The Toolkit for Incorporating General Supervision in Dental Private Practice and Safety Net Settings in Georgia

Dr. Eunice Chay, DMD, MPH

Dr. David Reznik, DDS

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Georgia Dental Hygienists' Association

Suzanne Newkirk, RDH

Valerie Ferro, RDH, BSDH

Pam Cushenan, RDH, MS

Charles Craig

Carol Smith, RDH, MSHA, *Georgia Department of Public Health*

Dr. Kevin Hendler, DDS, *Ina T. Allen Dental Center*

Keith Kirshner, *Ben Massell Dental Clinic*

Malinda Gowin

Joshua Littlejohn, MPH

Disclaimer:

The information presented is not intended to be legal advice. It is based on the interpretation of the law by the authors and information published in literature.

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Introduction

Toolkit Objectives

Effective January 1, 2018, a dental hygienist licensed in Georgia may perform specific duties in certain settings under general supervision. **The purpose of this toolkit is to aid dental care providers (i.e. dental hygienists, dentists) and interested stakeholders (i.e. administrators, medical providers) in how to utilize dental hygienists working under general supervision.** This toolkit does address the private office setting, but its main focus is on public oral health programs, especially as it pertains to increasing access to care.

Many states have allowed general supervision dental hygienist services for decades, and there is a wealth of expertise and knowledge that has resulted from experience. Studies have shown that using dental hygienists under general supervision has increased access to care and improved oral health.[1,2] **This toolkit seeks to highlight and recommend best practices based on published literature on what has or has not been effective.**

The State of Oral Health in Georgia

Specific to Georgia, out of its 159 counties, 118 are considered dental health professional shortage areas, which are areas that do not have enough licensed dentists to meet the dental care needs of the public. One result of this shortage is that individuals instead utilize hospital emergency departments to seek temporary relief from non-traumatic dental emergencies. In 2016 alone, 4,106 Georgians sought emergency dental care at Grady Memorial Hospital at a cost of $1.75 million.

Another effect of this shortage is untreated poor oral health. Approximately one-third of older adults have untreated tooth decay and one-quarter of adults ages 65 to 74 have severe periodontal disease.[3]

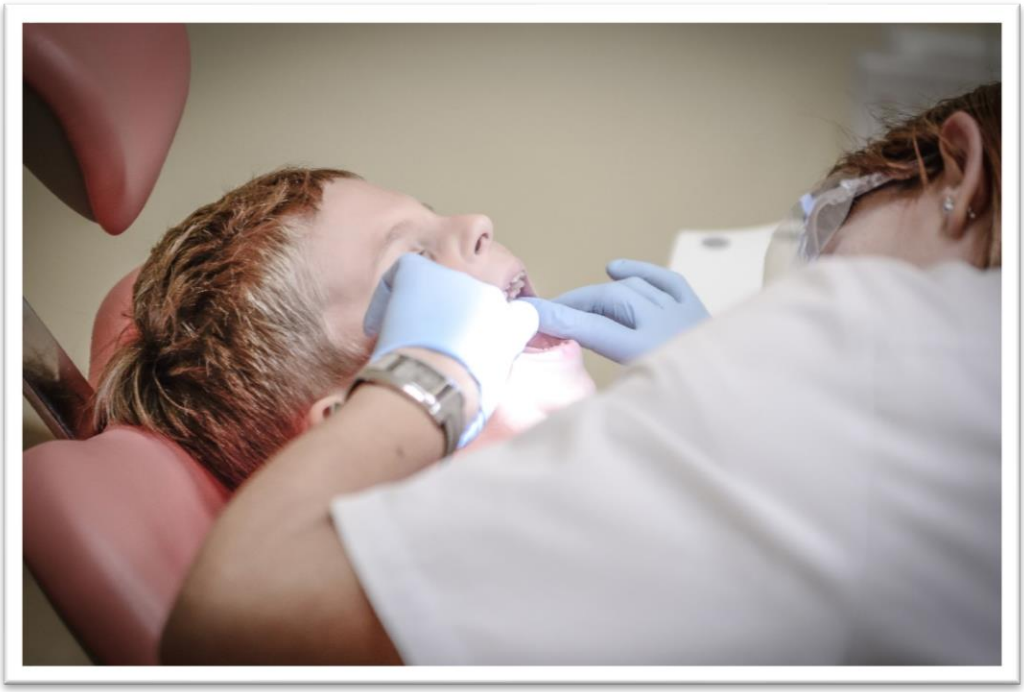
The burden of oral disease disproportionately affects minority and low-income children. A study conducted in 2011 of third graders in Georgia revealed that non-Hispanic black children were more likely to have untreated decay than non-Hispanic white children. Similarly, low-income children were found to be in need of immediate or urgent treatment more than high-income children.[4]

1 Langelier M, Continelli T, Moore J, Baker B, and Surdu S. *Expanded scopes of practice for dental hygienists associated with improved oral health outcomes for adults.* Health Affairs. 35(12):2207-2215, Dec 2016.
2 Levy D. *Maryland Public Health Dental Hygiene Act: Impact Study.* Maryland Department of Health and Mental Hygiene, Office of Oral Health. Baltimore, Maryland, 2013.
3 Preamble to HB154
4 Kabore HJ, Smith C, Bernal J, *et al. The Burden of Oral Health in Georgia.* Georgia Department of Public Health, Maternal and Child Health, Office of MCH Epidemiology, Georgia Oral Health Program, May 2014.

General Supervision and Preventative Services

Professional preventative hygiene services can help prevent dental disease before it occurs. Preventative care is the most cost-effective service that can be delivered to the public. Moreover, researchers have shown that dental hygienists practicing under general supervision in certain settings, such as school-based programs, would be effective in meeting the need for increased access to care and be a cost-saving approach as compared to other interventions, such as increasing Medicaid reimbursement rates.[5]

Professionally for dental hygienists, working under general supervision is an opportunity to take on greater depth and breadth of work experience and responsibilities. In addition to clinical work, there is administrative and case management work that requires leadership skills, critical thinking, and creativity.



5 Johnson B, Serban N, Griffin PM, and Tomar SL. *The cost effectiveness of three interventions for providing preventive services to low-income children.* Cmmty Dent Oral Epid. 1-7, 2017. Doi: 10.1111/doe.12315

Rules & Regulations

Dental hygienists under general supervision in GA

Effective January 1, 2018, a licensed dentist may authorize a dental hygienist to work under general supervision.

General supervision means that a licensed dentist can authorize certain allowable duties of a licensed dental hygienist but does not require that a licensed dentist be present when such duties are performed.

Georgia Legislation

http://www.legist.ga.gov/Legislation/20172018/170636.pdf

Requirements

Authorizing Dentist:

- Licensed to practice dentistry in Georgia
- May only authorize up to four dental hygienists in any setting or number of settings at any one time
- Practice in a physical and operational dental office in the state within 50 miles of the setting in which dental hygienists are providing dental hygiene services under general supervision

Dental Hygienist:

- At least 2 years of experience in the practice of dental hygiene
- In compliance with continuing education requirements
- In compliance with cardiopulmonary resuscitation requirements
- License in good standing
- Maintain coverage under a professional liability occurrence or claims insurance policy with a policy limit with a minimum of $1,000,000
    - (See ADHA for more information: http://www.adhainsurance.com/)
    - http://www.proliability.com/professional-liability-insurance/dental-hygienists-assistants

Settings

Private Office

A dentist may authorize general supervision of a dental hygienist upon meeting the following criteria:

- A **new patient** of record **must be clinically examined by the authorizing dentist during the initial visit**
- A patient must be examined by the authorizing dentist at least once every twelve months
- A patient must be notified *in advance* of the appointment that the patient will be treated by the dental hygienist under general supervision without the authorizing dentist being present or being examined by the authorizing dentist

Public or Safety Net Settings

A **new patient** of record **does NOT need to be clinically examined by the authorizing dentist during the initial visit.** However, the patient is advised to seek a clinical exam by the dentist **within 90 days** (unless a clinical exam has already been performed).

- Dental facilities of the Department of Public Health, county boards of health, Department of Corrections
- Approved off-site locations by personnel of the Department of Public Health or county boards of health
- Health facilities operated by federal, state, county, or local governments
- Schools
    - Title I schools (with at least 65% eligible for free or reduced price lunch)
    - Head Start programs
    - Georgia's Pre-K program
- Hospitals
- Nursing homes
- Long-term care facilities
- Hospices
- Rural health clinics
- Federally qualified health centers
- Family violence shelters
- Free health clinics

In public or safety net settings, patients need to be provided with written notice that contains:

- Name and license number of dental hygienist and authorizing dentist
- Any dental hygiene issues identified
- Statement advising the patient to seek a more thorough clinical exam by the dentist within 90 days (unless the authorizing dentist performed a clinical exam of the patient)
    - http://www.proliability.com/professional-liability-insurance/dental-hygienists-assistants

Scope of Practice

Private Office:

- Topical fluoride application
- Sealant placements
- Oral prophylaxis and assessment
- Exposure and processing of radiographs (with prior authorization from dentist)

Public or Safety Net Settings:

- Topical fluoride application
- Sealant placements
- Oral prophylaxis
- Dental screenings (see below)

Dental Screenings:

A dental screening is a visual assessment of the oral cavity without the use of radiographs, laboratory tests, or diagnostic models to determine if a more thorough clinical examination and diagnosis should be conducted by a licensed dentist.

Each person who receives a dental screening, or the parent or legal guardian if the person is a minor, must be informed in writing of the purpose and limitations of a dental screening and advised to seek a more thorough clinical examination by a licensed dentist to determine whether or not problems exist that might not be discovered in a dental screening.

In addition to the previously listed public settings, dental screenings can be conducted in the following:

- Volunteer community health settings
- Senior centers
- Other pre-approved health fairs

NOTE: Dental hygiene services ***may not*** be provided by dental hygienists working in a mobile dental van without a supervising dentist present.

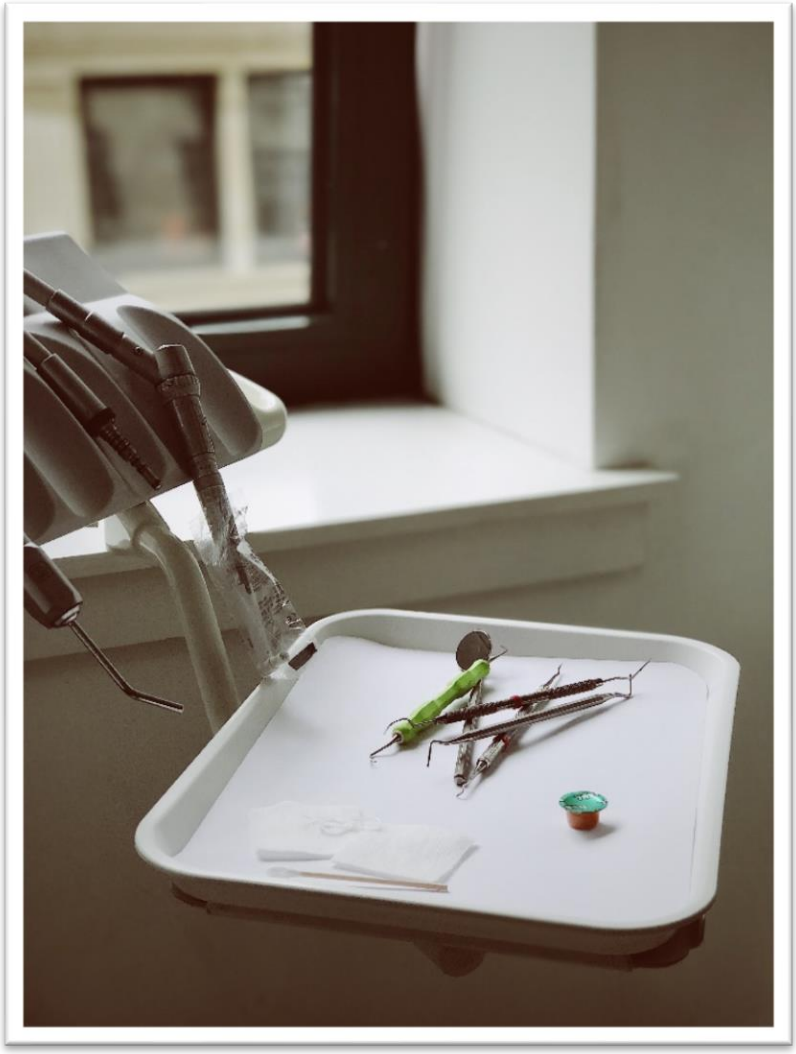
For All Settings:

If patient has dental pain or clearly visible evidence of widespread dental disease, then no dental hygiene services can be performed. An immediate referral must be made to the authorizing dentist for clinical exam and treatment.

- Dental hygiene services may be performed after a dentist has provided written authorization

Office Protocol:

Although the law does not require specific office protocol or written agreement between the authorizing dentist and the dental hygienist working under general supervision, it is recommended that there be clear, explicitly written office protocol agreed upon by all parties. Office protocol should include record keeping, addressing urgent and restorative care needs, and medical emergencies. It is recommended that the office protocol be in writing and signed by the authorizing dentist and dental hygienist. Ultimately, the authorizing dentist is responsible for hygiene services provided under general supervision.



Roles & Responsibilities

Skills & Traits Needed

Practicing under general supervision requires a unique set of skills and character traits. Listed below are such skills and character traits that have been identified in dental hygienists of successful oral health programs:[6]

Independent and Confident

A dental hygienist working under general supervision may oftentimes be working alone. Therefore, they need to be able to work independently and be self-directed and self-motivated.

Critical Thinking and Problem Solving

The dental hygienist must be able to think critically and solve problems that may arise when working independently. They may be developing and implementing a new program and may encounter unforeseen obstacles that require thoughtful solutions.

Creative and Innovative

The dental hygienist needs to be creative and innovative in their approach to conceptualizing and implementing an oral health program, especially in nontraditional settings. In particular, with programs that have limited resources, the dental hygienist needs to be able to optimize these limited resources.

Good Networking and Collaboration Skills

Although the dental hygienist may often be working independently, they cannot successfully implement an oral health program without others. They must be able to maintain good working relationships with the authorizing dentist based on mutual respect and clear communication. Also, they may need to work with other stakeholders depending on the setting (i.e. school principals, nurses, facility administrators). Thus, the ability to collaborate and work with others is vital to being successful.

Administrative and Management

If there is no separate administrator or case manager, the dental hygienist needs to be able to serve these roles. They need to be organized and able to handle the administrative work (i.e. paperwork, communicating with partners and stakeholders, reporting, record keeping).

6 Delinger J, Gadbury-Amyot C, Mitchell T, and Williams K. *A qualitative study of extended care permit dental hygienists in Kansas.* J of Dent Hygiene. 88(3):160-172, June 2014.

Dental Case Manager

The dental hygienist working under general supervision in public health settings often have to fulfill various roles, including administrator and clinician. Having a separate case manager can alleviate the dental hygienist's work load and allow them to focus on the clinical work. In the event that there is not a separate dental case manager, the dental hygienist serves this purpose as well. The role of case management is critical in the success of an oral health program.

Roles and Responsibilities[7]

- Assess the client's needs, strengths, and resources
- Develop an individualized plan for achieving optimal oral health outcomes
- Care coordination
    - Assist clients in identifying and accessing dental care
    - Link the client and client's family to appropriate community resources (i.e. social services)
- Facilitate communication
    - Among members of a health care team (i.e. hygienist, dentist)
    - Between patient care teams, families, and professional caregivers
    - Across health care settings (i.e. primary care, specialty care)
    - Between health care organizations
    - Between patients and community services
- Educate about treatment options, community resources, insurance benefits, etc.
- Actively problem solve with the client and client's family
    - Addressing potential obstacles to care (i.e. transportation, cost, childcare)
- Provide services that are family-centered and culturally appropriate
    - Engage in community-based social change that addresses both the children and the families/caregivers[8]
    - Acknowledge different cultural beliefs, values, attitudes, traditions, and language preferences and adapting information and services to accommodate these differences (e.g. use an interpreter)
- Utilize effective and supportive communication techniques

7 Silverman J, Douglass J, and Graham L. *The use of case management to improve dental health in high risk populations.* Pediatric Oral Health Research & Policy Center. American Academy of Pediatric Dentistry. June 2013. http://www.aapd.org/assets/1/7/Case_Management.pdf Accessed on 7 Aug 2017.
8 Zarkowski P, Aksu M. *Complexities of providing dental hygiene services in community care settings.* J Evid Base Dent Pract. 16S:113-121, June 2016.

Effective Case Management Strategies[9]

- Motivational interviewing (MI)
  - Brief, patient-centered, personalized counseling
  - Reflective listening and use of open-ended questions
  - Goal of MI
    - Helping raise client's own awareness of the problem
    - Identifying their own health-related goals
    - Increasing their understanding of how current behavior may not be consistent with their goals
- Health literacy activities
  - Utilize MI to provide anticipatory guidance and patient education
  - Use plain language to communicate concepts
    - Prioritize most important concepts first
    - Break complex information into smaller chunks
    - Use simple language and provide definition for technical terms
    - Do not use medical jargon
- Community outreach and education
  - Engage families where they live, work, and go to school
  - Examples: school-based oral health education, screenings at WIC clinics or Head Start programs
- Appointment reminder systems
  - Phone calls, text messages, emails, postcards. Be aware of what is appropriate and effective for the patient population.
  - Failed appointments
    - Deter providers from seeing Medicaid patients
    - Delay care for patients, which may mean continued pain and suffering
    - Has been identified as a risk factor for early childhood caries[10]

Regular and frequent encounters with case management can lead to an increase in dental care utilization, especially in children from low-income families.[11,12,13]

9 Silverman J, Douglass J, and Graham L. *The use of case management to improve dental health in high risk populations.* Pediatric Oral Health Research & Policy Center. American Academy of Pediatric Dentistry. June 2013. http://www.aapd.org/assets/1/7/Case_Management.pdf Accessed on 7 Aug 2017.

10 Schroth RJ, Cheba V. Determining the prevalence and risk factors for early childhood caries in a community dental health clinic. Pediatric dentistry. Sep-Oct 2007;29(5):387-396.

11 Greenberg B, Kumar J, and Stevenson H. *Dental case management: increasing access to oral health care for families and children with low incomes.* J Amer Dent Assoc. 139(8):1114-1121, Aug 2008.

12 Binkley C, Garrett B, and Johnson K. *Increasing dental care utilization by Medicaid-eligible children: a dental care coordinator intervention.* J Public Health Dent. 70(1):76-84, 2010.

13 Lemay, C, Tobias C, Umez-Eronini A, et al. *Dental case manager encounters: the association with retention in dental care and treatment plan completion.* Spec Care Dentist. 33(2):70-77, 2013.

Overview of the Roles and Responsibilities of the Authorizing Dentist and Dental Hygienist working under General Supervision: PRIVATE OFFICE SETTING

Effective January 1, 2018, a licensed dentist may authorize a dental hygienist to work under general supervision.

General supervision means that a licensed dentist can authorize certain allowable duties of a licensed dental hygienist but does not require that a licensed dentist be present when such duties are performed.

Requirements to Practice

Authorizing Dentist

- Licensed to practice in GA
- Practice within 50 miles in GA of dental hygienist's place of service
- Can only authorize a maximize of 4 dental hygienists

Dental Hygienist

- Minimum of 2 years experience
- In compliance with CE and CPR requirements
- License in good standing
- Liability insurance

Regulatory Responsibilities

All billing occurs under dentist's name.

Refer any patient with pain or widespread dental disease to dentist immediately.

Must obtain written order from dentist to resume hygiene services.

Clinical Duties

Required

- Perform initial exam
- Examine patient at least once every 12 months
- Provide patient with advanced notification of visit with dental hygienist under general supervision

Permissible

- X rays (with prior authorization)
- Oral prophylaxis and assessment
- Fluoride treatments
- Sealant application

Source:
http://www.legis.ga.gov/Legislation/20172018/170636.pdf

Overview of the Roles and Responsibilities of the Authorizing Dentist and Dental Hygienist working under General Supervision:

PUBLIC/SAFETY NET SETTING

Effective January 1, 2018, a licensed dentist may authorize a dental hygienist to work under general supervision.

General supervision means that a licensed dentist can authorize certain allowable duties of a licensed dental hygienist but does not require that a licensed dentist be present when such duties are performed.

Authorizing Dentist	Dental Hygienist
Requirements to Practice	
• Licensed to practice in GA • Practice within 50 miles in GA of dental hygienist's place of service • Can only authorize a maximize of 4 dental hygienists	• Minimum of 2 years experience • In compliance with CE and CPR requirements • License in good standing • Liability insurance

Regulatory Responsibilities

All billing occurs under dentist's name.

Submit annual report to GA Board of Dentistry.

Refer any patient with pain or widespread dental disease to dentist immediately.

Must obtain written order from dentist to resume hygiene services.

Provide patient with written notice with required information.

Clinical Duties

Optional Initial Exam

-Need for initial exam is at sole discretion of authorizing dentist

-If initial visit is NOT performed, patient is advised to seek clinical exam within 90 days of initial visit

Scope of Practice

-Dental Screening

-Oral prophylaxis and assessment

-Fluoride treatments

-Sealant application

Settings

- Dental facilities of the Dept of Public Health (DPH), county boards of health, Dept of Corrections
- Approved off-site locations by the DPH or county boards of health
- Health facilities operated by federal, state, county, or local governments
- Schools (Title I, Head Start Programs, GA's Pre-K program)
- Hospitals
- Nursing homes
- Long-term care facilities
- Hospices
- Rural health clinics
- Federally Qualified Health Centers
- Family violence shelters
- Free health clinics

In addition to the previously listed settings, dental screenings can also be conducted at:

Source:
http://www.legis.ga.gov/Legislation/20172018/170636.pdf

Financial Management

Payment/Reimbursement

The initial cost of establishing a program may include purchasing portable equipment, materials, and salaries for personnel. Some of these initial costs may be offset by grants in the public health setting.

The authorizing dentist is responsible for billing, and **all services are billed under their name**. Mechanisms of reimbursement include private insurance, public insurance (i.e. Medicaid), and fee for service.

Services should not be billed under the dental hygienist's name. Financial earnings made by the dental hygienist are in accordance with the employee contract made between them and their employer (i.e. an agency, the authorizing dentist).

Note: There shall be no fees charged for providing a dental screening except for dental screenings provided by employees of the Department of Public Health or county boards of health. These fees must be paid directly to that department or county board of health and not to the individual who performs the dental screening.

Data Collection

Data collection is important not only for oral health surveillance but also to measure the impact of oral health programs, particularly the new effort in Georgia allowing dental hygienists to work under general supervision.

The Department of Community Health is required to collect data on changes to utilization rates for dental services provided to recipients of Medicaid. Otherwise, although data collecting is strongly encouraged, it is not required for other providers.

Annually, the Georgia Board of Dentistry (GBOD) reports the number of licensed dentists providing dental hygienist services under general supervision in each of the following settings: hospitals; nursing homes; long-term care facilities; rural health clinics; federally qualified health centers; health facilities operated by federal, state, county, or local governments; hospices; family violence shelters as defined in Code Section 19-13-20; and free health clinics as defined in Code Section 51-1-29.4. **Licensed dentists who authorize general supervision need to report this utilization to the GBOD at the end of the calendar year.** Refer to the GBOD for more information.

Potential Barriers

Dentists

Dentists in the private sector may not be aware of the new law, which may lead them to being uncomfortable with acting as authorizing dentists. Dentists working in public health settings may be more willing to authorize general supervision.[14] **Educating dentists on what the law entails may help increase the utilization of general supervision.**

Some dentists may feel like dental hygienists working under general supervision are competing for patients. It is important to reach out to local dentists to form partnerships and reassure that public health programs are intended to increase access to care for people who would otherwise not receive care.[15]

Physical and Logistical

Oftentimes, dental hygienists are doing outreach work that takes them into non-traditional settings, such as nursing homes and schools. Working with portable equipment requires moving, setting up, and breaking down, which may be physical tasking.[16] Moreover, the actual physical space in these non-traditional settings may be limited or not ideal for clinical work. Working with established medical clinics, such as Federally Qualified Health Centers without a dental component, may alleviate this barrier.

Depending on the workforce and personnel availability or lack thereof, the dental hygienist may spend a significant amount of time and energy on administrative and case management work. For instance, they may be responsible for marketing, record keeping, scheduling, reporting, documenting charts, and managing cases. These duties can significantly add to and burden the dental hygienist's workload.

Financial

Establishing an oral health program may require initial funding, for example, to purchase portable equipment and materials and to hire the necessary personnel.

Sustainability is critical to any operation and should planned for from the beginning. Funding may come in the form of grants, reimbursements from state insurance programs, and fees directly paid by the patients.

14 Levy, D. *Maryland Public Health Dental Hygiene Act: Impact Study.* Maryland Department of Health and Mental Hygiene, Office of Oral Health. Baltimore, Maryland, 2013.
15 Levy, D. *Maryland Public Health Dental Hygiene Act: Impact Study.* Maryland Department of Health and Mental Hygiene, Office of Oral Health. Baltimore, Maryland, 2013.
16 Mertz E and Glassman P. *Alternative practice in dental hygiene in California: Past, present, and future.* J Calif Dent Assoc. 39(1):37-46, Jan 2011.

Buy-in from Stakeholders

Depending on the practice setting, there may be difficulty getting buy-in from key stakeholders. For instance, working in a school-based program requires buy-in from the school principal, parents, teachers, and school nurse. Without their support, the dental hygienist may find it difficult to get returned consent forms or secure an adequate physical space to work.

Partnering with local dentists is important for identifying potential authorizing and referring dentists.

Frequently Asked Questions[17]

How is General Supervisor defined in the new law?

General supervision means that a licensed dentist has authorized certain allowable duties of a licensed dental hygienist but does not require that a licensed dentist be present when such duties are performed.

In what settings with General Supervision be permitted?

- Private Dental Offices
- Public or Safety Net Settings
    - Dental facilities of the Department of Public Health, county boards of health, Department of Corrections
    - Approved off-site locations by personnel of the Department of Public Health or county boards of health
    - Health facilities operated by federal, state, county, or local governments
    - Schools
        - Title I schools (with at least 65% eligible for free or reduced price lunch)
        - Head Start programs
        - Georgia's Pre-K program
    - Hospitals
    - Nursing homes
    - Long-term care facilities
    - Hospices
    - Rural health clinics
    - Federally qualified health centers
    - Family violence shelters
    - Free health clinics

What functions may be provided under general supervision in *private* dental offices?

Oral prophylaxis and assessment, application of fluoride and sealants, oral hygiene instruction and education, and exposure and processing of radiographs (with prior authorization from dentist).

What functions may be provided under general supervision in *public* or safety net settings?

Oral prophylaxis, application of topical fluoride and sealants, oral hygiene instruction and education, and dental screenings.

Are there requirements that must be met by the supervising dentist before general supervision may be authorized in *private* practice?

Yes. Requirements include:

- The authorizing dentist must clinically examine a new patient during the initial visit so that they may become a patient of record
- A patient must be examined by the authorizing licensed dentist at a minimum of 12-month intervals
- A patient must be notified in advance of the appointment that they will be treated by the licensed dental hygienist under general supervision without the authorizing licensed dentist being present or be examined by the authorizing licensed dentist during that appointment. (See next question)
- A licensed dentist may only authorize up to four (4) licensed dental hygienists to provide dental hygiene services under general supervision

In the private setting, does advance notification to the patient need to be done in writing or by phone?

The law does not state what mode of communication must be used to provide advanced notification to the patient. However, since the dentist performs an initial exam, they should inform the patient at the time of the exam that hygiene visits might occur when the dentist is not present. The dentist should document in the patient's chart that the patient was informed and gave consent. The dentist could also include a signed verbal consent in the patient's chart. Subsequently, verbal reminders should suffice.

Are there any requirements that must be met by the dental hygienist before they may work under general supervision?

In both private practice dental offices and public or safety net settings, licensed dental hygienists working under general supervision must have:

- At least 2 years of experience in the practice of dental hygiene
- Shall be in compliance with CE and CPR requirements
- Shall be licensed and in good standing with the Georgia Board of Dentistry
- Shall maintain professional liability insurance in accordance with Board of Dentistry rules and regulations

Are there other requirements for the dental hygienists working under general supervision in *public* or *safety net settings*?

Dental hygienists working under general supervision in public or safety net setting shall provide to the patient or legal guardian in writing:

- The name and license number of the dental hygienist and authorizing dentist
- Any dental hygiene issues that the dental hygienist identified during treatment

- A statement advising each patient to seek a more thorough clinical examination by a Georgia licensed dentist within ninety (90) days, unless the authorizing dentist performed an initial clinical exam

What if the patient shows up for dental hygiene services under general supervision in public or safety net settings and has dental pain or clearly visible evidence of widespread dental disease?

Patients presenting with pain or clearly visible evidence of widespread dental disease:

- **Must be immediately referred to the authorizing Georgia licensed dentist for a clinical examination and treatment**
- These patients are ineligible to receive dental hygiene services and **must** be provided written notice to inform them that they are unable to receive dental hygiene care under general supervision until they receive a clinical examination by a Georgia licensed dentist
- Patients with active dental disease or pain must receive written authorization from the examining dentist allowing them to receive dental hygiene services under general supervision before they can be seen without a dentist physically present in the treatment facility
- The hygienist shall notate the patient's file that the patient shall not be seen under general supervision until the patient receives written authorization from the authorizing dentist

Are there requirements that the authorizing dentist must have in order for their dental hygienists to work under general supervision in public or safety net settings?

- Licensed to practice dentistry in Georgia
- May only authorize up to four dental hygienists in any setting or number of settings at any one time
- Practice in a physical and operational dental office in the state within 50 miles of the setting in which the dental hygienists are providing dental hygiene services under general supervision

Can a dental hygienist have several authorizing dentists?

Yes, the law does not specify otherwise.

May a dental hygienist have an authorizing dentist different from the dentist who employs them?

Yes, the authorizing dentist does not have to be an employer.

Can a dentist have a Georgia license, be practicing in a different state, and be an authorizing dentist?

The authorizing dentist must be a dentist licensed in Georgia with a practice in Georgia.

If a dental hygienist works in different settings (e.g. a long-term care facility and a Title I school), do they need different sponsoring dentists?

No, as long as the authorizing dentist practices in a physical and operational dentist office in the state within 50 miles of the setting.

Does the authorizing dentist need to report any data to the state or GA Board of Dentistry (GBOD)?

At the end of the calendar year, authorizing dentist utilizing general supervision need to complete and return a utilization survey to the GBOD.

Can dental hygienists work out a mobile dental van under general supervision?

Dental hygiene services ***may not*** be provided by dental hygienists working in a mobile dental van without a supervising dentist present.

Best Practice Approach and Evidence-Based Dentistry

Providing evidence-based care and incorporating a best practice approach is crucial. Listed below are resources:

- Association of State and Territorial Dental Directors https://www.astdd.org/best-practices/
- Centers for Disease Control and Prevention https://www.cdc.gov/oralhealth/guidelines.htm
- American Dental Association Center for Evidence-Based Dentistry http://ebd.ada.org/en

Best Practices Approach[18]

The ASTDD Best Practices Project uses five criteria to help identify best practices in dental public health and gain a deeper understanding of the practices. The criteria are:

Impact/Effectiveness
The practice has demonstrated impact, applicability, and benefits to the oral health care and well-being of certain populations or communities with reference to scientific evidence and/or documented outcomes of the practice.

Efficiency
The practice has demonstrated cost and resource efficiency where expenses are appropriate to benefits. This includes staffing and time requirements that are realistic and reasonable.

Demonstrated Sustainability
The practice shows sustainable benefits and/or is sustainable within populations/communities and between states/territories.

Collaboration/Integration
The practice builds effective partnerships among various organizations and integrates oral health with other health projects and issues.

Objectives/Rationale
The practice addresses Healthy People 2010 objectives, responds to the Surgeon General's Report on Oral Health, and/or builds basic infrastructure and capacity for state/territorial/community oral health programs.

18 Association of State and Territorial Dental Directors. *Best practices definitions and criteria.* Updated Feb 2017. http://www.astdd.org/best-practices-definitions-and-criteria/ Accessed on 20 Dec 2017.

When adapting ideas from best practices, the ASTDD Best Practices Committee recommends that each end-user consider these five criteria. Beyond these criteria, the Best Practices Committee also encourages end-users to consider an "X-Factor" when assessing best practices. The "X-Factor" should include variables related to leadership, political acceptability, available resources, feasibility and implementation that are specific to each end-user's program and environment, which will influence the acceptability/adaptability of the best practices.

Best Practices: Program Highlights

This section provides examples of successful oral health programs utilizing dental hygienists working under general supervision all over the country. Please keep in mind that each state has its own unique laws, regulations, and circumstances, which may not directly translate to the context of Georgia. However, these programs still provide examples of best practices that can be applicable.

Dental Hub Program and GraceMed, Kansas[19,20]

The Dental Hub Program is a private-public partnership funded by the Kansas Association for the Medically Underserved. It started as a four-year funding program from 2007 to 2010. The program is based on the hub and spokes model: “hubs” being dental homes in existing safety net clinics and “spokes” being outreach to public health and community settings that do not have existing oral health services.

The program learned that having a strong “hub” is essential to the success of the “spokes.” At the onset of the spokes, the hub must clearly communicate to the spokes the vision and a step-by-step process of how to set up the spokes (i.e. “who to target, why, and what services to provide”). These discussions need to be with staff and not just administrators.

GraceMed, a large Federally Qualified Health Center (FQHC) in Kansas established a network of school-based oral health programs funded by the Dental Hub Program. In this case, GraceMed is the “hub” and the school-based programs are the “spokes.” The program was exclusively staffed by Extended Care Permit (ECP) dental hygienists, which is the designation Kansas has given to dental hygienists who meet specific criteria to work under general supervision. They set up single-day, temporary clinics using portable equipment. Dental services provided include cleanings and applying fluoride and sealants. During the course of 2006 to 2016, the school-based program grew from one school to 130 elementary and middle schools.

19 Simmer-Beck M, Wellever A, and Kelly P. *Using registered dental hygienists to promote a school-based approach to dental public health.* Am J Public Health. 107:S56-S60, 2017.
20 Wellever A. *Evaluation of the Dental Hub Program*. Kansas Association for the Medically Underserved. May 2012. https://www.kamuonline.org/wp-content/uploads/2013/04/Evaluation-of-the-Dental-Hub-Program-by-Anthony-Wellever.pdf Accessed on 3 Aug 2017

Health Promotion Specialists, South Carolina[21]

Health Promotion Specialists was established by a dental hygienist and employed other dental hygienists to provide services to low-income children as allowed by law in SC. This school-based program was in 413 schools in 45 school districts. It partnered with 20 restorative dentists who agreed to see referred cases in their private offices. Caregivers were also given lists of dentists in their area, especially highlighting those who accepted Medicaid. Data collected showed that in the first five years of the program, sealant placements increased and incidence of untreated cavities decreased.

21 American Dental Hygienists' Association. *Transforming dental hygiene education and the profession for the 21st century.* 2015. http://tenndha.com/wp-content/uploads/2015/10/ADHA-White-Paper.pdf Accessed 20 Dec 2017.

Additional Resources

- Massachusetts Health and Human Services Public Health Dental Hygienist Toolkit http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/primarycare-healthaccess/healthcare-workforce-center/oral-workforce-dev/dental-hygienist/toolkit/training.html
- Georgia Oral Health Program https://dph.georgia.gov/OralHealth
- Georgia Dental Hygienists' Association https://www.gdha.org/
- American Association for Community Dental Programs' guide to developing and enhancing community oral health programs www.aacdp.com/docs/CommunityGuide.pdf
- GA legislation on general supervision http://www.legis.ga.gov/Legislation/20172018/170636.pdf

The Toolkit for Incorporating General Supervision in Dental Private Practice and Safety Net Settings in Georgia

Supplement: School-based Oral Health Programs

Public health dental hygienists have been serving students in schools for decades in Georgia and throughout the country. Years of working under general supervision in school-based oral health programs has resulted in improved oral health status, especially among children who otherwise would not have access to care.[22] This supplemental section is not intended to be a comprehensive implementation tool, but rather the purpose is to serve as reference for the abundant resources available and list some best practice strategies for a successful school-based oral health program utilizing general supervision.

Strategy 1: Focus on schools with underserved student populations.

- Title I schools with student populations 65% of whom are eligible for free or reduced price lunch.
- Health Professional Shortage Areas (HPSA) as designated by the Health Resources and Services Administration (HRSA).
- Areas without fluoridated water.

Strategy 2: Engage in community-based social change.[23]

- Establish relationship with key stakeholders (i.e. school administrators, school nurses, teachers, and families) based on open communication. Together, identify areas of need and ways to encourage buy-in and, ultimately, improve the oral health of not only the students but also their families.
- Engage those who are responsible for the child to ensure long-term and lasting change in oral health. Provide opportunities for those individuals to role model and reinforce desired behavior at home.
- Identify who are the "gatekeepers" in the school and community. For example, it may be the principal or school nurse. Not every school is the same.
- Some people in the schools may perceive that students are already being pulled out of class too frequently and missing valuable instruction time.[24] Collaborate with them on how to most effectively and efficiently use the time spent in the oral health program. Also clearly communicate what the oral health program entails and how it will impact the children (i.e. oral health benefits) and staff (i.e. logistics of coordinating and implementing the program).

Strategy 3: Collaborate inter-professionally.[25]

- Integrate oral health with general health by working with school nurses, pediatricians, and social services.

22 Melanie Simmer-Beck, Walker M, Gadbury-Amyot C, *et al. Effectiveness of an alternative dental workforce model on the oral health of low-income children in a school-based setting*. Amer J of Public Health. 105(9):1763-1769, September 2015.
23 Zarkowski P, Aksu M. *Complexities of providing dental hygiene services in community care settings.* J Evid Base Dent Pract. 16S:113-121, June 2016.
24 Delinger J, Gadbury-Amyot C, Mitchell T, and Williams K. *A qualitative study of extended care permit dental hygienists in Kansas*. J of Dent Hygiene. 88(3):160-172, June 2014.
25 Delinger J, Gadbury-Amyot C, Mitchell T, and Williams K. *A qualitative study of extended care permit dental hygienists in Kansas*. J of Dent Hygiene. 88(3):160-172, June 2014.

Strategy 4: Identify an appropriate and effective workspace.

- Whether fixed, permanent equipment is being installed or portable dental equipment is being used, adequate space with the necessary infrastructure (e.g. plumbing) needs to be identified. Infection control is a key concern that must be addressed in temporary settings, such as those using portable dental equipment.

Strategy 5: Maximize the return of consent forms.

- Aside from oral hygiene instruction and counseling, no other services can be provided without consent from the parent or legal guardian. Maximizing the return of consent forms is pivotal to any school-based program.
- The following recommendations have been adopted from strategies compiled from the research field and are based on published studies:[26]
    - Engage parents and school personnel.
        - Collaborate with school administrators, school nurses, teachers, and parents with open communication from the beginning.
        - Administrator and teacher support is instrumental in ensuring forms are returned
        - Include a cover letter from the principal that describes the oral health program, the importance of participation, and either answers potential questions or offers a mechanism for answering potential questions
    - "Piggyback" with existing form collection.
        - Students are sent home with forms to be reviewed, signed, and returned on several occasions in a school year. Sending an oral health program consent form along with one of these forms increases the likelihood that it will be reviewed and returned. Such occasions include beginning of the year announcements and quarterly report cards.
        - Have parents or legal guardians review and return forms during in-person events, such as PTA meetings, school fundraisers, parent-teacher conferences, fall registration, and sporting events.
    - Provide incentives.
        - Incentives can be given to school personnel, teachers, and parents for returned consent forms. For instance, incentives can be discounts for dental products (i.e. electric toothbrushes, tooth whitening products), discounted or free dental services with participating dentists, or gift cards to the local grocery store.
        - Class-based incentives can be given to the class with the most returned consent forms, such as a pizza party.

26 Rodgers P. *Maximizing the return of parent consent forms.* American Foundation for Suicide Prevention, Suicide Prevention Resource Center. Updated February 2006. http://www.sprc.org/sites/default/files/migrate/library/MaximizingParentConsent_0.pdf Accessed on 22 Nov 2017.

- Use simple, attention-grabbing forms.
  - Include a brightly-colored cover sheet with "eye-catching" words, such as "IMPORTANT! Please complete and return to school tomorrow. Your child's class receives a donation for each form returned—whether you check 'yes' or 'no'!"
  - Use easy-to-understand language on forms that can be easily filled out.
- Be prepared to "follow-up".
  - Engage "non-responders" by sending home "follow-up" reminders and phone calls. Depending on how far in advance the initial form was sent home, follow-ups can occur weekly until the week of the event. For example, if there is a "Monday folder" that goes home with the child every week, a "follow-up" letter can be included in this folder. If able, a phone call to the student's home can also be done.

Strategy 6: Establish a referral system for restorative treatment and dental emergencies.

- If a student is having dental pain, experiencing a dental emergency, or in need of restorative treatment, they should be referred to the authorizing dentist. In particular, there needs to be a system for treating urgent dental needs. There should be follow-up to ensure that they received the necessary care.
- Develop a referral system for *uninsured* patients. As an example, the "Miles of Smiles" program in Kansas established a referral network called "Dentists Community Care," which consisted of ten volunteer dentists who saw one child from the program with urgent need each month.[27]

Strategy 7: Plan for the long-term.

- Work to improve oral health literacy by equipping the child and their caregivers with the behaviors and skills necessary to access and navigate the healthcare system. Oftentimes, although school-based programs address the immediate need for dental care, they do not teach the child how to navigate the healthcare system as an adult.[28]
- As much as possible, there should be continuity of care, follow-up, and not just a "one-and-done" approach. A designated case manager or the dental hygienist can assist with ensuring patients have established dental homes.
- Financial sustainability is imperative to the success of a program and should be considered and planned for from the beginning.

27 Simmer-Beck M, Gadbury-Amyot C, Ferris H, *et al. Extending oral health care services to underserved children through a school-based collaboration: Part 1 – A Descriptive Overview.* J of Dent Hygiene. 85(3): 181-190, Summer 2011.
28 Zarkowski P, Aksu M. *Complexities of providing dental hygiene services in community care settings.* J Evid Base Dent Pract. 16S:113-121, June 2016.

Resources

Massachusetts Department of Public Health training specific to school settings: http://www.mass.gov/eohhs/docs/dph/com-health/oral-health/ph-dental-hygienist/training-procedures-school-setting.pdf

Basic Screening Survey developed by ASTDD: https://www.astdd.org/basic-screening-survey-tool/#children

Smart Mouths Smart Kids: Improving Dental Health for Colorado Students: http://smartmouthssmartkids.org/

http://www.gaohcoalition.org/community-programs/statewide.aspx

http://www.astdd.org/docs/sealant-bpar-update-02-2017-final.pdf