



# STATE OF IOWA

## IOWA DENTAL BOARD

TERRY E. BRANSTAD, GOVERNOR  
KIM REYNOLDS, LT. GOVERNOR

MELANIE JOHNSON, J.D.  
EXECUTIVE DIRECTOR

### IOWA DENTAL HYGIENE COMMITTEE

#### AGENDA

January 31, 2013

10:30 a.m.

**Location:** Iowa Dental Board, 400 SW 8<sup>th</sup> St., Suite D, Des Moines, Iowa

**Committee Members:** *Mary Kelly, R.D.H., Chair; Nancy Slach, R.D.H., Vice Chair;  
Steve Bradley, Secretary*

#### **I. OPEN SESSION**

*Mary Kelly*

1. Call to Order, Roll Call
2. Approval of Open Session Minutes
  - October 25, 2012 minutes

#### **II. 1<sup>ST</sup> OPPORTUNITY FOR PUBLIC COMMENT**

*Theresa Weeg*

#### **III. LEGAL REPORT**

1. Follow-Up Re: Review of Statutory Authority of Dental Hygiene Committee and Dental Board
2. Follow-Up Re: Subsequent Examinations & RDHs Under a Public Health Supervision Agreement

#### **IV. ADMINISTRATIVE RULES**

1. Recommendation re: Adoption of final amendments to Chpt. 10, "General Requirements," Rule 650—10.5 – Amending the definition of "public health setting" to include day care settings (NOIA, ARC 0471C, 11/28/12 IAB)

#### **V. \*APPLICATIONS FOR LICENSURE & OTHER REQUESTS**

1. Application for Dental Hygiene License from Jessica M. Koster, DH

#### **VI. \* CLOSED SESSION**

#### **VII. RECONVENE IN OPEN SESSION**

#### **VIII. OPEN SESSION ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS**

#### **IX. 2<sup>ND</sup> OPPORTUNITY FOR PUBLIC COMMENT**

*Mary Kelly*

**X. OTHER BUSINESS**

1. 2013 Meeting Schedule

**XI. ADJOURN**

If you require the assistance of auxiliary aids or services to participate in or attend the meeting because of a disability, please call the office of the Board at 515/281-5157.

\*This portion of the meeting may be conducted in closed session to discuss confidential matters that may concern examination information, peace officers' investigative reports, attorney records related to litigation, patient records and reports on the condition, diagnosis, care or treatment of a patient, or investigation reports and other investigative information which is privileged and confidential under the provisions of Sections 22.7(2), 22.7(4), 22.7(5), 22.7(9), 22.7(19), and 272C.6(4) of the 2011 Code of Iowa.

These matters constitute a sufficient basis for the committee to consider a closed session under the provisions of section 21.5(1), (a), (c), (d), (f), (g), and (h) of the 2011 Code of Iowa. These sections provide that a governmental body may hold a closed session only by affirmative public vote of either two-thirds of the members of the body or all of the members present at the meeting to review or discuss records which are required or authorized by state or federal law to be kept confidential, to discuss whether to initiate licensee disciplinary investigations or proceedings, and to discuss the decision to be rendered in a contested case conducted according to the provisions of Iowa Code chapter 17A.



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1/17/13 MJ edits to CB's 1/15/13 draft

### DENTAL HYGIENE COMMITTEE

#### OPEN SESSION MINUTES

October 25, 2012  
Conference Room  
400 S.W. 8<sup>th</sup> St., Suite D  
Des Moines, Iowa

#### Committee Members

Mary C. Kelly, R.D.H.  
Nancy A. Slach, R.D.H.  
Steven P. Bradley, D.D.S.

#### October 25, 2012

Present  
Present  
Absent

#### Staff Members

Melanie Johnson, Christel Braness, Brian Sedars, Phil McCollum, Janet Arjes

#### Attorney General's Office

Theresa Weeg, Assistant Attorney General

#### CALL TO ORDER FOR OCTOBER 25, 2012

Ms. Kelly called the meeting of the Dental Hygiene Committee to order at 10:23 a.m. on Thursday, October 25, 2012. A quorum was established with two members present.

#### Roll Call:

Member	<u>Kelly</u>	<u>Slach</u>	<u>Bradley</u>
Present	x	x	
Absent			x

#### APPROVAL OF MINUTES

- *July 12, 2012 Open Session Minutes*
- ❖ MOVED by SLACH, SECONDED by KELLY, to approve the July 12, 2012, minutes of the Dental Hygiene Committee meeting as submitted. Motion APPROVED unanimously.

## **ADMINISTRATIVE RULES**

### **RULEMAKING HISTORY FOR RULE 650—10.5, PUBLIC HEALTH SUPERVISION**

Ms. Weeg provided clarification regarding the history of the development of the Dental Hygiene Committee. In 1998, the Dental Hygiene Committee was established in statute. The law gives the Dental Hygiene Committee authority over dental hygiene matters. The Board is obligated, under Iowa law, to adopt the recommendations of the Committee. The statute clarifies that the Board is not required to approve motions that are outside of scope of dental hygiene, creates an undue financial burden, or the matter is not reflected in the record. The Dental Hygiene Committee can propose suggestions to the Board in these areas; however, the Board would not be required to adopt them.

When the law went into effect, the interpretation was that recommendations will go to the Board in two ways: recommendations must be adopted; if the recommendations falls into any of the categories for exception, it would go to the Board as a *suggestion*. Matters related to the scope of practice would be forwarded to the Board as suggestions, not as recommendations. It is the legal interpretation of Ms. Weeg, that the Dental Hygiene Committee does not have the authority under Iowa law to change the scope of practice for dental hygienists.

Ms. Kelly asked what the function of the Committee is, beyond discipline and other matters. Ms. Kelly stated that, based on Ms. Weeg's legal interpretation, the Committee has little authority over the practice of dental hygiene. Ms. Weeg stated that the Committee has authority in numerous ways. Ms. Slach asked how reinterpretations of the law would be handled. Ms. Weeg stated that those matters have been handled case-by-case. Ms. Weeg indicated that law can be reinterpreted; however, at this time, there are no legal grounds, of which she is aware, on which to change the original interpretation of the statute.

## **PUBLIC COMMENT**

Ms. Kelly allowed the opportunity for public comment.

Mr. Cope, IDHA, thanked Ms. Weeg for her time spent on working on the legal matters and with the Committee. Mr. Cope feels that Ms. Weeg's interpretation of the statute regarding the authority of the Dental Hygiene Committee is not in alignment with his interpretation. Mr. Cope stated, in his opinion, that alternate language would have been used if Ms. Weeg's interpretation was the intended application of the law. When a broad interpretation of scope of practice is used, it limits the scope and authority of this committee. Mr. Cope is not asking for an immediate change in policy at this time; however, he would ask the Committee and Board to be aware of Iowa Dental Hygienists' Association's opinion on the matter.

Ms. Veenstra, Iowa Dental Assistants Association, stated that, in her opinion, the scope of practice for dental hygienists is reinterpreted, the Board also needs to keep that reinterpretation in mind when considering dental assistants and dental assistant-related matters.

## **RULEMAKING HISTORY FOR RULE 650—10.5, PUBLIC HEALTH SUPERVISION**

Ms. Kelly provided an overview of the history of this rule. Ms. Kelly reported that the Board office received copies of the public health supervision agreements. The agreements have been scanned for electronic access.

Ms. Johnson reported that she has not yet been able to review all of the agreements. Ms. Johnson noted that, currently, the amount of time allowed for further dental hygiene services to continue, prior to examination, is established in each agreement as determined by the supervising dentist.

## **RULES & FLUORIDE VARNISH UNDER GENERAL SUPERVISION**

Ms. Kelly reported that prior to the establishment of public health supervision agreements, fluoride varnish was allowed under general supervision. At the meeting, Ms. Kelly distributed a letter, from several years ago, that provided some information regarding prior interpretation of supervision levels.

Ms. Weeg stated that it appeared that the letter, provided by Ms. Kelly at the meeting, suggested that these cases were reviewed individually. Ms. Weeg indicated that the matter is complicated since Jennifer Hart, the former rules administrator for the Dental Board, is no longer employed by this office. During her employment, Ms. Hart maintained most of these files and had a better understanding of the history of these matters.

Ms. Weeg stated that in cases, where services have been prior-prescribed by a licensed dentist to a patient of record, the services are provided under general supervision; and therefore, allowed under current regulations. Ms. Weeg stated that before making a final decision on the interpretation of supervision levels, she would need to see how supervision levels were defined at the time of the instruction provided in the letter. Since Ms. Kelly provided the letter at the time of the Committee meeting, Ms. Weeg was not prepared to make a decision on the matter.

Ms. Kelly provided some historical reference based on her personal experience. Ms. Kelly stated it was her understanding that if dental hygienists followed protocols established by IDPH, the services could be provided so long as they met the parameters established by the department.

Mr. McCollum asked whether fluoride varnish was considered preventative or therapeutic. Ms. Cacioppo, Iowa Dental Hygienists' Association, indicated that it could be considered both preventative and therapeutic. Mr. McCollum indicated therapeutic medicaments needs to be prescribed by a dentist. It was unclear if a licensed dentist would be comfortable prescribing medications in cases where the patient had not been seen by the dentist.

Ms. Kelly asked Ms. Tracy Rodgers, IDPH, for historical information related to the protocols established for dental hygiene services in public health settings. Ms. Rodgers stated that she does not have a solid recollection given that the protocols were established in the late 1990s. Ms. Rodgers reported that the fluoride varnish protocols are still used by the Department.

Ms. Weeg stated that Board staff can research this matter further and report back to the Committee. Mr. Cope asked if the interested parties could meet again on this matter at a later date. Ms. Johnson indicated that a teleconference could be scheduled if needed.

Ms. Slach pointed out that the discussion was starting to focus on areas outside of the scope of public health supervision agreements.

Mr. McCollum inquired as to how broadly the IDPH protocols applied. Ms. Kelly indicated that, in her recollection, the protocols are fairly broad in application.

### **COMMITTEE RECOMMENDATION – PROPOSED AMENDMENTS TO CHAPTER 10, “GENERAL REQUIREMENTS” (Amends Definition of “Public Health Setting”)**

Ms. Kelly indicated that this proposal would add Early Childhood Initiative settings to the approved list of public health care settings allowed under public health supervision agreements. Ms. Johnson provided some additional clarification on the proposed amendments.

Ms. Kelly’s one concern about the proposed amendments related to the terminology used. The proposed language may become an issue if a name change were to occur related to the Early Childhood Initiative.

Ms. Slach proposed using language that could be made broader, such as “licensed daycare centers”.

Ms. Johnson read the proposed language as drafted. The current proposal would exclude in-home day cares. Dr. Bradley, at a previous meeting, was opposed to the inclusion of in-home day cares. However, Ms. Slach stated that licensed day cares, including those in-home settings, should be allowed to utilize these services if other daycare settings are allowed.

Ms. Kelly indicated that she was not overly concerned about the inclusion of licensed, in-home, day cares. Ms. Kelly stated that there had been a proposal to include organizations who receive subsidies from the government. Ms. Slach inquired if all subsidized organizations are licensed.

- ❖ MOVED by SLACH, SECONDED by KELLY, to make a suggestion to the Board to adopt the proposed rule change as drafted. Motion APPROVED unanimously.

### **NEXT STEPS FOR EXPANDED FUNCTIONS RULE AMENDMENTS**

Ms. Kelly recommended that the Committee take no action on this matter at this point in time since this matter was on the agenda of the full Board, where it can be discussed more fully.

### **APPLICATIONS FOR LICENSURE & OTHER REQUESTS**

- *Application for Dental Hygiene License – Joan van Vliet, R.D.H.*  
DHC – OPEN MINUTES – DRAFT – Subject to final DHC approval  
October 25, 2012

Ms. Braness provided an overview of this application. Ms. van Vliet went to dental hygiene school and worked, primarily, in Canada. Ms. van Vliet was licensed, briefly, in the state of Pennsylvania.

- ❖ MOVED by SLACH, SECONDED by KELLY, to approve Ms. van Vliet’s application for license upon completion of all requirements. Motion APPROVED unanimously.

**CLOSED SESSION**

- ❖ MOVED by SLACH, SECONDED by KELLY, to go into closed session pursuant to Iowa Code 21.5(d) to discuss and review complaints and other information required by state law to be kept confidential.

Roll Call:

<u>Member</u>	<u>Kelly</u>	<u>Slach</u>	<u>Bradley</u>
Yes	x	x	
No			
Absent			x

Motion APPROVED by ROLL CALL.

- The Dental Hygiene Committee convened in closed session at 11:00 a.m.

**OPEN SESSION**

- ❖ MOVED by SLACH, SECONDED by KELLY, to go back into open session. Motion APPROVED unanimously.

**OPEN SESSION**

The Committee reconvened in open session at 11:29 am.

The meeting of the Dental Hygiene Committee was adjourned at approximately 11:32 a.m. on October 25, 2012.

**NEXT MEETING OF THE COMMITTEE**

The next meeting of the Dental Hygiene Committee is scheduled for January 31, 2013, in Des Moines, Iowa.

Respectfully submitted,

Melanie Johnson, J.D.  
Executive Director

MJ/cb

# REPORT TO THE DENTAL HYGIENE COMMITTEE

RECOMMENDATION

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**DATE OF MEETING:** January 31, 2013  
**RE:** **Rules: Final Amendments to Chapter 10, “General Requirements”**  
**SUBMITTED BY:** Melanie Johnson, Executive Director  
**ACTION REQUESTED:** Committee Recommendation re: Final Rule Amendments

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## *Amendment Eligible for Final Adoption*

At the October 24, 2102 meeting the Board approved the filing of proposed rule amendments to Chapter 10. The amendments expand the definition of “public health settings” to include programs affiliated with the Early Childhood Iowa (ECI) initiative authorized by Iowa Code Chapter 256I and day care centers (excluding home-based day care centers). The proposed amendment is eligible for final adoption at this time should the Board decide to move forward with a final rule amendment.

## *Public Hearing Held, Written Comments Received*

A public hearing was held on January 8, 2013 and written comments were accepted through that date. One person attended the public hearing. The Board office received a number of comments concerning these amendments (copies included with this Report). Comments were received from private practice dental hygienists, dental hygienists in public health settings, community college educators, a community health center director/dentist, a public health center president/CEO, licensed dentists, I-Smile coordinators, a dental hygiene student, Delta Dental of Iowa, the Iowa Dental Association, Iowa Association for the Education of Young Children, and Iowa Primary Care Association. All but one of the written comments submitted were in support of the proposed rule amendment.

## *IDA Raised Concerns and Requests Delay in Implementation*

The Iowa Dental Association expressed concern that the Board “noticed the Rule Amendment without adequate consideration for patient safety and without considering the need for enhanced oversight of participants in a public health supervision arrangement.” The IDA indicated that it is concerned that patient safety may be “unnecessarily compromised by expanding the number of settings in which dental hygienists are permitted to provide dental hygiene services under a public health supervision arrangement.” They indicate that their concern is based on the fact that under a public health supervision agreement a dentist need not be physically present to supervise the services provided by a dental hygienist. IDA requested that the Board delay implementation of the rule amendment and “conduct a comprehensive review of the patient safety implications.”

## *Comment RE: Changing “Day Care” to “Child Care”*

During the comment period the Administrative Rules Code Editor raised a question about the usage of “day care” vs. “child care” in the proposed rule amendment. The Code Editor indicated that in the Iowa Code, “child care” is used almost universally, most notably in chapters 135, 237, 237A and 279.

In the Iowa Administrative Code, “child care” is used, particularly in reference to child care centers and in-home providers; see 441—Chapters 109, 110, also Chapters 118, 170. By contrast, “day care” occurs only a handful of times, mostly in reference to adult day services; see 441—Chapter 171 and Iowa Code chapter 231D. The Board may want to consider changing “day care” to “child care” if it elects to adopt final rule amendments.

The comments from the Iowa Association for the Education of Young Children also suggested changing “day care” to “child care.” The Association indicated that “child care” is “commonly accepted language used by the profession for the service of providing care to children.”

#### *PHS Presentation at January 31, 2013 Board Meeting*

At the January 31<sup>st</sup> Board meeting there will be a presentation about public health supervision (PHS). The presentation will include: reason for the original PHS rule, rulemaking history, role of the Iowa Department of Public Health, role of the Iowa Dental Board, and a Board member’s observations concerning the PHS agreements he reviewed. In addition, copies of the PHS agreements will be made available electronically to Board members prior to the meeting.

#### **Attached for Review**

- ❖ ARC 0471C, Published in 11/28/12 IAB - Notice of Intended Action, Chapter 10
- ❖ Comments Received Concerning ARC O471C

**DENTAL BOARD[650]**

**Notice of Intended Action**

**Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”**

**Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.**

Pursuant to the authority of Iowa Code section 147.76, the Dental Board hereby gives Notice of Intended Action to amend Chapter 10, “General Requirements,” Iowa Administrative Code.

This proposed amendment expands the definition of “public health settings” to include programs affiliated with the Early Childhood Iowa (ECI) initiative authorized by Iowa Code chapter 256I and day care centers (excluding home-based day care centers).

Written comments about the proposed amendment will be accepted through January 8, 2013. Comments should be directed to Melanie Johnson, Executive Director, Iowa Dental Board, 400 SW 8th Street, Suite D, Des Moines, Iowa 50309-4687; or by e-mail to [Melanie.Johnson@iowa.gov](mailto:Melanie.Johnson@iowa.gov).

A public hearing will be held on January 8, 2013, at 2:30 p.m. at the office of the Iowa Dental Board located at 400 SW 8th Street, Suite D, Des Moines, Iowa. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendment.

Any person who plans to attend the public hearing and who may have special requirements, such as those related to hearing or mobility impairments, should contact the Board office and indicate what specific assistance is needed.

This proposed amendment was approved at the October 25, 2012, meeting of the Dental Board.

After analysis and review of this rule making, no impact on jobs has been found.

This amendment is intended to implement Iowa Code section 153.33.

The following amendment is proposed.

Amend subrule 10.5(1) as follows:

**10.5(1) *Public health settings defined.*** For the purposes of this rule, public health settings are limited to schools; Head Start programs; programs affiliated with the early childhood Iowa (ECI) initiative authorized by Iowa Code chapter 256I; day care centers (excluding home-based day care centers); federally qualified health centers; public health dental vans; free clinics; nonprofit community health centers; nursing facilities; and federal, state, or local public health programs.

## NOIA Comments Rec'd

Search NOIA Comments Rec'd

From Subject Received

### Date: Tuesday

		Barbara Merrill	Iowa Dental Board comments	Tue 1/8/2013 3:37 PM
		Tori Squires	Input on Rule Making	Tue 1/8/2013 2:12 PM
		Barbara Merrill	Iowa Dental Board rules	Tue 1/8/2013 1:47 PM
		Venker, Daniel [DOC]	Letter of support for addition of daycare centers to dental PH supervision s...	Tue 1/8/2013 7:37 AM

### Date: Monday

		Mike DeAnda	Support of adding Daycare Centers to the list of Public health Supervision ...	Mon 1/7/2013 4:29 PM
		joyce602@mchsi.com	letter to support DH in day care centers	Mon 1/7/2013 3:25 PM
		Suzanne Heckenlaible	Delta Dental of Iowa - Comment on Iowa Code section 153.33, subrule 10.5...	Mon 1/7/2013 2:15 PM
		Dawn Doore	dental board decision letter	Mon 1/7/2013 2:01 PM
		tena geis	[L2SPAM] public hearing testimony	Mon 1/7/2013 10:58 AM

### Date: Sunday

		Susan R. Hyland	PH Supervision & Daycare Centers	Sun 1/6/2013 10:09 PM
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### Date: Last Week

		David Miller	letter of testimony for Jan. 8th IDB hearing	Fri 1/4/2013 9:22 PM
		Mary Kay Brinkman	[L2SPAM] Public Comment on proposed rule change: Public Health Superv...	Thu 1/3/2013 4:11 PM
		Mary Jo knowles	Public Health supervision	Thu 1/3/2013 9:01 AM
		Miriam Burk	Including day care centers under public health supervision	Tue 1/1/2013 6:05 PM
		Mary Ann White	Public Hearing on January 8, 2013, adding day care centers to list	Mon 12/31/2012 11:41 PM
		Freed,Adam J.	ARC 0471C: Public Health Supervision	Mon 12/31/2012 9:37 AM
		Terry Kemp	Public Health Supervision comments on day care settings	Sun 12/30/2012 7:36 PM

### Date: Two Weeks Ago

		Reynolds, Julie C.	Jan 8 public hearing comments	Fri 12/28/2012 2:56 PM
		bill vanzuiden	Day Cares	Fri 12/28/2012 10:13 AM
		Megan W	Letter to the IDB	Fri 12/28/2012 9:57 AM
		Bianca Carmona	Daycare Screenings	Thu 12/27/2012 9:59 AM
		Linda Meyers		Wed 12/26/2012 4:57 PM
		Sherry Steinbach	Day care Centers and Public health Supervision	Mon 12/24/2012 8:04 AM

### Date: Three Weeks Ago

		Nancy Adrianse	Iowa code section 147.76 Public comment	Fri 12/21/2012 10:45 AM
		Ken Jones	Public Health Supervision/Hygiene Preventive Care at Daycare Centers	Thu 12/20/2012 3:50 PM
		Emily Boge	[L2SPAM] Iowa Dental Board Request	Tue 12/18/2012 8:31 PM
		Mary Jo Ketelsen	FW: Hygienist Public Health Supervision	Tue 12/18/2012 3:29 PM
		Sodawasser, Sara A	Preventive dental health in daycares	Tue 12/18/2012 12:38 PM
		Piper, Renee	Day care	Tue 12/18/2012 10:24 AM
		Carol Van Aernam	Day Care Centers	Mon 12/17/2012 6:11 PM
		Carol Van Aernam	Day Care Centers	Mon 12/17/2012 6:07 PM

### Date: Older

		Katie McBurney	Public Comment for Public Health Supervision Agreement	Thu 11/29/2012 9:48 AM
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## Johnson, Melanie [IDB]

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**From:** Katie McBurney [kmcburney@marionph.org]  
**Sent:** Thursday, November 29, 2012 9:48 AM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Public Comment for Public Health Supervision Agreement

As a dental hygienist practicing under public health supervision agreement, I am asking you to consider allowing day care settings and ECI supported settings to be included in the public health supervision agreement. By providing non-invasive dental screenings, fluoride varnish and OHI, we are giving these children a better chance to being cavity free and finding a local dentist for a lifetime. The majority of these children cannot get to a pediatric dentist who will see them by age 1 and therefore parents are unaware of dental care needs and/or prevention needs for their child's oral health. Also, a high percentage of the children targeted cannot find a dentist who will except their low paying Medicaid insurance. As dental hygienists, we can refer them to the appropriate dentist, educate them, and work with the dental community to prevent decay and educate parents about the causes of decay before the age of 3 or 4. We know as dental professionals that prevention is key to oral health and also in reducing costs from Medicaid and dental treatment/surgery. Let's all work together to prevent Early Childhood Caries!

Thanks for your time,  
Katie

***Katie McBurney, RDH, J-Smile Coordinator***

***Marion County Public Health***

2003 N. Lincoln St.

Knoxville IA 50138

Phone: 641-828-2238 ext. 226

Fax: 641-842-3442

I-Smile™ ~ Healthy Mouths for Healthy Kids

[www.ismiledentalhome.iowa.gov](http://www.ismiledentalhome.iowa.gov)

***Promoting and Protecting the Health of Marion County***

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**Johnson, Melanie [IDB]**

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**From:** Carol Van Aernam [cvanaernam@aol.com]  
**Sent:** Monday, December 17, 2012 6:07 PM  
**To:** "melanie.johnson"@iowa.gov  
**Subject:** Day Care Centers  
**Attachments:** December 17 Ia Dental Board Letter.docx

Ms. Johnson,  
Please find an attached letter in favor of adding Day Care Centers for the Public Hearing on January 8,2013.  
Thank you.

Carol Van Aernam  
[cvanaernam@aol.com](mailto:cvanaernam@aol.com)

December 17, 2012

Melanie Johnson

Executive Director Iowa Dental Board

400 SW 8<sup>th</sup> Street

Des Moines, IA 50309-4687

Dear Iowa Dental Board Members,

I urge you to add "Day Care Centers to the Public Health Supervision Agreement.

The Poverty Level for children living in Iowa has increased since 2000 by 50.5%. Nationally it has increased 33.3%. The Poverty Line was set at \$ 22,314 in 2010 for a family of four. These families cannot afford dental care. In 2011 *over 79,000* Medicaid enrolled children ages 0-5 did not see a dentist. Dental Hygienists with a Public Health Supervision Agreement need to be able to see these children and provide preventive services. Adding Day Care Centers allows greater access to preventive services by Public Health Supervision Hygienists. Hygienist's refer these children to dentists and give preventive services that can save a life and prevent chronic infection for our children in Iowa.

Dentists and hygienists need to work together to serve those in Iowa who cannot help themselves.

Thank you.

Carol Van Aernam RDH, BA

411 West Madison Place

Indianola, Iowa 50125

**Johnson, Melanie [IDB]**

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**From:** Carol Van Aernam [cvanaernam@aol.com]  
**Sent:** Monday, December 17, 2012 6:11 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Day Care Centers  
**Attachments:** December 17 la Dental Board Letter.docx

Ms. Johnson,  
Please find an attached letter in favor of adding Day Care Centers for the Public Hearing on January 8,2013.  
Thank you.

Carol Van Aernam  
[cvanaernam@aol.com](mailto:cvanaernam@aol.com)

December 17, 2012

Melanie Johnson

Executive Director Iowa Dental Board

400 SW 8<sup>th</sup> Street

Des Moines, IA 50309-4687

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Dentists and hygienists need to work together to serve those in Iowa who cannot help themselves.

Thank you.

Carol Van Aernam RDH, BA

411 West Madison Place

Indianola, Iowa 50125

## Johnson, Melanie [IDB]

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**From:** Piper, Renee [Piper@iowacentral.edu]  
**Sent:** Tuesday, December 18, 2012 10:23 AM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Day care

As an educator and dental hygienist I see the unmet dental health needs in our communities of the children under 5 years of age at every clinical session. The students provided the DFT for the patients seen in the clinic in the last 15 weeks. The results are as follows: Dft - 4.8

Low social economic status, (including those families who rely on daycares), lack of education, increase in language barriers (Hispanic children-who are at greatest risk) the documented shortage of dental providers, dentists who do not accept XIX, or new patients regardless of ability to pay, restrictive practices for hygienists, (who have the knowledge and skills), are access to care problems Iowa children face.

Please allow dental hygienists who are more than adequately trained to provide the necessary skill sets for the prevention of dental disease in our communities. Stop the politics and let the hygienists continue to provide a safe and effective modality for the children in our state.

Dental Disease is 100% preventable.

- Barriers to regular dental care are lack of insurance, lack of dental health literacy, and few dental providers taking Medicaid.
- In 2011, 119,053 Medicaid enrolled children ages 0-12 did not see a dentist.
  - Ages 0-2: 55,540 Medicaid enrolled children did not see a dentist.
  - Ages 3-5: 24,143 Medicaid enrolled children did not see a dentist.
- In 2011 Medicaid Enrolled Children Receiving a Dental Service from Title V Contractors.
  - Children ages 0-2: 10509 received a dental service, 56485 did not.
  - Children ages 3-5: 11,903 received a dental service, 45,779 did not.
- According to the Iowa Kids Count Report in 2011, 16.2% of Iowa Children live in poverty.
- Hygienists deliver essential Preventive Services, Education, and refer these individuals to dentists.
- Public health supervision of dental hygienists has allowed the state of Iowa to develop the I-Smile program significantly enhancing access to quality oral health care.
- According to the 2011 I-Smile report nearly 110,000 Iowa children between the ages of 0-12 received a dental service from a dentist in 2011, a 54% increase over 2005 numbers.
- The same report indicates that over 26,000 Iowa children, ages 0-12, received a dental service from a Title V contractor, a 231% increase since 2005.

***SMILES MEAN THE SAME IN EVERY CULTURE (AUTHOR UNKNOWN)***

Renee Piper, RDH, MA  
Coordinator Dental Hygiene  
Iowa Central Community College  
One Triton Circle  
Fort Dodge, Iowa 50501  
515-574-1335

**Johnson, Melanie [IDB]**

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**From:** Sodawasser, Sara A [SodawaSA@crstlukes.com]  
**Sent:** Tuesday, December 18, 2012 12:38 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Preventive dental health in daycares

Melanie,

It has been brought to my attention that day care settings have been removed from the IPH Supervision agreements. As a public health dental hygienist who has worked in the field, I will report to you that there are many day cares who have received our preventive services in the past, and who have greatly benefitted from them.

Many of the day cares served focus on the low income. Some don't. Either way, not only do the children receive preventive services, but parents are provided with educational information to help them understand the how/why's of oral health for their kids. These visits also help raise oral health awareness, and serve as a link to access to care for many children.

Please help support keeping the verbiage to include day care settings in the agreements, thank you.

Sara Sodawasser, RDH, BS  
Public Health Dental Hygienist/Supervisor  
St. Luke's Dental Health Center  
855 A Ave. NE MOP LL1  
Cedar Rapids, IA 52402  
319-369-7056 direct line  
319-369-7730 clinic line  
319-369-7192 fax

## Johnson, Melanie [IDB]

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**From:** Mary Jo Ketelsen [mketelson@davchc.com]  
**Sent:** Tuesday, December 18, 2012 3:28 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** FW: Hygienist Public Health Supervision

**From:** Mary Jo Ketelsen  
**Sent:** Tuesday, December 18, 2012 3:24 PM  
**To:** 'Melane.Johnson@iowa.gov'  
**Subject:** Hygienist Public Health Supervision

Dear Iowa Dental Board,

Please consider that Day Care Centers would be an excellent place to educate children on the importance of oral health care, and an effective way for hygienist to reach all children in need.

The American Academy of Pediatric Dentistry recommends that children have their first dental exam by age one. There are very few Parents aware of this and its importance, and there are only a few Dentist willing to see patients at this young age. Hygienist are in a perfect position under Public Health Supervision to screen these children mouths for concerns, possibly apply fluoride varnish, deliver a story time education on healthy diet and the importance of brushing, and getting out some of the wonderful educational pamphlets we have available to the Parents.

We all know dental decay is a preventable disease, and with the fast pace live styles these parent's lead, they need to be reminded of healthy eating and caring for their children's mouths. Day Care Centers are just as an ideal setting as WIC and Head Start sites are for educating Parents through their children.

Please allow a licensed dental hygienist help close the gap to children not receiving dental care. I find it very rewarding currently working in a WIC centers, and Head Start Sites screening children's mouths and educating these parents the importance of care, and healthy eating. This important information needs to be addressed to all demographics of the population Day Care Centers need to be included for the well-being of all children.

Sincerely,

Mary Jo Ketelsen RDH

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**Johnson, Melanie [IDB]**

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**From:** Emily Boge [ereinert@hotmail.com]  
**Sent:** Tuesday, December 18, 2012 8:31 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** [L2SPAM] Iowa Dental Board Request

**Importance:** Low

Greetings Ms. Johnson and IDB,

My name is Emily, and I am a private practice dental hygienist from rural eastern Iowa. I practice in Manchester in a larger office group, and am an advocate for dental health and overall public health for our state. I ask that you please include daycare centers in the scope of the RDH Public Health Supervision Agreement. Although this decision does not effect the way I am choosing to practice at this time, it does effect the care that small children (such as my 5 and 7 year old sons) receive in an alternative setting.

Many of us have heard excuses parents and caregivers provide when choosing to forgo dental care for young children. We all agree this choice is deleterious long-term, but allowing hygienists to be present as health professionals in daycares can be part of the answer to bridging this educational gap. Daycare centers provide a unique opportunity for us to reach these small kids. I desire for each child to be exposed to as much preventive care instruction, and disease prevention, as possible. As all of us remember from early pediatric-focused dental coursework, dental caries is nearly 100% preventable with proper instruction. Please allow these hygienists to get into these centers to provide the care these children need to be healthy, productive Iowans later in life.

I do appreciate your time and talents.

Sincerely,  
Emily Boge

*\_\_\_\_Emily Boge, RDH, BS, MPAC  
13151 Kramer Road  
Farley, IA 52046*

*319.231.1193  
[ereinert@hotmail.com](mailto:ereinert@hotmail.com)  
[toothfairyemily@hotmail.com](mailto:toothfairyemily@hotmail.com)*

## **Johnson, Melanie [IDB]**

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**From:** Ken Jones [KJones@riverhillshealth.org]  
**Sent:** Thursday, December 20, 2012 3:49 PM  
**To:** Johnson, Melanie [IDB]  
**Cc:** Denise Janssen; Rick Johnson; Ed Dye; ShiloHilger; Jason Phelps; Joseph Dougherty; elrbrown@aol.com; Nancy Adrianse  
**Subject:** Public Health Supervision/Hygiene Preventive Care at Daycare Centers  
**Importance:** High

Melanie,

I am in full support of giving Hygienists the ability to provide preventive services to young children at Daycare Centers in Iowa. I am the Dental Director at River Hills Community Health Center in Ottumwa Iowa. I can attest that outreach to children is critical to minimizing dental caries.

I have been involved in a partnership with the area Elementary Schools to provide dental screenings, fluoride varnish applications, and sealants. This program has made a substantial positive impact with these students. Many of them that we see in the school setting have never been to the Dentist before and many of them have follow-up needs. We collaborate with the I-Smile Coordinator in our area as well. She plays the important role of getting Care Coordination for these kids so that they can get their problems addressed.

We also have a partnership with the Head Start program to provide screenings, oral health education, and fluoride varnish to the pre-school children.

I am of the opinion that these programs/partnerships that involve a Hygienist and preventive care are wonderful. That is why I hope to see the Iowa Dental Board allow for Daycare Centers to be a point of access for these types of preventive services.

Thank you for your time! Happy Holidays!

Dr. Ken Jones  
Dental Director/Dentist  
River Hills Community Health Center  
Ottumwa Iowa 52501  
phone: 641-683-5773 ext 158

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**Johnson, Melanie [IDB]**

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**From:** Nancy Adrianse [adriansen@iowapca.org]  
**Sent:** Friday, December 21, 2012 10:45 AM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Iowa code section 147.76 Public comment

Dec. 21, 2012

Iowa Dental Board Members,

Please carefully consider the inclusion of day care centers and programs affiliated with the Early Childhood Iowa initiative in the definition of public health settings for public health supervision of dental hygienists.

In an open mouth survey conducted by the IDPH in 2012, it was found that more children in Iowa are now eligible for Medicaid benefits. This would indicate that more families are falling into a low income situation. Low income is one of the risk factors for children having decayed teeth. Allowing dental hygienists to provide preventive dental services such as fluoride varnish in day care centers will allow more children to benefit from this decay preventing service and help to reduce the risk of decay. Along with providing these preventive service this provides the opportunity to increase the oral health literacy of these families. Not only is this a benefit to these children but this low cost service will save Iowa money. Repairing decayed teeth is much more expensive for the state and filled teeth are much more expensive to maintain over a life time.

The Iowa Dental Board does a good job protecting the oral health of Iowans and this inclusion will continue that good work.

Thank you for your carefully consideration of this amendment.

Nancy Adrianse  
3210 SW 33<sup>rd</sup> Street  
Des Moines, Iowa 50321

## **Johnson, Melanie [IDB]**

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**From:** Sherry Steinbach [sherrysteinbach@hotmail.com]  
**Sent:** Monday, December 24, 2012 8:03 AM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Day care Centers and Public health Supervision

Iowa Dental Board,

I am writing in regards to the hygienists role in day care services.

We start teaching our children at an early age to dress themselves, how to eat with spoons and forks, and not to touch something or do something that could cause injury. Why not start with teaching brushing as well as good eating habits.

Day Care settings are an excellent way to reach large numbers of children. Children need early education in the area of good oral hygiene. The child learn to trust someone looking into their mouths and do listen to simple brushing instructions.

An oral exam by a hygienist can help spot potential dental problems, possibly before the situation becomes a real dental emergency with a severe abscess and a frightened child that is in pain.

I recently started working for the I Smile program with Marion County Public Health. While talking with mothers with small children, I was amazed at the number of parents that do not help brush their children's teeth, don't brush at all and never look in side their mouths.

We need to use every opportunity to reach children and improve their oral health .

As a dental hygienists I believe every child should have a healthy mouth.

Please include day care centers under the hygienist's Public Health Supervision Agreement.

Sincerely,

Sherry Steinbach, RDH

**Johnson, Melanie [IDB]**

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**From:** Linda Meyers [lmeyers@familyia.org]  
**Sent:** Wednesday, December 26, 2012 4:57 PM  
**To:** Johnson, Melanie [IDB]

Melanie and Members of the Iowa Board of Examiners,

I would like to express my support of the proposal to expand the public health sites that dental hygienists can offer preventive dental services to include daycare centers. As everyone is aware the under 3 year old child is a segment of the population that cannot easily access preventive dental care. We have seen a rise in Early Childhood caries over the past 10 years. We are seeing many more children being covered by preventive dental care by going to the children where they are such as schools, WIC Clinics and Head Start centers. It only makes sense to reach out to daycares where most of their clients are under 3 years old. I have been asked by day care centers to see their clients but have had to decline because their sites are not in my scope. Please consider this change so we can reach more children and realize full potential of what Public Health has to offer.

Sincerely, Linda Meyers

--

Linda G. Meyers, RDH  
I-Smile Coordinator for Pottawattamie and Mills Counties  
Family Inc  
3501 Harry Langdon Blvd, Suite 150  
Council Bluffs, Iowa 51501  
office: (712)256-9566  
fax: (712)256-9916

## Johnson, Melanie [IDB]

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**From:** Bianca Carmona [bcarmona@davchc.com]  
**Sent:** Thursday, December 27, 2012 9:57 AM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Daycare Screenings

Good morning,

I am a hygienist working for Community Health Care. I also do screenings at WIC two days per week, and also do Head Start screenings twice per year. I have no doubt that you are aware of all of the same statistics that I am:

- Barriers to regular dental care are lack of insurance, lack of dental health literacy, and few dental providers taking Medicaid.
- In 2011, 119,053 Medicaid enrolled children ages 0-12 did not see a dentist.
  - Ages 0-2: 55,540 Medicaid enrolled children did not see a dentist.
  - Ages 3-5: 24,143 Medicaid enrolled children did not see a dentist.
- In 2011 Medicaid Enrolled Children Receiving a Dental Service from Title V Contractors.
  - Children ages 0-2: 10509 received a dental service, 56485 did not.
  - Children ages 3-5: 11,903 received a dental service, 45,779 did not.
- According to the Iowa Kids Count Report in 2011, 16.2% of Iowa Children live in poverty.
- Hygienists deliver essential Preventive Services, Education, and refer these individuals to dentists.
- Public health supervision of dental hygienists has allowed the state of Iowa to develop the I-Smile program significantly enhancing access to quality oral health care.
- According to the 2011 I-Smile report nearly 110,000 Iowa children between the ages of 0-12 received a dental service from a dentist in 2011, a 54% increase over 2005 numbers.
- The same report indicates that over 26,000 Iowa children, ages 0-12, received a dental service from a Title V contractor, a 231% increase since 2005.

I wanted to share with you my personal opinion from an experienced stand point. I see several children in all of the environments that I'm working in. Several of the children that I have seen, I have seen in all three of these facilities, and they have had ongoing problems. I think that adding in day care facilities is **vital**, so that we can keep track of these, and see other children who are in need of care and not receiving it. If we see a child at WIC who has caries, we have documentation of that, and we are able to show the parent the areas of concern and document that. If we then see this child again in day care, again at WIC, in head start, this allows us to have several opportunities to instill the importance of regular dental care in the parent, and if they choose not to get care for the child, then it helps to establish documentation for possible cases of neglect.

It breaks my heart to see these children with blown out teeth that say “these ones hurt sometimes,” or “we get Mountain Dew at home.” We need as many opportunities to educate and inform parents as possible. We need every opportunity to document our findings, and be able to say, “I see that we have seen your child 3 times now, and have documented that he has complained of pain at all three visits, and the problem is getting worse,” and use that opportunity to offer appointments, and to advise, if need be, that this kind of continued dental problem has been documented and can be considered abuse and neglect—and we are mandatory reporters. (I am not throwing those words around lightly or regularly, but in the past few places of employment—since 2009—I have had to advise this maybe 3 times. Sometimes making the parents aware of this, is enough to get them to get the child the necessary treatment. I hate to see these poor little angels suffering, and I’d hate to think that we would choose to miss an opportunity to be able to catch problems early, educate children and parents, and help those in need.

I hope that this email may be helpful in making a decision.

Thank you for your time.

Bianca Carmona, R.D.H.

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**Johnson, Melanie [IDB]**

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**From:** Megan W [myvonne.ingew@gmail.com]  
**Sent:** Friday, December 28, 2012 9:57 AM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Letter to the IDB

Dear Iowa Dental Board,

My name is Megan Williams and I am a second year student in Iowa Central Community College's dental hygiene program. I am writing to you to express my concern about the decision made earlier this year to not expand dental hygiene Public Health Supervision Agreements to day care centers. This is a large missed opportunity to establish some basic education and preventative practices in these young children and their parents. So many of these children lack access to dental care due to not being insured, lack of the parents' dental health literacy, or due to the small number of dental providers that do take Medicaid. Any and all of these reasons are why large numbers of children are not being seen by a dental professional until there is already a high decay rate. By the time these children enter into the public school system, they should be seen by a dental professional, regardless of their ability to pay. This is where the Public Health Supervised Dental Hygienist comes in. The state of Iowa has done great things in allowing this position. For example, the I-Smile program has significantly enhanced access to quality care. According to I-Smile's 2011 report there has been a 54% increase (since 2005) in the number of children ages 0-12 that have received a dental service from a dentist. Because not only are these public health supervised hygienists providing education and preventative services, they are referring these children to dentists.

There are over 1,500 childcare centers in the state of Iowa. Excluding daycare centers from the dental hygiene Public Health Supervision Agreement would just add another block to dental care for thousands of children. I hope the IDB takes another look at the progress being made in Iowa children's dental health due to the Public Health Supervision Agreement and changes their minds in regards to day care centers.

Thank you,

Megan Williams

**Johnson, Melanie [IDB]**

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**From:** bill vanzuiden [wavanzui@yahoo.com]  
**Sent:** Friday, December 28, 2012 10:13 AM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Day Cares

To whom it may concern,

I am a dental hygienist with twenty-nine years in private practice and three years in public health with a public health supervision agreement. I have enjoyed my job in private practice but I can honestly say my work with children in public health far exceeds my other dental experience.

Recently I learned that day care centers are not included in the facilities we are allowed to provide dental care. I am not sure why exactly, but find it very surprising!! Parents who have children in daycare centers have them there obviously because they are working. In order to make dental appointments they are forced to take off valuable work time. Even though they may have private dental insurance that would cover these visits, many are not prioritizing early age dental visits. I believe there are several reasons for this which may include not knowing the ADA's recommendation for age of first visit, hours of dental office, and dentists not seeing children until age four or five.

Our children with state provided dental coverage(T19) actually have many more opportunities to receive a dental screening at a very early age. These children are seen in conjunction with the WIC program, at Head Start, preschools, and possibly other facilities. The number of children with public health coverage that are being seen and referred to private dental offices is incredible! Shouldn't we support those families that are helping fund these programs just as much.

By providing dental screenings in day cares we can educate parents on the importance of early dental intervention, helping them to prioritize their children's dental health. If issues are detected in these screenings we are not only increasing the dental health of the child but possibly the dental health of the entire family. Those families who may not have a dental home are provided with a list of dentists in their communities accepting new patients. This kind of referral system is guaranteed to increase business to the whole dental community. I see this as a win/win. Please allow dental hygienist to continue advancing our field and yours!!! Thank You for your consideration of this issue.

Sincerely,  
Elizabeth

Vanzuiden R.D.H.

## Johnson, Melanie [IDB]

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**From:** Reynolds, Julie C. [ReynolJC@crstlukes.com]  
**Sent:** Friday, December 28, 2012 2:56 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Jan 8 public hearing comments

To whom it may concern at the Iowa Dental Board,

As a dentist in a public health clinic and a graduate student in dental public health, I understand the barriers that children face to accessing dental services in Iowa. Although children's access to dental care in Iowa far exceeds many other states, a subset of children continue to go year after year without utilizing the dental care system for reasons that are out of their control. The best way to change this is to maximize the number of locations at which children are exposed to the dental healthcare system, and do so as early in their childhood as possible.

Currently, young children are exposed to oral health personnel at locations such as Head Start preschools, WIC centers, schools, and federally qualified health centers (FQHCs). In many cases, these personnel are public health dental hygienists who are able to have a presence in institutions whose clients are dentally underserved. These institutions are typically places where other oral health professionals would not otherwise be located. Increasing the scope of settings where public health hygienists are able to work will improve access to dental care for children in Iowa. In this case, the setting happens to be day care centers. **Day care centers should therefore be included in the list of public health settings in which public health dental hygienists are able to perform their duties.** This action will increase the robustness of our state's oral healthcare system and have a positive impact on the oral health of Iowa's children.

Sincerely,

**Julie C. Reynolds, DDS**

Dentist, St. Luke's Dental Health Center  
Cedar Rapids, IA

Graduate Student in Dental Public Health  
University of Iowa College of Dentistry  
Iowa City, IA

**Johnson, Melanie [IDB]**

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**From:** Terry Kemp [kemp4@yousq.net]  
**Sent:** Sunday, December 30, 2012 7:36 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Public Health Supervision comments on day care settings  
**Attachments:** IDB public health daycare supervision letter 12-31-12.docx

Please see the attached comments.

Thank you.

To: Iowa Dental Board

From: Patricia Kemp, RDH

I have been practicing dental hygiene in Iowa for 28 years. I have been in public health for the past thirteen years. I write in favor of allowing public health supervision of dental hygienists to include all settings with early childhood daycare, including home based.

General dental practices very rarely allow children under the age of three into their private practices. The families of very young children are misled into believing the child does not require dental services. They are told the child does not need to be seen unless there is a problem. How deplorable to wait until a problem exists! The American Dental Association recommends a child have an initial dental exam six months after the first tooth erupts. Unfortunately, only a minority of children ever see a dentist prior to age three.

In my years providing services at the Women, Infant, Children (WIC) program, I can attest to the very real need for dental hygiene services for children under the age of three. Dental decay does exist in this age group. Often decay is rampant and requires dental care under general anesthesia, thus costing the taxpayers thousands of dollars per child. Prevention and education beginning at birth prevents decay and saves money.

Our ultimate goal is to have healthy children. It makes the most sense to serve families and the children where they are. Please allow public health supervision to include day care centers in all areas.

Thank you for your time and attention to this matter.

Sincerely,

Patricia Kemp, RDH  
1865 Carter Road  
Dubuque, IA 52001

563-556-1498

**Johnson, Melanie [IDB]**

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**From:** Freed, Adam J. [afreed@brownwinick.com]  
**Sent:** Monday, December 31, 2012 9:37 AM  
**To:** Johnson, Melanie [IDB]  
**Cc:** Cownie, Catherine C.  
**Subject:** ARC 0471C: Public Health Supervision  
**Attachments:** Letter to Melanie Johnson - Expanded Definition of Public Health Settings (12-31-12) (00442550).pdf

Melanie:

Please find attached the Iowa Dental Association's comments on the Dental Board's proposed rules to expand the definition of "public health settings." Please let us know if you have any questions. Thanks. Happy New Year!

Adam

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 <b>BrownWinick</b> ATTORNEYS AT LAW	<b>Adam J. Freed</b> Attorney 515-242-2402 <i>direct</i> 515-323-8502 <i>direct fax</i> <a href="mailto:afreed@brownwinick.com">afreed@brownwinick.com</a> <a href="http://www.brownwinick.com">www.brownwinick.com</a> 666 Grand Avenue Suite 2000 Ruan Center Des Moines, IA 50309 Main Phone 515-242-2400 Toll Free 1-888-282-3515
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666 Grand Avenue, Suite 2000  
Ruan Center, Des Moines, IA 50309-2510

December 31, 2012

*direct phone: 515-242-2490*

*direct fax: 515-323-8590*

*email: cownie@brownwinick.com*

**VIA E-MAIL: [Melanie.Johnson@iowa.gov](mailto:Melanie.Johnson@iowa.gov)**

Melanie Johnson  
Executive Director  
Iowa Dental Board  
400 SW 8<sup>th</sup> Street, Suite D  
Des Moines, Iowa 50309-4687

Re: ARC 0471C: Expanded Definition of "Public Health Settings"

Dear Ms. Johnson:

This firm serves as counsel to the Iowa Dental Association (the "Association"). It has come to the attention of the Association that the Iowa Dental Board (the "Board") recently noticed an amendment to Chapter 10 of the Board's rules to expand the definition of "public health settings" to include programs affiliated with the Early Childhood Iowa initiative and certain day care centers (the "Rule Amendment"). The Association is concerned that the Board noticed the Rule Amendment without adequate consideration for patient safety and without considering the need for enhanced oversight of participants in a public health supervision arrangement.

Section 10.5 of the Board's rules authorizes a dentist and a dental hygienist to enter into a written agreement under which the dentist provides public health supervision over the dental hygienist when the hygienist provides services in specified public health settings. The dentist need not be physically present to supervise the services provided by the hygienist; but the dentist must be available to provide communication and consultation with the dental hygienist. The hygienist must only provide dental hygiene services pursuant to age- and procedure-specific standing orders from the dentist.

Patient safety may be unnecessarily compromised by expanding the number of settings in which dental hygienists are permitted to provide dental hygiene services under a public health supervision arrangement. The top priority of the Board's rulemaking should be ensuring the highest level of patient safety. The lack of direct supervision by dentists in a public health supervision arrangement clearly compromises patient safety and may present a heightened risk of harmful errors.

Page 2

One of the Association's top priorities is ensuring adequate access to high-quality dental care for all Iowans, regardless of their socioeconomic status. Access to dental care, however, should not be provided at the cost of compromised patient safety. Therefore, the Association hereby requests that the Board delay implementation of the Rule Amendment and conduct a comprehensive analysis of the patient safety implications of the overall public health supervision rule and the current proposed Amendment. If you have any questions regarding this issue, please do not hesitate to contact me.

Very truly yours,

  
Catherine C. Cowrie

CCC:af

**Johnson, Melanie [IDB]**

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**From:** Mary Ann White [merryannwhite@gmail.com]  
**Sent:** Monday, December 31, 2012 11:41 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Public Hearing on January 8, 2013, adding day care centers to list  
**Attachments:** dental health supervision.docx; National Call To Action To Promote Oral Health.docx

Dear Ms. Johnson:

Attached, please read the information I feel strongly will help the Iowa Dental Board regarding the public hearing scheduled January 8, 2013 to hear testimony concerning adding day care centers to the list of settings where a dental hygienist could provide services.

I have taken much time to state the truth as it relates to my personal experience. I admire the fact that I have been afforded the opportunity to provide this valuable information for you.

Respectfully,

Mary Ann White, RDH

December 31, 2012

Mary Ann White  
1662 South Bluff Boulevard  
Clinton, Iowa 52732  
H. 563.243.7848  
C. 563.219.1843  
merryannwhite@gmail.com

**SUBJECT:** Adding day care centers to the list of settings where a dental hygienist provide preventive services

Dear Iowa Dental Board:

Thank you for taking time to evaluate the ramifications of providing **PREVENTIVE DENTAL SERVICES** to groups of **UNDERSERVED IOWA CHILDREN**, our future.

- By providing preventive and referral services to Iowa *day care children*, we are setting up a higher standard of care for our future generations.
- *Day care children* are direct result of the **WORKING CLASS PEOPLE**, children of those mothers and/or fathers who work at least 40 hours a week, who contribute to the income and tax base of Iowa, many of whom do not have dental insurance.
- When mothers/fathers work full time, what dentist is available when the parents are working Monday through Friday? Parents must take off work to take child to dentist. At this point, it would be to the advantage of the family to have the Registered Dental Hygienist provide as many preventive services as possible while parents are at work, then make best use of the parents time off work with the child if referral to a dentist is foreseen. I have been a single parent and know this to be true as a serious and genuine personal example.
- I currently possess two Iowa Public Health Care Agreements with two different dentists and am employed full time in a private general dental office. I choose to offer my services in this capacity to further improve the dental plight from the standard of care which was in effect in my previous generation. Dental health begins at birth.
- Dr. Satcher noted that major barriers to oral health include socioeconomic factors, such as lack of dental insurance or the inability to pay out of pocket, or problems of access that involve transportation and the need to take time off from work for health needs. While 44 million Americans lack medical insurance, about 108 million lack dental insurance. Only 60 percent of baby boomers receive dental insurance through their employers, and most older workers lose their dental insurance at retirement. ( U. S. Department of Health and Human Services; Surgeon General, Vice Admiral Regina M. Benjamin, M.D., M.B.A., May 25, 2000 ).
- The hundreds of patients I have provided oral screenings for have been extraordinarily grateful.
- Enclosed please find a copy of the "U.S. Department of Health and Human Services. *National Call to Action to Promote Oral Health*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, Spring 2003." Within this document, you will find many highlighted areas which dental hygienists in the state of Iowa are required to be specifically trained to

carry out as set forth by the rules and regulations of the Iowa Dental Board. I personally have provided many volunteer hours of continuing education to many local hospitals, nursing homes and schools over, and most specifically *day care centers* to provide much needed and most commonly overlooked education to support the *day care teachers* who reach out to the community for my help annually (without interfering with the dentists in any technique). As uncovered in this report, there is an overwhelming—ever ending amount of work to be done, which could never be accomplished, as mentioned, without an organized mass state by state effort.

- I have been a dental hygienist for 17 years and have no desire to become a dentist. I never have. I also have many dental hygiene friends and I have never heard a word spoken which indicates the dental hygiene profession cares to interfere with the role of a dentist as it exists in the state of Iowa. I/we have great respect for the profession of dentistry, for which I would not have a job in the state of Iowa. It has never been nor ever will be the intention of myself or any dental hygienist I have ever met to negate or take away any referrals or take over any skills or monetary gain which a dentist perceives to be rightfully theirs as set forth by the Iowa Dental Board.
- Due to the overpopulation and difficulty of newer graduates in my particular area, I strongly consider the public health arena to be a valuable frontier for the young dental hygienists in the state of Iowa through proven outreach programs to day care, less chair time for the dentist and screening, education, sealant programs, fluoride programs, I-Smile programs and Title V contractors.

I am not directly involved in the state level, yet provide many hours of ground level volunteer hours of dental hygiene. I volunteer at the Gateway Free Dental Clinic, Clinton, Iowa. I greatly respect the two dentists who support me through this effort, one of whom provides free dental care to the underprivileged of our community. Without these remarkable state-wide organizations any many like it, and the continuing efforts of the hundreds of people that provide these services, the state of Iowa would be considered to be more negligent.

"If you give a man a fish you feed him for a day. If you teach a man to fish you feed him for a lifetime." Chinese Proverb. This is what dental hygienists love to do!

Respectfully,

Mary Ann White, RDH

# National Call To Action To Promote Oral Health

## *A Public-Private Partnership*

*under the leadership of*

*The Office of the Surgeon General*

### Acknowledgements

We express our appreciation to the many voluntary and professional organizations, private and government agencies, foundations, and universities that contributed to the development of this document. We thank them for their existing and future efforts to improve the nation's health through promoting oral health and for their commitment to public-private partnerships.

### Suggested Citation

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Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, Spring 2003.

### Preface from the Surgeon General

The great and enduring strength of American democracy lies in its commitment to the care and well-being of its citizens. The nation's long-term investment in science and technology has paid off in ever-expanding ways to promote health and prevent disease. We can be proud that these advances have added years to the average life span and enhanced the quality of life. But an "average" is necessarily derived from all values along a continuum and it is here that we come to recognize gaps in health and well-being. Not all Americans are benefiting equally from improvements in health and health care. America's continued growth in diversity has resulted in a society with broad educational, cultural, language, and economic differences that hinder the ability of some individuals and groups from realizing the gains in health enjoyed by many. These health disparities were highlighted in the year 2000 Surgeon General's report: *Oral Health in America* where it was reported that no less than a "silent epidemic of oral diseases is affecting our most vulnerable citizens—poor children, the elderly, and many members of racial and ethnic minority groups." The report also highlighted the disabling oral and craniofacial aspects of birth defects.

The report was a wake-up call, raising a powerful voice against the silence. It called upon policymakers, community leaders, private industry, health professionals, the media, and the public to affirm that oral health is essential to general health and well-being and to take action. No one should suffer from oral diseases or conditions that can be effectively prevented and treated. No schoolchild should suffer the stigma of craniofacial birth defects nor be found unable to concentrate because of the pain of untreated oral infections. No rural inhabitant, no homebound adult, no inner city dweller should experience poor oral health because of barriers to access to care and shortages of resources and personnel.

Now that call to action has been taken up. Under a broad coalition of public and private organizations and individuals, orchestrated by the principals who led the development of the *National Call To Action To Promote Oral Health* has been generated. We applaud the efforts of these partners to heed the voices of their fellow Americans. At regional meetings across the country concerned citizens addressed the critical need to resolve inequities in oral health affecting their communities. More than that, ideas and programs were described to explain what groups at local, state or regional levels were doing or could do to resolve the issues.

Combining this store of knowledge and experience with private and public plans and programs already under way has enabled the partnership to extract the set of five principal actions and implementation strategies that constitute the *National Call To Action To Promote Oral Health*. These actions crystallize the necessary and sufficient tasks to be undertaken to assure that all Americans can achieve optimal oral health. It is abundantly clear that these are not tasks that can be accomplished by any

single agency, be it the Federal government, state health agencies, or private organizations. Rather, just as the actions have been developed through a process of collaboration and communication across public and private domains, their successful execution calls for partnerships that unite private and public groups focused on common goals. The seeds for such future collaborative efforts have already been sown by all those who participated in the development of this *Call To Action*. We appreciate their dedication and take it as our mutual responsibility to further partnership activities and monitor their impact on the health of the public. We are confident that sizable rewards in health and well-being can accrue for all Americans as these actions are implemented.

Richard H. Carmona, M.D., M.P.H., F.A.C.S.

VADM, USPHS

Surgeon General and Acting Assistant

Secretary for Health

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## Introduction

The *National Call To Action To Promote Oral Health* is addressed to professional organizations and individuals concerned with the health of their fellow Americans. It is an invitation to expand plans, activities, and programs designed to promote oral health and prevent disease, especially to reduce the health disparities that affect members of racial and ethnic groups, poor people, many who are geographically isolated, and others who are vulnerable because of special oral health care needs. The *National Call To Action To Promote Oral Health*, referred to as the *Call To Action*, reflects the work of a partnership of public and private organizations who have specified a vision, goals, and a series of actions to achieve the goals. It is their hope to inspire others to join in the effort, bringing their expertise and experience to enrich the partnership and thus accelerate a movement to enhance the oral and general health and well-being of all Americans.

## Origins of the Call To Action

*Oral Health in America: A Report of the Surgeon General* alerted Americans to the importance of oral health in their daily lives<sup>11</sup>. The Report, issued in May 2000, provided state-of-the-science evidence on the growth and development of oral, dental and craniofacial tissues and organs; the diseases and conditions affecting them; and the integral relationship between oral health and general health, including recent reports of associations between chronic oral infections and diabetes, osteoporosis, heart

and lung conditions, and certain adverse pregnancy outcomes. The text further detailed how oral health is promoted, how oral diseases and conditions are prevented and managed, and what needs and opportunities exist to enhance oral health. Major findings and themes of the report are highlighted in Table 1.

**Table 1: Major Findings and Themes from *Oral Health in America: A Report of the Surgeon General***

- Oral health is more than healthy teeth.
- Oral diseases and disorders in and of themselves affect health and well-being throughout life.
- The mouth reflects general health and well-being.
- Oral diseases and conditions are associated with other health problems.
- Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health as well.
- Safe and effective measures exist to prevent the most common dental diseases—dental caries and periodontal diseases.
- There are profound and consequential oral health disparities within the U.S. population.
- More information is needed to improve America's oral health and eliminate health disparities.
- Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth, and teeth.

Source: U.S. Department of Health and Human Services *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000: 10-11.

The Report's message was that oral health is essential to general health and well-being and can be achieved. However, a number of barriers hinder the ability of some Americans from attaining optimal oral health. The Surgeon General's Report concluded with a framework for action, calling for a national oral health plan to improve quality of life and eliminate oral health disparities.

## The Rationale for Action

The rationale for action is based on data from the Surgeon General's Report (Table 2). These and other data on the economic, social, and personal burdens of oral diseases and disorders show that although the nation has made substantial improvements in oral health, more must be done.

**Table 2. The Burden of Oral Diseases and Disorders**

## The Burden of Oral Diseases and Disorders

Oral diseases are progressive and cumulative and become more complex over time. They can affect our ability to eat, the foods we choose, how we look, and the way we communicate. These diseases can affect economic productivity and compromise our ability to work at home, at school, or on the job. Health disparities exist across population groups at all ages. Over one third of the U.S. population (100 million people) has no access to community water fluoridation. Over 108 million children and adults lack dental insurance, which is over 2.5 times the number who lacks medical insurance. The following are highlights of oral health data for children, adults, and the elderly. (Refer to the full report for details of these data and their sources).

### Children

- Cleft lip/palate, one of the most common birth defects, is estimated to affect 1 out of 600 live births for whites, and 1 out of 1,850 live births for African Americans.
- Other birth defects such as hereditary ectodermal dysplasias, where all or most teeth are missing or misshapen, cause lifetime problems that can be devastating to children and adults.

- Dental caries (tooth decay) is the single most common chronic childhood disease – 5 times more common than asthma and 7 times more common than hay fever.
- Over 50 percent of 5- to 9-year-old children have at least one cavity or filling, and that proportion increases to 78 percent among 17-year-olds. Nevertheless, these figures represent improvements in the oral health of children compared to a generation gap.
- There are striking disparities in dental disease by income. Poor children suffer twice as much dental caries as their more affluent peers, and their disease is more likely to be untreated. These poor-nonpoor differences continue into adolescence. One out of four children in America is born into poverty, and children living below the poverty line (annual income of \$17,000 for a single family of four) have more severe and untreated decay.
- Tobacco-related oral lesions are prevalent in adolescents who currently use smokeless (spit) tobacco.
- Unintentional injuries, many of which include head, mouth, and neck injuries, are common in children.
- Intentional injuries commonly affect the craniofacial tissues.
- Professional care is necessary for maintaining oral health, yet 25 percent of poor children have not seen a dentist before entering kindergarten.
- Medical insurance is a strong predictor of access to dental care. Uninsured children are 2.5 times less likely than insured children to receive dental care. Children from families without dental insurance are 3 times more likely to have dental needs than children with either public or private insurance. For each child without medical insurance, there are at least 2.6 children without dental insurance.
- Medicaid has not been able to fill the gap in providing dental care to poor children. Fewer than one in five Medicaid-covered children received a single dental visit in a recent year-long study period. Although new programs such as the State Children's Health Insurance Program (SCHIP) may increase the number of insured children, many will still be left without effective dental coverage.
- The social impact of oral diseases in children is substantial. More than 51 million school hours are lost each year to dental-related illness. Poor children suffer nearly 12 times more restricted-activity days than children from higher-income families. Pain and suffering due to untreated diseases can lead to problems in eating, speaking, and attending to learning.

## Adults

- Most adults show signs of periodontal or gingival diseases. Severe periodontal disease (measured as 6 millimeters of periodontal attachment loss) affects about 14 percent of adults aged 45-54.
- Clinical symptoms of viral infections, such as herpes labialis (cold sores), and oral ulcers (canker sores) are common in adulthood affecting about 19 percent of adults 22 to 44 years of age.
- Chronic disabling diseases such as temporomandibular disorders, Sjögren's syndrome, diabetes, and osteoporosis affect millions of Americans and compromise oral health and functioning

- Pain is a common symptom of craniofacial disorders and is accompanied by interference with vital functions such as eating, swallowing, and speech. Twenty-two percent of adults reported some form of oral-facial pain in the past 6 months. Pain is a major component of trigeminal neuralgia, facial shingles (post-herpetic neuralgia), temporomandibular disorders, fibromyalgia and Bell's palsy
- Population growth as well as diagnostics that are enabling earlier detection of cancer means that more patients than ever before are undergoing cancer treatments. More than 400,000 of these patients will develop oral complications annually.
- Immunocompromised patients, such as those with HIV infection and those undergoing organ transplantation, are at higher risk for oral problems such as candidiasis.
- Employed adults lose more than 164 million hours of work each year due to dental disease or dental visits
- For every adult 19 years or older with medical insurance, there are three without dental insurance.
- A little less than two thirds of adults report having visited a dentist in the past 12 months. Those with income at or above the poverty level are twice as likely to report a dental visit in the past 12 months as those who are below the poverty line.

## Older Adults

- Twenty-three percent of 65- to 74-year-olds have severe periodontal disease (measured as 6 millimeters of periodontal attachment loss). (Also, at all ages men are more likely than women to have more severe diseases, and at all ages people at the lowest socioeconomic levels have more severe periodontal disease.)
- About 30 percent of adults 65 years and older are edentulous, compared to 46 percent 20 years ago. These figures are higher for those living in poverty.
- Oral and pharyngeal cancers are diagnosed in about 30,000 Americans annually; 8,000 die from these diseases each year. These cancers are primarily diagnosed in the elderly. Prognosis is poor. The 5-year survival rate for white patients is 56 percent; for blacks, it is only 34 percent.
- Most older Americans take both prescription and over-the-counter drugs. In all probability, at least one of the medications used will have an oral side effect – usually dry mouth. The inhibition of salivary flow increases the risk for oral disease because saliva contains antimicrobial components as well as minerals that can help rebuild tooth enamel after attack by acid-producing, decay-causing bacteria. Individuals in long-term care facilities are prescribed an average of eight drugs.
- At any given time, 5 percent of Americans aged 65 and older (currently some 1.65 million people) are living in a long-term care facility where dental care is problematic.
- Many elderly individuals lose their dental insurance when they retire. The situation may be worse for older women, who generally have lower incomes and may never have had dental insurance. Medicaid funds dental care for the low-income and disabled elderly in some states, but reimbursements are low. Medicare is not designed to reimburse for routine dental care.

**Source:** U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000:2-3.

The nation's total bill for dental services was estimated by the Department of Health and Human Services' Centers for Medicare and Medicaid Services to be \$70.1 billion in 2002; this figure underestimates the true cost because it does not take into account the indirect expenses of oral health problems, nor the cost of services by other health care providers. These other providers include specialists who treat people with craniofacial birth defects, such as cleft lip or palate, and children born with genetic diseases that result in malformed teeth, hair, skin, and nails, as happens in the ectodermal dysplasias. Patients with oral cancers, chronic pain conditions such as temporomandibular (jaw) disorders, autoimmune disease such as Sjögren's syndrome (which leads to the destruction of the salivary and tear glands) and victims of unintentional or intentional facial injury are examples of other groups of patients who may require costly and long-term oral and medical services. Beyond these expenses are the millions of school and work hours lost every year because of oral health problems.

## Partnering for Progress

Aware that the Report had reinforced and stimulated a number of ongoing activities, but seeing a need to facilitate communication and coordination of the nation's efforts, the Office of the Surgeon General extended an open invitation to organizations to launch the development of the *Call To Action*. The resulting Partnership Network (Appendix 1) was charged to enumerate promising existing initiatives to enhance oral health, with an emphasis on those related to the Surgeon General's Report and to the *Healthy People 2010* oral objectives<sup>[2]</sup>, and to expand these efforts by enlisting the expertise of individuals, health care providers, communities, and policymakers at all levels of society. Input was captured through convening listening sessions held in five cities and by using Internet websites. The listening sessions were much like town hall meetings, providing opportunities to present the issues and solutions and attracting participants with diverse points of view. The testimony proved to be extremely valuable in demonstrating the extent to which oral health concerns extend beyond the oral health community and in providing a wealth of ideas and activities for resolving the issues (Appendix 2). The text that follows expresses the vision, goals, and actions proposed for the *Call To Action*.

## Vision and Goals

### The Vision

of the *Call To Action* is

To advance the general health and well-being of all Americans by creating critical partnerships at all levels of society to engage in programs to promote oral health and prevent disease.

### The Goals

of the *Call To Action* reflect those of *Healthy People 2010*:

To promote oral health.

To improve quality of life.

To eliminate oral health disparities.

As a force for change to enhance the nation's overall health and well-being, the *Call To Action* urges that oral health promotion, disease prevention, and oral health care have a presence in all health policy agendas set at local, state, and national levels. For this to happen, the public, health professionals, and policymakers must understand that oral health is essential to general health and well-being at every stage of life. In addition, the oral health community must be ready to act in efforts to address the nation's overall health agenda.

# The Actions

Each of the five actions that follow should be read as a call for a response from the individuals and groups who are most concerned and in a position to act—whether as community leaders, volunteers, health care professionals, research investigators, policymakers, and other concerned parties, or as public and private agencies able to bring their organizational mandates and strengths to the issues. The groups and individuals responding need to work as partners, sharing ideas and coordinating activities to capitalize on joint resources and expertise to achieve common goals. The actions proposed reflect ideas and approaches outlined in the Surgeon General's Report and emphasized in public testimony during listening sessions. Note, however, that individual Network members may not necessarily concur with every assessment or conclusion in the text that follows.

The theme that emerged was that people care about their oral health, are able to articulate the problems they face, and can devise ingenious solutions to resolve them--often through creative partnerships. Ultimately, the measure of success for any of any of these actions will be the degree to which individuals and communities--the people of the nation itself--gain in overall health and well-being. To achieve those ends, the partners have proposed four guiding principles: Actions should be 1) culturally sensitive, 2) science based, 3) integrated into overall health and well-being efforts, and 4) routinely evaluated.

## Action 1. Change Perceptions of Oral Health

For too long, the perception that oral health is in some way less important than and separate from general health has been deeply ingrained in American consciousness. Activities to overcome these attitudes and beliefs can start at the grassroots level, which can then lead to a coordinated national movement to increase oral health literacy, defined as the degree to which individuals have the capacity to obtain, process, and understand basic oral and craniofacial information and services needed to make appropriate health decisions. By raising Americans' level of awareness and understanding of oral health, people can make informed decisions and articulate their expectations of what they, their communities, and oral health professionals can contribute to improving health; health professionals and researchers can benefit from work with oral health partners; and policymakers can commit to including oral health in health policies. In this way, the prevention, early detection, and management of diseases of the dental, oral, and craniofacial tissues can become integrated in health care, community-based programs, and social services, and promote the general health and well-being of all Americans.

**Implementation strategies to change perceptions are needed at local, state, regional, and national levels and for all population groups. All stakeholders should work together and use data in order to:**

### Change public perceptions

- Enhance oral health literacy.
- Develop messages that are culturally sensitive and linguistically competent.
- Enhance knowledge of the value of regular, professional oral health care.
- Increase the understanding of how the signs and symptoms of oral infections can indicate general health status and act as a marker for other diseases.

### Change policymakers' perceptions

- Inform policymakers and administrators at local, state, and federal levels of the results of oral health research and programs and of the oral health status of their constituencies.
- Develop concise and relevant messages for policymakers.
- Document the health and quality-of-life outcomes that result from the inclusion (or exclusion) of oral health services in programs and reimbursement schedules.

## Change health providers' perceptions

- Review and update health professional educational curricula and continuing education courses to include content on oral health and the association between oral health and general health.
- Train health care providers to conduct oral screenings as part of routine physical exams and make appropriate referrals
- Promote interdisciplinary training of medical, oral health, and allied health professional personnel in counseling patients about how to reduce risk factors common to oral and general health.
- Encourage oral health providers to refer patients to other health specialists as warranted by examinations and history. Similarly, encourage medical and surgical providers to refer patients for oral health care when medical or surgical treatments that may impact oral health are planned.

## Action 2. Overcome Barriers by Replicating Effective Programs and Proven Efforts

**Reduce disease and disability.** While the effectiveness of preventive interventions such as community water fluoridation and school-based dental sealants applied to children at risk have been persuasively demonstrated, very few states have implemented both measures sufficiently to meet their health objectives. Private and public agencies have conducted pilot projects and demonstration programs to inform the public and health professionals on ways to reduce the burden of oral disease through education, behavior change, risk reduction, early diagnosis, and disease prevention management. Local efforts to engage and educate community leaders in activities to improve oral health have been developed. The designs and outcomes of those programs should be well documented, evaluated, and made available to others. *The Guide to Community Preventive Services*<sup>13</sup> and *The Guide to Clinical Preventive Services*<sup>14</sup> provide criteria and strong foundations for evaluating the scientific evidence and promoting effective interventions. Testimony at the listening sessions also identified programs and interventions that warrant consideration.

Having accurate data on disease and disabilities for a given population is critical. Program success depends on how well the program is designed and implemented to address the defined problems. While available data reveal variations within and among states and population groups in patterns of health and disease, there are many subpopulations for which data are limited or nonexistent.

**Improve oral health care access.** Health disparities are commonly associated with populations whose access to health care services is compromised by poverty, limited education or language skills, geographic isolation, age, gender, disability, or an existing medical condition. While Medicaid, State Children's Health Insurance Programs (SCHIP), and private organizations have expanded outreach efforts to identify and enroll eligible persons and simplify the enrollment process, they have not completely closed the gap. Adults lacking language skills or reading competence may not know that they or their children are eligible for dental (or medical) services. In addition, some 25 million Americans live in dental care shortage areas, as defined by Health Professional Shortage Area criteria.

Those who seek care may be faced with health practitioners who lack the training and cultural competence to communicate effectively in order to provide needed services. Programs that have overcome these barriers, including outreach efforts and community service activities conducted through dental schools and other health professional schools and residency programs, should be highlighted and replicated.

Compounding health disparity problems is the lack of adequate reimbursement for oral care services in both public and private programs. Private insurance coverage for dental care is increasing, but still lags behind medical insurance. Inadequate reimbursement has been reported for many Medicaid and SCHIP programs. Eligibility for Medicaid does not ensure enrollment, and enrollment does not ensure that individuals obtain needed care. Several states are demonstrating the potential for improving

children's oral health access by conducting outreach programs to the public and improving provider participation through operational changes. These improvements include increasing dental reimbursement to competitive levels, eliminating bureaucratic administrative barriers, contracting out the management of dental benefit plans, and modeling commercial insurance programs to eliminate patient stigma associated with Medicaid.

The federal effort to address gaps in care through new funding for oral health services at Community Health Centers and Migrant Health Centers is also a positive step. Appendix 2 describes a number of approaches for improving oral health care access that were presented in testimony. No matter which approach is taken, a necessary first step is to establish close working relationships with the groups in question so that strategies tailored to their varying and continuing health needs can be developed.

**Enhance health promotion and health literacy.** Public policies and community interventions to make health care and information more accessible have been effective. So have been efforts to encourage healthier lifestyles and increase interventions for prevention or early detection of disease by changing the environment (the places where people work, play, learn, or live). Expansion of community-based health promotion and disease prevention programs, including increasing understanding of what individuals can do to enhance oral health, is essential if the needs of the public are to be met. Policies and programs concerning tobacco cessation, dietary choices, wearing protective gear for sports, and other lifestyle-related efforts not only will benefit oral health, but are natural ways to integrate oral health promotion with promotion of general health and well-being.

Many Americans don't know why oral health is important, they don't know all they can do to preserve their oral health, and may not recognize signs indicating that they are in trouble. Several oral health campaigns are raising awareness of why oral health is important and how to access care, such as a nationwide campaign by the American Dental Association emphasizing the importance of the early diagnosis of oral cancer. It is encouraging that messages like these are being communicated--through public service announcements, campaigns, and all the venues available in today's media-conscious culture. More needs to be done to increase the health literacy of the public.

**Implementation strategies to overcome barriers in oral health disparities need to engage all groups, particularly those most vulnerable, in the development of oral health care programs that work to eliminate health disparities and aim to:**

Identify and reduce disease and disability

- Implement science-based interventions appropriate for individuals and communities.
- Enhance oral health-related content in health professions school curricula, residencies, and continuing education programs, by incorporating new findings on diagnosis, treatment and prevention of oral diseases and disorders.
- Build and support epidemiologic and surveillance databases at national, state, and local levels to identify patterns of disease and populations at risk. Data are needed on oral health status, disease, and health services utilization and expenditures, sorted by demographic variables for various populations. Surveys should document baseline status, monitor progress, and measure health outcomes.
- Determine, at community or population levels, oral health care needs and system requirements, including appropriate reimbursement for services, facility and personnel needs, and mechanisms of referral.

- Encourage partnerships among research, provider, and educational communities in activities, such as organizing workshops and conferences, to develop ways to meet the education, research, and service needs of patients who need special care and their families.
- Refine protocols of care for special care populations based on the emerging science base.

#### Improve access to oral health care

- Promote and apply programs that have demonstrated effective improvement in access to care.
- Create an active and up-to-date database of these programs.
- Explore policy changes that can improve provider participation in public health insurance programs and enhance patient access to care.
- Remove barriers to the use of services by simplifying forms, letting individuals know when and how to obtain services, and providing transportation and child care as needed. Assist low-income patients in arranging and keeping oral health appointments.
- Facilitate health insurance benefits for diseases and disorders affecting craniofacial, oral, and dental tissues, including genetic diseases such as the ectodermal dysplasias, congenital anomalies such as clefting syndromes, autoimmune diseases such as Sjögren's syndrome, and chronic orofacial pain conditions such as temporomandibular disorders.
- Ensure an adequate number and distribution of culturally competent providers to meet the needs of individuals and groups, particularly in health-care shortage areas.
- Make optimal use of oral health and other health care providers in improving access to oral health care.
- Energize and empower the public to implement solutions to meet their oral health care needs.
- Develop integrated and comprehensive care programs that include oral health care and increase the number and types of settings in which oral health services are provided.
- Explore ways to sustain successful programs.
- Apply evaluation criteria to determine the effectiveness of access programs and develop modifications as necessary.

#### Enhance health promotion and health literacy

- Apply strategies to enhance the adoption and maintenance of proven community-based and clinical interventions, such as community water fluoridation and dental sealants application.
- Identify the knowledge, opinions, and practices of the public, health care providers, and policymakers with regard to oral diseases and oral health.
- Engage populations and community organizations in the development of health promotion and health literacy action plans.
- Publicize successful programs that promote oral health to facilitate their replication.
- Develop and support programs promoting general health that include activities supporting oral health (such as wearing oral facial protection, tobacco cessation, good nutrition).

### Action 3. Build the Science Base and Accelerate Science Transfer

Advances in health depend on biomedical and behavioral research aimed at understanding the causes and pathological processes of diseases. This can lead to interventions that will improve prevention, diagnosis, and treatment. Too many people outside the oral health community are uninformed about, misinformed about, or simply not interested in oral health. Such lack of

understanding and indifference may explain why community water fluoridation and school-based dental sealant programs fall short of full implementation, even though the scientific evidence for their effectiveness has been known for some time and was reaffirmed with the release of *Oral Health in America*. These and other effective preventive and early detection programs should be expanded—especially to populations at risk.

Biomedical and behavioral research in the 21st century will provide the knowledge base for an ever-evolving health care practice. This scientific underpinning requires the support of the full range of research from basic studies to large-scale clinical trials. To achieve a balanced science portfolio it is essential to expand clinical studies, especially the study of complex oral diseases that involve the interactions of genetic, behavioral, and environmental factors. Clinical trials are needed to test interventions to diagnose and manage oral infections, complications from systemic diseases and their treatment, congenital and acquired defects, and other conditions. Oral health research must also pursue research on chronic oral infections associated with heart and lung disease, diabetes, and premature low-birth-weight babies. Such research must be complemented by prevention and behavioral science research (including community-based approaches and ways to change risk behavior), health services research to explore how the structure and function of health care services affect health outcomes, and by population health and epidemiology research to understand potential associations among diseases and possible risk factors. Surveys are needed to establish baseline health data for America's many subpopulations as well as to monitor changing patterns of disease. No one can foresee the findings from genetic studies in the years ahead, but without question these advances will profoundly affect health, even indicating an individual's susceptibility to major diseases and disorders. Hybrid sciences of importance to oral health are also on the rise. For example, bioengineering studies are establishing the basis for repair and regeneration of the body's tissues and organs—including teeth, bones, and joints-- and ultimately full restoration of function. Oral diagnostics, using saliva or oral tissue samples, will contribute to overall health surveillance and monitoring.

If the public and their care providers are to benefit from research, efforts are needed to transfer new oral knowledge into improved means of diagnosis, treatment, and prevention. The public needs to be informed, accurately and often, of findings that affect their health. They need clear descriptions of the results from research and demonstration projects concerning lifestyle behaviors and disease prevention practices. At the same time, research is needed to determine the effect of oral health literacy on oral health. Communities and organizations must also be able to reap the benefits of scientific advances, which may contribute to changes in the reimbursement and delivery of services, as well as enhance knowledge of risk factors. Advances in science and technology also mean that life-long learning for practitioners is essential, as is open lines of communication among laboratory scientists, clinicians, and the academic faculties that design the curricula, write the textbooks, and teach the classes that prepare the next generation of health care providers.

**Implementation strategies to build a balanced science base and accelerate science transfer should benefit all consumers, especially those in poorest oral health or at greatest risk. Specifically there is a need to:**

Enhance applied research (clinical and population-based studies, demonstration projects, health services research) to improve oral health and prevent disease

- Expand intervention studies aimed at preventing and managing oral infections and complex diseases, including new approaches to prevent dental caries and periodontal diseases.
- Intensify population-based studies aimed at the prevention of oral cancer and oral-facial trauma.
- Conduct studies to elucidate potential underlying mechanisms and determine any causal associations between oral infections and systemic conditions. If associations are demonstrated, test interventions to prevent or lower risk of complications.
- Develop diagnostic markers for disease susceptibility and progression of oral diseases.

- Develop and test diagnostic codes for oral diseases that can be used in research and in practice.
- Investigate *risk assessment* approaches for individuals and communities, and translate them into optimal prevention, diagnosis, and treatment measures.
- Develop biologic measures of disease and health that can be used as outcome variables and applied in epidemiologic studies and clinical trials.
- Develop reliable and valid measures of patients' oral health outcomes for use in programs and in practice.
- Support research on the effectiveness of community-based and clinical interventions
- Facilitate collaborations among health professional schools, state health programs, patient groups, professional associations, private practitioners, industries, and communities to support the conduct of clinical and community-based research as well as accelerate science transfer

Accelerate the effective transfer of science into public health and private practice

- Promote effective disease prevention measures that are underutilized.
- Routinely transfer oral health research findings to health professional school curricula and continuing education programs and incorporate appropriate curricula from other health professions-- medical, nursing, pharmacy, and social work--into dental education.
- Communicate research findings to the public, clearly describing behaviors and actions that promote health and well-being.
- Explore ways to accelerate the transfer of research findings into delivery systems, including appropriate changes in reimbursement for care.
- Routinely evaluate the scientific evidence and update care recommendations.

#### Action 4. Increase Oral Health Workforce Diversity, Capacity, and Flexibility

**Meet patient needs.** The patient pool of any health care provider tends to mirror the provider's own racial and ethnic background<sup>[5]</sup>. As such, the provider can play a catalytic role as a community spokesperson, addressing key health problems and service needs. While the number of women engaged in the health professions is increasing, the number of underrepresented racial and ethnic minorities is decreasing and remains limited. Specific racial and ethnic groups are underrepresented in the active dental profession compared to their representation in the general population: African Americans comprise 2.2 percent of active dentists versus 12 percent of the population, Hispanics comprise 2.8 percent of active dentists versus 10.7 percent of the population; Native Americans comprise 0.2 percent of active dentists versus 0.7 percent of the population. The reasons are complex but certainly include the high cost of dental school education (upwards of \$100,000 indebtedness for dentist graduates). Efforts to address these problems at all levels—from improving K-12 education in science and math to providing scholarships and loan forgiveness programs for college and pre-doctoral programs--are essential if a truly representative health workforce is to be achieved. Efforts require full community participation, mentorship, and creative outreach as well as building upon federal or state legislation and programs.

**Enhance oral health workforce capacity.** The lack of progress in supplying dental health professional shortage areas with needed professional personnel underscores the need for attention to the distribution of care providers, as well as the overall capacity of the collective workforce to meet the anticipated demand for oral health care as public understanding of its importance increases. Dental school recruitment programs that offer incentives to students who may want to return to practice in rural areas and inner cities are in a prime position to act. Through these programs schools increase the diversity of the oral health

workforce. To effect change in oral health workforce capacity, more training and recruitment efforts are needed. The lack of personnel with oral health expertise at all levels in public health programs remains a serious problem, as does the projected unmet oral health faculty and researcher needs. In public health programs, oral health professionals are needed to implement surveillance, assess needs, and target population-based preventive programs. Oral health professionals in state health agencies frequently promote integration of federal, state, and local strategies and serve as the linking agent for public-private collaborations. Currently, there is an acknowledged crisis in the ability to recruit faculty to dental schools and to attract clinicians into research careers. Dental school faculty and oral health researchers are needed to address the various scientific challenges and opportunities oral health presents, and to help transfer emerging knowledge to the next generation of health care providers. The lack of trained professionals ultimately results in a loss in the public's health. Efforts are underway to address these needs, but the rate of recruitment and retention is slow. Scholarships and loan forgiveness programs have made a difference, but more public investment in developing health workforce personnel is needed.

**Enhance flexibility and develop local solutions.** The movement of some states towards more flexible laws, including licensing experienced dentists by credentials is a positive one and today, 42 states currently permit this activity. The goal of moving society toward optimal use of its health professionals is especially important in a society that has become increasingly mobile, especially since the oral health workforce has projected shortages that are already evident in many rural locales. State practice act changes that would permit, for example, alternative models of delivery of needed care for underserved populations, such as low-income children or institutionalized persons, would allow a more flexible and efficient workforce. Further, all health care professionals, whether trained at privately or publicly supported medical, dental, or allied health professional schools, need to be enlisted in local efforts to eliminate health disparities in America. These activities could include participating in state-funded programs for reducing disparities, part-time service in community clinics or in health care shortage areas, assisting in community-based surveillance and health assessment activities, participating in school-based disease prevention efforts, and volunteering in health-promotion and disease-prevention efforts such as tobacco cessation programs.

**Implementation strategies to increase diversity, capacity, and flexibility must be applied to all components of the workforce: research, education, and both private and public health administration and practice. Efforts are needed to:**  
Change the racial and ethnic composition of the workforce to meet patient and community needs

- Document the outcomes of existing efforts to diversify the workforce in practice, education, and research.
- Develop ways to expand and build upon successful recruitment and retention programs, and develop and test new programs that focus on individuals from underrepresented groups.
- Document the outcomes of existing efforts to recruit individuals into careers in oral health education, research, and public and private health practice.
- Create and support programs that inform and encourage individuals to pursue health and science career options in high school and during graduate years.

Ensure a sufficient workforce pool to meet health care needs

- Expand scholarships and loan repayment efforts at all levels.
- Specify and identify resources for conducting outreach and recruitment.
- Develop mentoring programs to ensure retention of individuals who have been successfully recruited into oral health careers.
- Facilitate collaborations among professional, government, academic, industry, community organizations, and other institutions that are addressing the needs of the oral health workforce.

- Provide training in communication skills and cultural competence to health care providers and students.

#### Secure an adequate and flexible workforce

- Assess the existing capacity and distribution of the oral health workforce.
- Study how to extend or expand workforce capacity and productivity to address oral health in health care shortage areas.
- Work to ensure oral health expertise is available to health departments and to federal, state, and local government programs.
- Determine the effects of flexible licensure policies and state practice acts on health care access and oral health outcomes.

### Action 5. Increase Collaborations

The private sector and public sector each has unique characteristics and strengths. Linking the two can result in a creative synergy capitalizing on the talent and resources of each partner. In addition, efforts are needed within each sector to increase the capacity for program development, for building partnerships, and for leveraging programs. A sustained effort is needed right now to build the nation's oral health infrastructure to ensure that all sectors of society--the public, private practitioners, and federal and state government personnel--have sufficient knowledge, expertise, and resources to design, implement, and monitor oral health programs. Leadership for successfully directing and guiding public agency oral health units is essential. Further, incentives must be in place for partnerships to form and flourish.

Disease prevention and health promotion campaigns and programs that affect oral and general health--such as tobacco control, diet counseling, health education aimed at pregnant women and new mothers, and support for use of oral facial protection for sports--can benefit from collaborations among public health and health care practicing communities. Interdisciplinary care is needed to manage the general health-oral health interface. Achieving and maintaining oral health requires individual action, complemented by professional care and community-based activities. Many programs require the combined efforts of social service, education, and health care services at state and local levels. Most importantly, the public in the form of voluntary organizations, community groups, or as individuals, must be included in any partnership that addresses oral and general health.

**Implementation strategies to enhance partnering are key to all strategies in the *Call To Action*. Successful partnering at all levels of society will require efforts to:**

- Invite patient advocacy groups to lead efforts in partnering for programs directed towards their constituencies.
- Strengthen the networking capacity of individuals and communities to address their oral health needs.
- Build and nurture broad-based coalitions that incorporate views and expertise of all stakeholders and that are tailored to specific populations, conditions, or programs.
- Strengthen collaborations among dental, medical, and public health communities for research, education, care delivery, and policy development.
- Develop partnerships that are community-based, cross-disciplinary, and culturally sensitive.
- Work with the Partnership Network and other coalitions to address the four actions previously described: change perceptions, overcome barriers, build a balanced science base, and increase oral health workforce diversity, capacity, and flexibility.
- Evaluate and report on the progress and outcomes of partnership efforts.

- Promote examples of state-based coalitions for others to use as models.

## The Need for Action Plans with Monitoring and Evaluation Components

Activities proposed to advance any or all of the actions described above must incorporate schemes for planning and evaluation, coordination, and accountability. Because planning and evaluation are key elements in the design and implementation of any program, the need to create oral health action plans is emphasized.

Whether individuals are moved to act as volunteers in a community program, as members of a health voluntary or patient advocacy organization, employees in a private or public health agency, or health professionals at any level of research, education, or practice, the essential first step is to conduct a needs assessment and develop an oral health plan. Because the concept of integrating oral health with general health is intrinsic to the goals of this Call To Action, oral health plans should be developed with the intent of incorporating them into existing general health plans. *Healthy People 2010* objectives can be used to help guide needs assessment and to establish program goals and health indicators for outcome measures. At the state level many, but not all, states have already developed oral health plans; however, not all of these plans have been integrated into the state's general health plan and policies. While a detailed plan is necessary to guide collaboration on the many specific actions necessary for enhancing oral health, integration of key components into the state's general health plan will assure that oral health is included where appropriate in other state health initiatives.

At any level, formal plans with goals, implementation steps, strong evaluation components, and monitoring plans will facilitate setting realistic timelines, guidelines, and budgets. The oral health plan will serve as a blueprint, one that can be a tool for enlisting collaborators and partners and attracting funding sources to ensure sustainability. Building this plan into existing health programs will maximize the integration of oral health into general health programs—not only by incorporating the expertise of multidisciplinary professional teams, but also allowing the plan to benefit from economies of scale by adding on to existing facilities, utilizing existing data and management systems, and serving the public at locations already known to patients.

**To facilitate establishing, monitoring and revising written plans and ensure their progress:**

- Use the *Healthy People 2010* objectives to help establish program goals and guide the needs assessment and development of health indicators for outcome measures.
- Develop and nurture a consortium of stakeholders.
- Align plan priorities with the views and expertise of primary stakeholders
- Build upon existing plans within your organization, state, or local community or apply aspects of plans established at other locations to suit program needs.
- Ensure that cultural sensitivity is utilized in the design, development, implementation, and evaluation of plans.
- Emphasize the value of incorporating oral health into general health plans by educating the public, health professionals, and policymakers about oral health and its relation to general health and well-being.
- Integrate existing oral health plans into general health plans.
- Establish and maintain a strong surveillance and evaluation effort.
- Regularly report on progress to all stakeholders and policymakers.
- Commit resources to ensure that oral health programs and systems include staff with sufficient time, expertise, and information systems, and address oral health needs.

## Next Steps

This *National Call To Action To Promote Oral Health* provides the basis for integrating efforts of current and future members of the Partnership Network to facilitate improvement of the nation's health through oral health activities. The five actions outlined in this report require public-private partnerships at all levels of society and a commitment from those who are involved in health programs to contribute expertise and resources. The Partnership Network members will serve to foster communication and collaborations and will act as a forum to measure progress toward these actions in coordination with the *Healthy People 2010* initiative.

### **Appendix 1**

#### Partnership Network Members (as of November 2001)

Academy of General Dentistry  
American Academy of Pediatrics  
American Academy of Pediatric Dentistry  
American Association of Public Health Dentistry  
American Association of Women Dentists  
American College of Nurse-Midwives  
American Dental Association  
American Dental Hygienists' Association  
American Dental Trade Association  
American Dental Education Association  
American Medical Association  
American Public Health Association  
American Society of Dentistry for Children  
Association of Maternal and Child Health Programs  
Association of Academic Health Centers  
Association of Clinicians for the Underserved  
Association of Maternal and Child Health Programs  
Association of Schools of Public Health  
Association of State and Territorial Health Officials  
Association of State and Territorial Dental Directors  
Bureau of Dental Health, New York State Health Department  
Campbell Hoffman Foundation  
Center for Child Health Research  
Children's Defense Fund  
Children's Dental Health Project  
Colorado Department of Public Health and Environment Oral Health Program  
Connecticut Health Foundation  
Consumer Health Care Products Association  
Delta Dental Plans Association

Delta Dental/Washington Dental Service  
DENTSPLY International/Families USA  
Family Voices (Federation for Children with Special Needs)  
Friends of NIDCR  
Colgate Palmolive Company  
Grantmakers In Health  
Henry Schein, Inc.  
Hispanic Dental Association  
Illinois Department of Public Health  
International Association for Dental Research, American Association for Dental Research  
Maryland Department of Health and Mental Hygiene  
National Oral Health Policy Center  
Minority Health Communications  
National Association of Child Advocates  
National Association of Children's Hospitals  
National Association of Community Health Centers  
National Association of County and City Health Officials  
National Association of Local Boards of Health  
National Association of State Medicaid Directors  
National Maternal and Child Oral Health Resource Center  
National Conference of State Legislatures  
National Dental Association  
National Foundation for Ectodermal Dysplasias  
National Governors' Association  
National Health Law Program  
National Health Policy Forum  
National Association of Urban-Based HMOs  
New York State Department of Health  
Oral Health America  
Reforming States Group  
Research America  
Ronald McDonald House Charities  
Special Olympics and Special Olympics University  
The Children's National Medical Center  
The Robert Wood Johnson Foundation  
The Rotunda  
Urban Institute Health Policy Center  
Washington Dental Service Foundation  
W.K. Kellogg Foundation  
Women's and Children's Health Policy Center

## Appendix 2

### What People Said

The sections that follow are derived from the presentations of individuals and organizations at the five regional listening sessions held during winter and spring 2002 and from the written testimony received. The issues identified in the Surgeon General's Report were restated in terms of objectives and grouped into five objectives: 1. Change perceptions, 2. Overcome barriers, 3. Enhance research and its application, 4. Strengthen infrastructure, and 5. Expand partnerships. These objectives formed the basis for summarizing the testimony and for the Actions described in the text. By describing general approaches as well as some specific programs and projects underway, this appendix can serve as a resource to aid responses to the *Call To Action*. Some programs might lend themselves to replication at other sites; others may inspire new and ingenious plans, programs, and partnerships. As background, each of the five objectives is preceded by a text box quoting relevant portions of *Oral Health in America: A Report of the Surgeon General*.

While it was expected that many of those who testified came from segments of the oral health community, it was especially gratifying that many of the respondents spoke from other perspectives. They were community leaders, concerned citizens, representatives of health voluntary organizations, and other nonprofit organizations and foundations, and employees of public agencies at all levels of local, state, and federal government.

#### A Rich Repertoire...

The listening sessions exemplified the kind of democracy-in-action associated with town meetings in America. The people who attended reflected the racial and ethnic diversity of the community's population and demonstrated the degree of innovation and creativity Americans can achieve when committed to resolve critical health issues. Participants were ingenious in describing coalitions, partnerships, and funding opportunities involving all kinds of entities: a community church working with the local dental society, a state health agency cooperating with a private foundation and volunteer dental professionals, a dental insurance corporation subsidizing treatment costs to improve access to services for poor people, school nurses working with parents, dental hygienists, and local dentists to implement dental screening programs and referrals for care, and private philanthropies financing mobile vans to reach people in remote areas. Several organizations detailed how they had competed for small federal grants, which they used to plan and conduct pilot programs. Several dental schools described using private foundation grants to fund community outreach programs utilizing dental students. Clearly there is no one-size-fits-all remedy to the health problems that the nations' communities and populations experience.

#### ...but an Uncertain Future

However, not every program was a demonstrable success. Indeed, more than one presenter expressed concern that their efforts were piecemeal and the future was cloudy: programs could last only as long as the resources and funding. In one case, a program that was built on the promise of partial support had to cease when state funding was cut back. Thus the listening sessions were also a declaration that more long-term strategies must be pursued and public awareness of the importance of oral health must grow. The commitment of communities to build the public-private partnerships by expending the social, political, and economic will at federal, state, and local levels can yield long-lasting health benefits for all community members.

### Testimony Highlights

**Objective 1:** Change perceptions of the public, policymakers, and health providers regarding oral health and disease so that oral health becomes an accepted component of general health.

#### *What the report said*

The mouth is the major portal of entry to the body and is equipped with formidable mechanisms for sensing the environment and defending against toxins or invading pathogens. In the event that the integrity of the oral tissues is compromised, the mouth can

become a source of disease or pathological processes affecting other parts of the body that can reveal signs of disease, drug use, domestic physical abuse, harmful habits or addiction such as smoking, and general health status. Imaging...may provide oral signs of skeletal changes such as those occurring with osteoporosis and musculoskeletal disorders, and may also reveal salivary, congenital, neoplastic, and developmental disorders. Oral-based diagnostics are increasingly being developed and used as a means to assess health and disease without the limitations and difficulties of obtaining blood and urine.

Oral diseases and disorders in and of themselves affect health and well-being across the life span. They include the common dental diseases, dental caries and the periodontal diseases, and other oral infections, such as cold sores and candidiasis, as well as birth defects occurring in infancy and chronic craniofacial pain conditions and oral cancers seen in later years....

Diseases and disorders that result in dental and craniofacial defects damage self-image, self-esteem, and well-being. Oral-facial pain and loss of sensori-motor functions limit food choices and the pleasures of eating, restrict social contact, and inhibit intimacy... Patients with oral and pharyngeal cancers may experience loss of taste, loss of chewing ability, difficulty in speaking, pain, and the psychological stress and depression associated with disfigurement.

Oral complications of many systemic diseases also compromise the quality of life. Problems of speaking, chewing, taste, smell and swallowing are common in neurodegenerative conditions such as Parkinson's disease; oral complications of AIDS include pain, dry mouth, and Kaposi's sarcoma; cancer therapy can result in painful ulcers, mucositis, and rampant dental caries; periodontal disease is a complication of diabetes and osteoporosis. Prescription and non-prescription drugs often have the side effect of dry mouth.

Oral infections can be the source of systemic infections, especially in people with weakened immune systems, while oral signs and symptoms are often a significant feature of a general health problem, such as the autoimmune disease, Sjögren's syndrome.

Most intriguing of all, are associations reported between chronic oral infections and serious health problems, such as diabetes, heart and lung disease, and adverse pregnancy outcomes. Investigators are actively engaged in research to confirm initial findings and discover the mechanisms involved.

Source: U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. pp.133, 283-284.

### **Addressing the Issue**

The testimony reinforced the concept that oral health is secondary and separate from general health is one that is deeply ingrained in American consciousness and hence may be the pivotal and most difficult barrier to overcome. Cultural historians can point to a tradition in Europe and America in which dentistry was long associated with tooth extractions performed by itinerant surgeons who were reviled as charlatans, despised as sources of acute pain and suffering, and abundantly caricatured in art and literature. Something of this stigma associated with dentistry and its practitioners remains today, not only in terms of the way the profession is popularly depicted in films and comedy routines, but also in terms of its ranking in the hierarchy of health and medical specialties. The very fact that dental education was established separately from medical training, as was the practice of dentistry, may have unwittingly contributed to the stigma—and may also in part account for why a lack of perceived need remains one of the major reasons that many people do not seek regular dental care. Thus, efforts to achieve acceptance of the intrinsic importance of oral health and its interdependence with general health must be directed to medical practitioners and other health professionals and researchers, as well as to educators, policymakers, and the general public. This point was brought home to attendees at one regional meeting during which a woman testified that in all her years as a diabetic patient in

which her physicians referred her to specialists such as ophthalmologists and neurologists for potential diabetes complications, no one had ever once suggested that she see a dentist concerning her oral health status. At another hearing it was reported that medical residents in a prenatal clinic were interested to learn that women with moderately severe periodontal disease might be at risk for pre-term and low birth weight infants. Even with that knowledge, however, they would not act on any new findings such as these, without an official recommendation from the American College of Obstetricians and Gynecologists.

*"No physician or other medical specialist I saw ever suggested I see a dentist."*

*-- a woman with diabetes*

Associations between oral infections and systemic conditions continue to be reported, and if the results of studies prove a cause-effect relationship, their widespread communication may very well effect a significant change in the practices and programs of health professionals as well as policymakers and the general public. In the meantime, the various programs described at the listening sessions to explain the oral health-general health connection are helping to make a difference. In so doing, they also reveal to what extent otherwise well-educated Americans, even health care providers, are uninformed about the multiple defense, repair, and maintenance functions performed by oral tissues as gatekeepers to the body, the fine-tuned sensory-motor skills of orofacial nerves and muscles, and the necessary role of oral hygiene and nutrition in keeping oral tissues healthy.

Listening session participants gave a number of examples of public relations awareness campaigns conducted at local and state levels, the exemplary use of public service announcements, and even dental product infomercials on the Internet with educational content.

Model programs in which volunteer oral health professionals educate segments of the population at the places where they congregate -older Americans at senior centers, primary grade students in school, pregnant women seen in prenatal clinics- offer the possibility of stimulating high interest by tailoring the message to the specific oral health problems and appropriate interventions for the given audience. Programs that test training methods for nurses and physicians to conduct oral health evaluations, make appropriate dental referrals, and apply preventive interventions such as fluoride varnishes or dental sealants were seen as ways to integrate oral health services with medical care and pave the way for a time when such practices will be routinely accepted. An example of a well-thought-out awareness campaign was the Watch Your Mouth program in Washington state, which used radio and print advertisements to educate the public on the importance of oral health. The campaign also included an evaluation component allowing before-and-after statistical analyses of effectiveness.

With regard to educating policymakers, there is no question that the advocacy of members of consumer and health voluntary organizations (e.g., Sjögren's Syndrome, March of Dimes, The Temporomandibular Joint Association, National Foundation for Ectodermal Dysplasias) as well as oral health research and professional organizations, has done much to inform and raise the consciousness of these leaders and with positive effects. These advocates have used persuasive and well-documented arguments concerning the impact of oral health—and its lack—on the health, education, financing, and productivity of large segments of the constituencies the legislators represent. On the principle of strength through numbers, coalitions of such groups, especially partnering oral health patient organizations with medical disease organizations (e.g., heart, cancer, diabetes, arthritis) might achieve a greater impact, while underscoring that oral health and general health are inextricably linked.

### **Changing the Paradigm**

Nonetheless, no matter how well meaning and constructive local, state, and regional efforts at changing perceptions have been, the best route to overcoming the cultural, historical, legal, and structural impediments to accepting oral health as essential to general health and well-being may be to create a broad awareness and education program that would be coordinated at the national level. This program could foster the necessary paradigm shift in perception. Such a program--supported by a broad

coalition of patient and consumer groups, private and public research and practitioner organizations--could achieve collectively what no one group has yet been able to achieve singly.

**Objective 2:** Remove known barriers between people and oral health services.

***What the Report said:***

This report presents data on access, utilization, financing, and reimbursement of oral health care; provides additional data on the extent of the barriers, and points to the need for public-private partnerships in seeking solutions. The data indicate that lack of dental insurance, private or public, is one of several impediments to obtaining oral health care and accounts in part for the generally poorer health of those who live at or near the poverty line, lack health insurance, or lose their insurance upon retirement. The level of reimbursement for services also has been reported to be a problem and a disincentive to the participation of providers in certain public programs.

**Source:** U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. p. 286.

**Addressing the Issue**

Concern about barriers to care was by far the issue that most engaged speakers at the *Call To Action* listening sessions, eliciting the widest range of proposals and programs. There was unanimous agreement that rates of reimbursement for oral health care under the Medicaid program are low and, as a result of many state budget shortfalls in recent years, will be subject to further cuts. These budgetary limitations have also affected State Children's Health Insurance Programs, in which dental care is only an option. States that have made concerted legislative efforts to raise Medicaid reimbursement rates to levels consistent with customary fees in the area have seen improvements in the number of poor patients served and providers willing to treat patients covered under Medicaid. Speakers also expressed hope that Medicare, which specifically excludes dental services other than in exceptional cases, such as when dental care is integral to treating a medical condition, could some day be expanded to cover oral health care for seniors.

***"When did we allow dental care to become medically unnecessary in the first place?"***

***--An advocate for special care dentistry***

While participants argued for coordinated and large-scale efforts at legislative and corporate reforms to extend coverage and improve oral health care benefits for Americans who lack dental insurance or have extremely limited coverage, a number of speakers described programs and demonstration projects targeted to particular risk groups. Rather than wait for policy changes and insurance reforms, they saw the urgency to create innovative access and delivery programs to serve poor children, members of racial and ethnic minorities, the elderly, rural residents, or individuals with disabilities and other special care needs. A few examples of targeted programs that have been launched in recent years have been chosen from the listening sessions to illustrate their variety and are described below. Subject to evaluation of their overall effectiveness and cost, they might be adapted to other venues. In all cases, it was clear that it was the dedication and drive of a few key individuals determined to turn dreams into realities that enabled these programs to be implemented. Whether a school nurse or principal, a health agency official, dental hygienist, a clergyman, academic faculty member, practicing dentist or physician, a private foundation director, or a local community leader, these were people who sought out and obtained the trust, cooperation, commitment, and funding from multiple sources to get their programs going and keep them going.

**A dental school-based program for children with special care needs.** The College of Dental Medicine of the Medical University of South Carolina in Charleston developed a demonstration project that provided the screening and referral of children to a state-wide network of dentists willing and able to treat children with complex care needs. Administrators have used this

project to enrich the education of dental students through clinical rotations and an expanded special care curriculum and to increase the competencies of practicing dentists to serve special care patients through continued education courses. The project has also advanced research by collecting data on the oral health problems seen in special care patients and by correlating these problems with the underlying health problem. The project resulted in greatly increased services, the publication of a dental directory for parents, and an extension of special care seminars and courses for other health professionals and administrators.

***“A hallmark of successful programs is community-level involvement”***

***--A community volunteer***

**SABER promotora model.** Much of the appeal of this model is its grassroots origin in a Hispanic community in southern California. As the program director indicates, “The model is based on naturally occurring networks and linkages that exist in the Latino community.” Promotoras are community health advocates who serve as role models for behavior change and work in traditional ways to provide culturally appropriate dental health education and information, while promoting the bonding of neighbors, friends, and family.

**Meeting the needs of rural communities.** “Rural communities are the canaries in the workforce coal mines,” was the way one federal dentist described the ever-growing shortage of dental care providers in rural and frontier communities. These communities are also unlikely to have access to a fluoridated water supply and adequate transportation to larger cities and towns. What is impressive is how some communities have taken it upon themselves to meet the challenges. For example, three rural communities in New York State have each implemented a different approach to the provision of care: a mobile dental clinic, a primary care-based dental clinic at a critical access hospital, and a freestanding satellite dental clinic. These facilities reflect the commitment of partners that included community and consumer groups, foundations, dental associations, hospitals, government agencies, and the dental school of the State University of New York at Buffalo.

**Care for institutionalized elderly.** A nonprofit charitable organization, Apple Tree Minnesota, was first designed to serve indigent elderly living in institutions and has since been expanded to serve poor children. The program brings dental care to individuals through mobile dental vans that work out of stationary clinics as hubs. The program also conducts needs assessment to support a role in public policy development and advocacy and creates regional advisory councils to develop grassroots advocates. The program has been replicated in other states, but because funding for care comes from Medicaid there have been severe shortfalls, which must be made up by seeking other sources of revenue.

**An Indian Health Service prenatal dental education program for Native American mothers.** This Oklahoma program was designed to provide oral health care to expectant mothers and to advise them on ways to prevent early childhood dental caries by adopting appropriate feeding practices to their babies and teaching appropriate oral hygiene for newborns (as well as the mothers). The program has a strong evaluation component that includes follow-up interviews with participants. Such a program provides an opportunity for integrating oral health education and services in a hospital where women are already being seen in an obstetrics unit.

**Private practitioners reach out.** The Georgia Dental Association in partnership with the Georgia Medicaid agency were effective at the level of the legislature and governor in increasing the state’s investment in oral health. In 2002 Georgia was the only state to receive an increase in Medicaid funding for dental care – a 3.5 percent increase in provider reimbursement rates. Georgia also successfully reduced administrative barriers, such as prior authorization requirements and burdensome provider applications. As a result, the number of dentists signing up to provide care to Medicaid patients continues to increase. Dentists themselves orchestrated a Medicaid promotional campaign called Take 5, encouraging each dentist to take on five new Medicaid patients.

**Objective 3:** Accelerate the building of the scientific and evidence base and accelerate the application of research findings to improve oral health.

#### ***What the Report Said***

The science base for dental diseases is broad and provides a strong foundation for further improvements in prevention; for other craniofacial and oral conditions the base has not reached the same level of maturity... The nation's continued investment in research is critical for the provision of new knowledge about oral and general health and disease... However the next steps are more complicated. The challenge is to understand complex diseases caused by interaction of multiple genes with environment and behavioral variables—a description that applies to most oral diseases and disorders—and translate research findings into health care practices and healthy lifestyles. At present there is an overall need for behavioral and clinical research, clinical trials, health services research, and community-based demonstration research. Also, development of risk assessment procedures for individuals and communities and of diagnostic markers to indicate whether an individual is more or less susceptible to a given disease can provide a basis for formulating risk profiles and tailoring treatment and program options accordingly.

**Source:** U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. p.284-285.

#### **Addressing the Issue**

Support for continued research to advance oral health science, particularly in exploring the oral health-general health connection, was implicit in the testimony of many individuals addressing the *Call To Action*. Clearly, additional well-designed research studies that can explore the role of chronic oral infections as risk factors for adverse pregnancy outcomes, poorly controlled diabetes, heart and lung diseases, and the potential role of oral infections in other conditions are needed. The major private oral health research organization, the American Association for Dental Research (AADR), stated that it was committed to promoting the goals of the *Call To Action* and is encouraging its section members to follow up with symposia at annual meetings. Also, the research agenda of the American Dental Association sets out many of the profession's research needs and can be used as a blueprint for research studies.

Many who testified at the listening sessions concentrated on the need to put research into practice. They spoke as community leaders, care providers, directors of clinics and public health and health care financing agencies, and as representatives of dental schools, schools of dental hygiene, and dental societies. Participants expressed frustration that known ways of preventing oral disease and promoting oral health are still not being adopted by individuals and communities, often where the needs are greatest. Many noted that in the 21st century, over a third of Americans fail to enjoy the benefits of community water fluoridation—one of the most effective and inexpensive means of preventing dental caries. Similarly, the need to increase applications of dental sealants and topical fluorides were emphasized. In addition, the need for epidemiology and surveillance studies to determine the scope of oral health problems and project future service needs at local, state, and national levels was stressed. There was also a call for expanding health services research and the use of outcomes measures to determine the effectiveness and cost-effectiveness of various prevention and treatment modalities as well as ways of delivering oral care services. Calls for the adoption of a universal oral survey assessment form and for research to develop diagnostic markers and other measures of risk assessment were also strongly recommended as ways to facilitate surveillance and epidemiology studies as well as providing optimal tailor-made oral health care to patients.

Comments made at the listening sessions highlighted the need for further research on biomaterials and their health effects, as well as on the science transfer of proven dietary preventive measures. For example, there was some discussion of the use of xylitol and other cariostatic sugar substitutes to prevent dental

**Objective 4:** Ensure the adequacy of public and private health personnel and resources to meet the oral health needs of all Americans and enable the integration of oral health effectively with general health. The focus is on having a responsive, competent, diverse, and flexible workforce.

#### ***What the report said***

The public health capacity for addressing oral health is dilute and not integrated with other public health programs. Local, state, and federal resources are limited in the personnel, equipment, and facilities available to support oral health program. There is also a lack of available trained public health practitioners knowledgeable about oral health. As a result, existing disease prevention programs are not being implemented in many communities, creating gaps in prevention and care that affect the nation's neediest populations...cutbacks in many state budgets have reduced staffing of state and territorial dental programs and curtailed oral health promotion and disease prevention programs.

There is a lack of racial and ethnic diversity in the oral health workforce. Efforts to recruit members of minority groups to positions in health education, research, and practice in numbers that at least match their representation in the general population not only would enrich the talent pool, but also might result in a more equitable geographic distribution of care providers.

A closer look at trends in the workforce discloses a worrisome shortfall in the numbers of men and women choosing careers in the education of oral health professionals and the conduct of oral health research.

Source: U.S. Department of Health and Human Services *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. p.286.

#### **Addressing the Issue**

If anything, testimony at the regional listening sessions affirmed that the oral health infrastructure has continued to deteriorate with additional shortfalls in personnel and budgets. Within the public sector, it is essential to have a strong federal oral health infrastructure that provides stability and support for state public oral health efforts. These state programs can then advise and provide technical assistance to community oral health programs. The Centers for Medicare and Medicaid Services has appointed a dental officer in recognition of the importance of having an oral health expert who can stimulate effective and efficient programs at the state and local levels as they relate to Medicaid and the State Children's Health Insurance Program. But the shortfall of oral health expertise in other state and federal agencies—individuals who can stimulate, facilitate, and ensure strong public-private partnerships—is critical. At present, 12 out of 50 states and 7 territories lack a permanent full time dental director. A similar lack of dental public health expertise exists in state agencies managing multi-million dollar Medicaid programs and the State Children's Health Insurance Program. The only remedy to this problem is to employ enough staff to enable states to conduct essential public health activities. One spokesperson defined the "minimum staffing requirement" to include dental public health experts and a support staff of epidemiologists, dental hygienists, public health educators, and information resource managers. Their collective expertise is essential to conduct needs assessments, surveillance studies, maintain databases such as the National Oral Health Surveillance System, identify dental shortage areas and underserved populations, and develop, implement, and evaluate preventive programs and state oral health plans.

Many public health programs and activities rely for their performance on long-established partnerships with other public health agencies and with private sector dental practitioners. Indeed, public health dentists also frequently serve as faculty members of dental schools, teaching dental public health classes. But absent an authoritative oral health administrator within critical state health agencies—a central hub—the system falls apart and the public's health suffers.

Turning to the problems of personnel needs within the education, research, and practitioner community, there was widespread support for programs to expand recruitment, especially of racial and ethnic minority dental students, by easing dental school indebtedness through loan repayment programs, the quid pro quo variously being willingness to serve in dental shortage areas, treat underserved and Medicaid patients, or participate in federal oral health research activities. State practice act changes that would allow a more flexible and efficient workforce were recommended. Some listening session participants argued for greater autonomy in practice rules, emphasizing the educational and preventive services they could perform in non-traditional sites such as nursing homes and schools, if they were free to practice under general dentist supervision. Dental hygienists and non-dental health professionals offered alternative approaches to care delivery, providing examples of how they can contribute to meeting oral health needs at the local and state levels through screenings, patient education, and preventive care.

**Objective 5:** Expand public-private partnerships and build upon common goals to improve the oral health of those who suffer disproportionately from oral diseases.

#### ***What the Report Said***

The collective and complementary talents of public health agencies, private industry, social service organizations, educators, health care providers, researchers, the media, community leaders, voluntary health organizations and consumer groups, and concerned citizens are vital if America is not just to reduce, but to eliminate, health disparities. This report highlights variations in oral and general health within and across *all* population groups. Increased public-private partnerships are needed to educate the public, to educate health professionals, to conduct research, and to provide health care services and programs. These partnerships can build and strengthen cross-disciplinary, culturally competent, community-based, and community-wide efforts and demonstration programs to expand initiatives for health promotion and disease prevention programs.

**Source:** U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. p.286.

#### **Addressing the Issue**

The establishment of the Partnership Network in the development of the *National Call To Action To Promote Oral Health* exemplifies how well this objective has been taken to heart. The partners will play a key role in disseminating the goals and objectives of the *Call To Action* and, as discussed in the final section, can propose how best to monitor and provide oversight in the implementation of the actions proposed.

In addition, abundant evidence from the listening sessions provides further examples of the creative public-private partnerships that are already being forged at all levels of community, state, and federal government. To facilitate partnership building, several sources can be mentioned that have been helpful in enabling groups to come together to develop oral health programs. For example, the Health Resources and Services Administration (HRSA) provided support for state dental health agencies to hold state summits, where interested private and public groups can come together to assess needs and opportunities. Other states have used technical assistance provided by the National Governors Association to convene problem-solving teams to develop state oral health plans.

Several states have received grants from the Centers for Disease Control and Prevention to improve basic oral health services, including support for program leadership, monitoring oral health risk factors, and developing and evaluating prevention programs. HRSA has a new cooperative agreement program where dental faculty train general pediatric and family medicine residents to provide basic components of oral health assessments to children from birth to five years who are medically or dentally underserved and at high risk for oral health problems. The National Institutes of Health also has a grant program targeted to health professional schools for enhancing faculty research skills and enriching curricula. Foundations such as the

Robert Wood Johnson, W. K. Kellogg, and The Pew Charitable Trust are among a number of private foundations concerned with health and health care in America that have supported health services research and demonstration projects. Grantmakers In Health has provided guidance to the broad array of foundations all across the nation by highlighting private and public sector initiatives to meet oral health challenges and suggesting additional strategies involving foundation participation.

Certainly the media can be enlisted in alerting the public to oral health concerns; they have been and can continue to be a lightning rod in many areas of health, especially in terms of populations at risk. Often their accounts name individuals and organizations that are actively engaged in the health issues in question. Among them are consumer groups and health voluntary organizations, which have played significant roles in raising awareness, expanding research, and improving care and treatment. Often these organizations have started as grassroots groups formed by a few individuals and families concerned with a health problem and have grown into effective national and international organizations.

The enthusiasm and commitment demonstrated by the scores of attendees at the regional listening sessions and from the many written submissions are testimony that a critical mass of Americans view oral health as a priority and need. They demonstrated and expressed the willingness and ability to be recruited to work as partners to achieve the vision and goals of the *National Call To Action To Promote Oral Health*.

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[1] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000:2-3. (<http://www.nidcr.nih.gov/>)

[2] U.S. Department of Health and Human Services. *Healthy People 2010*. 2nd ed. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000. (<http://www.healthypeople.gov/>)

[3] Interventions to Prevent Dental Caries, Oral and Pharyngeal Cancers, and Sports-related Craniofacial Injuries: Systematic Reviews of Evidence, Recommendations from the U.S. Task Force on Community Preventive Services, and Expert Commentary. *Am J Prev Med* 2002; 1-84; 23(1S)

[4] U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services*, 2nd Edition, Williams and Wilkins, Baltimore. 1996; 953p.

[5] Brown LJ, Lazar V. Minority dentists: why do we need them? Closing the gap. Washington Office of Minority Health, U.S. Department of Health and Human Services; 1999 Jul. p.6-7.

**Johnson, Melanie [IDB]**

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**From:** Miriam Burk [burkmiriam@yahoo.com]  
**Sent:** Tuesday, January 01, 2013 6:05 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Including day care centers under public health supervision  
**Attachments:** day care centers public health agreement.docx

Melanie,

I am sending a letter as an attachment to be included in the testimony on January 8th at the IDB public hearing. Thank you.

Miriam Burk, RDH

Miriam Burk, RDH  
340 South Downey St  
Walcott, IA 52773

January 1, 2013

Melanie Johnson  
Executive Director Iowa Dental Board  
400 SW 8<sup>th</sup> St  
Des Moines, IA 50309-4687

Dear Melanie,

I understand that the IDB will be holding a public hearing on January 8<sup>th</sup>, 2013 to hear testimony about whether to add day care centers to the list of settings where a dental hygienist could provide services under Public Health Supervision. I am unable to attend this hearing on the 8<sup>th</sup> but plan to come to the IDB meeting on the 10<sup>th</sup> of January.

Public Health Supervision has been successful in building on Iowa's private practice dental profession along with public health providers to enhance access to quality oral health care. In 2011 however, 55,540 Medicaid enrolled children ages 0-2 did not see a dentist and 24,143 children ages 3-5 did not. My grandson is a Medicaid enrolled child that attends daycare while his mom (my daughter) is either at work or attending college classes. I know that there is still an access to care issue in Iowa. I have seen this personally whether it is an issue of transportation or the fact that one can not afford to miss college classes or work to take their child to the dentist. I feel it should be an easy decision for the IDB to include day care centers in the list of settings where dental hygienists can provide services under Public Health Supervision. To be honest, I am not quite sure why it hasn't been included already.

Thank you for taking the time to hear my opinion on this matter.

Sincerely,

Miriam Burk, RDH

**Johnson, Melanie [IDB]**

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**From:** Mary Jo knowles [mzzz72@hotmail.com]  
**Sent:** Thursday, January 03, 2013 9:01 AM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Public Health supervision  
**Attachments:** dental board.docx

I have attached a letter for support of the Public Health supervision to include the daycares.  
Mary Jo Zern.

I am a dental hygienist that works at Community Health Center Dental Clinic in Southeast Iowa , which is a federally qualified health center . I also work as a dietitian at WIC clinics, where other dental hygienists do oral screening.

At the dental clinic we have seen many of the children that have been referred from the WIC , Head Start , and daycare centers from the dental hygienists in the I-Smile program. Many of the children do have Medicaid, but no other dental providers will accept this coverage. At the WIC clinic I see children from infants to age five. The infants do not always get off the bottle at age one. The sippy cup is used in bed or through the day with flavored milk, juice and fruit drinks. Many children drink bottled water without fluoride that also makes them at risk. It is very crucial from age 1-3 to be seen by a dental professional. With the benefit of education and fluoride varnish done by a dental hygienist at this age, all available opportunities including daycares are beneficial. The Public Health supervision of dental hygienist has increased access to dental health care. Prevention of dental caries is important to prevent dental treatment with extensive time at a dental office or hospital setting. Education, prevention and a referral to dentist at an early age is crucial.

From personal experience, I have seen many children with numerous dental needs. Not everyone goes to Head Start and WIC clinics. There will be more children at daycare centers that could be reached for dental care access.

Mary Jo Zern , RDH. RD.

**Johnson, Melanie [IDB]**

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**From:** Mary Kay Brinkman [marykay.brinkman@q.com]  
**Sent:** Thursday, January 03, 2013 4:11 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** [L2SPAM] Public Comment on proposed rule change: Public Health Supervision of Hygienists - adding ECI and daycare

**Importance:** Low

Hi Melanie,

I would like to submit my comments concerning the proposed amendment to the public health settings for dental hygienists practicing under public health supervision. I **strongly agree** with adding day care centers as a public health setting in which dental hygienists can provide oral health services under their public health supervision agreements. The key to reducing oral disease among Iowa children is to screen for problems early and educate both parents and caregivers about the importance of good oral health. Daycare centers are an ideal place to provide these services. I would advocate to include all *licensed* day care centers. Licensed daycare providers must take continuing education and the I-Smile Coordinators in Iowa have been working with the Child Care Resource Centers to include oral health education. Screening and providing fluoride varnish would be an excellent next step.

Amend subrule 10.5(1) as follows:

10.5(1) *Public health settings defined.* For the purposes of this rule, public health settings are

limited to schools; Head Start programs; programs affiliated with the early childhood Iowa (ECI)

initiative authorized by Iowa Code chapter 256I; day care centers (excluding home-based day care

centers); federally qualified health centers; public health dental vans; free clinics; nonprofit community

health centers; nursing facilities; and federal, state, or local public health programs.

Thank you for considering this important change.

Mary Kay Brinkman RDH, BS

3400 Melanie Dr.

Urbandale, IA 50322

515-278-9073

**Johnson, Melanie [IDB]**

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**From:** David Miller [dnmiller@myomnitel.com]  
**Sent:** Friday, January 04, 2013 9:21 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** letter of testimony for Jan. 8th IDB hearing  
**Attachments:** Personal letter to IDB.docx

Hello Ms. Johnson,

Please include this letter with those submitted for the January Iowa Dental Board hearing regarding public health RDHs providing services in day care centers.

Thank you,

Nancy Miller, RDH, BS

Nancy G. Miller, RDH, BS  
1898 Zinnia Avenue  
Rockford, IA 50468  
#641-749-2604  
RDH License #895

January 3, 2013

Melanie Johnson, JD  
Executive Director, Iowa Dental Board  
400 SW 8<sup>th</sup> Street  
Des Moines, IA 50309-4687

RE: Letter supporting RDHs providing services in day care centers under PH Supervision Agreements

Dear Ms. Johnson:

I am writing this letter for the upcoming January 8<sup>th</sup> hearing. I support the inclusion of day care centers as a setting dental hygienists can provide services under the public health supervision agreements.

I am a dental hygienist who has practiced for thirty seven years, most of which has been in private practice. In 1980, I was very fortunate to have the opportunity to work for a year and a half in a public health setting in a well child clinic in Muscatine, Iowa. The children I screened either had decay or had the potential for decay. I was able to influence care-givers as well as the children. It was not unusual to see babies fed with bottles filled with Kool-aid or other sweetened beverages. It was an eye-opening experience for me to realize the lack of dental health knowledge amongst parents and care-givers.

This experience helped me understand the importance of the preventive role of dental hygienists in public health settings. Not only do hygienists provide necessary preventive services but they are the link for many children to receive needed dental care by a referring dentist. At the dental office where I am employed, we have a waiting list of Medicaid and low-income customers who will be accepted for treatment; only a limited number are allowed each month and only those already screened by the public health dental hygienist are included on this list. We still receive phone calls daily from Medicaid eligible customers desiring an appointment.

I feel that increasing the settings where dental hygienists can reach more dentally underserved populations will only help increase access to dental care for Iowa's children. Statistics showing the increased numbers of children served by hygienists and referred dentists can be seen by viewing the reports collected by public health agencies. These reports can be viewed on the Oral Health Bureau of the Iowa Department of Public Health website. On the website, there is a sentence that states the important role the dental hygienist has – "Preventive dental services are particularly important to reduce overall disease and, in turn, current and future treatment costs."

Thank you for serving on the Iowa Dental Board and for your role in protecting the citizens of Iowa.

Sincerely,

Nancy G. Miller

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**Johnson, Melanie [IDB]**

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**From:** Susan R. Hyland [klas-hyland@juno.com]  
**Sent:** Sunday, January 06, 2013 10:08 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** PH Supervision & Daycare Centers

Ms. Johnson,

I support for Public Health Supervision & Adding Daycare Centers to PH Supervision Site List.

Access to dental care is a complex problem without a simple solution. Public Health Supervision for dental hygienists is an important part of the development of a solution.

*The Delta Dental Foundation held an event on November 30, 2012: Educate, Motivate, Activate: Access to Oral Health Care for Aging Iowans. At the event, the Delta Dental of Iowa Foundation introduced their 2020 Strategic Plan. \* The presentations included Best Practices in Iowa and across the country to improve oral health access (focusing on the elderly, but showed programs and technology used to provide services in the community). Two concepts were presented by multiple speakers:*

- *It is necessary to provide services where people Live, Work and Play.*
- *The Models included Dental Hygienists working under public health supervision or other collaborative agreements allowed in their states.*

Most public health dental hygienists in Iowa are working for Title-5 public health agencies, Federally Qualified Community Health Centers and Non-profit Community Health Centers. These hygienists deliver essential Preventive Services, Education, and refer these individuals to dentists.

According to the 2011 I-Smile report nearly 110,000 Iowa children between the ages of 0-12 received a dental service from a dentist in 2011, a 54% increase over 2005 numbers.

The same report indicates that over 26,000 Iowa children, ages 0-12, received a dental service from a Title V contractor, a 231% increase since 2005.

***Adding Daycare Centers to the list of PH Supervision Sites:***

1. Many low-income families receive childcare assistance to attend daycare centers that participate in this assistance program.
2. Screenings at these centers provide an opportunity to encourage routine dental exams and identify children with suspected treatment needs while providing preventive services.
3. Many of the families qualify for Medicaid, but have trouble finding a provider for a couple of reasons: few providers accept new Medicaid patients and many providers will not see children until they are 3-5 years old.

**As a dental hygienist and an Iowa citizen, I firmly believe that access to dental care especially preventive services must be increased. Efforts to limit PH Supervision are not in the best interest of the Iowa citizens we serve.**

Susan R. Hyland, RDH, BSDH  
Iowa Dental Hygienists' Association  
Lutheran Women in Missions  
*Tap Dancing Dental Hygienist*  
[klas-hyland@juno.com](mailto:klas-hyland@juno.com)

**Johnson, Melanie [IDB]**

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**From:** tena geis [tena.geis1@gmail.com]  
**Sent:** Monday, January 07, 2013 10:58 AM  
**To:** Johnson, Melanie [IDB]  
**Subject:** [L2SPAM] public hearing testimony  
**Attachments:** Iowa Dental Board public health supervision.docx

**Importance:** --Low

Please find attached my support of the inclusion of day care centers to the Public Health Supervision Agreement, Thank you, Tena

January 7, 2013

Dear Iowa Dental Board:

I am writing in regards to the public hearing to be held tomorrow, January 8, 2013 regarding the inclusion of Day Care centers in the Iowa Dental Hygienist's Public Health Supervision Agreement.

I am in complete support of this proposal to include qualifying day care centers in this agreement. As a former Dental Hygiene Professor that taught Community Health and now in my position as Dental Program Director at a Federally Qualified Health Center, I am very familiar with the access to care issues faced by all ages in our state, especially the children.

Daily, in our clinic, we experience small children with great dental needs. We try to treat most of these children, but many times the child is too small or the decay too extreme to manage well in our clinic and they must be referred to a specialty practice. Any and all efforts to reduce this amount of decay experienced by these populations will result in great benefits to all. Education, risk identification, and facilitating finding available providers can result in earlier intervention and better outcomes.

Because many of this population deal with transportation issues, difficulties missing work and language barriers-to name just a few of the barriers, preventive services provided at the day care center will help to reduce some of the barriers these children face. Our dental hygienists are skilled and educated to professionally and competently provide these services.

I urge you to support this proposal to help improve the status of oral health in our youngest and most vulnerable population.

Tena Geis, RDH, MA

Ankeny, IA 50023

515-257-8695

**Johnson, Melanie [IDB]**

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**From:** Dawn Doore [ddoore@yahoo.com]  
**Sent:** Monday, January 07, 2013 2:01 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** dental board decision letter  
**Attachments:** board letter.docx

Melanie,

I am a public health dental hygienist in Southeast Iowa. I have attached a letter which you may present to the dental board tomorrow. Sorry it took me so long but I wanted to make sure I had my thoughts together. I hope this will help get this change to the public supervision agreement sites changed. I would love to be able to see children in all kinds of settings. Hopefully this will be a stepping stone to more access to dental care in the state of Iowa.

Thank you for bring this to the board.

Dawn T. Doore, RDH

Dawn T. Doore, RDH  
3223 Timberline Drive  
Keokuk, IA 52632  
319-795-2376

To the Iowa Dental Board Members,

I am writing this letter to encourage you to consider adding daycare centers to the public health supervision agreement sites. I have been working in the public health arena since 2005. I have seen many children who have had dental needs which parents were not aware they had. Daycare center are a great place to be able to reach many children. Most preschools in my service area have between 15 to 20 children where child care centers have 3 to 4 times that amount. Having a large amount of children in one place, I can easily send information about first dental visits, brushing and flossing, and early childhood caries. Most of the dentists in Lee and Van Buren counties will not see children until they are 3 or 4 which leaves this children unable to receive any dental services unless they want to travel over 45 minutes to get to a dentist who will see children at age 1. Being able to see these very young at their daycare center, I am able to guide these children to a dentist who will see them. Many of the children at daycare center have working parents who many not be able to get their children into the dentists or may not have dental insurance. By being able to see these children, they will get screening which children in Head Starts, WIC and preschools are receiving. Why should these children be left out because they are too young for preschools, no room at early Head Start, or not eligible for WIC. Please think of the children which we would be able to help if you add daycare center to the public health supervision agreement sites. I would hate to have a child who needs our services just because where they are during the day.

Looking at the information that I have gathered from the last 6 years, the number of children with ECC has been dropping because of the programs which the children have been able to participate in. I have always felt that if I see 50 children and only find one that needs treatment that it is all worth it. I always hate to see a child who is getting ready to go to kindergarten and they have a mouthful of decay because they had not had the opportunity to have a dental screening through a public health program. In the last 6 years, I have been able to see over 3700 children in Lee and Van Buren counties in the preschool and daycare settings. Many children had their first dental encounter at a preschool or daycare

center. They may have been scared but having their friends have their teeth looked at make them understand that it is not a bad thing. Many parents will comment that their child may not cooperate. The child wants to have their teeth looked at because it is in a non-threatening place where they feel safe. Once a child has had a good experience then going into a dental office will not be scary for them because they have done it before at daycare or preschool.

Please consider adding daycare centers to the public health supervision agreement sites so we will be able to provide dental screening to as many children in the state of Iowa as we can. Wouldn't it be great if Iowa was the leader in reducing early childhood caries by seeing as many children as we can. Please think of the children which will greatly benefit from your decision.

Thank you for your consideration.

Dawn T. Doore, RDH  
Public Health Hygienist working in Southeast Iowa

**Johnson, Melanie [IDB]**

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**From:** Suzanne Heckenlaible [SHeckenlaible@deltadentalia.com]  
**Sent:** Monday, January 07, 2013 2:14 PM  
**To:** Johnson, Melanie [IDB]  
**Cc:** Ed Schooley, D.D.S.; Beth Jones  
**Subject:** Delta Dental of Iowa - Comment on Iowa Code section 153.33, subrule 10.5(1)  
**Attachments:** IDB Rules Public Comment Letter 1-7-2013.pdf

Melanie –

Please find attached Delta Dental of Iowa comments to Iowa Code section 153.33, subrule 10.5(1). Please let me know if you have any questions, thanks.

Suzanne Heckenlaible  
Vice President, Public Affairs  
Delta Dental of Iowa  
9000 Northpark Drive  
Johnston, IA 50131  
ph. 515-261-5559  
fax: 888-558-9215  
[sheckenlaible@deltadentalia.com](mailto:sheckenlaible@deltadentalia.com)

January 7, 2013

Ms. Melanie Johnson, Executive Director  
Iowa Dental Board  
400 SW 8th Street, Suite D  
Des Moines, IA 50309-4686

Dear Ms. Johnson:

We are writing to submit comment to Iowa Code section 153.33, subrule 10.5(1)  
“Public health settings defined. For the purposes of this rule, public health settings are limited to schools; Head Start programs; programs affiliated with the early childhood Iowa (ECI) initiative authorized by Iowa Code chapter 256I; day care centers (excluding home-based day care centers); federally qualified health centers; public health dental vans; free clinics; nonprofit community health centers; nursing facilities; and federal, state, or local public health programs.”

In 2012, The Delta Dental of Iowa Foundation announced new long term, strategic direction focuses on two visionary oral health 2020 goals, which include: every Iowa child age 0-12, living in a households with incomes below 300 percent of the federal poverty level, will be cavity-free; and every Iowa nursing home resident and homebound elderly person will have access to oral health care.

Increasing access to oral health care in a variety of settings that maintain quality of care is critical to achieve the Foundation’s long term goals. Access to screenings and preventive care, such as dental sealants and fluoride varnish, are important to assure low-income children who are more at risk of tooth decay, have good oral health. By offering preventive care to children and seniors in various settings, we can broaden our reach to this underserved population with preventive services.

Delta Dental of Iowa and the Foundation are committed to supporting initiatives that support and improve the oral health of Iowans. Thank you.

Sincerely,



Suzanne Heckenlaible  
Vice President, Public Affairs  
Delta Dental of Iowa



Ed Schooley, D.D.S, M.H.A.  
Dental Director  
Delta Dental of Iowa

**Johnson, Melanie [IDB]**

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**From:** joyce602@mchsi.com  
**Sent:** Monday, January 07, 2013 3:25 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** letter to support DH in day care centers  
**Attachments:** January 7 IDB.docx

Dear Melanie,

Please find attached letter of support for dental hygienists to visit day care centers utilizing the Public Health Supervision Agreement. Thank you for your time, I am sure you have been busy and have received many letters.

Sincerely yours,

Joyce Miller, DH

January 7, 2013

Executive Director Iowa Dental Board  
400 SW 8<sup>th</sup> Street  
Des Moines, IA 50309-4687

Dear Melanie Johnson,

I am writing to support dental hygienists providing preventive dental hygiene services utilizing the Public Health Supervision Agreement at day care centers.

Adding day care centers to the Public Health Supervision Agreement has merit because not all families understand the need for dental care and are unable to pay for dental treatment. The dental hygienists' visit may be the child's or the family's first contact with dental services or dental care. As part of the public health service, the dental hygienist provides care coordination which connects the family to a dentist, aids finding payment for these services, if necessary, and assists with additional needs that enable the family to receive care.

These are financially difficult times for both families and state agencies, but dental care is important. No dentist will ever disagree with the need for preventive dental care for children. It is important to introduce dental care early and educate parents and children to prevent decay. If young children receive preventive dental care, they will have better general health and be better dental patients in the future.

Starting prevention early avoids dental pain, decreases days missed from school which increases learning and reduces overall cost of dental care. Public health services provided by the dental hygienist, under the Public Health Supervision Agreement, are the first steps for children to receive dental treatment.

Sincerely yours,

Joyce Miller, RDH

## **Johnson, Melanie [IDB]**

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**From:** ..Mike DeAnda [mdeanda@dsmhealth.com]  
**Sent:** Monday, January 07, 2013 4:29 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Support of adding Daycare Centers to the list of Public health Supervision sites

Melanie,

I am writing you in support of adding Daycare Centers to the list of Public Health Supervision sites.

I am aware of how dental hygienists working under public health supervision can improve access to care. I am in the unique position of operating one of the largest public health dental clinics in Iowa and and largest school based oral health program (Smile Squad).

An overview of our program. We provide oral health education, screenings, and referrals to elementary school age children attending 36 elementary schools and screenings in 6 middle schools. Additionally, dental sealants and dental treatment services are provided in these same sites. Several years ago in conducting screenings of elementary school age children for dental sealants, we noticed that many children were already carious and not good candidates for dental sealants. We knew to be effective, we needed to reach children at an earlier age. This was the driving force to establish our Little Healthy Smiles Project, providing oral health education , screenings, referrals for treatment and fluoride varnish applications for children attending 52 headstart and pre-school programs in Polk County. Our target centers are low income sites- HeadStart and Early Childhood IA sites. Today we provide over 3200 screenings. This provides additional opportunities to identify pre-school age children in need of dental care and referral to a dentist for care. In our community, we can guarantee access to care in our clinic as we are also one of the largest dental Medicaid providers and also have a pediatric dentist on staff.

The short of all this is that our success in operating the Smile Squad is directly linked to our ability to use dental hygienists under Public Health Supervision and use our dentists to provide dental treatment services in our clinic and in our Mobile Dental Clinic. As dental access is an issue here in Iowa, we will look to dental hygienists to be a part of our efforts to address dental access in central Iowa.

As the administrator of a public dental health clinic, I believe that access to dental care, especially preventive services, is important. Efforts to limit Public Health Supervision are not in the best interest of children in Iowa. I strongly urge you to add Daycare Centers to the list of public health supervision sites.

Mike DeAnda  
President/CEO  
Des Moines Health Center, Inc.  
1111 -9th Street, Suite 190  
Des Moines, IA 50314  
ph: 515.244.9136 x 107; fax 515.244.9153

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**Johnson, Melanie [IDB]**

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**From:** Venker, Daniel [DOC]  
**Sent:** Tuesday, January 08, 2013 7:37 AM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Letter of support for addition of daycare centers to dental PH supervision sites  
**Attachments:** Support for Public Health Supervision Daycare Centers.doc

Dear Melanie,

Can you please enter my letter into the record at today's board hearing regarding the matter of adding daycare centers to the list of public health supervision sites to the board rules? I'd appreciate it. I have students today interning at the correctional facility so I cannot attend the board meeting in person.

Thank you so much.

Dr. Daniel Venker

## **Support for Public Health Supervision & Adding Daycare Centers to PH Supervision Site List**

Access to dental care is a complex problem without a simple solution. Public Health Supervision for dental hygienists is an important part of the development of a solution.

The Delta Dental Foundation held an event on November 30, 2012: **Educate, Motivate, Activate: Access to Oral Health Care for Aging Iowans**. At the event, the Delta Dental of Iowa Foundation introduced their 2020 Strategic Plan.\* The presentations included Best Practices in Iowa and across the country to improve oral health access (focusing on the elderly, but showed programs and technology used to provide services in the community). Two concepts were presented by multiple speakers:

- It is necessary to provide services where people Live, Work and Play.
- The Models included Dental Hygienists working under public health supervision or other collaborative agreements allowed in their states.

Most public health dental hygienists in Iowa are working for Title-5 public health agencies, Federally Qualified Community Health Centers and Non-profit Community Health Centers. These hygienists deliver essential preventive services, education, and refer these individuals to dentists in the community.

Significant strides have been made in access to care for many children ages 0 to 12 since 2005. The I-Smiles program has been a major player in making this progress across the state of Iowa. Others I am sure have quoted statistics to you in their statements to you regarding this important strategy of adding day care centers to the list of public health supervision sites.

The importance of adding day care centers to the list of public health supervised sites is:

1. Many low-income families receive childcare assistance to attend daycare centers that participate in this assistance program.
2. Screenings at these centers provide an opportunity to encourage routine dental exams and identify children with suspected treatment needs while providing preventive services.
3. Many of the families qualify for Medicaid, but have trouble finding a provider for a couple of reasons: few providers accept new Medicaid patients and many providers will not see children until they are 3-5 years old.

As a licensed dentist and an Iowa citizen, I firmly believe that access to dental care, especially preventive services, must be increased.

Thank you. Daniel Venker, DDS, MS

701 Rose Avenue, Des Moines, IA. 50315.

\*See second page

\*The Delta Dental of Iowa Foundation's long-term, strategic direction focuses funding primarily to programs and investments that help support two new visionary oral health 2020 goals, which include:

1. Every Iowa child age 0-12, living in a household with an income below 300 percent of the federal poverty level, will be cavity-free.
2. Every Iowa nursing home resident and homebound elderly person will have access to oral health care.

As part of the new strategic direction, the Foundation will begin to shift funding to oral health projects supporting these new goals. To achieve the two visionary goals, the Foundation's future funding will focus on four critical areas:

- Oral health education and prevention
- Fluoridation
- Access to care for underserved children
- Access to care for the homebound elderly and nursing home residents.

**Johnson, Melanie [IDB]**

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**From:** Barbara Merrill [bmerrill@iowaaeyc.org]  
**Sent:** Tuesday, January 08, 2013 1:47 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Iowa Dental Board rules  
**Attachments:** oral health letter.doc

Ms. Johnson,  
Please find attached written comments on the proposed rules.  
Thank you,  
Barb Merrill

***Barb Merrill***

Executive Director, Iowa Association for the Education of Young Children  
Program Manager, T.E.A.C.H. Early Childhood® IOWA  
5525 Meredith Drive Suite F, Des Moines, IA 50310  
Visit our website [www.iowaaeyc.org](http://www.iowaaeyc.org)  
(515) 331-8000 ext. 11; (800) 469-2392; fax (515) 331-8995

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Benjamin E. Mays



## **Iowa Association for the Education of Young Children**

January 8, 2013

Melanie Johnson, Executive Director  
Iowa Dental Board  
400 SW 8<sup>th</sup> Street, Suite D  
Des Moines, IA 50309-4687  
[Melanie.Johnson@iowa.gov](mailto:Melanie.Johnson@iowa.gov)

Dear Ms. Johnson:

On behalf of the Iowa Association for the Education of Young Children, I am writing to express our support for a proposed amendment to the Iowa Dental Board Rules (specifically subrule 10.5(1)) which expands the public health settings to include day cares and programs affiliated with Early Childhood Iowa.

We believe that access to oral health is a necessary prerequisite to educating young children and expanding the options for where oral health services can be accessed, especially by taking those services to where children are for major parts of the day, makes good sense. The program standards we promote for entities providing early childhood education already requires a comprehensive list of health and safety standards, including attention to the oral health of children. Specifically, it requires an agreement with a health professional who will address oral health needs of children in care. By expanding access to such professionals, we believe the proposed amendment will help our efforts to promote higher quality care and education settings for Iowa's young children.

Because we know that dental disease is the most common infectious disease among young children, expanding access to address this problem is of primary importance. Currently, dental hygienists have gone into preschools and other child care settings to provide dental care to all consenting children. Public health supervision has allowed thousands of Iowans to receive preventive dental care which they may not have otherwise been able to access. Last year, 76 dental hygienists provided more than 61,000 screenings through public health supervision (in addition to other services such as fluoride and sealant applications). The volume of preventive care provided through public health supervision each year indicates its importance.

Another recommendation we would be to consider changing your verbiage from day care to child care. This is the commonly accepted language used by the profession for the service of providing care to children.

We urge the board to support this amendment in the interest of the overall health and well-being of children.

Sincerely,

Barbara Merrill  
Executive Director  
Iowa Association for the Education of Young Children



***Iowa Association for the  
Education of Young Children***

## **Johnson, Melanie [IDB]**

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**From:** Tori Squires [tsquires@iowapca.org]  
**Sent:** Tuesday, January 08, 2013 2:09 PM  
**To:** Johnson, Melanie [IDB]  
**Subject:** Input on Rule Making

Iowa Dental Board Members,

On behalf of the Iowa Primary Care Association, we thank you for the opportunity to provide input as you consider the amendment to rules which would expand the definition of public health settings to include programs affiliated with the Early Childhood Iowa initiative and day care centers.

The Early Childhood Iowa Initiative targets the needs of young low-income children and their families by developing strong community support systems. Allowing dental hygienists to access those day care centers and preschools that this initiative supports will allow those children attending these centers early access to preventive oral health care. Dental decay is the most chronic disease found in young low income children. Early access to preventive oral health services reduces a child's risk to having decay and provides an opportunity to educate parents on the importance of oral health care. In 2011, 56,458 Medicaid enrolled children did not receive any dental services. Including these day cares and preschools in the settings that dental hygienists can provide services will reduce those numbers.

The Iowa Primary Care Association's mission is to provide leadership by promoting, supporting and developing quality health care for underserved populations in Iowa. Allowing low-income children to access oral health preventive services in preschools and daycares will increase the number of children receiving preventive oral health services and increase the oral health literacy of their parents.

The Iowa Primary Care Association supports increased access to preventive services for all underserved individuals and supports the inclusion of daycare and preschool centers supported by the Early Childhood Initiative in the definition of public health settings for dental hygienists working under Public Health Supervision.

Thank you for your thoughtful consideration of this amendment.

The Iowa Primary Care Association

Tori Squires  
Senior Program Director  
Iowa Primary Care Association (Iowa PCA)  
9943 Hickman Road, Suite 103  
Urbandale, Iowa 50322  
515-333-5012 (direct line)  
515-244-9610 (main office)  
[www.iowapca.org](http://www.iowapca.org)

## Johnson, Melanie [IDB]

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**From:** Barbara Merrill [bmerrill@iowaaeyc.org]  
**Sent:** Tuesday, January 08, 2013 3:31 PM  
**To:** Johnson, Melanie [IDB]  
**Cc:** Leann Andre; Susan Gray; mairy@gwaea.org; Rendon, Tom [ED]; rdcasto@mediacombb.net  
**Subject:** Iowa Dental Board comments  
**Attachments:** Letter to Iowa Dental Board.pdf

Ms. Johnson,

Please find attached the letter of support from our organization with comments regarding the proposed legislation regarding children's oral health.

Do not hesitate to contact me if you need more information.

Thank you,  
Barbara Merrill

***Barb Merrill***

Executive Director, Iowa Association for the Education of Young Children  
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January 8, 2013

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Barbara Merrill  
Executive Director  
Iowa Association for the Education of Young Children

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