Questions & Answers

1. What additional training is needed or hygienists to become public health dental hygienists?

   Answer: The training for public health dental hygienists is the same as for dental hygienists working in private practice.

2. What are the specific duties of public health dental hygienists as opposed to dental hygienists in private practice?

   Answer: Only public health dental hygienists can go into primary care settings such as schools, WIC, or Head Start. They can work under the general supervision of a dentist, and the dentist does not need to be on-site to see the patient first. Public health dental hygienists essentially do everything within their scope of practice that a private sector dentist can do, but in the field. For example, they can apply sealants and varnish and provide other preventative services and education; they do not do exams. Public health dental hygienists also become the link from the primary care site to the local health department where children indentified as high risk for oral disease can be referred and see a dentist.

3. Is there any way to isolate the effect of the public health dental hygienists from other oral health reforms that have been implemented?

   Answer: This study focused on the increases in access to oral health care for children and adults based on interviews with dental hygienists and public health administrators and already existing oral health data. So, while we cannot draw a direct link between the Public Health Dental Hygiene Act and increased access to care, the data we found and the qualitative feedback we received does support this conclusion. Additionally, the reforms that were implemented based on the recommendations of the Dental Action Committee were designed to work in tandem, so it is hard to isolate one particular reform as improving the situation in Maryland.

4. Given the positive experience of this law, do you envision further additions to the workforce such as dental therapists?

   Answer: The directive for the use of public health dental hygienists came out of the recommendations from the Dental Action Committee and legislation. In addition to increasing access to care, one aim of this model was to increase prevention activities to prevent problems from occurring in the first place. So, we wanted to frontload dental hygienists to provide services and activities as early as possible. For now, this is the model we have chosen in Maryland, and it appears to be a really good one.

5. How did local dental practices respond to the Act?

   Answer: They are very happy that we are out there providing services that children otherwise wouldn’t be able to access. There is a large population of children in Howard County that don’t have any insurance so, now, they can at least access care through a sliding fee scale. For those children
with Medicaid, the dentists are happy we are seeing the children and then referring them to a dentist for any advanced services. It’s a very good collaboration.

6. Must all public health dental hygienists receive their general supervision from a FQHC or local health center? If not, why were these the only sites included in the evaluation?

   Answer: It is rare for a public health dental hygienist to be supervised by a dentist working in private practice. Typically, public health dental hygienists are supervised by a dentist that is on-site at the facility where they are employed (e.g., FQHC, health department).

7. How are services reimbursed?

   Answer: There is no direct reimbursement to public health dental hygienists. Medicaid reimburses the site that is the billing center for these services. Some services are provided on a sliding fee scale or at no cost.

8. Are there school-based oral health programs in Maryland that have been in existence longer than the one described in Howard County? Or is this the first of its kind in the state?

   Answer: Some of our programs have existed for well over 20–25 years. One of our county programs won a national award back in the 1990s. So, we had some best practices to look at when we instituted our true statewide model. And, this is an area that Maryland has greatly improved on in the last few years. Our saturation at the Title 1 schools, WIC, and Head Start has been amazing.

9. Do the exams performed by registered public health dental hygienists count toward the federal requirement for Head Start to get children exams within 90 days?

   Answer: The screening does not count towards the Program Information Report; an actual exam needs to be performed by a dentist. However, the screening performed by the public health dental hygienist facilitates linkage to an actual dentist.

10. What is the encounter rate per child for the toothbrush prophy and the exam with mirror and fluoride varnish?

    Answer: It depends on the child and their comfort level. It is typically a two minute brushing and then additional time to apply the varnish.

11. Can I access the implementation guide mentioned by Deb Levy?

    Answer: The guide was a recommendation that came out of the evaluation and is not currently available.

12. For the Howard County school-based program, why is a dentist on the team? Doesn't the Public Health Dental Hygiene Act mean that a dentist isn’t required? Couldn't costs be reduced by not employing a dentist?

    Answer: A dentist is not required to be on-site, but is required to perform “general supervision.” General supervision requires a dentist to supervise the dental hygienists, but they are not required
to be present when dental hygiene procedures are performed. However, there are times when so many children may need to be seen that it helps to have the entire team including the dentist. But yes, the intent of the Act is that there is no requirement that the dentist needs to be present or see the child first with one outcome being reduced costs.

13. In terms of reimbursement, how did you overcome the issue of "taking away" services from the private sector?

Answer: There is no intent to “take away” services from or compete with the private sector. Children who are seen are assessed as to whether they currently have a dental home either by parental consent or by questionnaire. If a child already has a dental home and is found to still be at risk for oral disease, the child is then referred back to his or her own private dentist. However, most of the sites visited by public health dental hygienists are those populated by low-income children (e.g., Head Start, Title I schools, WIC), many of whom are unlikely to have a dental home. In these cases, the potential for a dental home is then established.

14. For those public health dental hygienists included in the study, what were their degrees? Does the panel feel that an advanced degree is necessary given the collaboration with health care professionals and decision making?

Answer: Public health dental hygienists do not need advanced degrees beyond traditional dental hygiene training because the services they provide are all taught as part of their curriculum and are within their scope of practice. This is an advantage of this model over other workforce models that require advanced training. As long as the public health dental hygienist has the requisite experience as spelled out in the law, they are able to participate. The collaboration and decision-making that they provide within the public health environment is quite similar to that in a private dental office.

15. What barriers still pose problems for public health dental hygienists? One dentist takes all referrals?

Answer: The only barriers for this Act are more entry points for those who want to become public health dental hygienists. In other words, there are only a finite number of public health programs and positions available which limits the size of the public health dental hygienist population. And, if we understand the second part of the question accurately, having a dentist take all referrals is not one such barrier since this isn’t the case. No one dentist is meant to take all the referrals. Many public health programs have multiple providers and children also can be referred to area dentists who participate in Medicaid.

16. Does the act reflect "collaborative care/practice"?

Answer: No, if you are referring to a formal and legal contract between a dental hygienist and a dentist similar to what is happening in Minnesota and a few other states. However, it is an informal mode of collaborative practice since the collaboration between the Public Health Dental Hygienist and the dentist is embodied by their trust and mutual respect in enabling the hygienist to provide preventive and assessment services in a primary care setting without the dentist being present and to refer back those children who are deemed at high risk for oral diseases.
17. What is the evidence base for applying sealants without the ability to dry with compressed air? How do you dry the tooth before applying the sealant?

Answer: This evaluation was not about how to apply dental sealants using mobile equipment but rather to evaluate the impact of the Public Health Dental Hygiene Act on the ability of public health programs to provide preventive services in primary care settings. The provision of dental sealants in a school setting was discussed only as an example of what public health dental hygienists can now offer in primary care settings. The method used to apply sealants as described in the presentation is the protocol used by this program and was not meant to serve as a treatise on the application of sealants in a school setting.

18. Are x-rays done at some point to verify whether there is decay, such as unseen interproximal decay?

Answer: Many programs provide varying means, including x-rays, to confirm whether teeth, including those that have sealants applied, have unseen decay. However, this evaluation was performed to evaluate the impact of the Public Health Dental Hygiene Act on the ability of public health programs to provide preventive services in primary care settings. It was not meant to evaluate the effectiveness or appropriateness of school-based dental services.

19. Can children be referred to any dentist, or just the supervising dentist?

Answer: Children can be referred to any dentist. If they have a dental home it is best that they continue to seek care there.

20. What case referral protocols are followed?

Answer: At the school visits, children are given a letter which informs their caregiver of any concerns and politely suggests that they make an appointment for their child to see a dentist. There is a return form that the dentist signs off on that goes back to the school nurse once the child has been seen.

21. What is the availability of fluoridated drinking water in the communities you've studied, and are you able or planning to assess how provision of fluoridated water may reduce the utilization (e.g., by assessing whether there are lower reimbursements in areas where fluoridated water is provided)?

Answer: While we know the availability of fluoridated drinking water in every community in the state and continually update this information, we did not do an assessment of water fluoridation as it pertains to this evaluation nor had we planned to, although it is a good premise. Such a study would need to take into account that a very high proportion of the population on public water supplies—99% according to CDC—receive fluoridated water in Maryland.

22. Are they exams or screenings?

Answer: Screenings. By law in Maryland, all licensed dental hygienists, including public health dental hygienists, are not allowed to diagnose and therefore cannot conduct a formal examination.