COMPLEXITIES OF PROVIDING DENTAL HYGIENE SERVICES IN COMMUNITY CARE SETTINGS

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Editor's Note

Legal and ethical quandaries faced by dental hygienists and others when delivering care in the complex public health arena are elucidated in this article. The dentist and dental hygienist co-authors, both of whom have legal degrees and are administrators in an academic dental institution, provide a unique perspective regarding the challenges ahead.

ABSTRACT

Direct access care provided by dental hygienists can reduce oral health disparities for the underserved, yet legal, regulatory, and ethical considerations create complexities and limits.

Background and purpose

Individual state dental practice acts regulate the scope of practice and level of supervision required when dental hygienists deliver care. Yet, inconsistent state practice act regulations contribute to ethical and legal limitations and dilemmas for practitioners. The dental hygienist is positioned to assume an increasingly larger role in the management of oral health disparities. However, there are several legal and ethical considerations that impact both dental hygienists and dentists providing care in complex community settings. This article informs dental hygienists and other related constituencies about conundrums that are encountered when providing care 'beyond the operatory.'

Methods

An evidence-based view of ways in which dental hygienists are reducing oral health disparities illustrates the complex issues involved in providing such care. Potential scenarios that can occur during care provision in underserved settings provide the basis for a discussion of legal and other associated issues impacting dental hygiene practice.

INTRODUCTION

The needs of the underserved are increasing in number and severity of oral disease and also in the complexity of the social determinants that impact care. Although the American Dental Association Health Policy Institute and the US Health Resources and Services Administration disagree as to the adequacy of the dental workforce, the disease statistics are consistent in the increased burden of dental disease in the United States.[1]

As more patients seek care in public health settings and as these delivery environments adapt to the changing needs of the public, the lessons learned will ultimately

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Conflict of interest: The authors have no actual or potential conflicts of interest.

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J Evid Base Dent Pract 2016:16S: [113-121]

1532-3382/$36.00

http://dx.doi.org/10.1016/j.jebdp.2016.02.002

Keywords: Access to care, Legal, Ethical, Scope of practice

drive change in the dental profession similar to those that have occurred within the medical profession. Examples of changes in the delivery of health services include the use of telemedicine to provide clinical health care at a distance and the enhanced roles and services provided by physician assistants (PAs) and nurse practitioners (NPs). In medicine, the role of the PA and NP has evolved over the past 4 decades to a level where each plays an important role in primary care and health maintenance in the United States.

The history of the development of PA practice suggests similarities between the evolution of PA and NP practice and dental hygiene practice.[2] Based on the timeline seen in Table 1, it was almost 3 decades before current NPs established themselves within the medical team.

The evolution and definition of the scope of practice in the allied health workforce in dentistry is similar to historical developments in the PA profession.[3] Recent changes in licensing and regulation to allow for limited prescribing of drugs, delivery of local anesthesia, and remote supervision or direct access are clear examples that dental hygiene is evolving. The evolution of the PA profession can be viewed as a good predictor for the evolution of the dental hygiene profession. The role of the registered dental hygienist in safety net care will continue to develop and advance. As the evolution progresses, the dental hygienist will increasingly need to negotiate the complexities of the regulatory world.

EVOLUTION OF ORAL HEALTH CARE SERVICES

A variety of existing circumstances will drive the evolution of the delivery of oral health care services; in reality, this evolution has already begun. Direct access care by dental hygienists to underserved populations is currently permitted in 38 states in America (see Battrell et al., in this issue).

In some of these direct access states, the dental hygienist is delivering care within the scope of dental hygiene practice without direct involvement of a dentist. This article presents 3 predictable scenarios given the current developments impacting the practice of dental hygiene. There are 6 presumptions that must be established: (1) dental hygiene direct access care in underserved areas will demonstrate success; (2) the recently accepted national educational standards for a dental therapist by the Commission on Dental Accreditation will expand the acceptance of direct access care resulting in inevitable change in the workforce models; (3) technology will continue to facilitate remote supervision which will improve outcomes, increase acceptance of 'indirect supervision,' and reduce access disparities; (4) a single standard of care will be established because underserved populations deserve the same care outcomes despite alternative delivery options; (5) the Patient Protection and Affordable Care Act and Accountable Care Organizations will derive increased reimbursements from improved outcomes facilitated by improved oral hygiene plans; and (6) the oral health care workforce will transform from 4 distinct members (dental assistant, dental hygienist, dental therapist, and dentist) to a team-based workforce continuum based on credentials, education, and competency (see articles by Brickle et al. and also article by Blue and Riggs, in this issue).

COMPLEXITIES OF NONTRADITIONAL SETTINGS

The dental hygienist is increasingly and often requested to provide care to the underserved and the at-risk populations that are not served by traditional fee-for-service practices. Increasingly, this care delivery occurs in nontraditional settings, such as mobile school-based programs, nursing homes, Head Start programs, community centers, and faith-based sites such as churches. These nontraditional settings often have associated complicating factors and challenges. The issues of

Table 1. NP time line.

1800-1960s	1970s	1980s	1990s	21st Century
◆ Psychiatric Nursing 1st specialty ◆ Nurse clinician defined as nurse with advance knowledge ◆ NPs not afforded the same status as cardiac CNS (cannot diagnose & treat) ◆ ↑ demand due to physicians specialization	◆ NP operated & prescribe medication under the direction of the physician ◆ NP role perceived as enticing nurses to switch to medical side ◆ Supported by physicians ◆ Confronted with ↑ resistance by organized medicine	◆ Conflict between NPs & CNS by ANA ◆ AMA opposed any attempt to empower nonphysicians ◆ NPs fight for prescriptive authority & reimbursement ◆ Assumed multiple roles	◆ Master degree required ◆ Gained prescriptive authority for narcotics prescription ◆ ↑ demand ◆ Multiple groups developed to represent PN (ANCC, AANP, and so forth)	◆ Battle over prescriptive authority ◆ Full recognition by insurers & health care organizations ◆ Doctorate NP (DNP) degree proposed by AACN to standardize the practice

CNS = Clinical Nurse Specialist; ANA = American Nurses Association; AMA = American Medical Association; ANCC = American Nurses Credentialing Center; AANP = American Association of Nurse Practitioners; AACN = American Association of Colleges of Nursing.