a full description of the scope of our review.

alternative models: 1) a model that uses dental hygienists working under either general supervision or without a dentist's supervision (but not independent practice) to provide preventive services; and 2) a model that uses physicians to provide screening, education, and in some cases, topical fluoride application to very young children. Our study states included Connecticut, Iowa, New Mexico, North Carolina, South Carolina, and Washington.

## **FINDINGS**

### **Analysis of State Health Professions Laws**

The licensing of dentists, as with other health professionals, is governed by state law. Health professions licensing statutes are implemented by boards dominated by the relevant professionals themselves.<sup>4</sup> In the case of dental practice, definitions and scope of practice provisions become important when considering the role of dental hygienists. Generally, dental hygienists are subject to governance by boards of dentistry, which define and in many jurisdictions limit the scope of permissible practice.

The licensing system and self-regulation by the dental and medical professions have profound implications for low-income children. In many jurisdictions, state laws restrict the delivery of preventive oral health care to dentists. In other jurisdictions, restrictive licensing laws restrict the scope of practice of dental hygienists. These legal restrictions operate as a barrier to the provision of preventive oral health services to low-income children by limiting the number of individuals who can provide such services.

Although some states have begun to loosen their practice acts to allow dental auxiliaries to perform more preventive oral health services, these focus primarily on hygienists. Many jurisdictions require a dentist to be on-site and sign-off on preventive oral health services provided by dental auxiliaries. Although many state dental licensing laws provide exemptions for the delivery of preventive oral health care by physicians, other obstacles limit such delivery (e.g., training and equipment).

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<sup>4</sup> See Furrow et al., *Health Law*. 2000. St. Paul, Minnesota: West Group Publishing, at 59. See also Orentlicher D, "The Role of Professional Self Regulation" in *Regulation of the Healthcare Professions* at 129 (Timothy S. Jost, ed. 1997).

## **State Options**

Our analysis revealed that states have elected to use one of three options in changing existing laws to allow for alternative models of oral health care delivery: 1) a state legislature can pass a new statute that explicitly permits an alternative model; 2) a state agency or dental/medical board can establish new regulations or rules (based on existing law) allowing an alternative model; and 3) a state agency, dental/medical board, or group of providers can reinterpret an old law or set of regulations/rules, usually with a broader interpretation, and implement an alternative model.

## **Supervision Requirements for Dental Hygienists**

Two key issues stand out in the design of alternative delivery models for the delivery of preventive health services to low-income children: 1) whether a dentist has to be on the premises when services are provided; or 2) whether a dentist has to sign-off on the work performed prior to patient discharge.

The review of the dental practice laws demonstrates that for the four identified preventive oral health services, most state dental practice laws require supervision of a dentist at some level (direct, indirect, general) for the delivery of preventive oral health services by dental hygienists. Colorado has an independent practice law that allows dental hygienists to provide oral health services without the supervision of a dentist, and Washington state allows independent practice under certain conditions. The more restrictive the supervisory requirements are, the less flexibility states will have in designing alternate models of preventive oral health delivery by dental hygienists. The efforts to control dental auxiliaries by procedure and varying degrees of supervision lead to confusion in what can be done, where, with what level of supervision and approval. This confusion, in itself, is a deterrent to designing alternate delivery models.

## **Case Studies**

Our findings reveal that making a change in the law does not result in an *immediate* change to the oral health care delivery system. In fact, in three of the cases (IA, NC, and WA) the alternative model could be developed *without* the creation of a new public health-oriented law. In

these states, existing dental and medical practice laws, accompanied by changes to rules, regulations, or administrative policies, were sufficient to permit a new model. In the remaining cases the alternative model could not be pursued unless the law was changed. Where laws are changed, it may take a substantial amount of time for the dental profession and the market to respond to such changes. However, in all cases we learned that the success of the alternative oral health care models lay not merely in the laws themselves, but in certain factors essential to their implementation.

Our findings suggest that a combination of essential factors is required for the implementation of an alternative oral health care delivery model, whether or not a new public health-oriented law has been enacted. The factors that facilitated the implementation of alternative models for delivering preventive oral health care are summarized below:

- Gaining the **support of dentists**, either through their organizational representatives or through the leadership of individual dentists is perhaps the most important factor in the success of an alternative model.
- Creating a **reimbursement mechanisms** for providers in the alternative model.
- Gaining **state Medicaid agency support** is essential.
- The **lack of a formal referral mechanism** severely hindered the successful implementation of most of the alternative models.
- The **type of alternative model** may predetermine how easily it is implemented in a state.
- Alternative models that utilize an **incremental approach** seem to have more success.
- **Outreach and training** are necessary.
- **Professional recognition and acceptance of the need** for the alternative model.

## **CONCLUSION**

The alternative models we studied have had little impact on the preventive oral health care delivery systems in our study states. In states with dental hygienist alternative models (CT, NM, and SC), the law and models have not yet significantly changed the way that dental hygienists work. In all three states, dental hygienists provide the same services they did before the law or model was enacted or implemented (e.g., treatment planning, prophylaxis, and care coordination). Prior to the law, dental hygienists worked under some degree of supervision by a dentist, and they continue to do so currently. Until a reimbursement mechanism can be instituted, thus creating a provider number to allow for direct billing, dental hygienists will be forced to maintain their ties to a dentist of record. As we have seen, this can encourage the old models of general supervision (or indirect supervision), and discourage increased access since dental hygienists interested in the alternative model will have to rely on a dentist to bill for their services.

Given the arduous task of implementing an alternative oral health care model, and the slow progress that accompanies such an endeavor, we conclude that states planning to undertake such an effort should be mindful of several factors: 1) it is difficult to make changes in the scope of practice of one class of professionals who are overseen by a different group of professionals; 2) action should be taken at deliberate speed, and incremental steps should be made; 3) preventive oral health care providers operating within the model must have the ability to self-regulate; 4) viable funding mechanisms must be set up prior to implementing the program; and 5) careful consideration should be given to the type of model the state seeks to implement, the types of providers it will include, and the political viability of such a model.

## **RECOMMENDATIONS**

This study did not focus on dentist workforce training and supply issues, and, therefore, our recommendations do not address these factors. Instead we focus on those elements that facilitate the development and implementation of alternative models of delivering preventive oral health care services.

- Public health leadership is needed to create a greater awareness of the need for oral health among poor children.

- Public health and dental professional leadership is needed to destigmatize the services provided by non-dentists. Disseminating the results of recent studies indicating that dental hygienists provide safe care may facilitate these efforts.
- Federal and state Medicaid officials can be effective leaders in implementation and reimbursement issues. In particular, officials can follow the example of the North Carolina Medicaid agency and its leadership in promoting the alternative oral health care model.
- Federal government and professional societies should address outreach and training issues associated with implementation of these models.
- Even without legal changes, Medicaid and public health officials can encourage the role of pediatricians regarding applying fluoride varnish. In most states physicians are already permitted to provide such services.
- Further study is needed on successfully implemented preventive oral health care models. Study should be undertaken at the individual provider level to learn exactly what elements are necessary to make a particular model successful.