

Critical Issues in Dental Hygiene

Legislative Initiatives of the Developing Advanced Dental Hygiene Practitioner

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Introduction

The National Call to Action to Promote Oral Health was published in 2003 by the U.S Department of Health and Human Services. The National Call identified the need for an enhanced oral health workforce, and in response the American Dental Hygienists' Association (ADHA) proposed the Advanced Dental Hygiene Practitioner (ADHP).^{1,2} An extensive process involving many stakeholders worked on the development and validation of competencies for the ADHP. The resulting document, which includes the background and justification for the ADHP mid-level provider, can be found on the ADHA website (<http://www.adha.org/adhp/index.html>). With the competencies and curriculum developed, it was time to focus energy on implementing legislative initiatives that would allow the ADHP entry into the oral health workforce.

Under Action 4 of the National Call to Action's report, (Increase Oral Health Workforce Diversity, Capacity and Flexibility), there is a call for more flexibility in the licensure laws for dental professionals. The report makes the case for increased flexibility in state practice acts that would permit alternative models of delivery to increase access to care and promote oral health in underserved and unserved populations. This paper will describe the fundamentals of the legislative process as it relates to licensure of oral health care providers. An example of how one state has progressed toward making

Abstract

Purpose: Today there is a heightened awareness to address access issues and unmet oral needs. The current private practice system of delivering oral health care is failing many Americans. Healthcare advocates and policy makers are taking a greater interest in addressing access problems and have begun to explore new approaches to eliminate oral health care disparities. One solution is the introduction of a new member of the dental team, which is creating a power paradigm shift within the dental profession. As the Advanced Dental Hygiene Practitioner (ADHP) becomes a reality it will be necessary to advocate for change in state dental practice acts to allow this new provider access to populations that are currently unserved or underserved. The National Call to Action to Promote Oral Health report that was published in 2003 called for flexibility in licensure laws that would permit alternative models of delivery of oral healthcare services to vulnerable populations. The American Dental Hygienists' Association responded to the Call to Action by proposing a mid-level provider, the ADHP. Six years later extensive work has led to curricula and one program that accepted applicants for the fall of 2009. This short report will outline steps necessary for changing the practice act along with an example of one state's experience at planning and implementing creative solutions to increase access and eliminate disparities in oral healthcare in a socially responsible and cost-effective approach.

Keywords: Advocacy, Advanced Dental Hygiene Practitioner, Dental Practice Acts, Healthcare Policy, Statutory Law

This study supports the NDHRA priority area, Health Services Research: Evaluate strategies that position and gain recognition of dental hygienists as a primary care providers in the health care delivery system; Identify how public policies impact the delivery, utilization, and access to oral health care services.

their state practice act more flexible will be provided. Recommendations for how to proceed in other states can be found at the end of this paper.

Legislative Process

State practice acts and licensure are regulated within the legislative branch of law (the 3 branches being executive, legislative and judicial).

The overarching purpose of licensure is the protection of the public. Dental hygiene practice acts are statutory law, passed by the respective state legislatures. These statutory laws outline such areas as the allowable scope of practice, requirements necessary to obtain a dental hygiene license and dental supervision requirements. Statutory law can only be changed by

the state legislature.

The state legislative process generally includes 2 legislative bodies, the Senate and the House of Representatives. In order to make any statutory changes, it is necessary for a concept (bill) to become a law. Both houses (Senate and House of Representatives) must pass a bill after it has spent time in specific committees, which may amend or make changes to each respective bill. It is not unusual for a bill to “die” in committee only to have the most vital ideas added to a totally different bill. This process functions as a political compromise between legislators. If both houses fail to pass a bill, the bill will not become a law. If both houses pass the bill, it is necessary for the governor to sign it into law, or if the governor vetoes the bill, both houses have the ability override the veto by a two-thirds majority vote.

When state lawmakers enact legislation, the details of implementation are often left to state agencies. A mechanism commonly used to implement legislation is rulemaking. A rule is a statement of general applicability that implements and interprets law or defines the practice and procedure requirements of an agency of a state government. In other words, rulemaking is lawmaking in areas which the legislature has decided are too specific or too detailed to be handled by legislation, such as dentistry and dental hygiene. The legislature therefore delegates its lawmaking power to an agency (such as state dental boards) by passing a law granting rulemaking authority to the agency to adopt rules pursuant to the approved legislation. In dentistry and dental hygiene, these state agencies are generally appointed by the governor. State dental boards (executive branch) are responsible to the legislature to regulate the practice of dentistry and dental hygiene in their respective states. Some of the functions carried out by state dental boards generally include:

- Determination of the qualifications of applicants for licensure to practice
- Issuance of licenses to those persons

who meet the standards of professional competences set forth in the statutes

- Maintaining high standards of professional competence and ethical conduct among members of the profession through the requirement of continuing education for licensure

The rule-making process is ongoing, and state dental boards may promulgate rules at any time, provided they follow the provision of the law or statute. A rule can be changed by the board or by a person petitioning the board to promulgate, amend or repeal a rule. Clearly, it is in the best interest of dental hygiene to work toward legislative changes in the practice act passed by state legislators that result in statutory law, rather than a rule or regulation that has the potential to be changed by a dental board which may or may not be representative of the profession of dental hygiene.³

While efforts to legislate an increased scope of practice for dental hygienists as ADHPs sounds relatively simple in theory, in practice it is quite complex. In the United States, individual states have differing requirements for licensure to practice, and not all states offer reciprocity of licensure (which means if a dental hygienist is licensed in one state another state will recognize that license and grant the dental hygienist licensure in their state). This system of licensure is possible because the U.S. Constitution reserves many rights to the states, and regulation of occupational licenses is deemed to be a state’s right. This constitution law was observed as early as 1898 when a U.S. Supreme Court decision authorized states to set their own requirements for licensure of physicians.⁴ This decision still serves today as the basis for supporting state over federal regulations in health care licensure, including dental hygiene. The prospect of 50 different licensing bodies (in 50 U.S. states) agreeing to mutual licensure recognition is highly unlikely. This is why it is important as a licensed dental hygiene practitioner to understand how the legisla-

tive process works in your individual states when advocating and lobbying for a workforce change, such as the ADHP. A recent effort by one state to address Action 4 of the National Call to Action Report (Increase Oral Health Workforce Diversity, Capacity and Flexibility) is instructive for dental hygienists across the country.

Case Report: The Minnesota Story

The political culture in Minnesota has historically valued the concept that government exists to achieve goals that are in the public’s best interest.⁵ The government is given a broad role in permitting legislators to initiate new programs as long as they can be justified as being beneficial to all Minnesotans.

In 1969, Minnesota became the first state to establish and implement a continuing education requirement for relicensure of dentists and dental hygienists.⁶ In 2001, the Minnesota Legislature brought forth statutory language and passed the “Limited Authorization for Dental Hygienists.” This legislation, commonly referred to as the “collaborative agreement” language, authorizes dental hygienists to serve as “gateways” to oral health promotion and primary preventive oral health services in a health care facility, program or non-profit organization utilizing a collaborative agreement with a Minnesota licensed dentist. In 2007, the Minnesota legislature embarked on addressing oral health workforce issues through the creation of a new mid-level practitioner.

A partnership was formed in late 2005 between Metropolitan State University and Normandale Community College allowing these institutions to take a pivotal leadership role in advancing the concept of a new practitioner model in dental care. For the majority of 2006, these partners collaborated in the completion of a lengthy Minnesota State Colleges and Universities new program application, which received final approval in November 2007. The new programs were a baccalaureate

degree completion program, a post-baccalaureate certificate program and an oral health care practitioner master's of science (to be credentialed as an ADHP). During the application process, letters of support had to be solicited indicating the need for the development of these new programs. Advocacy efforts during 2006 paved the way for building valuable, sustaining relationships with influential community leaders and organizations. The one common theme voiced by the community partners was that the current workforce simply cannot meet the oral health needs of Minnesotans, especially the young and old. The ADHP was seen as one solution to increase access to oral health care to address unserved and underserved vulnerable populations.

During the 2007 legislative session, it was determined that one strategic initiative was needed to educate not only legislators and the public at large but dental hygienists and dentists on how a new approach was needed to provide additional, affordable, sustained access to the oral health care system. Before any legislative and public policy changes could be planned, dental health care professionals needed to become engaged and learn about the problems unserved and underserved vulnerable populations face on a daily basis.

Informal legislative visits with House and Senate members resulted in potential authors for future legislation as well as advice and direction. However, the consistent message was the need for the Minnesota Dental Hygienists' Association (MnDHA) to continue discussion with the Minnesota Dental Association to avoid a controversial turf battle.

At the conclusion of the 2007 legislative session, a legislative commission on health care access reform was formed to make recommendations to the 2008 legislature on steps needed to achieve the goal of universal oral health care coverage for all of Minnesota. Over the next 6 months, different subcommittees held open forums and hearings to address health care access. Two different subcom-

mittees addressed workforce issues, and the MnDHA was able to provide testimony regarding the ADHP. The final report was submitted to the legislature on January 15, 2008, and included a recommendation to explore a new dental mid-level practitioner during the 2008 legislative session.

A most critical advocacy relationship transpired about this time between the MnDHA and the Minnesota Health Care Safety Net Coalition (SNC) under the leadership of Halleland Consulting, a law firm with health care as one of their identified practice areas. The SNC policy activities included developing a legislative agenda and strategy, building relationships with policymakers, collecting data and preparing reports, preparing legislative handouts and lobbying and activating SNC member involvement. One of the SNC recommendations was to support the creation of an ADHP to partially address the shortage of dentists willing to serve low-income and disadvantaged patients. In late 2007, an invitation was extended to the MnDHA to have a member serve on the SNC Oral Health Committee.

The formation of a strong strategic alliance between the Minnesota Health Care SNC, the MnDHA and the Minnesota State Colleges and Universities resulted in legislation moving forward without challenges from the opposition. Midway through the legislative session, as pressure on legislators to address dental care access mounted, a shift occurred when the University of Minnesota School of Dentistry, announced that the university would create a new member of the dental team. This member would practice within the traditional dental team and would not build upon the competencies of a licensed dental hygienist in the collaborative practice model. As a result there was a name change from Advanced Dental Hygiene Practitioner to an Oral Health Practitioner (OHP) to encompass both the School of Dentistry and the Minnesota State Colleges and Universities proposed models.

Amid controversy, the 2008 Min-

nesota Legislature passed legislation establishing a new oral health practitioner discipline, which would be licensed by the Board of Dentistry, and practice under a collaborative management agreement with a dentist.⁷ The legislation also created a work group to advise the Commissioner of Health on recommendations and legislation to specify the training and practice details for an OHP. The Minnesota Department of Health's Office of Rural Health & Primary Care convened and hosted the 13 member work group which met 8 times and completed its work by December 15, 2008. The work group process did not result in consensus on all issues and a minority report was filed. The Commissioner of Health and the Board of Dentistry submitted the work group's recommendations and proposed legislation to the Legislature on January 15, 2009. The final report and proposed legislation for 2009 can be found at the Minnesota Department of Health website (<http://www.health.state.mn.us/healthreform/oralhealth/index.html>).

As the 2009 legislative session began, the proponents of the OHP final report once again began in earnest its lobbying and advocacy efforts. They determined resistance to specific elements of the work group's recommendations that most significantly extend access to oral health care to Minnesotans who are uninsured and underserved (i.e., general supervision and some scope of practice duties). In spite of opposition by certain entities, the Metropolitan State University's program prepared to admit its first cohort of dental hygiene students in the fall of 2009, when the legislative outcome was still pending. MnDHA held numerous strategic planning meetings to work on legislative handouts, mobilize dental hygienists, schedule listening sessions, and finalize an agenda for Day at the Capitol and other lobbying and advocacy efforts. A final compromise once again resulted in a name change from an Oral Health Practitioner to a Dental Therapist, both at a basic and advanced level. On May 13, 2009,

Minnesota Governor Tim Pawlenty signed into law Senate Bill 2083 establishing the Dental Therapist and the Advanced Dental Therapist.

Discussion

The political development of the MnDHA has strengthened the organization's ability of its members to influence public policy. As we are learning in Minnesota, a strong professional organization can be a powerful force with the Legislature, but we can not succeed without the support of other stakeholders. Due to the commitment and support MnDHA has received from joining forces with the SNC and Minnesota State Colleges and Universities, this collaborative network will continue to advocate as a unified voice on behalf of the uninsured and underinsured individuals to ensure access to oral health care through the OHP legislation and other health care policy changes initiated during the 2009 legislative session. To move new oral workforce models forward,

Table I: Recommendation for states to create flexible practice acts

Recommendations

- Know your state practice acts and stay involved with state legislators
- Stay informed about oral health care needs in your state
- Work with individuals and organizations that can advocate for change in oral health care workforce models, e.g., ADHP
- Remain focused on access and the underserved, not the providers
- Stay grounded in facts, research, and proven experience

the proponents pledge to stand firm to their convictions, maintain integrity and remain flexible, open and ready for the unknown.

Conclusion

This review of the legislative process, along with a "real life" example, should provide direction for dental hygienists across the country to advocate for increased access to oral health care through more flexible licensure laws. Advocacy is a calling and it takes active involvement on behalf of people. Health care policy is the nexus for change and feeling em-

powered to act is critical for advocacy success. The end point of advocacy is the health and welfare of the public.⁸

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