Pathways to Improved Access to Dental Health Services

Even after the adoption of the Affordable Care Act, the existing oral health delivery system leaves enormous levels of unmet need. While multiple strategies will be required to improve oral health, states can and should consider whether legal barriers unnecessarily hamper licensed dentists and allied dental providers from delivering more services to more patients. The Network for Public Health Law has performed a legal analysis of how each state’s laws define — and in many cases limit — the roles of these dental health service providers.

This Fact Sheet describes the state laws governing the respective services provided by members of the dental workforce. The companion Access to Oral Health Care Science and Law Brief more fully explores policy options that public health professionals and community members might consider to expand access to care through allied dental providers. Together the Network intends for these documents to serve as a starting point for developing policies to improve oral health.

There are of course other important means of expanding access to dental health services. For children, programs to encourage oral health screenings by pediatricians and providing wider access to school–based sealant services can provide important benefits. And for many underserved populations, changes in Medicaid reimbursement policies coupled with innovative service delivery models are critical means of delivering needed services. The Network has explored in depth the issue of scope of practice for allied dental providers, as evidenced by this Fact Sheet, and we are prepared to investigate other policy options to improve oral health. If expanding scope of practice is not the focus of your efforts in this area, you are still encouraged to contact your Network Region for legal technical assistance on any oral health issue. There is no cost for this assistance. The Network will monitor requests for assistance in this area and prepare more extensive materials on issues that surface frequently, present promising outcomes or are particularly challenging from a legal perspective.

Oral Health and Scope of Practice of Allied Dental Providers in Iowa

Poor oral health has severe negative repercussions on overall health, productivity and quality of life. Untreated oral health problems in children can result in attention deficits, trouble in school, and problems sleeping and eating.¹ Employed adults lose more than 164 million hours of work each year due to dental disease and dental visits, and in 2009 over 830,000 emergency room visits were the result of preventable dental conditions.² Poor oral health is also associated with a number of other diseases, including diabetes, stroke and respiratory disease.³ In older adults, poor oral health is significantly associated with disability and reduction in mobility.⁴

The following table highlights indicators of oral and dental health, and shows how Iowa compares with the nation on these indicators.

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<th>Iowa Compared with the National Average on Oral Health Indicators</th>
<th>U.S.</th>
<th>IA</th>
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| Adults | Adults aged 18+ who have visited a dentist or dental clinic in the past year (2008) | 68.5% | 72.4% |
| Adults | Adults aged 18+ who have had their teeth cleaned in the past year (among adults with natural teeth who have ever visited a dentist or dental clinic) (2008) | 69% | 74.1% |
| Adults | Adults aged 65+ who have lost six or more teeth due to tooth decay or gum disease (2008) | 43% | 42.3% |
| Children | Children with a preventive dental visit in the past year (2011-2012) | 77.2% | 77% |
| Children | Children with oral health problems in the past 12 months (2011) | 18.7% | 17.2% |
| Children | Children with two or more oral health problems in the past six months (2007) | 8.4% | 6.7% |
| Children | 3rd Grade students with untreated tooth decay (2006-2007) | 25% | 21.9% |
| Children | 3rd Grade students with dental sealants (protective of decay) on at least one permanent molar tooth (2006-2007) | 40.8% | 49.2% |
| Children | Children with decayed teeth or cavities within the past six months (2007) | 19.4% | 15.1% |
| Children | Special needs children with unmet preventive dental care needs (2009-2010) | 8.9% | 6.2% |

The burden of oral disease is unequally distributed, with minorities and low-income people significantly more likely to report oral health problems. Many of these disparities are exacerbated by lack of access to dental providers, including non-dentist medical professionals. Allied dental providers, such as dental hygienists and dental therapists, are educated and trained to teach patients proper oral hygiene practices and provide a host of preventive dental services and assessments, typically at lower cost. Lack of access to allied dental providers is a key predictor of poor dental health. These dental professionals play a critical role in improving access to dental services, particularly for underserved or vulnerable populations. There is reason to believe that increased utilization of allied dental providers can help improve access to care, particularly among underserved populations. Regulation of allied dental providers varies across states. Although some states permit hygienists or therapists to practice only in the same physical location as dentists, many have taken steps to improve access to care for low-income people by relaxing this restrictive rule.

**Allied Dental Providers in Iowa**

What does the practice of dental hygiene include?

Performance of educational, therapeutic, preventive, and diagnostic services including:

**Educational:**
- Assessing need for, planning, implementing, and evaluating oral health education programs for patients and community groups
- Conducting workshops and in-service training for nurses, school personal, and community groups
- Providing consultation and technical assistance for promotional, preventive, and educational services.

**Therapeutic assessment and performance of:**
- Oral prophylaxis
- Periodontal scaling and root planing
- Removing and polishing hardened excess restorative material
- Applying or administering medicaments prescribed by a dentist

**Preventive:**
- Applying pit and fissure sealants
- Applying medication or methods for caries and periodontal disease control
- Organizing and administering fluoride rinse or sealant programs

**Diagnostic**
- Reviewing medical and dental health histories
- Performing oral inspections
- Indexing dental and periodontal disease
- Making occlusal registrations for mounting study casts
- Testing pulp vitality
- Analyzing dietary surveys.

**Upon delegation by a dentist:**
- Placement of sealants
- Removal of plaque other than with a toothbrush, floss, or rubber cup coronal polish

**Administering Anesthetics:**
- Administration of local anesthesia, upon delegation and while dentist is present
- Administration of nitrous oxide, upon delegation and while dentist is present

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<th>Level of Required Dentist Supervision</th>
<th>Hygienist Activities Within a Dental Office</th>
<th>Public Health Setting</th>
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</table>
| Direct                               | Full Scope of Practice
  ✓ Local Anesthesia
  ✓ Nitrous Oxide
| n/a                                  |
| General                              | Limited Scope of Practice
  ✓ May not administer local anesthesia
  ✓ May not administer nitrous oxide
| n/a                                  |
| Public Health with Written Supervision Agreement | n/a | Limited Scope of Practice
  ✓ May not administer local anesthesia
  ✓ May not administer nitrous oxide |

**What services may a dental hygienist not perform?**

A licensed dental hygienist may not: perform services that exceed the scope of practice of a dental hygienist granted by statute. A dental hygienist may not practice independent from the supervision of a dentist.

**What are the supervision requirements for the practice of dental hygiene?**

A dental hygienist may practice under the general, direct, or public health supervision of a licensed dentist.

- **General supervision** means that a dentist has examined the patient and has prescribed authorized services to be provided by a dental hygienist. The dentist need not be present in the facility while these services are being provided, as long as certain requirements are met.

- **Direct supervision** means that the dentist is present in the treatment facility, but it is not required that the dentist be physically present in the treatment room. Administration of anesthesia or nitrous oxide requires direct supervision.

- **Public Health supervision** means that the dentist authorizes and delegates the services provided by a dental hygienist in a public health setting. A public health setting includes: schools, Head Start programs and
other state early childhood initiatives (ECI), child care centers, federally qualified health centers, public health dental vans, free clinics, nonprofit community health centers, nursing facilities, and federal, state, and local public health programs. The licensed dentist need not examine each patient before hygienist services are provided. The dentist and dental hygienist must enter into a written supervision agreement that sets forth the responsibilities of each party.

What body is responsible for professional oversight of licensed dental hygienists?
The Iowa Dental Board is responsible for oversight of dental hygienists. The Board has broad discretion to define the scope of practice of dental hygienists. Agreements between dental hygienists and dentists to practice in a public health setting must be filed with the Oral Health Bureau of the Iowa Department of Public Health.

SUPPORTERS

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This document was developed by Neil Pederson, law student at William Mitchell College of Law and reviewed by Jill Krueger, Senior Attorney, at the Network for Public Law—Northern Region, at the Public Health Law Center at William Mitchell College of Law. The Network for Public Health Law provides information and technical assistance on issues related to public health. The legal information and assistance provided in this document does not constitute legal advice or legal representation. For legal advice, please consult specific legal counsel.

2 HHS, Oral Health in America, supra note 1, at 3; PEW CENTER ON THE STATES, A COSTLY DESTINATION: HOSPITAL CARE MEANS STATES PAY DEARLY 1 (2012).
4 IOM, Improving Access, supra note 3, at 52.
5 Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, National Oral Health Surveillance System: Adults Aged 18+ Who Have Visited a Dentist or Dental Clinic in the Past Year, available at http://apps.nccd.cdc.gov/nohss/ListV.asp?qkey=5&DataSet=2 (last visited October 7, 2014).
7 Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, National Oral Health Surveillance System: Adults Aged 65+ Who Have Lost 6 or More Teeth Due to Tooth Decay or Gum Disease, available at http://apps.nccd.cdc.gov/nohss/ListV.asp?qkey=7&DataSet=2. (last visited October 7, 2014).


18 See generally David Nash, Adding Dental Therapists to the Health Care Team to Improve Access to Oral Health Care for Children, 9 ACAD. PEDIATRICS 446 (2009).

19 See Ann Battrell et al., A Qualitative Study of Limited Access Permit Dental Hygienists in Oregon, 72 J. DENTAL EDUC. 329, 340 (2008).


21 See Id., IOM, Improving access at 3-29.

22 The Scope of Practice (here, “scope of term”) provisions for dental hygienists can be found in Iowa Code § 153.15.

23 Iowa Admin. Code 650-10.3(1)(a).

24 Iowa Admin. Code 650-10.3(1)(b).

25 Iowa Admin. Code 650-10.3(1)(c).

26 Iowa Admin. Code 650-10.3(1)(d).

27 Iowa Admin. Code 650-10.3(1)(e).

28 Iowa Admin. Code 650-10.3(4).  

29 Iowa Admin. Code 650-10.3(4).  


31 If the dentist is not present, then the patient, or the patient’s legal guardian, must be informed that no examination will take place; the hygienist must consent; emergency procedures that the hygienist is capable of implementing must be in place; and, the treatment must have been prescribed beforehand by the dentist and entered into writing. Iowa Admin. Code 650-1.1(153).

32 Iowa Admin. Code 650-1.1.

33 Iowa Admin. Code 650-10.3(1), (2), (4).

34 Iowa Admin. Code 650-10.5(1).

35 Iowa Admin. Code 650-10.5(2) and (3); 10.3(5). The agreement requirements are specified in Id. 650-10.5(3).

36 See Iowa Code § 147.13.

37 See Iowa Code § 153.15; Iowa Admin. Code 650-10.3.

38 Iowa Admin. Code 650-10.5(3)(d).