Background

Expanded function dental auxiliaries (EFDAs), which includes both dental assistants and hygienists, are a classification of health care providers that are licensed and recognized in many states. In Iowa, expanded functions that can be performed by dental assistants include: fabricating temporary crowns; removing temporary crowns; taking occlusal registrations; placement and removal of gingival retraction; taking final impressions; applying cavity liners, bases, desensitizing agents, or bonding systems; and testing pulp vitality. [1]

Some states have expanded the list of functions that EFDAs can provide to include restorative functions including placement and shaping of amalgam and composite restorations. The Dental Assistant National Board (DANB) maintains a web-based list of dental assisting job titles and the procedures that each are allowed to perform on a state-by-state basis. [2] States in the Midwest that currently allow EFDAs to place and contour amalgams and composites include Michigan, Minnesota, Missouri, and Ohio. [2] Increasing the services that EFDAs can perform has many advantages that may allow for improved practice efficiency. Several studies have demonstrated that EFDAs can provide more advanced services while maintaining quality of work similar to dentists. [3-5] EFDAs able to perform expanded duties could also contribute to increasing the profitability of dental practices and increasing access to care for patients. [6-13]

Additionally, it is anticipated that these EFDAs with increased procedural capacity will experience improved job satisfaction and professional development. [11]

During the past several years there has been increased interest in Iowa about allowing EFDAs to provide additional functions. This recent interest is largely the result of statewide interest to maximize the efficiency of our current dental workforce to provide oral health care to the state's population. The idea of increasing EFDAs' duties in Iowa is not new. In fact, Iowa has a rich history in training and utilizing EFDAs to improve practice efficiency through the University of Iowa College of Dentistry's EFDA program of the 1970s.

In October 2011, Iowa Dental Association leadership presented a proposal to the Iowa Dental Board asking the board to consider expanding the number of reversible dental procedures a dental assistant is allowed to do after proper training and to allow dental hygienists to provide all reversible procedures that dental assistants are allowed to provide. This recommendation would, thereby, allow both hygienists and dental assistants to function as "expanded function dental auxiliaries" (EFDAs). The list of additional procedures recommended by the Iowa Dental Association included the following:

- Crown lengthening
- Ceramic veneers
- Ceramic crowns
- Porcelain fused to metal crowns
- Ceramic inlays
- Ceramic onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
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- Temporary crowns
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- Temporary veneer crowns
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- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
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- Temporary veneer crowns
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- Temporary veneer crowns
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- Temporary veneer crowns
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- Temporary veneer crowns
- Temporary crowns
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- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
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- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
- Porcelain onlays
- Temporary veneer crowns
- Temporary crowns
- Ceramic onlays
- Porcelain inlays
the IDA included: removal of adhesives; placement and shaping of amalgam or composite restorations; forming and placement of stainless steel crowns; taking final impressions and records for the fabrication of dentures and partial dentures; and cementation of final restorations.

To address the IDA’s recommendation, the Iowa Dental Board appointed a task force to deliberate about expanding the number of allowed procedures that can be performed by EFDA’s and to make a recommendation to the board. Membership on the task force included dentists, dental hygienists, dental assistants and a lay member. In order to make a more informed recommendation to the Iowa Dental Board, the task force had three major questions about Iowa dentists’ utilization and opinions of EFDA’s:

1. How do dentists utilize EFDA’s to perform currently allowed services?
2. What are Iowa dentists’ attitudes toward using EFDA’s to perform any of the additional duties being proposed?
3. How willing are Iowa dentists to pay for EFDA’s to receive training in these additional services?

In sum, this study aimed to address these three major questions posed by the task force, and in turn, help the task force determine the acceptability of expanding the scope of practice for dental auxiliaries in order to increase the ability of Iowans to receive oral health care.

Methods
This study collected and merged information from several different sources in order to answer the three major questions charged by the EFDA task force. Results from the “2013 Survey of Iowa Dentists,” the Iowa Dentist Tracking System (IDTS), and the United States Department of Agriculture Economic Research Service’s Rural-Urban Continuum Codes (RUCCs) were merged and analyzed using univariate and bivariate statistics.

Several questions about EFDA’s were included into the “2013 Survey of Iowa Dentists,” a study designed and administered by The University of Iowa Public Policy Center. First, dentists were provided a list of allowable services and asked if they ever delegate these to an EFDA in their practice. Second, dentists were provided a list of proposed expanded functions and asked if they would consider delegating these to an EFDA in their practice. Finally, dentists were asked how strongly they would consider paying to train one of their own dental auxiliaries to perform one of the proposed services.

Continued on next page
Other questions in the survey assessed dentists' acceptance of new Medicaid patients, percent of patients in practices enrolled in Medicaid, and perceived workload.

The "2013 Survey of Iowa Dentists" was sent to all private practice dentists in Iowa and asked about their participation in and attitudes toward Medicaid. The survey was not sent to dentists practicing at community health centers or the University of Iowa College of Dentistry. We limited our study only to primary care providers in private practice (general and pediatric dentists) in Iowa. Other dental specialties are excluded from analysis here because EFDA procedures currently allowed in Iowa and those being proposed are most applicable to the practice of general and pediatric dentistry (e.g., fitting stainless steel crowns).

Responses to the survey were linked to data from the Iowa Dentist Tracking System (IDTS), which provides demographic data about all licensed dentists in the state. \(^{(12,13)}\) IDTS data includes: dentist specialty; gender; age; dental school; practice arrangement; practice location; and hours worked per week. Full-time was considered 32 or more hours worked per week while part-time was considered any amount less than this.

Practice location information from the IDTS was used to describe the urbanicity of counties as either metropolitan or non-metropolitan using Rural-Urban Continuum Codes (RUCCs, also known as a Beale Codes) of the county in which dentist’s practice was located. The United States Department of Agriculture's Economic Research Service developed the 2013 RUCC classification system for counties in the United States. \(^{(14)}\) Metropolitan counties are distinguished by population size while non-metropolitan counties are characterized by degree of urbanization and proximity to metropolitan area(s).

Descriptive statistics were performed to examine characteristics of survey respondents, their current use of EFDA, and the acceptability of additional expanded functions. Bivariate analysis was performed to determine possible associations between dentists' characteristics and whether they delegated any of the currently allowed procedures to EFDA.

Results

Overall, 677 primary care providers responded to this survey, resulting in a response rate of 59.1% (Table 1). Over three-fourths of respondents were male. Slightly over half of respondents were 50 years or older. The majority of respondents were general dentists (N = 657). Approximately 44% of pediatric dentists in Iowa responded to the survey. Responders to the survey were representative of all surveyed dentists in gender and age (p > 0.05). General dentists were significantly more likely to respond to the survey than pediatric dentists (59.7% vs. 44.4% p = 0.042).

The proportion of dentists delegating services to EFDA ranged from 48.1% for fabricating temporary crowns to 15.8% for testing pulp vitality (Table 2). More than half of the dentists (58.5%) delegated at least one of the procedures EFDA are currently allowed to perform. Bivariate analyses were performed to determine the characteristics of dentists that currently delegate at least one of the currently allowed services. Dentist characteristics of interest included specialty, gender, age, dental school attended, practice arrangement, county urbanicity, hours worked per week, perceived workload, and current Medicaid participation (Table 3).

Two dentist characteristics, gender and age, were found to be significantly associated with their decision to delegate services to EFDA. Female dentists were significantly more likely than males to report delegating duties to EFDA (p = 0.010). As age increased, dentists were significantly less likely to report delegating tasks to EFDA (p = 0.004).

A majority of dentists would consider allowing EFDA to perform at least one of the proposed services (71.1%) (Table 4). We found that dentists were less likely to consider using EFDA for more complex duties than simpler ones. For example, most dentists (63.3%) reported that they would consider allowing EFDA to remove cement/adhesives following permanent cementation of crowns/bridges. Dentists were least likely to consider delegating placing and shaping composite restorations with only 18.6% saying they would consider using EFDA for this procedure. When considering only the more complex duties of placing and shaping composite or amalgam restorations as well as fitting and cementing stainless steel crowns, 37.0% of dentists would consider delegating at least one of those procedures to EFDA.

Among 429 dentists who would consider delegating at least one of the proposed duties to EFDA, 61.1% of dentists would give moderate or extreme consideration to covering the cost for training EFDA, and an additional 20.3% of these primary care dentists would slightly consider paying for training. Only 18.6% of dentists that would allow EFDA to perform at least one of the proposed expanded functions

Continued on next page
would not consider covering the cost of EFDA training at all.

**Discussion**

As many studies have demonstrated, EFDA can increase practice efficiency by enabling practices to see more patients. \(^6,^9,^11-14^\) Increasing EFDA duties in Iowa may have significant implications on dental practices and improving patients' access to oral health care. This study investigated dentists' characteristics and willingness to utilize EFDA to determine the acceptability of improving access to oral health care in Iowa by expanding the number of procedures EFDA may perform.

Most Iowa dentists are open to utilizing EFDA. Nearly 60% of the dentists in this study already utilize EFDA for currently allowed procedures and over 70% were willing to delegate at least one of the proposed expanded duties. Of the dentists willing to consider delegating a proposed duty to EFDA, over 80% of them would consider paying for the training of EFDA to perform these expanded duties. This study also found that younger dentists and female dentists were more likely to delegate procedures that are currently allowed in the state of Iowa. These encouraging results suggest that increasing the services EFDA can provide would be a well-accepted and utilized policy change among Iowa's dental workforce that may help address issues about the future of Iowa's dental workforce and its ability to address Iowans' needs for dental care.

The substantial proportion of dentists in Iowa who are approaching retirement is a source of concern for access to dental care in Iowa. Over half of Iowa's primary care dentists in private practice are 50 years or older and approaching retirement, so there could be a substantial decrease in dentists in the coming two decades. \(^11^,^13^\) Younger dentists' increased willingness to utilize EFDA could offer a feasible way to help compensate for the coming decrease in dentists due to retirement.

Another trend in Iowa is the increasing number of female dentists. The percent of dentists in Iowa who are women increased from only 10.5% in 1997 to 23% in 2011. \(^12^,^13^\) Female dentist's increasing presence in the workforce makes their greater likelihood of delegating to EFDA significant for policy making concerning improving access to oral health care. This is because expanding EFDA duties can increase the number of patients seen per day in a dental practice.

Because low income patients' ability to receive dental care is of particular concern in the access to care issue, we also investigated respondents' Medicaid participation. Although Medicaid participation was not associated with dentists' willingness to utilize EFDA in this study \((p = 0.053)\), there is still a strong likelihood that expanding EFDA duties can increase the number of Medicaid patients who receive care in Iowa. A 2010 survey supported this by demonstrating that 37% of pediatric dentists would care for more Medicaid patients if utilizing EFDA with expanded duties would allow them to see more patients. \(^10^\)

This study may underestimate the impact EFDA can have on access to oral health care in Iowa. Community health center dentists, academic dentists, and non-primary care providers who may also utilize EFDA were not included in this study. This is especially important when considering that community health centers and dental schools largely care for low income patients as part of the dental safety net. \(^13^\)

The complexity of a procedure

Continued on next page
is important in a dentist’s decision to delegate it to an EFDA. As the complexity of duties increases, dentists’ willingness to delegate allowable duties decreases, as does their willingness to consider delegating proposed expanded functions. Regardless of whether EFDA’s are trained in a procedure, dentists are likely to consider the difficulty and risks of a procedure before deciding if they would allow EFDA’s to perform it. Convenience may be another aspect of a procedure that dentists consider before deciding to delegate it to an EFDA. For example, only 18.5% of dentists currently allow EFDA’s to apply cavity liners, bases, desensitizing agents, or bonding agents on patients. This may be due to the fact that dentists are already present chairside to perform a restoration, so dentists may apply those materials themselves for convenience and practical reasons. The complexity and the context in which a procedure is performed are both factors likely to influence whether a dentist delegates an allowable procedure to an EFDA.

**Conclusion**

The following findings of this study support the idea that increasing the number of procedures EFDA’s may perform (following appropriate training) could be a feasible way to improve access to care in Iowa:

1. Most dentists in Iowa utilize EFDA’s for at least one of the currently allowed EFDA procedures.

2. Most dentists in Iowa would consider delegating at least one of proposed expanded functions to appropriately trained EFDA’s.

3. The majority of Iowa dentists who are willing to allow EFDA’s to perform one of the proposed duties are also willing to consider paying for training EFDA’s.

4. Younger dentists’ increased willingness to delegate to EFDA’s could improve practice efficiency, which in turn may help compensate for the aging Iowa dentist population.

5. Women dentists are more likely to delegate to EFDA’s, which is significant when considering that delegating to EFDA’s could improve their practices’ efficiency and allow them to see more patients.

6. Dentists consider the complexity and the context in which a procedure is performed in their decision of whether to delegate it to EFDA’s.

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### Table 1. Survey response rates

<table>
<thead>
<tr>
<th>Total Responders</th>
<th>677 / 1,146 (59.1%)</th>
</tr>
</thead>
</table>

| Gender | | |
|--------|--------|
| Male   | 518 (76.5%) |
| Female | 159 (23.5%) |

| Age | | |
|-----|--------|
| <30 years | 39 (5.8%) |
| 30-39 | 134 (19.8%) |
| 40-49 | 127 (18.8%) |
| 50-59 | 199 (29.4%) |
| 60-69 | 154 (22.8%) |
| ≥70 | 23 (3.4%) |

| Specialty | | |
|-----------|--------|
| General dentistry | 657 (97.0%) |
| Pediatric dentistry | 20 (3.0%) |

### Table 2. Current use of expanded function dental auxiliaries (EFDAs) among primary care dentists (N=677)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fabricate temporary crowns</td>
<td>310 (45.1%)</td>
<td>335 (49.9%)</td>
</tr>
<tr>
<td>Remove temporary crowns</td>
<td>291 (45.1%)</td>
<td>354 (54.9%)</td>
</tr>
<tr>
<td>Take occlusal registrations</td>
<td>283 (43.8%)</td>
<td>363 (56.2%)</td>
</tr>
<tr>
<td>Placement and removal of gingival retraction</td>
<td>179 (27.8%)</td>
<td>464 (72.2%)</td>
</tr>
<tr>
<td>Take final impressions</td>
<td>143 (22.2%)</td>
<td>502 (77.8%)</td>
</tr>
<tr>
<td>Apply cavity liners, bases, desensitizing agents, or bonding systems</td>
<td>120 (18.5%)</td>
<td>527 (81.5%)</td>
</tr>
<tr>
<td>Test pulp vitality</td>
<td>102 (15.8%)</td>
<td>543 (84.2%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you ever delegate any of the duties listed above?*</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>396 (58.5%)</td>
<td>281 (41.5%)</td>
</tr>
</tbody>
</table>

*Used as dependent variable in Table 3.

---

**Live Patient Extraction Classes 40 CE Credit Hours**

Dr. Gayle Fletcher and Dr. Tommy Murph, instructors for Dental Developmental Seminars, will teach all the 40 hour live patient extraction classes.

**Date:** January 17-25, 2014  
**Location:** Guatemala  
**Cost:** $4000  
**Contact:** Dr. Murph 843-488-4357  
[drtommymurph@yahoo.com](mailto:drtommymurph@yahoo.com)

**Refund Policy:** 50% 90 days prior to class start, 25% 60 days prior. No refunds under 60 days.

You will be able to section teeth, reflect flaps, suture, identify problems and learn how to recover from them. Learn how to handle dry sockets, sinus perforations, bleeding, pain, abscesses, swelling, etc. confidently.

---

**WINTER ONE DAY COURSE**

8 hour CE Class Saturday December 7, 2013 in Minneapolis, Minnesota. The class will address the basics of tooth extractions with Hands-On Experience using pig heads.

Party after the class on Saturday Night.

Approved PACE Program Provider FAGD/MAGD credit
Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement
4/1/2012 to 3/31/2016 provider ID 218239
<table>
<thead>
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<th>Variable</th>
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<th>No</th>
<th>p-value</th>
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<td><strong>Specialty</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General dentistry</td>
<td>657 (97.0%)</td>
<td>388 (59.1%)</td>
<td>269 (40.9%)</td>
<td>0.088</td>
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<tr>
<td>Pediatric dentistry</td>
<td>20 (3.0%)</td>
<td>8 (40.0%)</td>
<td>12 (60.0%)</td>
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</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>518 (76.5%)</td>
<td>289 (55.8%)</td>
<td>229 (44.2%)</td>
<td>0.010*</td>
</tr>
<tr>
<td>Female</td>
<td>159 (23.5%)</td>
<td>107 (67.3%)</td>
<td>52 (32.7%)</td>
<td></td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.0001*</td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>49.8 ± 12.6</td>
<td>48.1 ± 12.6</td>
<td>52.3 ± 12.3</td>
<td></td>
</tr>
<tr>
<td><strong>Age group</strong></td>
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<tr>
<td>&lt;30 years</td>
<td>39 (5.8%)</td>
<td>27 (69.2%)</td>
<td>12 (30.8%)</td>
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</tr>
<tr>
<td>30-39</td>
<td>134 (19.8%)</td>
<td>93 (69.4%)</td>
<td>41 (30.6%)</td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>127 (18.8%)</td>
<td>81 (63.8%)</td>
<td>46 (36.2%)</td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>199 (29.4%)</td>
<td>106 (53.3%)</td>
<td>93 (46.7%)</td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>154 (22.8%)</td>
<td>78 (50.6%)</td>
<td>76 (49.4%)</td>
<td></td>
</tr>
<tr>
<td>&gt;70</td>
<td>23 (3.4%)</td>
<td>11 (47.8%)</td>
<td>12 (52.2%)</td>
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<tr>
<td><strong>Dental school</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.901</td>
</tr>
<tr>
<td>University of Iowa</td>
<td>198 (73.6%)</td>
<td>292 (58.6%)</td>
<td>206 (41.4%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>179 (26.4%)</td>
<td>104 (58.1%)</td>
<td>75 (41.9%)</td>
<td></td>
</tr>
<tr>
<td><strong>Practice Arrangement</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.107</td>
</tr>
<tr>
<td>Solo practice</td>
<td>201 (29.7%)</td>
<td>127 (63.2%)</td>
<td>74 (36.8%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>476 (70.3%)</td>
<td>269 (56.5%)</td>
<td>207 (43.5%)</td>
<td></td>
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<tr>
<td><strong>County Urbanicity</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.278</td>
</tr>
<tr>
<td>Metro</td>
<td>287 (42.4%)</td>
<td>161 (56.1%)</td>
<td>126 (43.9%)</td>
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</tr>
<tr>
<td>Nonmetro</td>
<td>390 (57.6%)</td>
<td>235 (60.3%)</td>
<td>155 (39.7%)</td>
<td></td>
</tr>
<tr>
<td><strong>Full-Time/Part-Time</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.666</td>
</tr>
<tr>
<td>≥32 hours/week</td>
<td>579 (88.1%)</td>
<td>47 (60.3%)</td>
<td>2 (39.7%)</td>
<td></td>
</tr>
<tr>
<td>&lt;32 hours/week</td>
<td>78 (11.9%)</td>
<td>334 (57.7%)</td>
<td>245 (42.3%)</td>
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</tr>
<tr>
<td><strong>Perceived workload</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.135</td>
</tr>
<tr>
<td>Too busy</td>
<td>162 (24.8%)</td>
<td>105 (64.8%)</td>
<td>57 (35.2%)</td>
<td></td>
</tr>
<tr>
<td>Comfortable workload</td>
<td>366 (56.0%)</td>
<td>322 (57.7%)</td>
<td>155 (42.3%)</td>
<td></td>
</tr>
<tr>
<td>Not busy enough</td>
<td>125 (19.1%)</td>
<td>67 (53.6%)</td>
<td>58 (46.4%)</td>
<td></td>
</tr>
<tr>
<td><strong>Accepts new Medicaid patients</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.084</td>
</tr>
<tr>
<td>Yes</td>
<td>385 (57.4%)</td>
<td>214 (55.6%)</td>
<td>171 (44.4%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>286 (42.6%)</td>
<td>178 (62.2%)</td>
<td>108 (37.8%)</td>
<td></td>
</tr>
<tr>
<td><strong>Current percent of patients covered by Medicaid</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.053</td>
</tr>
<tr>
<td>0%</td>
<td>87 (14.9%)</td>
<td>61 (70.1%)</td>
<td>26 (29.9%)</td>
<td></td>
</tr>
<tr>
<td>1-5%</td>
<td>208 (35.7%)</td>
<td>121 (58.2%)</td>
<td>87 (41.8%)</td>
<td></td>
</tr>
<tr>
<td>6-10%</td>
<td>106 (18.2%)</td>
<td>63 (59.4%)</td>
<td>43 (40.6%)</td>
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<tr>
<td>11-15%</td>
<td>55 (9.5%)</td>
<td>32 (58.2%)</td>
<td>23 (41.8%)</td>
<td></td>
</tr>
<tr>
<td>&gt;15%</td>
<td>126 (8.1%)</td>
<td>62 (49.2%)</td>
<td>64 (50.8%)</td>
<td></td>
</tr>
<tr>
<td>If the practice act was changed, would you consider utilizing an EFDA to provide any of these duties?</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>Removal of cement/adhesives following permanent cementation of crowns/bridges</td>
<td>414 (63.3%)</td>
<td>240 (36.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take final impressions and records for the fabrication of dentures and partial dentures</td>
<td>224 (34.3%)</td>
<td>429 (65.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fit and cement stainless steel crowns on primary teeth</td>
<td>209 (31.9%)</td>
<td>446 (68.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place and shape amalgam restorations following preparation of a tooth by a dentist</td>
<td>145 (22.3%)</td>
<td>504 (77.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cement final restorations (i.e., crowns, fixed partial dentures)</td>
<td>143 (22.0%)</td>
<td>506 (78.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place and shape composite restorations following preparation of a tooth by a dentist</td>
<td>122 (18.6%)</td>
<td>534 (81.4%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Would you delegate any of the proposed duties?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>466 (71.1%)</td>
<td>189 (28.9%)</td>
</tr>
</tbody>
</table>

Would you delegate any of the following duties?

- Place/shape amalgam restorations
- Place/shape composite restorations
- Fit/cement stainless steel crowns

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>242 (37.0%)</td>
<td>412 (63.0%)</td>
</tr>
</tbody>
</table>

References