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Arthur Coccodrilli, Chairperson
Independent Regulatory Review Commission
333Market St. 14th Floor
Harrisburg, PA 17101

RE: Final-Form Regulation #16A-4617 (IRRC #2720)
Pennsylvania State Board of Dentistry
Dental Hygiene Scope of Practice; Local Anesthesia

Dear Chairperson Coccdilli:

This is letter is additional commentary for the above referenced Final-Form Regulation. My first commentary letter was dated October 23, 2009, addressing the administration of local anesthesia by dental hygienists. This letter addresses some of the other issues in the State Board of Dentistry's Final-Form Regulation, IRRC #2720.

Public Health Dental Hygiene Practitioner

Background. The Pennsylvania Dental Hygienists' Association, with the support of the state dental Association, succeeded in amending the Dental Law (Act 51-2007), creating the "Public Health Dental Hygiene Practitioner (PHDHP)". Any traditional licensed dental hygienist is eligible to become a PHDHP, as per requirements proposed by the Board. PHDHPs would provide dental hygiene procedures in public and private institutions, Section 11.9(b) of the Dental Law, i.e., nursing homes, schools, personal care facilities, correctional facilities, senior living centers, federally qualified health centers to name a few. Procedures would be provided absent dentist authorization and absent any form of dental supervision.

It appears that Act 51 in no way restricts or prohibits any public or private institution from hiring or contracting with traditional dental hygienist to provide dental hygiene services. In these instances, hygienists would come under the general supervision rule of § 33.205(d)(2) of the current dental regulations.

Other Issues

Commenting on § 33.116(b)(2):

As proposed by the dental Board, one of the qualifications to qualify for certification as a PHDHP, a licensed dentist must certify that a licensed dental hygienist has completed 3,600 hours of practice under the supervision of a licensed dentist.

Question: What is the degree of supervision? General? Direct? In all probability, many public and private institutional patients at some practice sites (Section 11.9(b) of the Dental Law) will be medically compromised patients, e.g., nursing homes. Would it be it in the public interest of these patients if a portion of the hygienist's 3,600 hours were accrued under a dentist's direct supervision when medically compromised patients are seen? There would time to do this. Full-time hygiene practice will take two years to accrue 3,600 hours. "Half-time" hygiene practice will take four years. Will the supervising dentist be solely counting hours or, based on the number of hours involved, does the Board perceive some mentoring responsibilities? In actual practice, PHDHPs will be treating patients absent any dentist authorization and absent any dentist supervision.

Act 51 requested that PHDHPs have professional liability insurance. Was the General Assembly suggesting that the public would be at risk without dentist authorization and supervision? The Board is proposing $1,000,000 single occurrence / $3,000,000 aggregate professional liability coverage.

Question: Must the 3,600 hours be accomplished by a dentist, as written in the proposed regulation, or may the traditional hygienist have worked or will work in different locations under several dentists?

Question: Does the Board intend to discuss the matter of PHDHP practice sites being properly equipped for maximum patient protection when hygiene services are provided, i.e., dental equipment, sterilization equipment, instruments, x-ray units, dental lighting, and lifesaving equipment?

Question: Will there be informed consent, by the patient or a representative?

§ 33.116 A side bar. What about the dichotomy in the provision of, for example, a dental hygiene service, (*ADA Code D1110, dental prophylaxis -adult)* provided to a physical health status ASA III dental patient in private practice, compared with the performance of the same service and the same physical health status ASA III dental patient in a PHDHP practice site? In private practice, according to the current dental regulations, ASA III patients must have dental prophylaxis provided under the direct supervision of a dentist. In a nursing home PHDHP practice site, there is no dentist supervision for ASA III patients. Nursing home residents by and large are seriously medically compromised. Two standards of care? One standard protects the health, safety and welfare of patients? What is the other standard?

Commenting on § 33.205(d)(1):

The Board proposes to eliminate the ASA health classification system.(See Footnote Next Page). The system was adopted by the American Society of Anesthesiology in 1963 as a system for

assessing the physical health status for patients undergoing medical care and surgery. The Board in the early nineties, placed the ASA system in the dental regulations for the purpose determining general and direct supervision on the basis of the physical health status of patients. The more serious the physical health status of a hygiene patient is, the dentist would be present in the facility when the hygienist is treating the patient (direct supervision). The healthier the patient, the dentist could choose to be absent from the facility after authorizing the hygienist to perform hygiene procedures (general supervision).

The Pennsylvania Dental Hygienist's Association (PDHA), on its website, has decried the ASA system as "..... scrapping the confusing and antiquated ASA classifications for supervision....." The ASA system is "clear as a bell" and not confusing, and it is not antiquated. It is currently in use by the medical community throughout the United States and serves as an effective physical health gauge when physicians, surgeons and anaesthesiologists discuss their patients. Think of it as a "code" that works well, much like SOS, STAT and so forth. The ASA system is referenced in textbooks, lectures, and hospitals.

Whatever bias the PDHA and the Board have in regard to the ASA system, it pales in comparison to the use of the ASA health status system as an important patient protection communication tool between dentists, and between dentists and physicians.

See **EXHIBT A**, affixed to this letter, for the Board's "conversion" of the ASA system to one proposed by the Board. Column 5 of the Exhibit would laborious in provider to provider communication.

Column 5 will also disclose a "new" role for dental hygienists in giving INPUT to dentists in physical status decisions. The Board is mandating that dentists assume FULL professional responsibility for hygiene procedures. This is to be expected for "captains of the ship." But if hygienists want to take part in physical status decisions, they should also take responsibility for their roles in that process. This "new"role dictates a SHARED legal responsibility for patient care and dental hygiene performance.

The American Society of Anesthesiologists (ASA) Physical Status Classification System was adopted in 1963 by the American Society of Anesthesiologists. The purpose of this grading system is simply to assess the degree of a patients' "sickness" or "physical state" prior to selecting an anesthetic or prior tp performing surgery. Describing a patient's preoperative physical status is used ..., for communicating between colleagues.....Dentistry's interest in "tapping in" to this system is the communication world of health care providers. When dentists talk to other providers, there is clear understanding of the physical health status of patients. Communication means protection for patients. There are five pertinent ASA categories:

ASA I Normal healthy patient
ASA II Patients with mild systemic disease
ASA III Patients with severe systemic disease
ASA IV Patients with systemic disease that is a constant threat to life
ASA V Moribund patients who are not expected to survive without surgery

Comments on § 33.302(a):

§ 33.302 states a PHDHP may take dental x-rays at his or her option. If x-rays are taken, they shall be taken as follows: within 30 days of taking an x-ray(s) the PHDHP shall give the patient a

copy(ies) and a referral to a dentist consultant (the words "to consult" are in § 33.302(a)) for an examination and a report back to the PHDHP with a diagnostic interpretation of the x-ray(s). The PHDHP shall also issue a written statement for the consultant dentist citing the PHDHP's reason for taking the x-ray(s) and any observations noted by the PHDHP. The reason for the referral is that dental diagnoses shall be made by licensed dentists.

Question: If the PHDHP deems x-ray(s) are necessary and the practice site does not have x-ray capability, is the PHDHP is excused from obtaining the x-ray(s)?

Question: Who selects the dental consultant? The patient? The PHDHP?

Question: Before ionizing radiation exposure of the patient, should the consultant dentist agree to see the patient?

Question: What happens if a practice site patient is physically unable to go to the dentist?

Question: If a patient's health decisions are made by a "guardian," must x-ray(s) permission be obtained by the person or persons?

Question: How are the x-ray(s) paid for? Who is paid and by what rationale?

Question: Do any of the events elicited in the above questions cause any legal difficulties for the PHDHP, the consultant dentist and the practice site?

In the interest of protecting the health of the public, IRRC should disapprove IRRC #2720.

Respectfully submitted,

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EXHIBIT A.

1	2	3	4	5
Hygiene procedures §33.205	***Using ASA Classi-fication system***	***Super-vision***	***IRRC #2720 Hygiene procedures § 33.205 Repeating procedures as in Column 1. * Is wording the same ** Wording changed***	***IRRC #2720 Dental Board Proposed "classification" system. No alphabet or number code. NO EASY CODE LIKE ASA, USING NARRATIVE APPROACH BOARD SUPERVISION PROPOSED***
(a)(1) Placement of microbial cord	ASA classes I II III IV V	Direct	(a)(1) Subgingival agents - therapeutic agents, including antimicrobials, antibiotics, antiseptics, or anesthetics, placed below the free margin of the gingiva by a local ....discs or chips.	.....under direct supervision except may be general supervision if dentist has reviewed patient records and written an Rx or given order. Copies in chart not mentioned.
(a)(2) Oral prophylaxis	ASA I	General	(a)(2) Oral prophylaxis **	.....under general supervision when the patient is free of systemic disease or suffers from mild systemic disease as determined by the dentist WITH INPUT FROM THE DENTAL HYGIENIST AND upon review of medical history. NOTE: ASA I and II combined.
(a)(2) Oral prophylaxis)	ASA II III IV V	Direct	(a)(2) Oral prophylaxis **	.....under direct supervision when the patient is suffering from systemic disease which is severe, incapacitating, or life threatening, as determined by the dentist WITH INPUT FROM THE DENTAL HYGIENIST AND upon review of medical history. NOTE: ASA III and IV combined. ASA V ignored.
(a)(3) See (a)(4) Column (a)(5) 4 (a)(6)	ALL ASA I to V	General	(a)(3) Data collection (a)(4) Fluoride application (a)(5) Dental sealants (a)(6) Athletic mouthguards	..... under the general supervision of a dentist.

The Board proceeds to define direct supervision with respect to Column 5 as follows:
FOR THE PURPOSES OF THIS SUBPARAGRAPH (Referring to direct supervision in the above Table), DIRECT SUPERVISION MEANS SUPERVISION BY A DENTIST WHO HAS EXAMINED THE PATIENT AND AUTHORIZED THE PROCEDURE TO BE PERFORMED, IS PHYSICALLY PRESENT IN THE DENTAL FACILITY AND AVAILABLE DURING THE PERFORMANCE OF THE PROCEDURE, AND **TAKES FULL PROFESSIONAL RESPONSIBILITY FOR THE PROCEDURE.**

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