

DENTAL HYGIENIST

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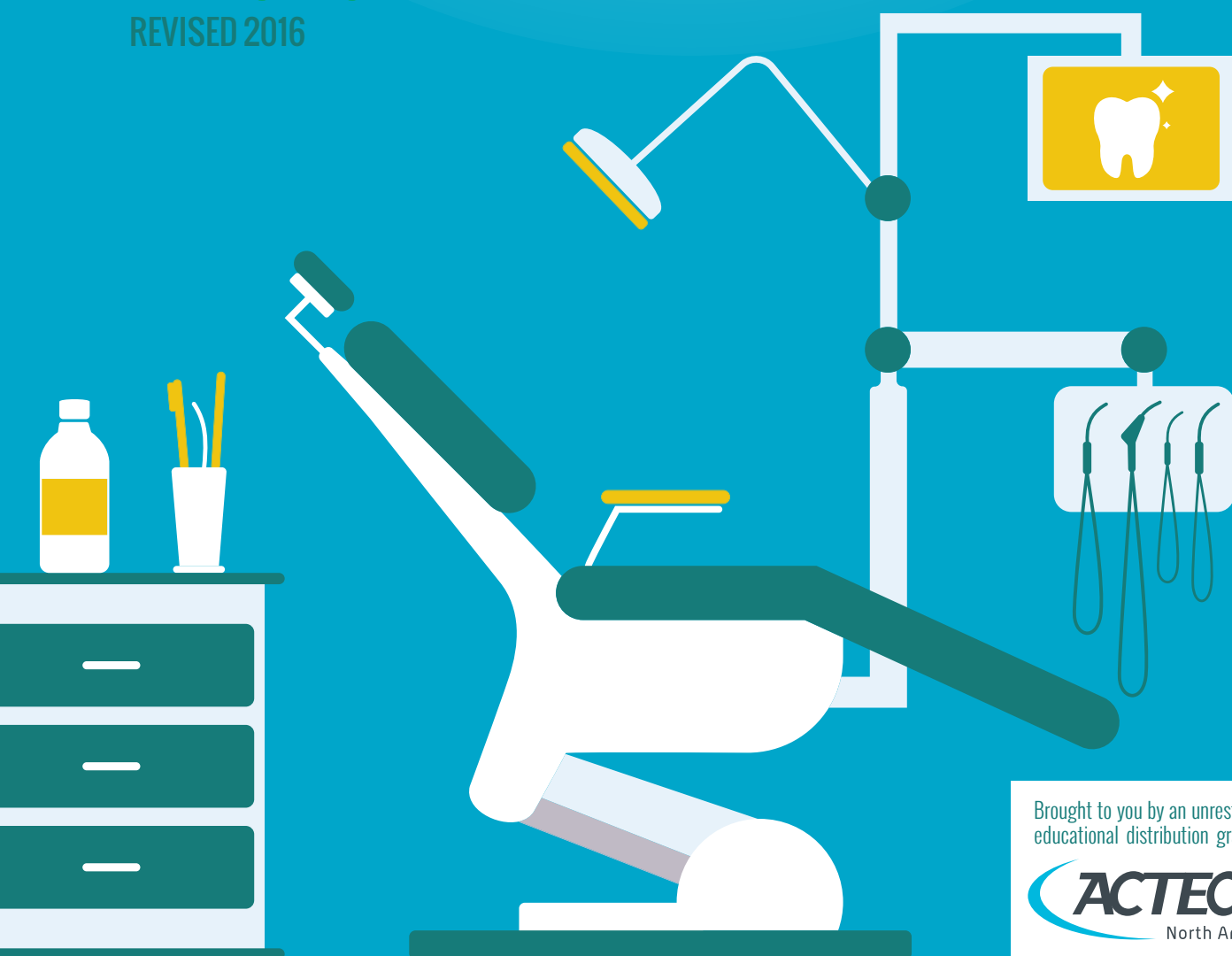
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American
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Association

STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE

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STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE

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History

One hallmark of a true profession is its willingness to assume responsibility for the quality of care that its members provide. In 1985, the American Dental Hygienists' Association (ADHA) took a major step toward fulfillment of that responsibility with the development of Applied Standards of Clinical Dental Hygiene Practice.¹ This document is the third revision² to build on those Standards and promote dental hygiene practice based on current and relevant scientific evidence.

Introduction

The Standards for Clinical Dental Hygiene Practice outlined in this document guide the individual dental hygienist's practice. Dental hygienists remain individually accountable to the standards set by the discipline and by applicable federal, state, and local statutes and regulations that define and guide professional practice.³ These Standards should not be considered as a substitute for professional clinical judgment. In addition, they should not be confused with the Accreditation Standards for Dental Hygiene Education Programs, which are chiefly concerned with the

structure and operation of dental hygiene education programs.⁴

Dental hygienists are valued members of the health care workforce. They have the knowledge, skills, and professional responsibility to provide oral health promotion and health protection strategies for all individuals as well as groups. As licensed professionals, they are accountable for the care and services they provide.

These Standards promote the knowledge, values, practices, and behaviors that support and enhance oral health with the ultimate goal of improving overall health. The primary purpose of the Standards for Clinical Dental Hygiene Practice is to assist dental hygiene clinicians in the provider-patient relationship. In addition, dental hygienists in other professional roles such as educator, researcher, entrepreneur, public health professional, and administrator — as well as those employed in corporate settings — can use these Standards to facilitate the implementation of collaborative, patient-centered care in interprofessional teams of health professionals. This collaboration can occur in a variety of practice settings including community and public health centers, hospitals, school-based programs, long-term care facilities, outreach, and home care programs. The secondary purpose of these Standards is to educate other health care providers, policymakers, and the public about the clinical practice of dental hygiene. The purpose of medical and dental science is to enhance the health of individuals as well as populations. Dental hygienists use scientific evidence in the decision-making process impacting their patient care. The dental hygienist is expected to respect the diverse values, beliefs, and cultures present in individuals and communities. When providing dental hygiene care, dental hygienists must support the right of the individual to have access to the necessary information and provide opportunities for dialogue to allow the individual patient to make informed care decisions without coercion. Facilitating effective communication might require an interpreter and/or translator based on the patient and practitioner's need to communicate. Dental hygienists must realize and establish their professional responsibility in accordance with the rights of individuals and groups. In addition, when participating in activities where decisions are made that have an im-

pact on health, dental hygienists are obligated to assure that ethical and legal issues are addressed as part of the decision-making process. Dental hygienists are bound by the Code of Ethics of the American Dental Hygienists' Association.³

The Standards for Clinical Dental Hygiene Practice provide a framework for clinical practice that focuses on the provision of patient-centered comprehensive care. The Standards describe a competent level of dental hygiene care^{1,2,4-7} as demonstrated by the critical thinking model known as the dental hygiene process of care.⁷ As evidenced by ADHA policy⁶ and various dental hygiene textbooks,⁸⁻¹⁰ the six components of the dental hygiene process of care include assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation (Appendix A). The dental hygiene process encompasses all significant actions taken by dental hygienists and forms the foundation of clinical decision-making.

Definition Of Dental Hygiene Practice

Dental hygiene is the science and practice of recognition, prevention and treatment of oral diseases and conditions as an integral component of total health.¹¹ The dental hygienist is a primary care oral health professional who has graduated from an accredited dental hygiene program in an institution of higher education, licensed in dental hygiene to provide education, assessment, research, administrative, diagnostic, preventive and therapeutic services that support overall health through the promotion of optimal oral health.¹² In practice, dental hygienists integrate multiple roles to prevent oral diseases and promote health (Appendix B).

Dental hygienists work in partnership with all members of the dental team. Dentists and dental hygienists practice together as colleagues, each offering professional expertise for the goal of providing optimum oral health care to the public. The distinct roles of the dental hygienist and dentist complement and augment the effectiveness of each professional and contribute to a collaborative environment. Dental hygienists are viewed as experts in their field; are consulted about appropriate dental hygiene interventions; are expected

to make clinical dental hygiene decisions; and are expected to plan, implement, and evaluate the dental hygiene component of the overall care plan.⁷⁻¹⁰ All states define their specific dental hygiene practice scope and licensure requirements.

Educational Preparation

The registered dental hygienist (RDH) or licensed dental hygienist (LDH) is educationally prepared for practice upon graduation from an accredited dental hygiene program (associate, post-degree certificate, or baccalaureate) within an institution of higher education and qualified by successful completion of a national written board examination and state or regional clinical examination for licensure. In 1986, the ADHA declared its intent to establish the baccalaureate degree as the minimum entry level for dental hygiene practice (Appendix C).^{7,13-14}

Practice Settings

Dental hygienists can apply their professional knowledge and skills in a variety of work settings as clinicians, educators, researchers, administrators, entrepreneurs, and public health professionals, and as employees in corporate settings. Working in a private dental office continues to be the primary place of employment for dental hygienists. However, never before has there been more opportunity for professional growth. Clinical dental hygienists may be employed in a variety of health care settings including, but not limited to, private dental offices, schools, public health clinics, hospitals, managed care organizations, correctional institutions, or nursing homes.⁶

One example of an innovative, interprofessional practice model was tested by Patricia Braun, MD, MPH, Associate Professor, Pediatrics and Family Medicine at the University of Colorado Anschutz School of Medicine. This project co-located a dental hygienist in the pediatrician's office. Co-locating dental hygienists into medical practices is a feasible and innovative way to provide oral health care, especially for those who have limited access to preventive oral health services.¹⁴

Another innovative model exists in Oregon, where expanded practice dental hygienists (EP-DHs) do not need a collaborative agreement with a dentist to initiate dental hygiene care for populations that qualify as having limited access to care; however, some aspects do require a collaborative agreement.¹⁵

EPDHs in Oregon are able to work in a variety of settings,¹⁶ such as nursing homes and schools, and many are employed as private business owners.¹⁴

Professional Responsibilities and Considerations

Dental hygienists are responsible and accountable for their dental hygiene practice, conduct, and decision-making. Throughout their professional career in any practice setting, a dental hygienist is expected to:

- Understand and adhere to the ADHA Code of Ethics.
- Maintain a current license to practice, including certifications as appropriate.
- Demonstrate respect for the knowledge, expertise, and contributions of dentists, dental hygienists, dental assistants, dental office staff, and other health care professionals.
- Articulate the roles and responsibilities of the dental hygienist to the patient, interprofessional team members, referring providers, and others.
- Apply problem-solving processes in decision-making and evaluate these processes.
- Demonstrate professional behavior.
- Maintain compliance with established infection control standards following the most current guidelines to reduce the risks of health-care-associated infections in patients, and illnesses and injuries in health care personnel.
- Incorporate cultural competence¹⁷ in all professional interactions.
- Access and utilize current, valid, and reliable evidence in clinical decision-making through analyzing and interpreting the literature and other resources.

- Maintain awareness of changing trends in dental hygiene, health, and society that impact dental hygiene care.
- Support the dental hygiene profession through ADHA membership.
- Interact with peers and colleagues to create an environment that supports collegiality and teamwork.
- Prevent situations where patient safety and well-being could potentially be compromised.
- Contribute to a safe, supportive, and professional work environment.
- Participate in activities to enhance and maintain continued competence and address professional issues as determined by appropriate self-assessment.
- Commit to lifelong learning to maintain competence in an evolving health care system.

Dental Hygiene Process of Care

The purpose of the dental hygiene process of care is to provide a framework where the individualized needs of the patient can be met; and to identify the causative or influencing factors of a condition that can be reduced, eliminated, or prevented by the dental hygienist.⁸⁻¹⁰ There are six components to the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation and evaluation, and documentation; see Appendix A).^{7-10, 18}

The dental hygiene diagnosis is a key component of the process and involves assessment of the data collected, consultation with the dentist and other health care providers, and informed decision-making. The dental hygiene diagnosis and care plan are incorporated into the comprehensive plan that includes restorative, cosmetic, and oral health needs that the patient values. All components of the process of care are interrelated and depend upon ongoing assessments and evaluation of treatment outcomes to determine the need for change in the care plan. These Standards follow the dental hygiene process of care to provide a structure for clinical practice that focuses on the provision of patient-centered comprehensive care.

STANDARDS OF PRACTICE

Standard 1: Assessment

The ADHA definition of assessment: The collection and analysis of systematic and oral health data in order to identify client needs.¹⁹

I. HEALTH HISTORY

A health history assessment includes multiple data points that are collected through a written document and an oral interview. The process helps build a rapport with the patient and verifies key elements of the health status. Information is collected and discussed in a location that ensures patient privacy and complies with the Health Insurance Portability and Accountability Act (HIPAA).

Demographic information is any information that is necessary for conducting the business of dentistry. It includes but is not limited to address, date of birth, emergency contact information, phone numbers, and names and addresses of the referring/previous dentist and physician of record.

Vital Signs including temperature, pulse, respiration, and blood pressure provide a baseline or help identify potential or undiagnosed medical conditions.

Physical characteristics of height and weight provide information for drug dosing and anesthesia

and indicate risk for medical complications. Disproportionate height and weight also combine as a risk factor for diabetes and other systemic diseases that impact oral health and should prompt the practitioner to request glucose levels for health history documentation.

Social history information such as marital status, children, occupation, cultural practices, and other beliefs might affect health or influence treatment acceptance.

Medical history is the documentation of overall medical health. This information can identify the need for physician consultation or any contraindications for treatment. This would include any mental health diagnosis, cognitive impairments (e.g., stages of dementia), behavioral challenges (e.g., autism spectrum), and functional capacity assessment. It would also include the patient's level of ability to perform a specific activity such as withstanding a long dental appointment as well as whether the patient requires modified positioning for treatment. Laboratory tests such as A1C and current glucose levels may need to be requested if they are not checked regularly.

Pharmacologic history includes the list of medications, including dose and frequency, which the patient is currently taking. This includes but is not limited to any over-the-counter (OTC) drugs or products such as herbs, vitamins, nutritional supplements, and probiotics. The practitioner should confirm any past history of an allergic or adverse reaction to any products.

II. CLINICAL ASSESSMENT

Planning and providing optimal care require a thorough and systematic overall observation and clinical assessment. Components of the clinical assessment include an examination of the head and neck and oral cavity including an oral cancer screening, documentation of normal or abnormal findings, and assessment of the temporomandibular function. A current, complete, and diagnostic

set of radiographs provides needed data for a comprehensive dental and periodontal assessment.

A comprehensive periodontal examination is part of clinical assessment. It includes

- A. Full-mouth periodontal charting including the following data points reported by location, severity, quality, written description, or numerically:
 1. Probing depths
 2. Bleeding points
 3. Suppuration
 4. Mucogingival relationships/defects
 5. Recession
 6. Attachment level/attachment loss
- B. Presence, degree, and distribution of plaque and calculus
- C. Gingival health/disease
- D. Bone height/bone loss
- E. Mobility and fremitus
- F. Presence, location, and extent of furcation involvement

A comprehensive hard-tissue evaluation that includes the charting of existing conditions and oral habits, with intraoral photographs and radiographs that supplement the data.

- A. Demineralization
- B. Caries
- C. Defects
- D. Sealants
- E. Existing restorations and potential needs
- F. Implants
- G. Anomalies
- H. Occlusion
- I. Fixed and removable prostheses retained by natural teeth or implant abutments
- J. Missing teeth

III. RISK ASSESSMENT²⁰⁻²¹

Risk assessment is a qualitative and quantitative evaluation based on the health history and clinical assessment to identify any risks to general and oral health. The data provide the clinician with the information to develop and design strategies

for preventing or limiting disease and promoting health. Examples of factors that should be evaluated to determine the level of risk (high, moderate, low) include but are not limited to:

- A. Fluoride exposure
- B. Tobacco exposure including smoking, smokeless/spit tobacco and second-hand smoke
- C. Nutrition history and dietary practices including consumption of sugar-sweetened beverages
- D. Systemic diseases/conditions (e.g., diabetes, cardiovascular disease, autoimmune, etc.)
- E. Prescriptions and over-the-counter medications, and complementary therapies and practices (e.g., fluoride, herbal, vitamin and other supplements, daily aspirin, probiotics)
- F. Salivary function and xerostomia
- G. Age and gender
- H. Genetics and family history
- I. Habit and lifestyle behaviors
 1. Cultural issues
 2. Substance abuse (recreational drugs, prescription medication, alcohol)
 3. Eating disorders/weight loss surgery
 4. Piercing and body modification
 5. Oral habits
 6. Sports and recreation (swimming, extreme sports [marathon, triathlon], energy drinks/gels)
- J. Physical disability (morbid obesity, vision and/or hearing loss, osteoarthritis, joint replacement)
- K. Psychological, cognitive, and social considerations
 1. Domestic violence
 2. Physical, emotional, or sexual abuse
 3. Behavioral
 4. Psychiatric
 5. Special needs
 6. Literacy
 7. Economic
 8. Stress
 9. Neglect

Standard 2: Dental Hygiene Diagnosis

The ADHA defines dental hygiene diagnosis as the identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. The dental hygiene diagnosis requires evidence-based critical analysis and interpretation of assessments in order to reach conclusions about the patient's dental hygiene treatment needs. The dental hygiene diagnosis provides the basis for the dental hygiene care plan.²²

Multiple dental hygiene diagnoses may be made for each patient or client. Only after recognizing the dental hygiene diagnosis can the dental hygienist formulate a care plan that focuses on dental hygiene education, patient self-care practices, prevention strategies, and treatment and evaluation protocols to focus on patient or community oral health needs.²³

- I. Analyze and interpret all assessment data.
- II. Formulate the dental hygiene diagnosis or diagnoses.
- III. Communicate the dental hygiene diagnosis with patients or clients.
- IV. Determine patient needs that can be improved through the delivery of dental hygiene care.
- V. Identify referrals needed within dentistry and other health care disciplines based on dental hygiene diagnoses.

Standard 3: Planning

Planning is the establishment of realistic goals and the selection of dental hygiene interventions that can move the client closer to optimal oral health.²⁴ The interventions should support overall patient goals and oral health outcomes. Depending upon the work setting and state law, the dental hygiene care plan may be stand-alone or part of collaborative agreement. The plan lays the foundation for documentation and may serve as a guide for Medicaid reimbursement. Dental hygienists make

clinical decisions within the context of legal and ethical principles.

The dental hygiene care plan should be a vehicle for care that is safe, evidence-based, clinically sound, high-quality, and equitable. The plan should be personalized according to the individual's unique oral health needs, general health status, values, expectations, and abilities. When formulating the plan, dental hygienists should be sensitive and responsive to the patient's culture, age, gender, language, and learning style. They should demonstrate respect and compassion for individual patient choices and priorities.

- I. Identify all needed dental hygiene interventions including change management, preventive services, treatment, and referrals.
- II. In collaboration with the patient and/or caregiver, prioritize and sequence the interventions allowing for flexibility if necessary and possible.
- III. Identify and coordinate resources needed to facilitate comprehensive quality care (e.g., current technologies, pain management, adequate personnel, appropriate appointment sequencing, and time management).
- IV. Collaborate and work effectively with the dentist and other health care providers and community-based oral health programs to provide high-level, patient-centered care.
- V. Present and document dental hygiene care plan to the patient/caregiver.
- VI. Counsel and educate the patient and/or caregiver about the treatment rationale, risks, benefits, anticipated outcomes, evidence-based treatment alternatives, and prognosis.
- VII. Obtain and document informed consent and/or informed refusal.

Standard 4: Implementation

Implementation is the act of carrying out the dental hygiene plan of care.²⁴ Care should be delivered in a manner that minimizes risk; optimizes oral health; and recognizes issues related to patient comfort including pain, fear, and/or anxiety. Through the presentation of the dental hygiene

care plan, the dental hygienist has the opportunity to create and sustain a therapeutic and ethically sound relationship with the patient.

Depending upon the number of interventions, the dental hygiene care plan may be implemented in one preventive/wellness visit or several therapeutic visits before a continuing or maintenance plan is established. Health promotion and self-care are integral aspects of the care plan that should be customized and implemented according to patient interest and ability.

- I. Review and confirm the dental hygiene care plan with the patient/caregiver.
- II. Modify the plan as necessary and obtain any additional consent.
- III. Implement the plan beginning with the mutually agreed upon first prioritized intervention.
- IV. Monitor patient comfort.
- V. Provide any necessary post-treatment instruction.
- VI. Implement the appropriate self-care intervention; adapt as necessary throughout future interventions.
- VII. Confirm the plan for continuing care or maintenance.
- VIII. Maintain patient privacy and confidentiality.
- IX. Follow-up as necessary with the patient (post-treatment instruction, pain management, self-care).

Standard 5: Evaluation

Evaluation is the measurement of the extent to which the client has achieved the goals specified in the dental hygiene care plan. The dental hygienist uses evidence-based decisions to continue, discontinue, or modify the care plan based on the ongoing reassessments and subsequent diagnoses.²⁵ The evaluation process includes reviewing and interpreting the results of the dental hygiene care provided and may include outcome measures that are physiologic (improved health), functional, and psychosocial (quality of life, improved patient

perception of care). Evaluation occurs throughout the process as well as at the completion of care.

- I. Use measurable assessment criteria to evaluate the tangible outcomes of dental hygiene care (e.g., probing, plaque control, bleeding points, retention of sealants, etc.).
- II. Communicate to the patient, dentist, and other health/dental care providers the outcomes of dental hygiene care.
- III. Evaluate patient satisfaction of the care provided through oral and written questionnaires.
- IV. Collaborate to determine the need for additional diagnostics, treatment, referral, education, and continuing care based on treatment outcomes and self-care behaviors.
- V. Self-assess the effectiveness of the process of providing care, identifying strengths and areas for improvement. Develop a plan to improve areas of weakness.²⁶

Standard 6: Documentation

The primary goals of good documentation are to maintain continuity of care, provide a means of communication between/among treating providers, and to minimize the risk of exposure to malpractice claims. Dental hygiene records are considered legal documents and as such should include the complete and accurate recording of all collected data, treatment planned and provided, recommendations (both oral and written), referrals, prescriptions, patient/client comments and related communication, treatment outcomes and patient satisfaction, and other information relevant to patient care and treatment.

- I. Document all components of the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation, and evaluation) including the purpose of the patient's visit in the patient's own words. Documentation should be detailed and comprehensive; e.g., thoroughness of assessment (soft-tissue examination, oral cancer screening, periodontal probing, tooth mobility) and

- reasons for referrals (and to whom and follow-up). Treatment plans should be consistent with the dental hygiene diagnosis and include no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.²⁶
- II. Objectively record all information and interactions between the patient and the practice (e.g., telephone calls, emergencies, prescriptions) including patient failure to return for treatment or follow through with recommendations.
 - III. Record legible, concise, and accurate information. For example, include dates and signatures, record clinical information so that subsequent providers can understand it, and ensure that all components of the patient record are current and accurately labeled and that common terminology and abbreviations are standard or universal.
 - IV. Recognize ethical and legal responsibilities of recordkeeping including guidelines outlined in state regulations and statutes.
 - V. Ensure compliance with the federal Health Information Portability and Accountability Act (HIPAA). Electronic communications must meet HIPAA standards in order to protect confidentiality and prevent changing entries at a later date.
 - VI. Respect and protect the confidentiality of patient information.

Summary

The Standards for Clinical Dental Hygiene Practice are a resource for dental hygiene practitioners seeking to provide patient-centered and evidence-based care. In addition, dental hygienists are encouraged to enhance their knowledge and skill base to maintain continued competence.²⁷⁻²⁸ These Standards will be modified based on emerging scientific evidence, ADHA policy development, federal and state regulations, and changing disease patterns as well as other factors to assure quality care and safety as needed.

KEY TERMS

Client: The concept of client refers to the potential or actual recipients of *dental hygiene* care, and includes persons, families, groups and communities of all ages, genders, socio-cultural and economic states.²⁹

Cultural Competence: the awareness of cultural difference among all populations, respect of those differences and application of that knowledge to professional practice.¹⁷

Dental Hygiene Care Plan: an organized presentation or list of interventions to promote the health or prevent disease of the patient's oral condition. The plan is designed by the dental hygienist and consists of services that the dental hygienist is educated and licensed to provide.^{5, 7}

Evidence-Based Practice: the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual clients. The practice of evidence-based dental hygiene requires the integration of individual clinical expertise and client preferences with the best available external clinical evidence from systematic research.³⁰

Intervention: dental hygiene services rendered to clients as identified in the dental hygiene care plan. These services may be clinical, educational, or health promotion related.²⁹

Interprofessional Team: a group of health care professionals and their patients who work together to achieve shared goals. The team can consist of the dental hygienist, dentist, physician, nutritionist, smoking cessation counselor, nurse practitioner, etc.³¹

Outcome: result derived from a specific intervention or treatment.

Patient: the potential or actual recipient of dental hygiene care, including persons, families, groups, and communities of all ages, genders, and socio-cultural and economic states.²²

Patient-Centered: approaching services from the perspective that the client is the main focus of attention, interest, and activity. The client's values, beliefs, and needs are of utmost importance in providing evidence-based care.³²

Risk Assessment: an assessment based on characteristics, behaviors, or exposures that are associated with a particular disease; e.g., smoking, diabetes, or poor oral hygiene.²¹

REFERENCES

1. Standard of Applied Dental Hygiene Practice. Chicago: American Dental Hygienists' Association. 1985.
2. Standards for Clinical Dental Hygiene Practice. American Dental Hygienists' Association [Internet]. September 2014 [cited 2016 March 3]. Available from: http://www.adha.org/resources-docs/7261_Standards_Clinical_Practice.pdf
3. Code of Ethics. American Dental Hygienists' Association [Internet]. 2-14 [cited 2016 March 24]. Available from: https://www.adha.org/resources-docs/7611_Bylaws_and_Code_of_Ethics.pdf
4. Accreditation Standards for Dental Hygiene Education Programs. Chicago: American Dental Association. Commission on Dental Accreditation. Revised January 2016.
5. ADEA Competencies for Entry into the Allied Dental Professions. *J Dent Educ.* 2011; 75(7): 941-948.
6. *ADHA Policy Manual*. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 March 3]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
7. *ADHA Policy Manual* [4-10/SCDHP/18-96]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
8. Darby ML, Walsh MM. *Dental Hygiene Theory and Practice*. 4th ed. St. Louis, MO: Saunders. 2015. pp. 2, 9, 314-217.
9. Wilkins EM. *Clinical Practice of the Dental Hygienist*. 12th ed. Philadelphia: Wolters Kluwer. 2017. pp. 12-14.
10. Henry R, Goldie MP. *Dental Hygiene: Applications to Clinical Practice*. Philadelphia: FA Davis. 2016. pp. 549-553.
11. *ADHA Policy Manual* [3-14/14-83]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
12. *ADHA Policy Manual* [4-14/19-84]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
13. *Focus on Advancing the Profession*. Chicago: American Dental Hygienists' Association. 2005
14. *Transforming Dental Hygiene Education and the Profession for the 21st Century*. Chicago: American Dental Hygienists' Association. 2015.
15. State of Oregon Board of Dentistry. *Dental Practice Act – ORS Chapter 679*. Oregon.gov [Internet]. 2016 [cited 2016 May 17]. Available from: <https://www.oregon.gov/dentistry/docs/Rules/DPA2016Statutes01012016Color.pdf>
16. Oregon State Statute §679.010(2). Oregon State Legislature [Internet]. 2013 [cited 2015 July 20]. Available from: https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013orLaw0310.pdf
17. *ADHA Policy Manual* [7-07]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
18. *ADHA Policy Manual* [16-93]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
19. *ADHA Policy Manual* [SCDHP/18-96]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
20. *ADHA Policy Manual* [12-10]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
21. *ADHA Policy Manual* [11-10/21-82]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
22. *ADHA Policy Manual* [1-14/SCDHP/18-96]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
23. Swigart DJ, Gurenlian JR. Implementing Dental Hygiene Diagnosis into Practice. *Dimensions Dent Hyg.* 2015; 13(9): 56-59.
24. *ADHA Policy Manual* [SCDHP/18-96]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
25. *ADHA Policy Manual* [5-14/SCDHP/18-96]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
26. Guidelines for Medical Record Documentation. National Committee for Quality Assurance [Internet]. [cited 2016 January 31]. Available from: http://www.ncqa.org/portals/0/policyupdates/supplemental/guidelines_medical_record_review.pdf
27. *ADHA Policy Manual* [18-15]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
28. *ADHA Policy Manual* [17-15]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
29. *ADHA Policy Manual* [17-93]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
30. *ADHA Policy Manual* [1-07]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
31. *ADHA Policy Manual* [18-14/16-85]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
32. *ADHA Policy Manual* [6-97]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf
33. *ADHA Policy Manual* [12-05]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

RESOURCES

The following websites can provide evidence upon which to base clinical decisions in compliance with the Commission on Dental Accreditation (CODA) Accreditation Standards for Dental Hygiene Education Programs.

ADHA Policy Manual. Glossary, 18-96. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 March 28]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

American Academy of Public Health Dentistry: <http://www.aaphd.org/>.

American Academy of Pediatric Dentistry: <http://www.aapd.org/>.

American Academy of Periodontology: <http://perio.org/>.

American Dental Association: <http://www.ada.org/>.

Commission on Dental Accreditation. Accreditation Standards for Dental Hygiene Education Programs. American Dental Association [Internet]. 2016 January [cited 2016 March 3]. Available http://www.ada.org/~media/CODA/Files/2016_dh.ashx

American Diabetes Association: <http://www.diabetes.org/>.

American Heart Association: <http://www.americanheart.org/>.

Association of State and Territorial Dental Directors: <http://www.astdd.org/>.

Canadian Dental Hygienists' Association: www.cdha.org.

Centers for Disease Control and Prevention (caries, mineralization strategies, and health protection goals): <http://www.cdc.gov/> <http://www.cdc.gov/osi/goals/goals.html> <http://www.cdc.gov/niosh/homepage.html>

CDC Guidelines for Infection Control in Dental healthcare Settings. Centers for Disease Control and Prevention [Internet]. 2003. [cited 2016 March 28]. Available from; <http://www.cdc.gov/OralHealth/infectioncontrol/guidelines/index.htm>

Center for Evidence-Based Dentistry: <http://www.cebd.org/>.

Clinical Trials: <http://www.clinicaltrials.gov/>.

The Cochrane Collaboration: <http://www.cochrane.org/>.

Forrest JL, Miller SA. An Evidence-Based Decision-Making Model for Dental Hygiene Education, Research and Practice. *J Dent Hyg.* 2001; 75(1): 50-63.

Health Insurance Portability and Accountability Act (HIPAA): <http://www.hipaa.org/>.

National Guideline Clearing House: <http://www.guidelines.gov/>.

Nunn ME. Understanding the Etiology of Periodontitis: An Overview of Periodontal Risk Factors. *Periodontol* 2000. 2003; 32:11-23.

Occupational Safety and Health Administration: <http://www.osha.gov/SLTC/dentistry/index.html>.

The Organization for Safety and Asepsis Procedures (OSAP): <http://www.osap.org/>.

Special Care Dentistry: <http://www.scdonline.org/>.

The Selection of Patients for Dental Radiograph Examinations. American Dental Association and the US Department of Health and Human Services [Internet] Revised 2012 [cited 2016 March 28]. Available from: <http://www.fda.gov/downloads/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/MedicalX-Rays/UCM329746.pdf>

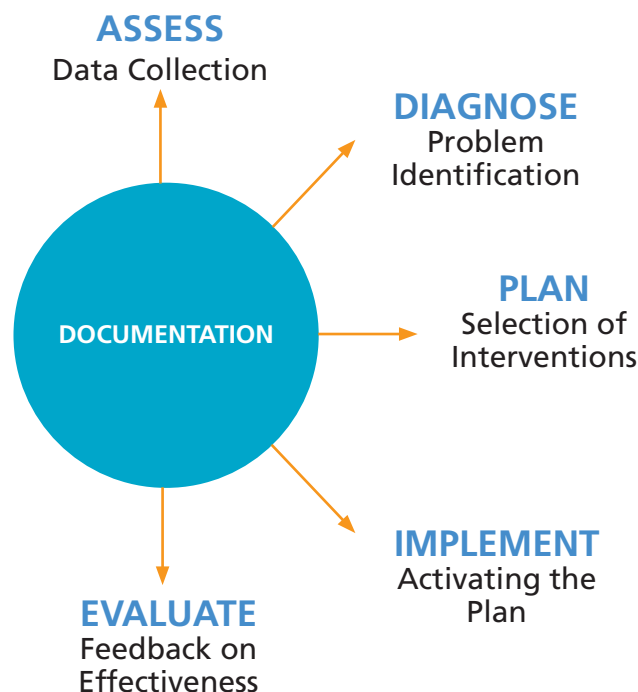
Comprehensive Periodontal Therapy: A Statement by the American Academy of Periodontology. *J Periodontol.* 2011; 82(7): 943-949.

Appendix A

DENTAL HYGIENE PROCESS OF CARE ⁷

There are six components to the dental hygiene process of care. These include assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation. The six components provide a framework for patient care activities.

Adapted from: Wilkins EM. Clinical Practice of the Dental Hygienist. 12th ed. Philadelphia, PA: Wolters Kluwer. 2017. pp. 12-14.



Appendix B

PROFESSIONAL ROLE OF THE DENTAL HYGIENIST³³

Overview

The dental hygienist plays an integral role in assisting individuals and groups in achieving and maintaining optimal oral health. Dental hygienists provide educational, clinical and consultative services to individuals and populations of all ages in a variety of settings and capacities. The professional roles of the dental hygienist are outlined below .

Clinician	Corporate	Public Health	Researcher	Educator	Administrator	Entrepreneur
<p>Dental hygienists in a clinical role assess, diagnose, plan, implement, evaluate and document treatment for prevention, intervention and control of oral diseases, while practicing in collaboration with other health professionals. Examples of clinical employment settings include:</p> <ul style="list-style-type: none"> • Private dental practices • Community clinics • Hospitals • University dental clinics • Prison facilities • Nursing homes • Schools 	<p>Corporate dental hygienists are employed by companies that support the oral health industry through the sale of products and services. Leaders throughout the dental industry often employ dental hygienists due to their clinical experience and understanding of dental practice. Examples of corporate positions include:</p> <ul style="list-style-type: none"> • Sales representatives • Product researchers • Corporate educators • Corporate administrators 	<p>Community health programs are typically funded by government or non-profit organizations. These positions often offer an opportunity to provide care to those who otherwise would not have access to dental care. Examples of positions for dental hygienists in public health settings include:</p> <p>Clinician</p> <ul style="list-style-type: none"> • Rural or inner city community clinics • Indian Health Service • Head Start programs • School sealant programs <p>Administrator</p> <ul style="list-style-type: none"> • State public health officer • Community clinic administrator 	<p>Research conducted by dental hygienists can be either qualitative or quantitative. Quantitative research involves conducting surveys and analyzing the results, while qualitative research may involve testing a new procedure, product or theory for accuracy, effectiveness, etc. Examples of employment settings for dental hygienist researchers include:</p> <ul style="list-style-type: none"> • Colleges and universities • Corporations • Governmental agencies • Nonprofit organizations 	<p>Dental hygiene educators are in great demand. Colleges and universities throughout the U.S. require dental hygiene instructors who use educational theory and methodology to educate competent oral health professionals. Corporations also employ educators who provide continuing education to licensed dental hygienists. Examples of dental hygiene educators include:</p> <ul style="list-style-type: none"> • Clinical instructors • Classroom instructors • Program directors • Corporate educators 	<p>Dental hygienists in administrative positions apply organizational skills, communicate objectives, identify and manage resources, and evaluate and modify programs of health, education and health care. Examples of administrative positions held by dental hygienists include:</p> <ul style="list-style-type: none"> • Clinical director, statewide school sealant program • Program director, dental hygiene educational program • Executive director, state association staff • Research administrator, university • Director, corporate sales 	<p>By using imagination and creativity to initiate or finance new commercial enterprises, dental hygienists have become successful entrepreneurs in a variety of businesses. Some examples of business opportunities developed by dental hygienists include:</p> <ul style="list-style-type: none"> • Practice management company • Product development and sales • Employment service • CE provider or meeting planner • Consulting business • Founder of a nonprofit • Independent clinical practice • Professional speaker / writer

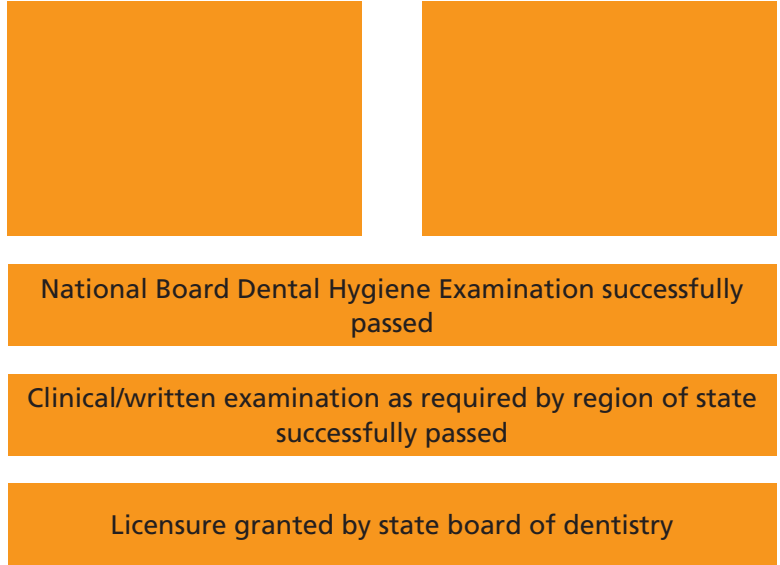
Appendix C

EDUCATIONAL PATH FOR ENTRY INTO THE PROFESSION

Dental hygienists must complete an accredited educational program to qualify for licensure in a particular state or region. Dental hygienists are licensed with the credential of Registered Dental Hygienist (RDH) or Licensed Dental Hygienist (LDH) following completion of an academic program that includes didactic and clinical requirements.

PROFESSIONAL SPECIALIZATION

Dental hygienists can further their academic credentials after earning a certificate, associate, and/or baccalaureate degree. A dental hygienist can continue their educational advancement by enrolling in a variety of Master's level programs which provides eligibility for a Doctoral level degree.



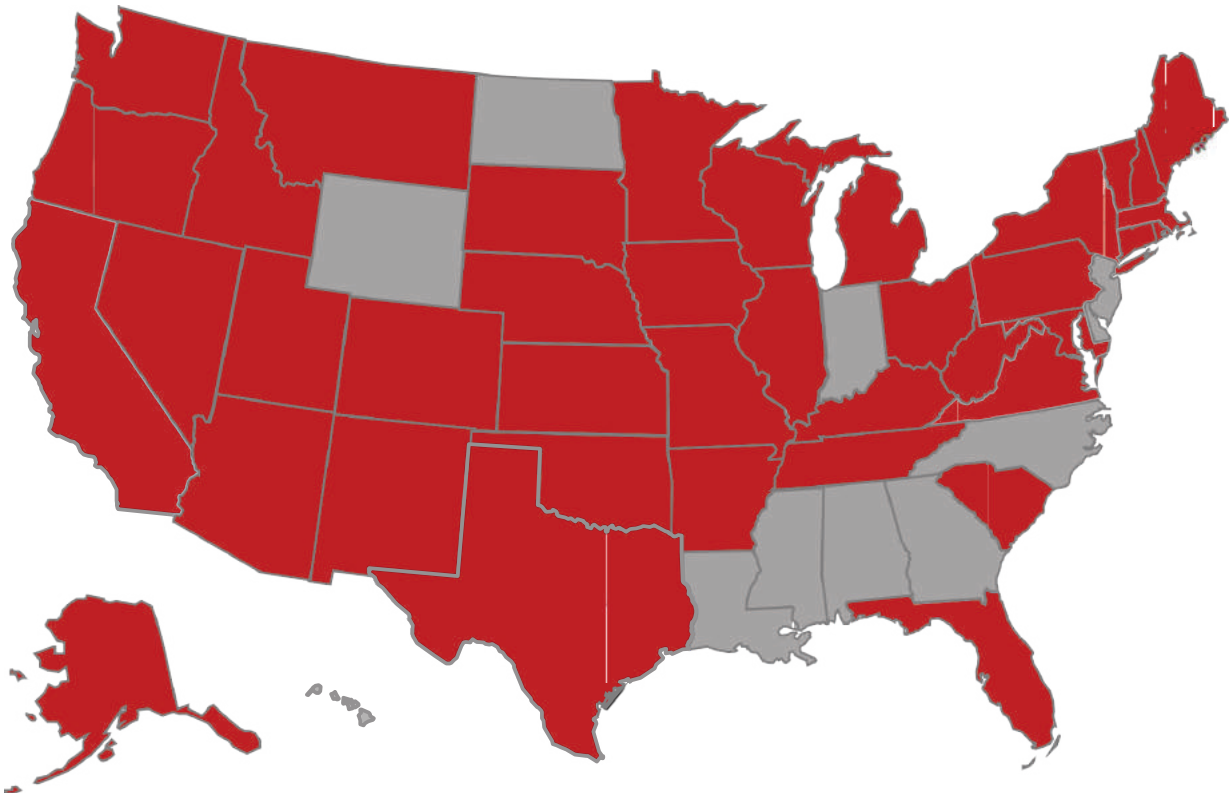
Appendix D

DIRECT ACCESS 2016

The American Dental Hygienists' Association (ADHA) defines direct access as the ability of a dental hygienist to initiate treatment based on their assessment of a patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and main-

tain a provider-patient relationship (ADHA Policy Manual, 13-15).

States that permit direct access to dental hygienists
Revised April 2016 www.adha.org



Development and Validation Process for the Standards for Clinical Dental Hygiene Practice

In 2003, the ADHA Board of Trustees approved the establishment of a task force to define and develop standards of clinical dental hygiene practice. The previous standards of practice document created by ADHA was published in 1985 and was no longer being distributed due to the significant changes in dental hygiene practice; therefore the association did not have document accurately reflecting the nature of clinical dental hygiene practice. A series of task force meetings occurred by phone, electronically and in-person from 2004-2008 in order to create and revise the draft standards document.

As part of the validation process, in November 2005, a survey was distributed to all ADHA council members, 50 participants in the ADHA Constituent Officers Workshop, and a 50-member random selection of the ADHA membership to provide feedback regarding the draft Standards of Practice that had been created by the task force. The data collected from these audiences was collated, analyzed and reviewed by the task force in making subsequent modifications.

During the 2006 ADHA Annual Session, the chair of the task force presented the draft Standards document to the membership, responded to questions, and requested written and verbal feedback regarding the direction of the document. The Standards were also posted on the ADHA website prior to the annual meeting and for a period following in order to solicit feedback from the membership and other communities of interest. In the fall of

2006, the task force met and considered the comments from all respondents and made additional revisions to the document. The task force also reviewed clinical standards of practice documents from other professions as a point of comparison.

In 2007, the revised Standards were shared during the ADHA Annual Session with the draft document posted online and open for comments from the communities of interest. Following the annual meeting, the draft document was also broadly distributed to the broad communities of interest, which included a pool of approximately 200 organizations.

Following the collection of feedback from all interested parties, the task force considered all feedback and met by conference call in order to finalize the document. The final document was submitted to the ADHA Board of Trustees in March 2008 for their consideration and adoption.

In September 2014, the Standards for Clinical Dental Hygiene Practice policies and references were updated and the document was reprinted. It was determined at the 2015 Annual Session that the Standards would need to be revised since at least three years had passed since the last full revision of the document. A new task force was appointed by ADHA President Jill Rethman, RDH, BA, for the revision of the Standards.

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