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Ariel O'Malley, Board Counsel
Pennsylvania State Board of Dentistry
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Dear Ms. O'Malley,

I am writing to express my opposition to the expansion of locations at which a public health dental hygiene practitioner may practice in *Regulation #16A-4633*. This new regulation would allow public health dental hygiene practitioners to provide services to patients in their place of residence, child and adult day care centers, boarding homes, etc. The regulation also would also allow PHDHP's the ability to provide dental hygiene services to include "an office or clinic of a physician licensed by the State Board of Medicine or the State Board of Osteopathic Medicine."

As a practicing pediatric dentist in the State of Pennsylvania, I do believe that there is a lack of access to dental care for Pennsylvanians and I applaud the effort of this regulation to increase access to care for these individuals. However, expanding PHDHP sites to physicians' offices does not necessarily provide additional access. This proposed regulation is inconsistent with both the American Academy of Pediatric Dentistry's "Dental Home" by age one where children who have a dental home are more likely to receive appropriate preventive and routine oral health care, thereby improving families' oral health knowledge and practices, especially in children at high risk for early childhood caries. It is also inconsistent with the American Academy of Pediatrics' policy on Maintaining and Improving the Oral Health of Young Children.

As a pediatric dentist, I can honestly say that I have a great working relationship with our local pediatricians. Pediatricians already perform oral hygiene screenings, place therapeutic fluoride varnish and make referrals to pediatric dentists by age one. We are on hospital medical staff together where we discuss relevant cases and pediatric dentists treat children in the operating room in both hospital settings and outpatient medical facilities. I am concerned that taking a hygienist, who is a valuable member of a dental team that works in a dental home and placing them in a physician office will create a two-tiered system where our most vulnerable populations will receive inadequate care.

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Patients come to our office every six months for routine examination, prophylaxis and fluoride treatment. This is the standard of care in dentistry. By allowing a hygienist to function independently in a primary care office, the dental team and concept of a dental home is broken. A hygienist is not trained to diagnose dental decay or pathology and develop a treatment plan. There is obvious concern that a patient who visits a physician office and receives treatment from an existing dental home member, will think that there is no need to visit a dental office. Again, we work together. A dentist, benefits from a mouth that is clean to do a proper examination. We do our best work together and the patient does not benefit when we are not together.

If this proposed regulation passes, how will a proper examination be completed in a dental office? Is the dentist to perform an proper examination on teeth that are covered in food, plaque and debis? How is that going to be an exam that is up to the standard of care? Are dentists to perform an additional prophylaxis prior to our examination without a hygienist? Current state insurance plans allow one prophylaxis every 6 months as well as most commercial plans. How will this happen? Also, will the patients actually show for their exam at a dental office after their teeth are cleaned in a primary care office? This is one more step for a population that already has severe access to care and transportation issues. Will the state fund more transportation and additional prophylaxis for these children? How is a hygienist working in a pediatrician office going to tell if a child is an established patient of record by a dental office? Do they take the word of the adult accompanying the child? What happens when the child appoints to his or her routine dental visit and the allowed prophylaxis is already performed? Also, what happens when sealants are placed on teeth that are not free of decay because they have not had a diagnostic examination by a dentist? Do we have more hospital admissions from cellulitis due to sealed decay? What happens when teeth are sealed and the patient goes to the orthodontist and has bands placed on teeth for 2 years without an examination prior? Do we perform endodontic treatment on interproximal decay that progresses into the pulp that is sealed occlusally, looks good clinically, but cannot be diagnosed without radiographs? How happy will that patient be?

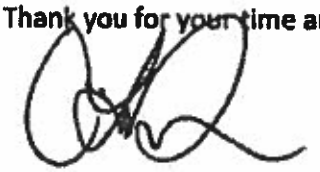
I own a private pediatric dental office which is in an underserved area and has a large base of Medical Assistance patients. I love my patients and they enjoy coming to our office. There is already a "bus" from the eastern side of the state that comes into our western Pennsylvania school districts that are underserved in our area. The bus stops at the underserved schools and provides examinations, prophylaxis, fluoride and dental sealants to students. Permission slips are sent home for parents to fill out and insurance information is given on these forms, if known. This bus visit is considered a "field trip" for the students where they receive free goods. They do not want to miss it. These children then receive services by this school bus. Several patients consider this their dental visit and do not follow up on the referral slips that are sent home. I have had several documented cases of patients that did not follow up for several years because they thought the treatment, including dental restorations, extractions, etc. was being done at school and it was convenient for them. They did not have to come to a dental office. However, when the child complains of pain or there is facial swelling, the parent/guardian brings the child to the dental office. Each time, the parent or guardian is distraught because

they felt that their child was being treated. They did not understand, even though they had to sign a permission form, that their child was only receiving an exam, prophy, fluoride and sealants, if necessary. Because we see this concept now with a school bus visit once a year, I am concerned that it will amplify if a dental home if broken and we will have even more extensive treatment needs, more costly treatment needs, and emergency treatment that could have otherwise been prevented.

In response to this lack of access to available dentists, the American Dental Association launched the Community Dental Health Coordinator (CDHC) program in 2006 to provide community-based prevention, care coordination, and patient navigation to connect people who typically do not receive care from a dentist in underserved rural, urban and Native American communities. CDHCs are currently working in 40 states, one of which is Pennsylvania. The CDHC provides a limited range of preventive dental care services—including screenings and fluoride treatments. There is documented success with the CDHC program by the ADA, the most recent article in the April 15, 2019 ADA News titled: Vermont Community Dental Health Coordinators Shine. CDHC's are a dental liaison (role) for communication between the community, schools, parents and dental offices. Treatment does not take place, but referrals are made. This program even goes as far as recognizing social and socio-economic burdens and placing an appropriate CDHC in the situation in which they can relate. A program like this, which is already in place in Pennsylvania can increase access to care without breaking the dental home concept.

The national medical association representing pediatricians (The American Academy of Pediatrics) recommends and has adopted a policy that is in the best interest of the oral health and general health of children to have them seen by a dentist to establish a dental home by age one. Allowing this regulation to pass, would jeopardize the concept of the dental home and the oral health of children.

Thank you for your time and consideration,



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