SENATE BILL REPORT
SB 6126

As Reported by Senate Committee On:
Health & Long-Term Care, February 2, 2012

Title: An act relating to dental practitioners.

Brief Description: Concerning dental practitioners.

Sponsors: Senators Frockt, Keiser, Chase, Nelson, Kline and Murray.

Brief History:
Committee Activity: Health & Long-Term Care: 1/19/12, 2/02/12 [DPS, w/oRec].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 6126 be substituted therefor, and the substitute bill do pass.
Signed by Senators Keiser, Chair; Conway, Vice Chair; Frockt, Kline and Pridemore.

Minority Report: That it be referred without recommendation.
Signed by Senators Becker, Ranking Minority Member; Carrell, Parlette and Pflug.

Staff: Kathleen Buchli (786-7488)

Background: Dental Personnel in Washington. Washington currently has a variety of credentialed providers who provide assistance to licensed dentists. Dental hygienists remove deposits and stains from the surfaces of teeth, apply topical preventive or prophylactic agents, polish and smooth restorations, perform root planing and soft tissue curettage, and other operations and services delegated to them by a dentist. In order to be licensed, dental hygienists must complete an educational program, pass an examination, and fulfill continuing education requirements. Dental assistants are authorized to perform patient care and laboratory duties as authorized by the Dental Quality Assurance Commission (DQAC) in rule. Dental assistants must register with DQAC. Expanded function dental auxiliaries may perform the duties of a dental assistant and may also perform coronal polishing, give fluoride treatments, apply sealants, place dental x-ray film and expose and develop the films, give the patient oral health instruction, place and carve direct restorations, and take final impressions. In order to be licensed, an expanded function dental auxiliary must complete a dental assistant education program and an expanded function dental auxiliary education program approved by DQAC and pass an examination.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Mid-Level Dental Providers In Other States. Other states have established mid-level dental providers who are authorized to provide a wide range of services. In Minnesota, dental therapists and advanced dental therapists are authorized to perform a variety of tasks under the supervision of a dentist, including the administration of certain legend drugs and certain types of extractions. Dental therapists must possess a bachelor's or master's degree and pass an examination. Advanced dental therapists must possess a master's degree, complete additional training, and pass an additional examination. Dental therapists and advanced dental therapists are limited to practicing in settings that serve low-income, uninsured, and underserved populations. In Alaska, dental health aide therapists are authorized to provide a variety of services pursuant to an agreement with a supervising dentist, including fillings, preventive services, and uncomplicated extractions. A dental health aide therapist must have a high school education, complete a two-year educational/clinical program, and a perceptorship of at least 400 hours with a supervising dentist.

Summary of Bill (Recommended Substitute): Two new professions are created: dental practitioners and dental hygiene practitioners. To qualify for licensure by the DQAC, dental practitioners must: posses a high school education, complete a dental health aide therapist education program, and complete a preceptorship of at least 400 hours under the supervision of a dentist. To qualify for licensure by DQAC, dental hygiene practitioners must: possess a license in good standing as a dental hygienist, complete a post-baccalaureate advanced dental hygiene therapy education program at an institution accredited by the American Dental Association or other national accreditation organization, complete 250 hours of advanced dental therapy clinical practice under the supervision of a dentist; and pass an examination.

Dental practitioners and dental hygiene practitioners may perform the following services and procedures: oral health instruction and disease prevention education; preliminary charting of the oral cavity; making radiographs; mechanical polishing; application of topical preventative agents; pulp vitality testing; application of desensitizing medication or resin; fabrication of athletic mouth guards; placement of temporary restorations; fabrication of soft occlusal guards; tissue conditioning and soft reline; atraumatic restorative therapy; dressing changes; tooth reimplantation; administration of local anesthetic; administration of nitrous oxide; emergency palliative treatment of dental pain; the placement and removal of space maintainers; cavity preparation; restoration of primary and permanent teeth; placement of temporary crowns; preparation and placement of preformed crowns; pulpotomies on primary teeth; indirect and direct pulp capping on primary and permanent teeth; stabilization of reimplanted teeth; extractions of primary teeth; suture removal; brush biopsies; repair of defective prosthetic devices; recementing of permanent crowns; oral evaluation and assessment of dental disease and the formulation of an individualized treatment plan; nonsurgical extractions of periodontally diseased permanent teeth if the teeth are not unerupted, impacted, fractured, or do not need to be sectioned for removal; and the dispensation and administration of the following drugs: analgesics, anti-inflammatories, preventive medicaments, and antibiotics. Additionally, dental hygiene practitioners may perform the work of dental hygienists.

Dental practitioners and dental hygiene practitioners must practice pursuant to a written practice plan contract with a dentist. The contract must specify: practice settings; limitations on the services or procedures that are provided; age and procedure-specific practice

protocols; procedures for creating and maintaining dental records; a plan to manage medical emergencies; a quality assurance plan; protocols for the administering and dispensing medications; criteria for serving patients with specific medication conditions or complex medical histories; specific protocols for situations in which the needs of the patient exceed the dental practitioner's or dental hygiene practitioner's scope of practice or capabilities; and for a dental practitioner only, the services and procedures that may be provided. Practice plan contracts must be filed annually with DQAC and must be made available at the practice of the dental practitioner or dental hygiene practitioner to clients upon their request.

A collaborating dentist must make arrangements for the provision of advanced procedures and services needed by the patient or any treatment that exceeds the dental practitioner's or dental hygiene practitioner's scope of practice or capabilities. The collaborating dentist must also ensure a dentist is available for consultation via video conferencing. A dental practitioner may only provide services and procedures under the off-site supervision of the collaborating dentist, who must accept responsibility for all of the services and procedures provided by the dental practitioner. A collaborating dentist who knowingly allows a dental practitioner to perform services or procedures that are not authorized in the collaborative agreement, or any dental practitioner who performs such service or procedures, commits unprofessional conduct for purposes of the Uniform Disciplinary Act.

Dental practitioners and dental hygiene practitioners may supervise up to five expanded function dental auxiliaries and dental assistants, but only with respect to tasks that the dental practitioner or dental hygiene practitioner may perform. The American Dental Association and the Washington State Dental Association are encouraged to work with stakeholders and suggest ways to provide specialty care services into underserved areas of the state.

EFFECT OF CHANGES MADE BY HEALTH & LONG-TERM CARE COMMITTEE (Recommended Substitute): A dentist must be available via video conferencing for consultation by a dental practitioner or dental hygiene practitioner during treatment if needed. Practice plan contracts must be made available at the practice of the dental practitioner or the dental hygiene practitioner and provided to patients of the practitioners' practice upon request. The American Dental Association and the Washington State Dental Association are encouraged to work with stakeholders and suggest ways to provide specialty care services into underserved areas of the state.

Appropriation: None.

Fiscal Note: Available.
[OFM requested ten-year cost projection pursuant to I-960.]

Committee/Commission/Task Force Created: No.

Effective Date: The bill takes effect on January 1, 2013.

Staff Summary of Public Testimony on Original Bill: PRO: This bill is part of a strategy to move to better health care for all and help address the crisis in dental care. Affordable dental care is hard for many people to get, people are turning to emergency rooms to get dental care and using emergency services for nonemergency purposes. This is a way to

improve access to lower income and rural people. Dental care is important because it affects the whole health of a person. Mid-level dental providers provide basic care and the narrow scope of care addresses concerns people can raise regarding safety issues. Dentists will have input into the provider's practice and what procedures the provider is determined to be capable to deliver. The mid-level provider model is used in 50 other counties and has been successfully implemented in Alaska. Dental malpractice costs will be minimal. Research shows these providers provide safe and competent care and also care that is culturally-sensitive. This program would be a good fit for Washington State and would be simple to adapt to a well-functioning state; it provides a local solution to a local problem. Mid-level providers teach dental care and are part of a dental team that includes dentists; they would not be replacing the dentist. The level of supervision is not an issue because these providers are trained to deal with emergencies. These providers are recruited from specific communities and return to those communities. It will allow service to low-income populations at a low costs. The challenge is to provide regular dental care for uninsured people; not just emergency care, but routine care.

CON: The underlying need stated for this bill is not there. Emergency room visits related to dental care is less that 2 percent of the total charges related to emergency rooms; dental visits have a small impact in relation to emergency room costs. The models from the other counties are very different from the practice model in this legislation. We only know that a procedure is simple when it has been completed, complications do happen. Current efforts to provide dental care and to reduce untreated decay in low-income preschools are working. The state rates as having one of the best programs in the country for dental homes. Reports about successes of the mid-level programs are limited to studies of small groups; we cannot make conclusions regarding safety issue with these small groups. Practicing dentists are meeting the needs for children's care. Many provide this care without billing Medicaid because of the difficulties involved with making Medicaid claims; they are taking care of their communities by providing pro bono care. The model proposed for mid-level providers in the bill is almost the same as what the scope of practice of dentists is now. Mid-level provider models require extensive government subsidies through government support and higher Medicaid fees, otherwise these programs would be unsustainable. The costs of a mid-level provider would be the same as in a dental practice; they have the same overhead needs. The bill needs to affirmatively say what these practitioners can and cannot do instead of relying on the practice plan contract to limit the scope.

Persons Testifying: PRO: Senator Frockt, prime sponsor; Jen Estroff, WA Dental Access Campaign; Helen Plaja, Consumer; Dr. Raymond Dailey, Swinomish/Upper Skagit Dental; Dr. Mary Willard, Alaska Native Tribal Health Consortium; Ruth Ballweg, University of Washington Medex Program.

CON: Linda Hull, Dr. Chris Herzog, Dr. Rodney Wentworth, Alan Wicks, Washington State Dental Association.