The Dental Hygienists' Association of Australia Inc.

June 2013

Response to the Dental Board of Australia's
Preliminary Consultation on the
Draft Scope of Practice Registration Standard and Guidelines

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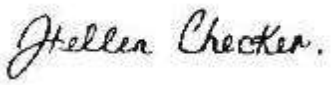

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About DHAA Inc.

The Dental Hygienists' Association of Australia (DHAA) Inc., established in 1975, is the peak body representing registered dental hygiene service providers. Membership includes registered dental hygienists, oral health therapists, undergraduate dental students and affiliate members from dental industries. The DHAA Inc. represents leaders in oral health who have been actively practising evidence based clinical practice and non-communicable disease management for many years. Despite this long history of professional practice, the role and skills of a dental hygienist professional are not well understood by policy-makers and are therefore outlined below.

The Professional Expertise of a Dental Hygienist

Dental hygienists are professional highly-trained dental practitioners who specialise in preventive oral health, focusing on techniques that ensure oral tissues and teeth are maintained and remain healthy in order to prevent dental disease, especially common diseases such as dental caries, gingivitis and active periodontitis.

Dental hygienists and oral health therapists specialise in disease prevention, through clinical intervention and education. This is fundamental to the management of oral health. The provision of dental health education, including dietary advice and smoking cessation, and clinic procedures such as root debridement also assists patients to manage existing conditions such as periodontal disease, cardiovascular disease, oral cancers, diabetes and respiratory disease (in aged care facilities). Dental hygienists and oral health therapists and dental therapists are the primary preventive oral health providers and are the acknowledged experts in the field of dental disease prevention by our dental professional and health service provider colleagues.

The skills, knowledge and training of the dental hygienist professional are extensive. Training includes health sciences, human biology, anatomy and physiology, microbiology, pathology, oral medicine, dental medicine, pharmacology, dental materials, periodontics, risk factors, etiology of disease, cariology, orthodontics, geriatric dentistry, special needs dentistry, oral health promotion and education, dental public health, preventive dentistry, community dentistry, minimal intervention, dental radiography, temporary restorations, local anaesthesia and clinical practice, including examinations, diagnosis and treatment planning and delivery within scope of practice.

The National Law requires the same level of professional responsibility from dental hygienists, oral health therapists and dental therapists as it does from dentists, dental specialists and dental prosthetists in that all practitioners must have their own professional indemnity insurance and radiation licences. They are also required to complete 60 hours of mandatory continuing education in a three year cycle.

The DHAA Inc. acknowledges that all dental practitioners are part of a team who work together within their particular areas of competence to provide the best possible care for their patients. However, the notion that dental hygienists, oral health therapists, and dental therapists are ancillary health care providers is misconceived.

Dental hygiene and oral health therapy are unique, highly qualified preventive professional disciplines. This position is supported by the Australian Industrial Relations Commission (AIRC) 2009 Decision via a successful Award variation application from the DHAA Inc. (re MA000027 – Health Professionals and Support Services Award 2010) to remove dental hygienists from the award and have them declared award free. In supporting the DHAA Inc.'s application, the Full Bench of the AIRC recognised that dental hygienists are not ancillary health care providers and therefore accepted that the closest comparison profession to dental hygiene is the employed dentist.[1]

Our objective is the effective delivery of quality oral health services, improving oral health and therefore also general health. Dental hygienists are employed throughout Australia as academics and educators by tertiary and vocational education providers to develop, deliver and evaluate programs which educate future providers of public and private oral health services. They have a critical role in maintaining standards which deliver the highest possible care to all population groups and in developing education strategies that align with the optimum provision of oral health care within an array of policy frameworks in States and Territories of Australia.

General Feedback on Draft Scope of Practice Registration Standard & Guidelines

DHAA Inc.'s submission to the Review of the Scope of Practice Registration Standard focused on four main points:

1. The need for a paradigm shift to preventive care, with dental hygienists offering outreach services in a number of community settings
2. The need for a flexible model to allow direct access to dental hygienists, operating their own referral pathways as a member of a multi-disciplinary team, in a structured professional relationship with a dentist
3. The need for a new definition of dentistry and f or definitions of each dental practitioner
4. The benefits of dividing education for dental practitioners into three areas: formal education; advanced practice / add-ons; and continuing professional development.

DHAA Inc. is pleased to see some of these points addressed in the revised standard and guidelines. We offer qualified support to the revisions proposed in option 2, though we believe greater clarity is needed over the meaning of a 'structured professional relationship' in order to ensure that a primary preventive model of dental hygiene outreach services can be developed. We propose that the scope of practice be tailored to delivering a Comprehensive Primary Health Care Model.

[1] Rule 5 of the Australian Industrial Relations Commission Rules Work Place Relations Act 1996 (Section 576H of the Act)

Response to Specific Feedback Sought

1. *Does the revision to the standard provide greater clarity and certainty for dental practitioners to work within their scope of practice?*

DHAA Inc. supports the removal of 'supervision' terminology and much prefers the concept of a 'structured professional relationship' between dental hygienists and dentists. However, as currently drafted, the revision does not provide greater clarity or certainty to the profession.

The revised standard needs to be much more explicit about what a structured professional relationship entails. As currently drafted, there is too much ambiguity and too great a risk of varying interpretations causing confusion in practice.

Does a structured professional relationship mean that a dental hygienist is employed by a dentist to work on site in a close working relationship with the dentist? Does it mean that a dental hygienist is self-employed, contracting services to different dental practices, hospitals, or community facilities, whilst consulting with a particular dentist? Does it mean that a dental hygienist is employed by an external agency such as an aged care home or prison but has a referral pathway to a particular dentist? Does it mean something else? Indeed, it can be argued that all dental practitioners need structured professional relationships with one another as no individual clinician can provide all the necessary services to one patient but must refer to the expertise of other members of the dental team.

The Dental Board needs to provide greater clarity on this point to assist both the dental profession and external agencies wishing to employ a dental hygienist, such as providers of aged care.

In DHAA Inc.'s view, a dental hygienist does not need to be employed by a dentist but can independently assess patients and make treatment plans within their scope of practice whilst working in the community. The revised standard needs to make this very clear and should also specify what referral procedures need to be in place.

The majority of dental hygienists will, of course, work for a dental practice, but the improvements in oral health will be much greater if dental hygienists are clearly released to work in a range of community settings without a dentist being present, as is understood under the current standard. This clarity is important to enable aged care homes, for example, to feel secure in employing a dental hygienist rather than a dentist for preventive work within their facility.

In 2007, General Practice Victoria (GPV) reported that carers in all regions listed dental care as the most frequently requested service within aged care facilities.[2] However, the necessary expansion of services proved too difficult to achieve because of the barriers to dental hygienists practising alone. These regions now fall under Medicare Locals rather than GPV.

[2] *Aged Care Access Initiative Needs Assessment and Program Plan for the Victorian Divisions' Network 2008 – 2009,* General Practice Victoria, September 2008, page i

Dental hygienists are autonomous decision-making oral health professionals who care for individuals of all ages in all communities, seeking to meet the complex oral health needs of clients. This role includes assessment (taking of radiographs, periodontal charting, and dental examination), formulation of a treatment plan, management of clients, evaluation of responses to treatment and adjusting the treatment plan as necessary. Wider roles include advocacy, oral health promotion, research, teaching and diet counselling. Dental hygienists have the capacity and qualifications to fulfil these roles.

The scope of practice should encourage the placement of dental hygiene services in many outreach settings rather than just in a dental practice. It should facilitate direct access to a dental hygienist, without need for a referral.

This is hardly a radical reform. In other areas of healthcare, members of the public can self-refer to appropriately trained professionals and claim rebates for services through Medicare or through private health insurance. Australians can directly access the services of physiotherapists, speech pathologists, psychologists, podiatrists, occupational therapists, acupuncturists, massage therapists and optometrists to name only a few, but cannot see a dental hygienist without first consulting a dentist.

There is an international shift towards preventive healthcare. Australia is adopting this model in other areas of health with the introduction of Medicare Locals, local hospital networks and an increased emphasis on disease prevention. It is an appropriate time to remove the barriers that exist in oral health.

DHAA Inc. would like to see an explicit statement that a structured professional relationship does not require a dentist to be on site. DHAA Inc. suggests the following statement be included:

> *Dental hygienists, dental therapists and oral health therapists are professional health care providers who are part of the dental team. They practice dental procedures included in the definition of dentistry in which they have been formally educated and trained. They do not need to be employed by a dentist and may work for a number of community, government and non-government facilities whose clients may benefit from their services. They practice within a range of environments and they have the ability to refer or seek advice when required in relation to patient care outside their scope of practice.*

This is how DHAA Inc. interprets a 'structured professional relationship'. DHAA Inc. would like to see this definition included in the scope of practice.

2. *Does the introduction of the guidelines further support this clarity for dental practitioners and the public?*

The guidelines give minimal clarity to dental professionals, especially the dental therapists and oral health therapists who recognise a paradigm shift in dentistry will involve changes in their workplace settings to better utilise their training and skills. Greater clarity could be achieved by including

references to different service models of care, relating to dentists (restorative), dental hygienists (preventive) and oral health therapists (preventive and restorative). As DHAA Inc. argues below, the scope of practice needs to support a paradigm shift to a preventive model of care.

Our members have some concerns about the meaning of 'independent practitioner'. The guidelines state that dentists and dental specialists are independent practitioners but that dental hygienists, dental therapists and oral health therapists:

> *… may only work within a structured professional relationship with a dentist and/or dental specialist.*[3]

Because it is still unclear what a 'structured professional relationship' entails,[4] there is a risk that readers will incorrectly assume that other dental professionals are unable to work on their own, undermining confidence in the role of dental hygienists. This statement makes our profession seem very much like the junior party in dentistry, a little like the traditional view of a nurse taking orders from a doctor. In reality, dental hygienists as a profession are more akin to midwives, maternal and child health nurses or nurse practitioners. These professionals practice independently within their scope of practice whilst usually belonging to a wider team.

The Australian College of Nurse Practitioners explains that:

> *A Nurse Practitioner (NP) is a Registered Nurse who has completed both advanced university study at a Master's Degree level and extensive clinical training to expand upon the traditional role of a Registered Nurse. They use extended skills, knowledge and experience in the assessment, planning, implementation, diagnosis and evaluation of care required.*
>
> *Through their training and expertise Nurse Practitioners are able to autonomously perform advanced physical assessment, order diagnostic tests, interpret the results of these tests, initiate referrals to relevant healthcare providers, and prescribe appropriate medications and other therapies as needed.*
>
> *The expanded role of the NP is clearly defined by the scope or specialty area in which the NP practices.*
>
> *Nurse Practitioners work as key members of the healthcare team and collaborate with other nurses and healthcare professionals including GPs, medical and surgical specialists, physiotherapists, dieticians, occupational therapists, social workers, and many others. They work in a variety of locations, both in hospital and community settings.*[5]

DHAA Inc. has two suggested approaches to this difficulty, which are both aimed at giving proper recognition to our profession and, by extension, proper access to our professional services:

1. Remove all references to dentists and dental specialists as 'independent practitioners' as these statements are unnecessary, or

[3] *Draft Scope of practice registration standard and guidelines,* Dental Board of Australia, page 15
[4] See comments in response to question 1 above.
[5] *What is a Nurse Practitioner?* Australian College of Nurse Practitioners, http://www.acnp.org.au/content/what-is-a-nurse-practitioner.html

2. Include dental hygienists and oral health therapists and dental therapists as 'primary preventive dental providers who operate as independent practitioners within structured professional relationships in a team based approach to dentistry'.

It is important to note that we are not seeking to become independent practitioners as defined by the scope of practice, which states that such providers practice without a structured professional relationship. We certainly wish to operate within a team based approach to dentistry. But we must be recognised as highly skilled members of the dental team.

The guidelines need to emphasise that dental hygienists, dental therapists and oral health therapists are autonomous professionals who work collaboratively when required as part of the professional dental team. It needs to be made clear, both to dental practitioners and the public, that dental hygienists, dental therapists and oral health therapists are extensively trained professionals, properly qualified and registered and possessing the expertise needed to perform their roles.

DHAA Inc. would like the guidelines to state that dental hygienists, dental therapists and oral health therapists:

> *… work as key members of the dental team in a variety of locations, including dental practices, hospitals and community settings. There is no requirement for a dentist to be present. Dental hygienists, dental therapists and oral health therapists work within a structured professional relationship with a dentist and are able to consult with and refer patients to a dentist for treatment that is outside their scope of practice, just as a dentist will refer patients to a dental hygienist or other specialist health practitioner where appropriate.*

For public consumption, it would be helpful to provide a brief explanation of the meaning of 'scope of practice' as this is specialised terminology within the health disciplines. It would be useful to include a care pathway showing how a consumer can access each dental practitioner and the type of settings in which they can be found. It should also state that all dental practitioners have the ability to refer to one another, provide professional advice when required in relation to their scope of practice and refer patients onward when requiring care outside their scope of practice. The description of each division of dental practitioner informs the general public of the specific dentistry focus of each team member. Clarifying the different branches of dentistry may have the potential to increase the uptake of services as a result this better public understanding.

3. *Are there additional factors which could be included in the guidelines to support the standard?*

As a guiding principle, the standard and guidelines need to reorient dentistry into a primary preventive paradigm. Currently, the restorative treatment model of service dominates in both privately operated independent practices and public dental health practices. Preventive dentistry is delivered as a low level sub-service within the restorative treatment model. This is a significant reason for the under-utilisation of dental hygienists, oral health therapists and dental therapists as primary oral health practitioners in many general practices.

DHAA Inc.'s membership strongly identifies with the development of preventive practice strategies to address increasing oral disease rates. Such a paradigm shift is taking place within many other countries and Australia needs to realign its dental services to this model if it is to make any significant advances in oral health. Regulatory bodies should not only set standards to support health professionals, public safety and quality care. They should also act as a catalyst for changing service models to improve oral health standards in the community.

The Comprehensive Primary Health Care Model

Changes to the scope of practice should reflect the alignment of dental hygiene and oral health therapy services with the Comprehensive Primary Health Care Model, which emphasises working within multi-disciplinary teams and multi-sectoral collaborations.[6] Endorsing dental hygiene services in this way will remove one of the most significant barriers to direct public access to preventive oral health services, which would in turn help to reverse the decline in public oral health. These are key reforms identified by Health Workforce Australia, which recognises that the public needs access to preventive dental services in community settings.

Tailoring the scope of practice standard to facilitate delivery of primary health care is the first step in the paradigm shift necessary for economically responsible dental service delivery and workforce training and utilisation. The Comprehensive Primary Health Care Model is highly adaptable to community settings and congruent with the scope of practice requirement for supportive structured professional relationships to expedite the cross referral process.

The standard and guidelines need to vigorously emphasise a preventive model with direct access to primary preventive dental providers such as dental hygienists and oral health therapists working in unsupervised community settings. Denying this, or giving only lukewarm support as an add-on to restorative services, is to deny long-suffering population groups the right to oral health.

Who should be team leader in a flexible workforce model?

Despite talk of more flexible workforce models, the guidelines make a blanket statement that, 'the dentist or dental specialist is the clinical team leader.' Nominating the dentist as the team leader in each and every situation is not a team model; it is simply the old hierarchical structure once again.

DHAA Inc. argues that the guidelines need to support a safe, functional, flexible team. To enable this, the team leader should be assessed in terms of experience in the field. Which member of the dental team holds this position should vary depending on the make-up of each team. It should not always have to be the dentist.

Consider the following scenarios:

1. A dental hygienist works in a hospital, undertaking prophylactic cleans to support a cardiologist but the work is made awkward by the requirement to refer to a dentist to prescribe antibiotics. The cardiologist should lead this team.
2. A dental team includes a recently graduated dentist and a very experienced dental hygienist. The dental hygienist should lead this team.

[6] *What is primary health care?* http://www.phcconnect.unsw.edu.au/phcweb.nsf/page/What+is+PHC

3. A dentist of 20 years' experience runs a private practice, employing other dental professionals. The dentist should lead this team.
4. A dental team provides outreach services into a remote area. The dental hygienist and dental therapist travel to the area, every six months, treating appropriate patients on site and referring others to a dentist in the nearest town. An oral health professional other than the dentist should lead this team.

Dentists work primarily in the private sector, in private dental clinics. As the business owners, they may automatically expect to lead teams in this situation. However, the additional workload and the accompanying clinic-focused mentality make it very difficult for dentists to outreach into the community effectively. It can be hard to find dentists willing to work in rural and remote areas, in residential facilities, in schools and in other settings where the need is great but the remuneration poor. Dental hygienists work in a range of community settings and their expertise here is greater than that of the dentist, who may never even visit the premises. Insisting that the dentist must always be the clinical team leader may work well in private practice but it does not translate well to any other sector or environment within dentistry.

In a comprehensive primary health care model the dental hygienist is the team leader for preventive dental services, appropriately trained and working within scope of practice. This health care model is essential for increasing public access where demand is high and dental services non-existent. Dentists are the clinical team leaders in adult restorative dental service models providing the clinical expertise for surgical restorative dental treatments.

The requirement for a 'structured professional relationship' is the platform for a team based practice of dentistry where collaboration, consultation and referral define the collegial conduct across all team members. Therefore the title of clinical team leader will vary according to the service model and other constraints such as geographical location, the availability of a dentist and other factors. In all cases the requirement for a 'structured professional relationship' facilitates the key outcomes of the need to protect the public and regulate the dental profession in a framework where innovation and reform can proceed.

4. Do you agree with the list of skills in the guidelines relating to programs to extend scope? Are there additional skills which the National Board should consider adding to the list? Do you agree that there should be a formal accreditation process where the skills are not a sub-set of an approved program?

DHAA Inc. agrees with the skills relating to programs to extend scope and agrees that there should be a formal accreditation process where the skills pertain to increased scope of practice.

5. *Does the preferred proposal balance the need to protect the public with the needs of regulating the profession?*

Yes. The public is already well protected and will continue to be. Dental hygienists are well trained professionals with the same accountability and responsibility as dentists. This includes professional registration, liability insurance and continuing professional development (60 points per 3 year cycle). Dental hygienists bear sole responsibility and legal accountability for their services. Dental hygienists work within scope of practice in a team environment that may include allied health professionals, cardiologists, nurses and doctors providing preventive treatment and dental health education.

There is a rather quaint view in some very influential quarters that the dentist is the only person who can safely treat a patient and control their treatment plan. This is simply untrue. Dental hygienists working within scope of practice offer a high standard of public safety and accountability. Indeed, the oral health of the population will actually be better protected if restrictions on independent practice are removed and consumers can directly access dental hygiene services when required. A structured professional relationship which clearly affirms the dental hygienist's freedom to practice in a range of settings without a dentist, allows dental hygienists to do the work they are trained for, referring patients on to a dentist where appropriate. Patient safety is not compromised by improving access to the services of highly trained professionals working within their scope of practice.

DHAA Inc. maintains that our scope of practice should empower us to address the unmet need for preventive dental care for the benefit of all, particularly those who find it difficult to access mainstream services, such as those in rural or remote areas, or those in institutional settings such as hospitals, residential aged care facilities or care homes.

The revised scope of practice should help dental professionals to care for patients to a high standard that suits our times and climate. Modern consumers expect to be able to access the services they want. They do this for many other aspects of their head-to-toe healthcare, from psychology and optometry services to visiting a podiatrist. They should be able to make an appointment directly with a dental hygienist, who will provide excellent care within their scope of practice and refer to colleagues for any further care that is needed. The onus to provide safe and appropriate treatment to each and every client already exists for registered dental hygienists under registration regulations and responsibilities. Though we are <u>not</u> deemed to be independent practitioners, we still fulfil the personal and professional responsibilities required of an independent practitioner.

Dental professionals as a team need to work on mutual understanding, trust, respect and co-operation. The contribution and knowledge of each team member must be valued and respected in its own right. Professional practice is dynamic and influenced by the changing environment. Our scope of practice should be flexible enough to enable us to deliver primary preventive dental outreach services in a range of community settings.

6. What is the impact of the preferred proposal in your jurisdiction?

The proposed changes to scope of practice are likely to have a small but welcome impact on the work of dental hygienists, hopefully releasing more people to work in settings other than a dental surgery.

DHAA Inc. welcomes the removal of the requirement for a dentist's supervision but remains concerned that there is too much ambiguity about the meaning of a structured professional relationship. We would like a clear statement that a dental hygienist can work autonomously in a range of settings without the presence of a dentist but will consult with and refer to a dentist for matters beyond scope of practice.

Conclusion

DHAA Inc. welcomes the revised standard and guidelines but argues that greater clarity is needed about the meaning of a structured professional relationship for it to have any real impact on the ground.

There is a great need to move to a preventive model of care, where dental hygienists are released to work in a range of community settings without a dentist on site. This direct access would greatly benefit the Australian public which currently demonstrates high levels of unmet need. A multidisciplinary dental team offers comprehensive care to consumers but the leadership of each team should be determined on case by case basis, conferring leadership on the most experienced and appropriately skilled member.

DHAA Inc. therefore supports option 2, as the preventive model of care that we seek cannot be achieved without revisions to our scope of practice registration standard. As noted above, we believe greater clarity is needed over the meaning of a 'structured professional relationship' in order to ensure that a primary preventive model of dental hygiene outreach services can be developed. We also propose that the scope of practice be tailored to delivering a Comprehensive Primary Health Care Model.

DHAA Inc. looks forward to commenting further at the next iteration of the revised standard and guidelines.

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June 2013