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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: March 15, 2019**

**RE: Comments on Adoption of Proposed Regulations** 234 CMR 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 concerning Public Health Dental Hygienists.

We applaud 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, we are concerned with certain provisions and the implications they may have on the timely delivery of critical dental care. Specifically, **we stand in opposition to** the inclusion of item *(1)(c) under 234 CMR 5.08: 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. We believe that 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 such as Polished, LLC, 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, we believe 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, we ardently oppose the aforementioned provision as set forth.

In addition to the ambiguity of the language regarding the need for a PHDH to own his/her own equipment, we firmly believe 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.

**Shared Challenges in Data Collection**

As you know, in recent years, the absence of a formal Dental Director has contributed to significant challenges in data collection within the Commonwealth. Unfortunately, this vacancy has resulted in only having a published data set through 2013, and thus, the count of PHDHs may not accurately reflect current practitioners.

While we understand 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, we argue that the same accounting could be completed using other means. We believe 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. We are 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, we would also respectfully suggest that the Board review the existing requirements for the PDO Permit M application– we believe 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, we request that in considering the requirement that all PHDH’s 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 is equivalent across the spectrum.

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

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

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