STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

January 15, 2014

The Honorable Joan Carter Conway, Chair
Senate Education, Health, and Environmental Affairs Committee
Miller Senate Building
2 West
Annapolis, MD 21401

The Honorable Peter A. Hammen, Chair
House Health and Government Operations Committee
House Office Building
6 Bladen Street, Room 241
Annapolis, MD 21401

RE: HB 1302 (Ch. 733) of the Acts of 2010
2013 Legislative Report on Dental Hygienists in Long-Term Care Facilities

Dear Chair Conway and Chair Hammen:

House Bill 1302 (2010) requires the Department of Health and Mental Hygiene to issue this one-time legislative report evaluating the use, effectiveness, and impact of this bill, which authorizes dental hygienists to provide services in long-term care facilities under certain circumstances.

I hope this information is useful. If you have any questions regarding this report, please do not hesitate to contact Ms. Christi Megna, Assistant Director of Governmental Affairs, at (410) 767-6509.

Sincerely,

Joshua M. Sharfstein, MD
Secretary

Enclosure

cc: Senate Education, Health, and Environmental Affairs Committee Members
House Health and Government Operations Committee Members
Christi Megna, JD
Patrick Dooley, MA
Laura Herrera, MD, MPH
Donna Gugel, MHS
Harold Goodman, DMD, MPH
Sarah Albert, MSAR #

MARYLAND'S LEGISLATIVE REPORT ON DENTAL HYGIENISTS IN LONG-TERM CARE FACILITIES

(Ch. 733) of the Acts of 2010

Martin O'Malley	Anthony G. Brown	Joshua M. Sharfstein, MD
Governor	Lieutenant Governor	Secretary

Dental Hygienists in Long-Term Care Facilities

Evaluation Report of House Bill 1302 (2010)

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Background

In 2010 the Maryland General Assembly passed House Bill 1302 , Chapter 733 of the Acts of 2010, amending §4-308 of the Health Occupations Article. This authorized licensed dental hygienists (also known as registered dental hygienists, or RDHs) in the State to provide services within their scope of practice to patients in long-term care (LTC) facilities, defined as nursing homes and assisted living programs, under the general supervision of a dentist. HB 1302 requires the Department of Health and Mental Hygiene (DHMH), Office of Oral Health (OOH) to evaluate the use, effectiveness, and impact of this statute, and to submit its findings in a report to the Maryland General Assembly on or before December 31, 2013.

Specifically, this statute enables qualified Maryland dental hygienists practicing under the general supervision of a qualified dentist, to provide dental hygiene services to patients of LTC facilities when certain criteria are met. With these changes patients in LTC facilities no longer need to be evaluated by a dentist prior to the delivery of certain dental hygiene services by a licensed dental hygienist.

Qualified dentists and dental hygienists shall:

- Hold an active license to practice in the State;
- Hold a current CPR certificate; and
- Have at least two years of active clinical practice in direct patient care;

Further, qualified dental hygienists shall ensure that the LTC facility where they will practice under general supervision has:

- A written medical emergency plan;
- Adequate equipment for the delivery of dental hygiene services; and
- Adequate safeguards to protect the patient's health and safety.

Additional requirements include:

- The dental hygienist and supervising dentist must have a written agreement clearly describing the terms under which the dental hygienist may practice and provide hygiene services without the supervising dentist on the premises;
- Dental hygiene tasks and procedures must be limited to: toothbrush prophylaxis, application of fluoride, dental hygiene instruction, assessment of the patient's need for further evaluation by a dentist, and other duties as they may be delegated by the supervising dentist;
- The supervising dentist must be available for consultation with the dental hygienist in person, by phone, or electronically; and
- The dental hygienist must:
    - Consult with the supervising dentist or a treating physician before treatment if there is a change in a recall patient's medical history;
    - Assess the appropriate recall interval based on the needs of the patient or as recommended by the supervising dentist; and
    - Submit assessment of the patient's initial evaluation to the supervising dentist for a determination of future treatment.

Provisions of this statute sunset on June 30, 2014.

Oral Health of Elderly Residents of Long-Term Care Facilities

Improvements in oral health care over previous decades, including: regular brushing with fluoride toothpaste, flossing, and dental examinations; drinking fluoridated water if available; eating a healthy diet; and avoiding tobacco products; have helped today's older adults keep their natural teeth much longer than in prior generations. However, longer retention of natural teeth also puts older adults at an increased risk for developing tooth and root decay, as well as gum disease. Elderly residents of LTC facilities, like nursing homes or assisted living care, usually have additional difficulty accessing dental care due to geographic, socioeconomic, or other factors. Further, in these environments it is difficult for facility staff to care for and monitor the mouths of older adult residents who may be experiencing medical or cognitive problems, or a combination thereof. According to Chiappelli et al., elderly people who live in nursing homes are at greater risk for oral health problems compared to elderly people who live independently.[1]

Older adults often take multiple medications, many of which cause dry mouth, increasing the risk of developing oral diseases. In addition, elderly individuals frequently suffer from chronic medical diseases such as diabetes and cardiovascular disease, which can complicate their receipt of oral health treatment as well as compromise their overall health. Past and current risk behaviors, like tobacco and alcohol use, put older adults at increased risk for oral cancer and other soft tissue diseases. If conditions like gum disease and tooth and root decay persist, teeth can become painful, loose, or broken, leading to nutritional issues and changes in appearance. If oral infections are unnoticed and allowed to fester, they may exacerbate chronic disease conditions often found in older adults such as diabetes and cardiovascular disease. These types of problems are especially prevalent among older adults living in LTC facilities.

In an effort to address these and similar issues by increasing access to oral health services, many states have expanded the professional practice environment for dental hygienists to include pre-schools, schools, and LTC facilities. According to the Association of State and Territorial Dental Directors listserv polling of state dental directors, more than 30 states allow dental hygienists to provide some initial treatment in LTC settings without specific authorization from a dentist.[2]

Dental Hygienists

Dental hygienists are part of the team that supports a dentist in the practice of dentistry. Dentists are licensed health care providers that specialize in the diagnosis, prevention, and treatment of diseases and conditions of the oral cavity, while dental hygienists, also licensed health care providers, administer a range of oral health services including but not limited to oral health education, dental hygiene instruction, and preliminary dental examinations and prophylaxis, including scaling, sealants, and fluoride treatments. Dental hygienists undergo rigorous training

[1] Chiappelli F, Bauer J, Spackman S, Prolo P, Edgerton M, Armenian C, Dickmeyer J, Harper S. *Dental needs of the elderly in the 21st century*. Gen Dent 2002; Jul-Aug;50(4):358-63.

[2] Louis S. Catherine. *In Nursing Homes, an Epidemic of Poor Dental Hygiene*. NYTimes.com, August 4, 2013.

and testing for licensure, including both written and clinical examinations, and are required to obtain continuing education credits as part of their license renewal requirements. Because of their versatility to provide comprehensive dental services in a variety of settings, including but not limited to private dental offices, educational sites, and public health facilities, dental hygienists can play an instrumental role in providing dental services to at-risk populations.

Methodology

To meet the specific requirements of HB 1302 to evaluate the use, effectiveness, and impact of this act, the OOH designed the Dental Hygienists Practice in Long-Term Care Facilities Questionnaire (DHPLQ) (see Appendix). The questionnaire was self-administered online through Survey Monkey, an online survey application. In order to measure behavior change of dental hygienists over time as related to the tenets of HB 1302, the OOH collaborated with the Maryland State Board of Dental Examiners (MSBDE), the entity charged with regulating, licensing, standard setting, and resolution of complaints for dentists, dental hygienists, and dental radiology technicians in the State, to e-mail the DHPLQ to all licensed registered dental hygienists (approximately 3,300 in each of the three survey years) in the State with e-mail addresses on file at MSBDE. The first questionnaire was e-mailed in September 2011; the second in January 2013; and the third in September 2013. The survey distribution schedule was dictated by resource availability at the MSBDE. Because the survey was distributed to all currently licensed dental hygienists, some dental hygienists may have completed this survey in each of the three years, others may have responded in one or two of the survey years, and still others may have never responded. Descriptive statistics were produced for each survey question.

Results

Overall Response

In September 2013 there were 3,311 registered dental hygienists on file with MSBDE. A total of 1,755 dental hygienists responded to the questionnaire over the three-year period. On average 585 dental hygienists, or 18 percent, responded to the questionnaire each year. Except where otherwise specified, the results presented in this report represent total average responses over the three-year period. It should be noted that not every dental hygienist responded to every question; if the question was not applicable to the respondent, they were directed to skip that question and go to the next applicable one.

Current Roles and Patient Care Experience

Ninety-nine percent of the sample had an active Maryland license to practice dental hygiene; 88 percent were practicing as clinicians. The remaining non-clinical dental hygienists were working as educators, researchers, administrators, and/or managers; their responses were automatically excluded from the results. When those practicing clinical dental hygiene were asked about direct patient care, 93 percent had the minimally required two years of active clinical experience, as did 99 percent of their supervising dentists.

Seventeen percent of dental hygienists reported that their supervising dentist currently treats patients in LTC facilities. When asked whether their supervising dentist planned to treat patients

in LTC facilities in the next calendar year, 3 percent responded "yes," 60 percent responded "no," and 37 percent did not know. Over each of the three years of the survey an average of 6 percent of those possessing the required two years of clinical practice experience had a supervising dentist treating patients in LTC facilities.

The majority of active dental hygienists (94.1 percent over three years) met the criteria established by HB 1302 for treating patients in LTC facilities (active dental hygiene license and two years of clinical practice). Only a small proportion of dental hygienists reported treating patients in a LTC facility despite growth each year in the number of dental hygienists in clinical practice eligible to treat patients in this venue (see Chart 1). An average of 82 percent of respondents over three years indicated that they would need alternate dental supervision, or supervision other than their usual dentist, in order to treat patients in LTC facilities because their dentist was not treating such patients (see Table 1). Based on this, it would seem that the low number of dental hygienists treating patients in LTC facilities can be linked to the low number of supervising dentists providing care in these facilities. Without a supervising dentist working in the LTC facility, a dental hygienist has no route to provide care at these facilities.

CHART 1.

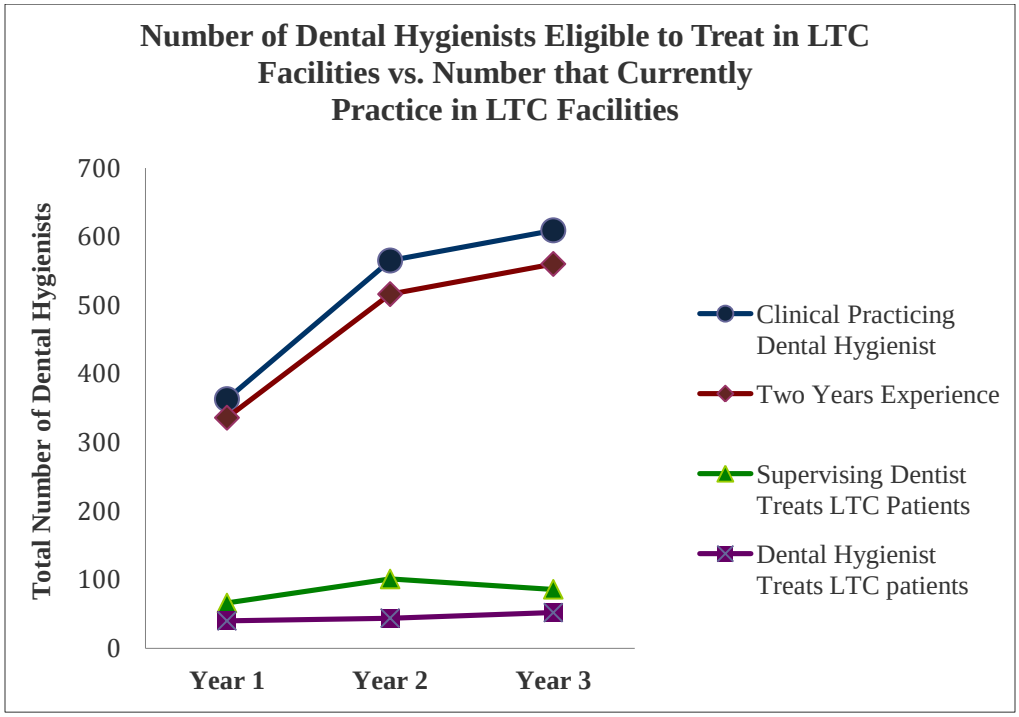


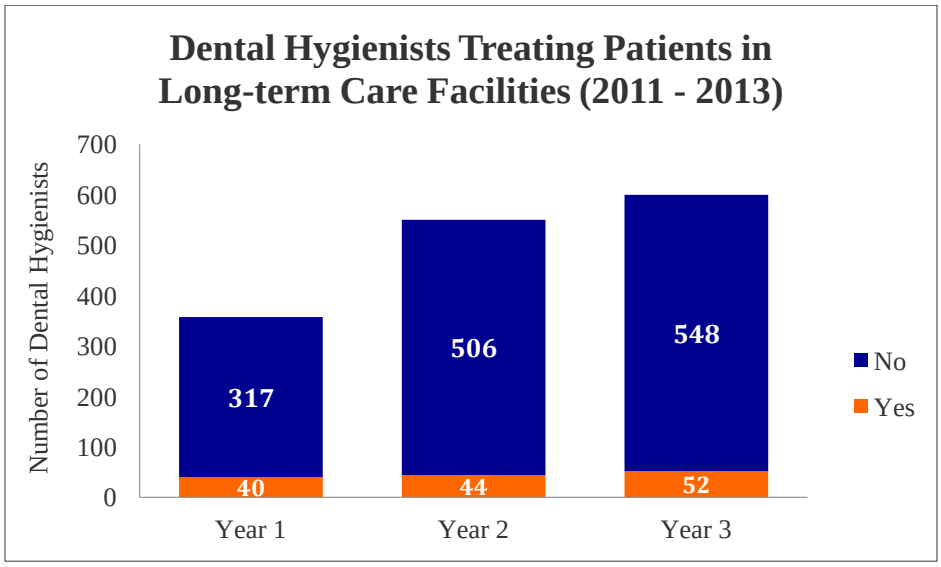
TABLE 1.

	Dental Hygienists that Meet Requirements to Treat in LTC Facility	Dental Hygienists Whose Supervising Dentist Treats in LTC Facility	Dental Hygienists that Meet all Requirements, but Supervising Dentist Does Not Serve LTC Facility Patients
Year 1	77.6%	18.6%	80.4%
Year 2	82.4%	18.5%	80.4%
Year 3	80.5%	14.4%	84.6%

Current and Future Plans to Treat LTC Facility Patients

One hundred and thirty-six dental hygienists (9 percent) reported treating patients in a LTC facility between 2011 and 2013 (see Chart 2). Between the year one and three surveys, there was a 22.3 percent decrease in respondents that treated LTC facility patients. Over all three years, 15 percent of those sampled planned to treat patients in LTC facilities. From year one to year three, there was a 4.4 percent increase in the number of dental hygienists planning to treat patients in LTC facilities.

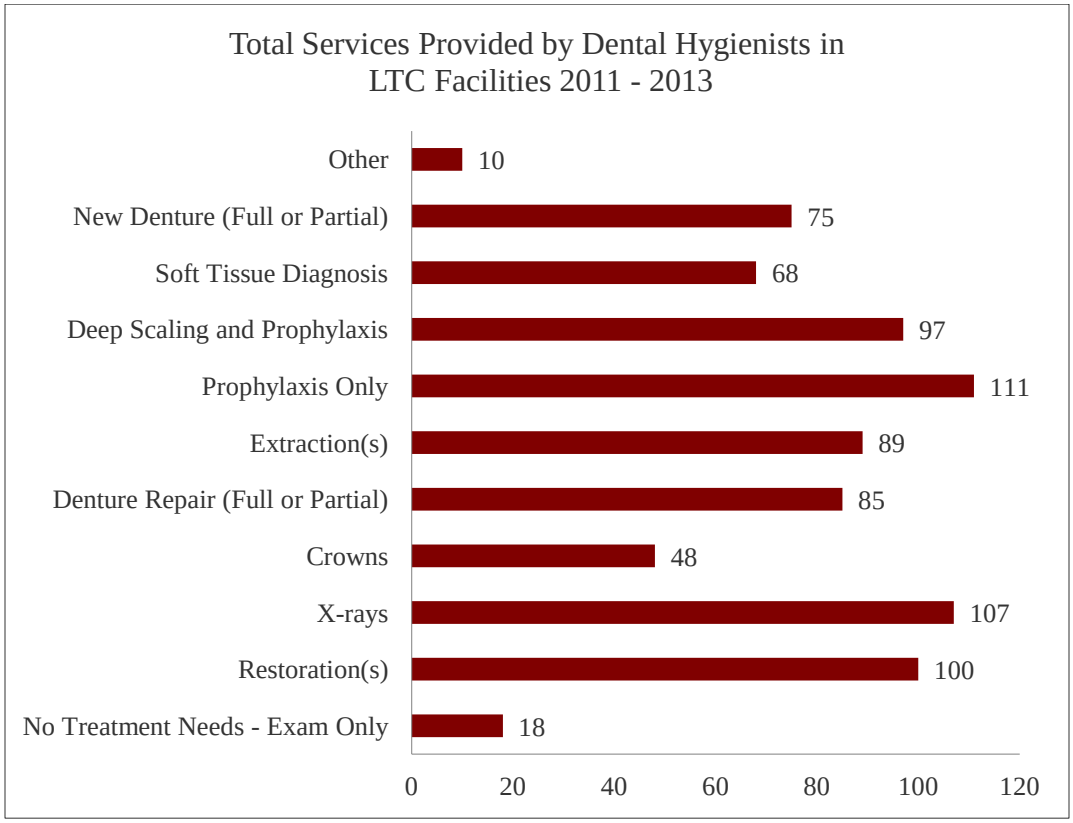
CHART 2.



Services in Long-Term Care Facilities

Dental hygienists that treated patients in LTC facilities cited the top treatment needs of elderly residents as x-rays, prophylaxis, restoration, deep scaling, and denture repair (see Chart 3). Thirty-two percent of patients treated by dental hygienists in LTC facilities required follow-up care. There was a 45 percent increase in dental hygienists acknowledging the need for follow-up care over the three years of the survey. Fifty nine percent of the dental hygienists who practiced in long-term care facilities treated an average of 1-10 patients per year.

CHART 3.



Barriers to Providing Care

In year three, dental hygienists who were not treating patients in LTC facilities but expressed interest in doing so were asked what has kept them from providing this care. The most common response was a lack of time or scheduling issues (81). Seventy-six (76) dental hygienists were unaware of employment or other opportunities that would allow them to do so. Seventy-one (71) individuals were either unaware that they qualified to do this, or cited that they did not know how to get started. Fifty-six (56) individuals cited their lack of connection with a supervising dentist who worked with or was willing to work with LTC facilities. Respondents named these additional barriers: lack of local facilities or access to them (23), not meeting experience requirements (18), lack of initiative (18), no compensation for services (14), limitations of the law requiring dental supervision (11), working in private practice (9), lacking equipment and supplies (8), and fear of lawsuits with elderly population (3).

Some dental hygienists were not interested in seeing patients in LTC facilities. In year three, when asked why they were not interested in treating patients in LTC facilities in the next calendar year, 70 dental hygienists stated that they were employed full-time or happy in their current position. Fifty-three (53) dental hygienists would not plan to see LTC patients because their supervising dentist does not see these patients. Forty-six (46) individuals named private practice obligations, and 37 cited lack of time. Lack of awareness of jobs or opportunities (43) and not knowing how or where to start (32) were frequently cited. Other responses included:

school and family obligations (20), working in pediatrics (20), treating LTC patients in the office (17), lack of compensation (14), lack of interest (13), environment and physical demands (11), area/location accessibility (7), equipment (7), and retiring or approaching retirement (7).

Awareness

Awareness of HB 1302 and its tenets was not widespread in the dental hygiene community; about 21 percent of respondents did not have knowledge of this legislation. Awareness increased over time; 7.6 percent more dental hygienists had heard of the bill in 2013 (80.8 percent) than in 2011 (75.1 percent). Even with increasing awareness of HB 1302, understanding the content of the bill remained a barrier; survey responses indicated that very few dental hygienists understood the language in the legislation. Furthermore, those that expressed interest in treating patients in LTC facilities were unsure of how to get started or where to find information about employment opportunities in these facilities.

Limitations

An issue not addressed in this survey is that of safety for elderly patients in LTC facilities. Many of these patients have complex medical, dental, or cognitive conditions, or a combination thereof. This generally should not be a concern as the dental hygiene curriculum includes training in patient safety, and because HB 1302 clearly defines safety requirements for those practitioners who would provide care in these facilities. Only Maryland licensed dental hygienists who hold a current certificate with Health Provider C Proficiency (or its equivalent) in cardiopulmonary resuscitation and who have at least two years of active clinical practice in direct patient care are eligible to provide care under the provisions of this bill. Further, LTC facilities where dental hygienists provide their services must have a written medical emergency plan, and adequate equipment and safeguards in place to protect the patient's health and safety. As of October 2013, the MSBDE reported that no complaints had been filed against dental hygienists providing services in LTC facilities as permitted by this legislation, indicating that patient safety remains protected with the enactment of HB 1302.

Discussion and Recommendations

The oral health of older adults, especially those living in LTC facilities, is and will continue to be an important public policy issue as large segments of the population age and the number of adults in these facilities grows. While a high percentage of dental hygienists are qualified to provide services to LTC patients, the majority of dental hygienists are not currently doing so; a top reason for this is the low percentage of supervising dentists providing care to these patients. Further, because neither Medicare nor Medicaid provides coverage for basic dental services for adults, there is little financial incentive for the dental workforce to serve this population. The Affordable Care Act does not contain any mandatory provisions for dental care services for adults of all ages, so this is not expected to change. Finally, because of their complex dental needs and the frequency of complex medical and cognitive conditions in this population, providers may opt to avoid these complications by not treating these individuals.

Elderly persons are not the only residents of LTC facilities; these institutions also serve a sizeable number of residents with disabilities who likely face similar barriers to receiving oral

care. Residents of LTC facilities who have disabilities will also benefit from the research and follow-up actions associated with this report.

In order to better quantify the issue of oral health care for this population, the OOH, in collaboration with the Maryland Department of Aging, has instituted the first Older Adult Basic Screening Survey in selected regions of the State. Dental examinations are currently being conducted for elderly patients who live in nursing homes or assisted living centers, or who congregate at meal sites, or other similar venues. Data from this survey will be incorporated into the newly expanded OOH oral health surveillance system, and will be used to develop new programmatic priorities and initiatives addressing means to improve the oral health of this population.

It is important to find novel approaches to providing oral care to this growing population. New and better-trained cohorts of dentists and dental hygienists are entering the workforce; potential exists for innovative solutions to meet the oral health needs of this population. For older adults living on fixed incomes and dealing with other health problems, dental care is often expensive and difficult to access.[3] As our population ages and lives longer, both need and demand for oral health care services are anticipated to grow exponentially, and will likely require the services of the entire dental workforce. Numerous states have acknowledged these trends and have introduced legislation similar to Maryland's HB 1302 (2010) to meet the need. Such new and innovative responses by states will be needed to address the ever-growing oral health needs of seniors in LTC facilities. Based on these factors, the OOH recommends permanently repealing the sunset clause on HB 1302 (2010).

The low number of dental hygienists currently treating elderly patients in LTC facilities may be heavily influenced by other factors, including the small number of supervising dentists that treat this population. The dental needs of this group are extensive, and information currently available indicates that dental hygienists are providing safe treatment to LTC facility residents. With no fiscal and/or policy solutions looming, all members of the dental workforce are needed to provide care to this population. Permanently enacting this statute will maximize the number of eligible members of the dental workforce able to serve this population. To that end, DHMH will continue to work with partners to achieve the following next steps:

- Collaborate with the state dentist and dental hygiene professional associations to encourage their respective members to treat elderly patients in LTC facilities. Encourage these professional associations to work together to develop solutions such as initiating pilot projects.
- Work with the MSBDE to promote HB 1302 to all dentist and dental hygienist licensees and ensure that its provisions are continually monitored and regulated.
- Develop and/or sponsor educational programs and resources that highlight the dental needs and appropriate treatment of LTC residents, and demonstrate best practices of dentists and dental hygienists already treating this population.
- Continue planning efforts with the Maryland Department of Aging to advance potential policy solutions that address the dental needs of LTC facility residents.

[3] Oral Health America, *State of Decay, Are Older Americans Coming of Age Without Oral Healthcare?,* Oct 2013.

- Expand surveillance efforts of older adult dental care in LTC facilities Statewide through continued use of the Older Adult Basic Screening Survey to quantify the dental needs of this population.
- Partner with the Maryland Dental Action Coalition to carry out the State Oral Health Plan, which includes a goal to address several oral health challenges that impact older adults, especially those in LTC facilities.
- Encourage dental and dental hygiene schools to emphasize the dental and treatment needs of older adults, especially those in LTC facilities, in the curriculum.

DHMH recognizes the importance of this public health issue, and will continue to work with advocates, stakeholders, and the Maryland General Assembly to improve the oral health status of Marylanders in LTC facilities.

Appendix

Dental Hygienists Practice in Long-Term Care Facilities Questionnaire (DHLFQ)

1. Do you currently have an active Maryland license to practice dental hygiene?
    a. Yes
    b. No
2. Are you currently practicing clinical dental hygiene in Maryland?
    a. Yes
    b. No
3. Does your supervising dentist have at least two years of clinical practice in direct patient care?
    a. Yes
    b. No
    c. Don't know
4. Do you have at least two years of active clinical practice in direct patient care?
    a. Yes
    b. No
5. Are you aware that dental hygienists are able to treat patients in long-term care facilities (nursing homes or assisted living programs) under the general supervision of a dentist?
    a. Yes
    b. No
6. Does your supervising dentist currently treat patients residing in long-term care facilities (nursing homes or assisted living programs)?
    a. Yes
    b. No
7. Does your supervising dentist plan to treat patients residing in long-term care facilities (nursing homes or assisted living programs)?
    a. Yes
    b. No
    c. Don't know
8. Have you treated any patients in a long-term care facility in the past year?
    a. Yes
    b. No
9. Approximately how many patents have you treated in long-term facilities in the past year?
    a. 1-10
    b. 11-20
    c. 21-30
    d. >30
10. Which of the following best describes the patient treatment needs? (Check all that apply)
    a. No treatment needs – exam only
    b. Restoration(s)
    c. X-rays
    d. Crowns
    e. Denture repair (full or partial)
    f. Extraction(s)

    g. Prophylaxis (toothbrush or rubber cup) only
    h. Deep scaling and prophylaxis (toothbrush or rubber cub)
    i. Soft tissue diagnosis
    j. New denture (full or partial)
    k. Other (please specify)
11. Did these patients require follow-up/referral?
    a. Yes
    b. No
12. Would you like to treat patients in long-term care facilities?
    a. Yes
    b. No
13. In previous responses you expressed interest in treating patients in long-term care facilities, what has kept you from doing so thus far?
    a. Yes
    b. No
14. Do you plan to see patients in a long-term care facility in the next calendar year?
    a. Yes
    b. No
15. If you will not be treating in long-term care facilities in the next calendar year, please explain why.