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The Board of Registration in Dentistry

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To Whom It May Concern:

 It has come to my attention revisions to 234 CMR 5.00 have been proposed, specifically the removal of scaling and root planing services from the scope of practice of public health dental hygienists (PHDH). The development of the PHDH provider was the answer to growing access to care concerns, especially for the MassHealth population, within Massachusetts. This population faces great difficulty finding a dental provider to treat them and long wait times are common. This lack of routine care contributes to a rise in periodontal concerns.

 Scaling and root planing is currently a general supervision requirement and a common delegable procedure within private practice, therefore falls within the current parameters of Section 51 Chapter 112 which states:

 *“A registered dental hygienist practicing as a public health dental hygienist may perform in a public health setting, without the supervision or direction of a dentist, any procedure or provide any service that is within the scope of his practice and that has been authorized and adopted by the board as a delegable procedure for dental hygienists in private practice under general supervision.”*

 It is my understanding concern lies with obtaining a proper diagnosis. Since PHDHs are required to have a collaborative agreement with a dentist, this relationship could allow for communication necessary to obtain diagnosis. In my opinion, development of guidelines for obtaining proper diagnosis should be established, so needed services can be kept. Elimination of periodontal services will result in the underserved not receiving proper care.

 While it’s proposed to remove scaling and root planing, gross debridement remains. Gross debridement cannot replace scaling and root planing, which is the scientifically proven improved standard of care for periodontal disease. According to the Centers for Disease Control and Prevention, 47.2% of the American population over 30 years of age and 70.1% of the over 65 age group have some form of periodontal disease, so it will undoubtedly be encountered regularly. Eliminating the scaling and root planing services will force PHDHs to ignore periodontal concerns they encounter or provide mediocre care, which raises ethical concerns. Forcing PHDHs to provide care known to be subpar is unfair to the public who entrust them to provide preeminent care.

 PHDHs are a workforce willing to accept the reimbursement rates and alternative settings required to treat the MassHealth population. According to the National Governor’s Association, only 20% of dentists showed significant public insurance billing and less than 40% of children aged 1-5 saw a dentist within the last year. Of the dental practices which accept MassHealth, many limit the amount of patients they accept. Also, research by Nunez et al concluded 72% of dentists prefer to work in private practice and show limited interest in treating in public health settings. If an individual has periodontal disease requiring treatment and is on MassHealth or can’t access a traditional dental practice, who will treat them? For most, the answer will be the emergency room, which according to the Pew Children’s Dental Campaign is ten times more expensive than preventing the issue. Emergency room visits from preventable oral disease burdens an already overwhelmed system, which in most cases are not equipped to effectively treat the problem. The fact that the emergency room has become the last resort for individuals with dental issues shows the effects of the barriers families encounter when seeking care.

 I also disagree with the anticipated financial impact on small businesses. Attached to the announcement of the public hearing for modifications to 234 CMR 5.00, it states the proposed changes are not expected to impact small business. The removal of periodontal services will greatly influence portable dental hygiene practices, which are already limited to the acceptance of MassHealth reimbursement. PHDHs may chose not to practice as a portable practice because of the removal of billable services. For the areas of Massachusetts still labeled as “Dental Shortage Areas” this would be disastrous. To not be allowed to bill for services which are common practice for hygienists and which will be encountered routinely is unfair and would greatly impact monetary income.

 While clear protocol for the diagnosis of periodontal disease is warranted, the broad stroke removal of services from the scope of practice of PHDHs is not. Dental hygienists are well educated professionals trained in periodontal services. In my opinion, we should utilize this workforce to the full extent. A collaborative relationship between dentists and PHDHs would allow for proper diagnosis and treatment of periodontal issues. As dental professionals, our actions should always be to put the patient first, to adapt care when necessary, and prevent oral disease when possible. Let’s work together to develop guidelines that would provide greatest benefit to the public and not just eliminate services necessary for overall health. If needed, I can be reached at (508) 364-5134 or smiles@mobiledentalhygiene.com.

Regards,

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