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**TO: Executive Office of Health and Human Services,**

**Department of Public Health; Board of Registration in Dentistry**

**FROM: Massachusetts Dental Hygienists’ Association**

**DATE: October 12, 2021**

**RE: Comments on Adoption of Proposed Regulations** 234 CMR 2.00, 5.00,

Public Health Dental Hygienists

The following comments are being submitted on behalf of the Massachusetts Dental Hygienists’ Association (MDHA) in response to proposed changes to 234 CMR 2.00.

**2.02 Definitions**

Board. The suggestion is to include the BORID acronym in the definition as BORID is the commonly utilized term to refer to the Board of Registration in Dentistry.

The following comments are being submitted on behalf of the Massachusetts Dental Hygienists’ Association (MDHA) in response to proposed changes to 234 CMR 5.00

**5.04**

Dental Specialties. The phrase “sufficient to maintain expertise” is vague and not measurable. Specific language delineating a percentage of the practice being devoted to the specialty would clarify and be measurable towards maintaining expertise.

**5.05 (3**)

Posting of Licenses and Permits and Identification of Personnel. There is confusion relative to whether or not the name tag with the licensee’s name must include the licensee’s first and last names or first name only. BORID regulations should specify the name requirements on name tags.

**5.06 (1)**

The suggestion is to add a phrase “… or most recent recommendations by the CDC…” to accommodate for future infection control recommendations especially in the Covid-19 era.

**5.09 (1)**

Dental Hygiene Practice and Public Health Dental Hygienist (PHDH) Practice. The suggestion is to delete the words “…in nature…” from the definition because they are superfluous.

**5.09 (2)**

The suggestion is to delete this section because it is duplicative. The scope of practice for RDHs and PHDHs is clearly defined in the delegable duties section of the regulations. Separately, there are typos in the draft document. RHD should read RDH throughout.

**5.09 (3)**

The suggestion is to rewrite the section with specific language defining both the didactic and hands-on educational requirements. The didactic education includes four hours as follows: CDC Guidelines; Risk Management for practice in a public health setting; and Management of medical emergencies. This should be followed by the six hours hands-on experiential education. Documentation in this section should include the name(s) of the public health dental hygienists providing the services as well as any licensed dentist or dental assistant. Name tag requirements for public health dental hygienists, dentists and dental assistants should be consistent with those delineated in 5.05. Finally (in the green (3) (a), the language is vague and confusing and should be clearly defined.

**5.10**

Written Collaborative Agreement (WCA) with a PHDH. The following comments are being submitted on behalf of the Massachusetts Dental Hygienists’ Association (MDHA) in response to proposed changes to 234 CMR concerning Public Health Dental Hygienists.

MDHA applauds the Board’s efforts to undertake such a thorough and comprehensive revision of the preexisting regulations. Prior language was unnecessarily verbose and, at times, redundant. These revisions stand to improve the clarity and accessibility of this guiding document. While appreciative of this goal, MDHA is concerned with certain provisions and the implications they may have on the timely delivery of critical dental care. Specifically, **MDHA stands in opposition to** the inclusion of item *(1) (c) under 234 CMR 5.10: Written Collaborative Agreement (WCA) with a Public Health Dental Hygienist.*

**(1)(c) Obtain and practice public health dental hygiene under a PDO Permit pursuant to 234 CMR 7.00 (Mobile and Portable Dentistry)**

This inclusion would place an undue burden on public health dental hygienists, especially those who practice in a part-time capacity, thereby hampering their efforts to provide essential and appropriate care to vulnerable populations. Under this provision, every public health dental hygienist (PHDH) in the Commonwealth would be mandated to hold a PDO Permit M - regardless of frequency of practice. MDHA believes this imprecise language constitutes a slippery slope wherein the provision could be interpreted as requiring all PDO Permit M holders to own the equipment utilized in their practice.

Currently, PHDH practitioners are able to obtain a PDO Permit M for the purpose of operating such equipment in qualified, public health settings. The ability to utilize equipment under the control of a PDO Director, allows PHDHs to provide services without incurring expenses that might otherwise prove prohibitive. The requirement to obtain a PDO Permit M disparately impacts groups, who can provide oral health services to children across the Commonwealth, in part, due to PHDHs being able to practice part-time *without* the need for their own equipment.

In keeping with the original intent of Chapter 530 of the Acts of 2008, MDHA believes that the role of the PHDH, and subsequently the PDO Permit M, is to better provide expansive access to quality oral healthcare for those who have been historically underserved. Recognizing oral healthcare as a fundamental right that is strongly associated with other indicators of health and wellbeing, MDHA ardently opposes the aforementioned provision as set forth. As a member of the original PHDH workgroup, the intent of the PDO Permit M was to ensure that BORID had a mechanism to inspect the PDO equipment.

In addition to the ambiguity of the language regarding the need for a PHDH to own his/her own equipment, MDHA firmly believes that the permit fee of $180 biannually would be prohibitive for those hygienists who may only practice a few times annually as a PHDH, for example at a community health fair. These individuals would most likely decide to forego registration as a PHDH due to the burden of obtaining the Permit M, and thus would not be able to provide much-needed care to residents across the Commonwealth.

While MDHA understands that the Board of Registration in Dentistry [BORID] may view the adoption of the abovementioned language concerning the PDO Permit M as a measure to track practitioners, MDHA argues that the same accounting could be completed using other means. MDHA believes that the addition of a few simple and very specific survey questions, thoughtfully designed to identify PHDHs, on the pre-existing license renewal form would provide a more efficient way to track current practitioners, *without* establishing regulations and procedures that could lead to a decrease in access.

**Strengthening our Collaborative Relationship**

MDHA stands behind its members who practice within public health settings and celebrates their commitment to enhancing oral health and overall wellbeing. The Board’s efforts to simplify the language of current regulations are symbolic of that same commitment. MDHA is confident that alongside BORID we can continue to make oral healthcare accessible to *all people*, but most especially the children and families who would otherwise lack access to consistent and high-quality treatment.

In addition to clarification around the Permit M, as outlined above, MDHA would also respectfully suggest that the Board review the existing requirements for the PDO Permit M application– MDHA believes that these could be clarified and streamlined, continuing to enable PHDHs to practice at the top of their license and provide quality care to those who lack access. Lastly, MDHA requests that in considering the requirement that all PHDHs carry a Permit M, the Board takes into consideration all RDHs working in public health settings, especially those practicing in a DPH-licensed clinic, and ensures that requirements and scrutiny are equivalent across the spectrum.

**5.11**

Radiology Supervision and Training. There is a question. Do EFDAs currently practice in Massachusetts? If not, the suggestion is to delete all references to EFDA. All radiology course attendees should successfully complete a course with a curriculum that complies with CODA standards for radiological techniques and safeguards in dentistry in order to protect the public.

**5.13**

Delegable Procedures

1. Review medical history. OJT assistants should not be permitted to review a medical history under G. It should be N/A. Education is needed in understanding medical conditions, medications, etc.
2. Record dental screenings. If a dental assistant is recording in a public health setting with a dental hygienist, is that considered direct supervision with a PHDH?
3. Assist or monitor nitrous oxide analgesia. Immediate supervision is required for all. What does that mean? Is the dentist ever permitted to leave the room once he/she starts to administer the NO2?

45. Administer local anesthesia. It is listed as D for PHDH but should be WCA which is

very clear on RDH duties.

48. PHDH with WCA should be allowed to perform brush biopsies especially in long term

care facilities/nursing homes, etc.

49. Lasers (low frequency for the DH) should be permitted for use by hygienists in public

health settings to disinfect/clean out periodontal pockets in long term care facilities/

nursing homes, etc.

70. OJT assistants should not be permitted to utilize hand instruments in a patient’s mouth.

The public must be protected from procedures being performed by unqualified

dental personnel.

**5.14 (3)**

Non-delegable Dental Duties. Question-Does this prohibition conflict with the ability of a dental hygienist, who holds a Permit L, to provide the Covid-19 vaccine or other future vaccines?

**5.15 (1)**

Content of Patient Record. The word scans should be added to the list because records now include scanned information that can be an integral component of a patient record.

**5.15 (1) & 5.16 (1)**

Content of Patient Record. The verbiage of each section should be consistent to ensure completeness of the patient dental record, including adding scans in each description.

Multiple references are contained in these sections relative to licensee signatures. Currently, licensees include dentists, dental hygienists and dental assistants. The signatory should be the licensee reviewing a medical record or providing treatment. For example, if a dental assistant reviews a medical history, the dental assistant should sign the medical history. The same should occur for treatment provided by dental assistants just as it is currently required for dentists and dental hygienists.

**5.16 (2) (b) (1)**

Medical and History Form. The suggestion is to add the words conditions and allergies in this line. A patient may have a condition that is not necessarily defined as a disease or disability. Drug allergies are listed in (2) (b) (2), but it doesn’t include other allergies such as latex or iodine allergies.

**5.20 (2) (a)**

Advertising Dental Services and Dental Fees. The suggestion is to delete “dental auxiliary” and insert “PHDH” because dentists and PHDHs are the only listed dental professionals in 5.20 (1).

Please do not hesitate to reach out to Katherine Pelullo with any questions or concerns at: [katherine.pelullordh@gmail.com](mailto:katherine.pelullordh@gmail.com).

MDHA looks forward to collaborating with the Board towards identifying evidence-based best practices leading to better health outcomes in the Commonwealth of Massachusetts.

Submitted by: Katherine M. Pelullo, RDH, MEd, 69 Sargent Road, Westminster, MA 01473