



STATE OF IOWA

IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

IOWA DENTAL HYGIENE COMMITTEE

Revised 7/26/13

* New information in green

AGENDA

August 1, 2013

9:00 a.m.

New start time

Location: Iowa Dental Board, 400 SW 8th St., Suite D, Des Moines, Iowa
Committee Members: *Mary Kelly, R.D.H., Chair; Nancy Slach, R.D.H., Vice Chair; Matthew McCullough, D.D.S.*

- I. CALL TO ORDER, ROLL CALL** *Mary Kelly*
- II. ELECTION OF OFFICERS**
 - a. Committee Chair
 - b. Committee Vice Chair
 - c. Committee Secretary
- III. APPROVAL OF OPEN SESSION MINUTES**
 - a. March 28, 2013 Telephonic Meeting
 - b. May 9, 2013 Quarterly Meeting
 - c. June 27, 2013 Telephonic Meeting
- IV. 1ST OPPORTUNITY FOR PUBLIC COMMENT** *Sara Scott*
- V. LEGAL REPORT**
- VI. OTHER BUSINESS**
 - a. Public Health Supervision Revised agenda item title 7/26/13
 - b. ~~Revised FAQs Re: Dental Hygiene for Board Website~~ Removed 7/26/13
 - c. Licensing Renewals New agenda item added 7/26/13
- VII. *APPLICATIONS FOR LICENSURE & OTHER REQUESTS**
 - a. Lindsay A. Fitzgerald, R.D.H. – Application for Dental Hygiene License
Additional material added 7/19/13
- VIII *CLOSED SESSION**

IX. RECONVENE IN OPEN SESSION

X. OPEN SESSION ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS

XI. 2ND OPPORTUNITY FOR PUBLIC COMMENT

XII. OTHER BUSINESS

XIII. 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 2013 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 2013 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.

Please Note: At the discretion of the Committee Chair, agenda items may be taken out of order to accommodate scheduling requests of members, presenters or attendees or to facilitate meeting efficiency.



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7/12/13 - Draft for DHC Review

DENTAL HYGIENE COMMITTEE - TELEPHONIC MEETING -

OPEN SESSION MINUTES

March 28, 2013
Conference Room
400 S.W. 8th 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.

March 28, 2013

Present
Present
Present

Staff Members

Melanie Johnson, Christel Braness, Brian Sedars, Phil McCollum, Janet Arjes, Dee Ann Argo

Attorney General's Office

Theresa Weeg, Assistant Attorney General

Other Attendees

Larry Carl, Iowa Dental Association
Eileen Cacioppo, R.D.H.
Briana Boswell, R.D.H.
Jackie Zwack, R.D.H.
Gayla Moore, R.D.H.
Sheila Temple, R.D.H.
Kim Howard, R.D.H.
Rachel Patterson-Rahn, R.D.H.
Denise Janssen, R.D.H.
Katie McBurney, R.D.H.
Sara Schlievert, R.D.H.
Lori Brown, R.D.H.
Tom Cope, Iowa Dental Hygienists' Association
Nancy Adriense, R.D.H.

I. CALL TO ORDER FOR MARCH 28, 2013

Ms. Kelly called the meeting of the Dental Hygiene Committee to order at 12:03 p.m. on Thursday, March 28, 2013. A quorum was established with all members present.

Roll Call:

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

II. 1st OPPORTUNITY FOR PUBLIC COMMENT

Ms. Kelly allowed the opportunity for public comment.

Ms. Kelly reported that a comment was received in writing this morning regarding the proposed changes concerning public health supervision.

Tom Cope, IDHA, commented on the proposal to change the regulation of public health supervision agreements. Mr. Cope expressed his hope that any changes would be supported by real-life data. Mr. Cope requested that a review of the regulations be completed within the constraints of the information available.

Mr. Cope stated that he hoped that any concerns with public health supervision agreements would be discussed during the public portions of the meetings. Mr. Cope hoped that changes would be supported by data, and not by anecdotes.

Ms. Lori Brown, Iowa Dental Hygienists' Association (IDHA), supported and agreed with Mr. Cope's comments. Ms. Brown expressed hope that the Dental Hygiene Committee and the Board would look at workable solutions, which would not be cumbersome, while remaining within the privacy and confidentiality laws. Ms. Brown stated the Dental Hygiene Committee and the Board is meant to serve the public.

Ms. Temple expressed her agreement with Ms. Brown's and Mr. Cope's statements. Ms. Temple feels that the public health supervision program works as currently established. Ms. Temple expressed some concern about potential downfalls or problems, which may be result due to changes to the regulations.

Ms. Patterson-Rahn, I-SMILE coordinator, shared her agreement with the previous comments. Ms. Patterson-Rahn stated that she has seen the program work in her work within public health. Ms. Patterson-Rahn is concerned about some of the proposed changes to the public health supervision regulations, and expressed her hope that Iowa can remain a leader in the access to dental public health.

Ms. McBurney agreed with the comments made previously. The public health supervision program allows practitioners to fill in some of the gaps in the treatment provided to the public at

Dental Hygiene Committee – OPEN SESSION – Subject to final DHC approval
March 28, 2013 (7/1213 draft)

large. In particular, the public health supervision program provides service to Title XIX that may otherwise have difficulty getting access to care.

Ms. Kelly stated that she was going to take some agenda items out of order to make it easier for the members of the public who were connected to the meeting by telephone. She announced that the closed portion of the Dental Hygiene Committee will be held after the open portion of the Board meeting to better facilitate participation with the public.

Ms. Kelly reviewed some of the portions of Iowa Administrative Code 650 which address the priorities and purposes of the Board and Dental Hygiene Committee. Ms. Kelly stated that the Board and Dental Hygiene Committee need to focus on the need to serve public safety.

III. FOR DISCUSSION & POSSIBLE ACTION

a. Review of Public Health Supervision

Ms. Kelly reported that at the last teleconference meeting, a motion was approved, which recommended that the Board solicit input from interested parties concerning public health supervision for discussion at future meetings

❖ MOVED by SLACH, SECONDED by KELLY, to have Board staff solicit information from interested parties for public health supervision and future oversight of the program. Motion APPROVED unanimously.

b. Registered Dental Hygienists with Prior Expanded Functions Training While Registered as a Dental Assistant

Ms. Kelly reported that there is a proposal to amend the rules to allow dental hygienists to perform the same expanded functions as dental hygienists so long as the dental hygienists performing those services completed Board-approved training pursuant to IAC 650—20.15. Ms. Kelly read the proposed language:

Add paragraph “f” to rule 650--10.3:

f. Expanded functions duties performed by dental hygienist. A dentist may delegate an expanded function duty to a licensed dental hygienist if the dental hygienist has completed board-approved training pursuant to rule 650—20.15 in the specific expanded function that will be delegated. The supervising dentist and registered dental hygienist shall be responsible for maintaining in the office of practice documentation of board-approved training. A dentist may delegate to a dental hygienist with expanded functions training the expanded function duties listed in 650—20.3(3).

Ms. Kelly stated that what this is doing is taking the current language in the dental assistant part of the rules and putting it in the dental hygienist section of the rules as well.

Ms. Slach expressed her agreement with the proposed changes, and indicated that it is a good time to pursue this change.

- ❖ MOVED by SLACH, SECONDED by KELLY, to file a Notice of Intended Action for the proposed changes as requested. Motion APPROVED unanimously.

c. Proposed Frequently Asked Questions (FAQs) Re: Dental Hygiene for the IDB Website

Ms. Kelly reported that this information very recently came to the Dental Hygiene Committee for review. Ms. Kelly expressed a preference for more time to review the proposed FAQs.

Ms. Slach feels that the proposed FAQs are a good start; however, she has some concerns about the editing and proposed responses.

Ms. Kelly agreed and recommended that this discussion be tabled to the next meeting the Dental Hygiene Committee.

- ❖ MOVED by BRADLEY, SECONDED by SLACH, to table the discussion on the proposed FAQs regarding dental hygiene to the next meeting. Motion APPROVED unanimously.

VIII. 2nd OPPORTUNITY FOR PUBLIC COMMENT

Ms. Kelly allowed a second opportunity for public comment.

Ms. Brown expressed her support for allowing more time to review for the FAQs.

Ms. Temple asked that the Board and Dental Hygiene Committee consider allowing public input in reference to the proposed FAQs. Ms. Kelly stated that public comments are always allowed.

- The Dental Hygiene Committee recessed at 12:22 p.m.
- Due to time constraints, the Dental Hygiene Committee finished the discussion of closed session agenda items during the closed meeting of the full Board.
- The Dental Hygiene Committee adjourned after the discussion of the Committee-related items concluded at 1:37 p.m.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Dental Hygiene Committee is scheduled for May 9, 2013, in Des Moines, Iowa.

These minutes are respectfully submitted by Christel Braness, Program Planner 2, Iowa Dental Board.



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7/12/13 Draft – For DHC Review

DENTAL HYGIENE COMMITTEE

OPEN SESSION MINUTES

May 9, 2013

10:00 A.M.

Conference Room

400 S.W. 8th 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.

May 9, 2013

Present
Absent
Present

Staff Members

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

Attorney General's Office

Theresa Weeg, Assistant Attorney General

I. CALL TO ORDER FOR MAY 9, 2013

Ms. Kelly called the meeting of the Dental Hygiene Committee to order at 10:04 a.m. on Thursday, May 9, 2013. A quorum was established with two members present.

Roll Call:

Member	Kelly	Slach	Bradley
Present	x		x
Absent		x	

II. APPROVAL OF OPEN SESSION MINUTES

- *January 13, 2013 – Open Session Minutes*
- ❖ MOVED by KELLY, SECONDED by BRADLEY, to approve the minutes of the January 31, 2013, Dental Hygiene Committee meeting as submitted. Motion APPROVED unanimously.

III. 1st OPPORTUNITY FOR PUBLIC COMMENT

Ms. Kelly allowed the opportunity for public comment.

Ms. Kelly asked everyone to introduce themselves.

There were no comments received.

IV. LEGAL REPORT

Ms. Weeg indicated that there was nothing to report.

V. ADMINISTRATIVE RULES UPDATE

Ms. Johnson reported that the proposed rules adopted at the March 28, 2013 telephonic meeting regarding authorizing dental hygienists to perform expanded functions were filed and are working through the rulemaking process. A public hearing has been scheduled for June 5, 2013.

VI. OTHER BUSINESS

a. Public Health Supervision

Ms. Kelly reported that the Board has posted a notice for input regarding public health supervision on its website. Comments will be collected through the end of June 2013.

b. Expanded Functions Dental Assistant & Geriatric Work Group

Ms. Kelly stated that this agenda item should reference “dental auxiliary”, not dental assistant. Ms. Kelly indicated that Dr. Kanellis will report on this agenda item at the Board meeting.

There is a proposal to allow dental hygienists to go into nursing homes and provide care. This will occur under general supervision since the dentist(s) will have gone into the facility previously, and these would, therefore, be patients of record. This will fall in line with what dental hygienists are currently allowed to do.

Mr. Cope asked that legal counsel provide input on what medicaments are allowed under the scope of practice for dental hygiene. Ms. Weeg stated that she will look into this and follow up at a later date.

c. Frequently Asked Questions (FAQs) RE: Dental Hygiene for Board Website

Ms. Kelly suggested that the Dental Hygiene Committee review each question in order, as time allowed.

Can a RDH perform dental assistant duties?

Ms. Kelly recommended that the proposed response be revised to be little clearer. There are some things in the scope of practice of dental hygienists that are allowed, that are also expanded functions for dental assistants.

Ms. Kelly would recommend putting a list together of allowed duties. This will be addressed further at the next meeting of the Dental Hygiene Committee.

What is the scope of practice of an Iowa-licensed RDH?

Ms. Kelly asked for clarification on the language of the current rule addressing this subject. The Dental Hygiene Committee, temporarily, went on to the next question while waiting for a current copy of the rules.

Ms. Kelly and Dr. Bradley indicated, after reviewing the rules as currently drafted, that they would approve the response as drafted.

What are the requirements for a RDH working under “general supervision”?

Ms. Kelly read aloud the proposed response. Ms. Kelly indicated there were a few small issues with the proposed response. For example, a dentist may have gone into a facility previously, prior to a dental hygienist going to work at a location.

Ms. Johnson asked Mr. McCollum to clarify the reason for the proposed response.

Dr. Bradley asked for clarification about how often an examination must occur prior to dental hygiene services continuing. Mr. McCollum provided clarification about the scope of practice of a dental hygienist under general supervision and what services may be performed.

Dr. Bradley asked about cases relating to new patients and if a dental hygienist can see the new patient. Mr. McCollum indicated that this rule has changed to conform to standard practice. The rule requires an exam at the initial visit, not necessarily at the start of the appointment.

Ms. Johnson asked if the proposed answer was acceptable. Ms. Kelly expressed some reluctance. Mr. McCollum proposed answering the question in two parts: patients of record and new patients. The Committee members were open to this suggestion.

Mr. McCollum also explained that the licensed dentist has some responsibility and the opportunity to establish protocols for seeing and treating patients.

The Committee members asked how the proposed answer should be revised. Ms. Weeg proposed referencing the definitions section of the IAC 650—Chapter 10 for better explanation.

Ms. Kelly asked for clarification about data collection. Mr. McCollum stated that the rules are not very specific in that regard. Mr. McCollum stated the rules reference general supervision, which requires that they be a patient of record. Patient of record is not defined in IAC 650—Chapter 1.

Ms. Weeg recommends citing the definition of general supervision, and the Board can look at proposed changes at a later date. The rules can be amended if the Board so chooses.

Ms. Kelly asked to review the updated responses prior to posting on the Board's website.

Can a RDH work under the “general supervision” of a dentist and provide services to individuals in a nursing home?

Ms. Kelly pointed out that there is a reference to patient of record. Mr. McCollum suggested that the Board propose a rule change to define patient of record to remove any potential confusion.

Ms. Kelly stated that sentences 2-3 make more sense to her. Ms. Weeg agreed and clarified the proposed statements.

Mr. McCollum stated that if the dentist has already conducted an examination at the nursing home, it could be seen as an extension of the office. Ms. Kelly indicated that there is a reference to “facility” and not “office.” Mr. McCollum indicated that it is ultimately up to the dentist to determine the comfort level of assigning services to auxiliary personnel.

What level of supervision is required for a RDH?

Ms. Kelly indicated that a practitioner should refer to the Board rules. Ms. Weeg agreed that a link to the rules could be provided or the text of the rules copied and included with the response.

Ms. Johnson stated that the idea is to make the responses concise and offer some interpretation.

Ms. Lori Brown, pointed out that dental hygienists are not subject to personal supervision. Everyone agreed to that point of clarification. Ms. Kelly and Dr. Bradley agreed to strike the reference to “personal supervision.”

Ms. Kelly proposed looking at this more closely at the next meeting to better address the response.

Ms. Brown asked what happens to comments as they are received. Ms. Kelly indicated that it may vary depending upon what the issue is and how it would best be handled. Ms. Kelly stated that she would be open to reviewing those comments as they are received.

Can dental hygienists provide services in a medical office or wellness center?

Ms. Kelly stated she was satisfied with the response for this question.

Ms. Kelly asked for clarification on procedure for approving these responses. Ms. Weeg indicated that it would be best for a vote to be taken prior to posting the FAQs.

Under a public health supervision agreement, after the initial examination by a dentist, how much time can elapse before another examination by a dentist is required before additional dental hygiene services can be provided?

Ms. Kelly stated that this has been addressed by rule on the Board level. Ms. Kelly stated that the supervising dentists can dictate some of the requirements including the length of time between services.

Dr. Bradley has some concerns about this and feels like there should be more limitation on the amount of time allowed between examinations and continued services.

Ms. Kelly would propose using option one (1) for the proposed response, and then the Board could choose to revisit this issue at a later date if they so choose.

Can a dental assistant work under a “public health supervision agreement”?

Ms. Kelly agrees with the response, particularly after reviewing the rules.

Can a RDH place dental sealants as part of a sealant program in a “public health setting” pursuant to a public health supervision agreement? Or does the placement of sealants by a RDH require the RDH to be under the “general supervision” of a dentist?

Ms. Kelly indicated that this is allowed under both levels of supervision when the requirements for general supervision or public health supervision are met.

Dr. Bradley expressed some concerns about the current provisions of public health supervision.

Can a registered dental assistant provide assistance to a registered dental hygienist working under a public health supervision agreement?

Ms. Kelly recommended more clarification in the response. Public health supervision is not the same as general supervision. Board rules currently do not have any provision under which a dental assistant can practice.

Mr. McCollum stated that dental assistants can only assist with suctioning and dental radiography under general supervision.

Ms. Kelly revisited the prior question about dental assistants and public health supervision to ensure an accurate response. Mr. McCollum suggested providing specific direction regarding supervision levels and what is allowed, or not allowed.

Ms. Kelly provided clarification on what a dental assistants can do under general supervision. There are limited services with which a dental assistant can assist a dental hygienist under general supervision. For example, a dental assistant cannot hold the light under general supervision; however, they can under direct supervision. Dr. Bradley feels like a dental assistant should be able to assist with holding the light if they are allowed to perform intraoral assistance under general supervision.

Dr. Bradley and Ms. Kelly indicated that the rule should be changed to add to the list of dental assistant duties that would be allowed under general supervision such as assisting with lights, retraction, and passing cotton rolls.

Ms. Brown asked for clarification on when a dental assistant would be allowed to assist in public health supervision. Ms. Kelly indicated that short of general supervision, dental assistants should not even be at a public health supervision site.

Ms. Kelly reported that the Board will also look at the dental assistant questions. Mr. McCollum indicated that the proposed expanded functions changes could change some of this.

VII. APPLICATIONS FOR LICENSURE & OTHER REQUESTS

Request For Continuing Education Extension

This will be discussed in closed session.

XII. 2nd OPPORTUNITY FOR PUBLIC COMMENT

- Ms. Kelly moved the agenda item for public comment up to convenience those who attended the open session portion of the meeting.

Ms. Brown indicated that some public health dental hygienists may want to comment on the public health supervision issue.

Ms. Patterson-Rahn reported that she submitted comments regarding public health supervision. Ms. Patterson-Rahn has concerns about patients in her county that cannot, or may not, be seen since many offices do not accept Medicaid, or do not accept new patients.

Ms. Patterson-Rahn indicated that public health dental hygienists work hard to ensure that patients can be seen whenever possible.

Another hygienists agreed with Ms. Patterson-Rahn. The hygienists indicated that there are struggles and barriers to getting assistance to patients who need to be seen and treated by dentists. She would ask the Committee to consider these situations when looking at proposed changes.

Mr. Cope thinks the Board is on the right road in asking interested parties for comments regarding potential changes to public health supervision. Mr. Cope would recommend that data be used as a basis to support proposed changes. Mr. Cope does not think that regulations should be made unnecessarily burdensome.

VIII. CLOSED SESSION

- ❖ MOVED by KELLY, SECONDED by BRADLEY, 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 10:56 a.m.

IX. RECONVENE IN OPEN SESSION

- The Dental Hygiene Committee reconvened in open session at 11:06 a.m.

X. ACTION ON CLOSED SESSION ITEMS

Request For Continuing Education Extension

- ❖ MOVED BRADLEY, SECONDED by KELLY to approve a continuing education exemption based on information provided with the request. Motion APPROVED.
 - The Dental Hygiene Committee recessed at 11:06 a.m.
 - The Dental Hygiene Committee intended to reconvene after the election of the dental member to the Dental Hygiene Committee during the Board meeting.
 - The Dental Hygiene Committee was not able to reconvene due to time constraints.

The meeting of the Dental Hygiene Committee ended at approximately 11:06 a.m. on May 9, 2013.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Dental Hygiene Committee is scheduled for August 1, 2013, in Des Moines, Iowa.

These minutes are respectfully submitted by Christel Braness, Program Planner 2, Iowa Dental Board.



STATE OF IOWA

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7/12/13 – Draft for DHC Review

DENTAL HYGIENE COMMITTEE - TELEPHONIC MEETING -

OPEN SESSION MINUTES

June 27, 2013
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Committee Members

Mary C. Kelly, R.D.H.
Nancy A. Slach, R.D.H.
Matthew McCullough, D.D.S.

June 27, 2013

Present
Present
Absent

Staff Members

Melanie Johnson, Christel Braness, Brian Sedars, Phil McCollum, Janet Arjes, Dee Ann Argo

Other Attendees

I. CALL TO ORDER FOR JUNE 27, 2013

Ms. Kelly called the open session meeting of the Dental Hygiene Committee to order at 12:04 p.m. on Thursday, June 27, 2013. A quorum was established with two members present.

Roll Call:

Member	Kelly	Slach	McCullough
Present	x	x	
Absent			x

II. OPPORTUNITY FOR PUBLIC COMMENT

Ms. Kelly allowed the opportunity for public comment.

No comments were received.

III. APPLICATIONS FOR LICENSURE/REGISTRATION & OTHER REQUESTS

- *Jessica Koster, D.H. – Application for Dental Hygiene License*
- This discussion was held in closed session.

IV. CLOSED SESSION

- ❖ MOVED by SLACH, SECONDED by KELLY, to go into closed session pursuant to Iowa Code Section 21.5(1)(d)(c) to discuss and review complaints and investigative reports which are required by state law to be kept confidential.

<u>Member</u>	<u>Kelly</u>	<u>Slach</u>	<u>McCullough</u>
Aye	x	x	
Nay			
Absent			x

Motion APPROVED by ROLL CALL

- The Committee went into closed session at 12:05 p.m.

V. OPEN SESSION

- The Board reconvened in open session at 12:07 p.m.

VI. ACTION, IF ANY, ON CLOSED SESSION ITEMS

Licensure/Registration Applications

- *Jessica Koster, D.H. – Application for Dental Hygiene License: Review of Stipulated License Agreement*
- ❖ MOVED by KELLY, SECONDED by SLACH, to APPROVE the Stipulated License Agreement as drafted. Motion APPROVED.

VII. 2nd OPPORTUNITY FOR PUBLIC COMMENT

Ms. Kelly allowed the opportunity for public comment. No comments were received.

VIII. OTHER BUSINESS

There weren't any items to discuss for this agenda item.

IX. ADJOURN

Ms. Kelly adjourned the meeting at 12:08 p.m. on June 27, 2013.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Dental Hygiene Committee is scheduled for August 1-2, 2013, in Des Moines, Iowa.

These minutes are respectfully submitted by Christel Braness, Program Planner 2, Iowa Dental Board.

REPORT TO THE IOWA DENTAL BOARD

INFORMATION ONLY

DATE OF MEETING: August 1, 2013
RE: **Public Health Supervision – Comments Received**
SUBMITTED BY: Melanie Johnson
ACTION REQUESTED: None, FYI Only

At the direction of the Board, a request for public input regarding oversight of public health supervision was posted on the Board's website on May 7, 2013. The deadline for written comments was June 28, 2013.

Attached for Review

- ❖ Public Comments Received
- ❖ Historical Information:
 - May 7, 2013 Request for Input
 - March 28, 2013 Report to the Board w/Proposal
 - Current PHS rule (650 IAC Rule 10.5)

Comments Received

IDB May 7, 2013

Request for Input re:
Oversight of Public
Health Supervision

Johnson, Melanie [IDB]

From: Sodawasser, Sara A [SaraA.Sodawasser@unitypoint.org]
Sent: Thursday, May 02, 2013 10:28 AM
To: Johnson, Melanie [IDB]; Iowa Dental Board [IDB]
Subject: Public Health Supervision

Iowa Dental Board,

I am writing in response to the recent proposed changes the Board has made regarding public health supervision. I am firmly opposed to most of the proposals stated on the report that I have received.

I am a public health dental hygienist at St. Luke's Dental Health Center. For years our dental hygienists have provided dental services to our community under the supervision of our dental director.

The proposal that is most concerning to me is that potentially a hygienist would need an exam by a dentist before providing billable services. This would eliminate several of our valuable programs. We currently are able to reach many low income children in WIC clinics and through our school sealant program. Having a dentist provide an exam before these billable services are provided would be impossible and unnecessary. Many children would not receive valuable preventive services if this were the case.

The proposals regarding hygienists filing reports with client/children's names is an extra unnecessary step that also raises some valid confidentiality concerns. We work very closely with our supervising dentist and have a very effective system for documenting data. These extra steps you propose seem rather ridiculous and not at all warranted. Our data reports change daily with documentation regarding contact with parents and schools, so providing reports to the State that are constantly changing would be completely senseless.

It is very surprising to me that the Board would try to limit the abilities of hygienists who are providing important and valuable services to populations that are not easy to reach. Helping people by making it easier to attain oral health services is something that I would think anyone would support, not try to restrict. We hygienists are qualified, experienced professionals who use our education, experience, and expertise to maximize our abilities to help families remove barriers to oral health care in our community, and we are proud of our solid access-to-care programs here in Linn County. These proposals would be yet one more barrier for families to successfully access care.

Please reconsider denying the proposed terms and leaving the public health agreements as is. Thank you.

Sara Sodawasser, RDH, BS
Public Health Dental Hygienist/Supervisor Dental Health Center

UnityPoint Health - St. Luke's Hospital
855 A Ave. NE MOP LL1
Cedar Rapids, IA 52402
SaraA.Sodawasser@unitypoint.org
319-369-7056 direct line
319-369-7730 clinic line
319-369-7192 fax
unitypoint.org/cedarrapids

Please note that my previous email address will no longer be effective after April 17, 2014.

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Johnson, Melanie [IDB]

From: Iowa Dental Board [IDB]
Sent: Thursday, May 02, 2013 6:53 AM
To: Johnson, Melanie [IDB]
Subject: FW: Public Health supervision

Christel Braness, Program Planner

Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309

Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

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From: Terry Kemp [<mailto:kemp4@youso.net>]
Sent: Wednesday, May 01, 2013 7:51 PM
To: Iowa Dental Board [IDB]
Subject: Public Health supervision

May 1, 2013

Dear Iowa Dental Board,

I am writing in support of Public Health Supervision. The current rules regarding this supervision benefits underserved Iowans. It allows for the low income, very young, and their families to gain basic oral health services, education, care coordination and access to dental providers.

The agreements between the supervising dentists and dental hygienists are agreed upon and are individualized. The filing of an annual report to the Iowa Department of Public Health is released to the Iowa Dental Board currently. HIPPA rules are also in place that does not allow the release of client information to anyone other than those involved in their care and have signed consent to release. A dental hygienist is a mandatory reporter in the state of Iowa and therefore must report any suspected case of denial of critical care or child abuse. The storage of records is monitored and reviewed by IDPH and each agency involved. These records are secure and rules are strictly enforced.

Any unnecessary and redundant requirements for public health supervision would increase costs for the agencies involved and would deny those at most risk preventive oral health services. I respectfully petition for no changes in this supervision because it is effective and improves the oral health status of many.

Respectfully submitted,

Patricia Kemp, RDH

1865 Carter Road
Dubuque, IA 52001

Johnson, Melanie [IDB]

From: Susan R. Hyland [klas-hyland@juno.com]
Sent: Thursday, May 09, 2013 8:02 AM
To: Johnson, Melanie [IDB]
Subject: Proposed Changes to PH Supervision Comments

Melanie,

I have not seen anything on the website, but heard about this so I am sending comments. I hope that I am correct in thinking I should do so.

I am speaking against the proposed changes to Public Health Supervision for dental hygienists.

1. These proposals will make public health supervision too cumbersome and time consuming to be effective.
2. The supervising dentist is not the dentist of record for these clients/patients so there would be confidentiality issues.
3. There have not been complaints, these changes are unnecessary.
4. To meet the needs of the citizens of Iowa, we need more than one delivery system for dental care. No system will be perfect for everyone. Public Health Supervision is an avenue for many Iowans to receive preventive services and be referred for comprehensive dental care. It allows the opportunity to educate Iowans and encourage them to access treatment services. Many of them are accessing services with our help, if they can find a dentist that will accept them as a patient. All are referred for routine dental care.
5. In private and public systems, we can't make people get their treatment unless it is a case of neglect. Dental hygienists are mandatory reporters and are already addressing this issue.
6. Limiting the number of public health agreements could hamper efforts to develop new systems for bringing dental care to low income families, i.e. outreach into surrounding counties by Federally-Qualified Community Health Centers that have Dental Clinics. This is my hope/dream for another, more comprehensive system that will meet the needs of Iowans that find it difficult to access dental care..

Dental hygienists are:

- -educated in accredited dental hygiene programs.
- -required to pass National Written Boards.
- -required to pass Clinical Boards.
- -required to obtain and maintain their license.

We want to be a part of the dental team and can be a valuable part of the team, but we need more than one team/system for providing dental care. Private dental practices do not and cannot meet the needs of all Iowans. Thank you for considering my comments.

Susan R. Hyland, RDH, BSDH
1010 Scenic View Blvd.
Altoona, IA 50009
klas-hyland@juno.com

Johnson, Melanie [IDB]

From: AmyHunziker [AHunziker@newopp.org]
Sent: Wednesday, May 29, 2013 2:02 PM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision Comments

Thank you for taking the time to read my comment and take it into consideration.

In my opinion why ruin/change a GREAT thing for Iowa, especially small town Iowa. I am a General Supervision Dental Hygienist and I cannot tell you the parent's, expectant Mothers, and children who thank me for the job that I do. I LOVE what I do, and especially love that people (especially children) look forward to seeing me and learning about good oral hygiene and overall healthy habits.

What do I do? I go into preschools and educate them on going to the Dentist, I teach them about brushing, flossing, and the importance of fluoride. I do everything in my power to follow up with anyone that has suspicious areas, hasn't been to the Dentist, or is having trouble finding a Dentist. Unless they have a disconnected phone number or moved to another location without notifying me, I do my best to reach them all. By the end of the year the kids look forward to opening their mouths and counting teeth and telling me about all the tooth stories that have gone on since I was there last. They are like sponges and remember so much of the education that I provided them. I also feel that this helps with their routine dental visits in which I encourage every 6 months and get them excited to go. Is there anything better than children learning?

I work in WIC clinics. Here I see expectant Mothers and their children. I teach them the importance of good oral hygiene during pregnancy and after. I teach them how to take care of their children's teeth and what to look out for. We discuss passing of bacteria, baby bottle decay, eruption, and so many other topics. I encourage the Moms to get into the dentist as soon as possible. I help them schedule an appointment if they have trouble with that. You would be surprised the number of people that need assistance in doing such a simple task. We give out oral hygiene supplies- toothbrushes, toothpaste, floss, and educational brochures. You would be surprised at the number of kids that don't even have a toothbrush! I get thanked over and over on a daily basis for the work I do at WIC clinics. Let me tell you- everyday is a good day when you are helping people and making a difference.

The next thing I do is school audits. Where I just go into the schools and report the Dental numbers back to the State.

I also go into schools by request and give presentations on good oral hygiene habits and demonstrations.

I am not doing anything invasive. I feel that we are partners with the Dentist. While the Dentist is completeing the dental work, we are out in our communities doing everything in our power to get people into the Dentist and educating the Dentist. If I have a question I don't hesitate to ask my Supervising Dentist. If we continue what we are doing, this could be a very good thing- public more educated, kids excited, and just that linkage that we provide between the community and the Dentist is such a GREAT thing. Don't let a good tihng get away.

I really do not think that anything at this point needs changed. I feel it's working very well for the State and I hope that you can see the value as well. I know the people I serve are so very grateful for each and everything we provide. Let's keep the teamwork and stay strong as we make better futures for all people involved.

Amy

Johnson, Melanie [IDB]

From: bkelly@mediacombb.net
Sent: Friday, June 07, 2013 3:46 PM
To: Johnson, Melanie [IDB]
Subject: Letter of support
Attachments: scan.pdf

Please read and share the attached letter in support of keeping current rules for public health supervision for dental hygienists.

Respectfully,

Kelly Bailey, DM, CDE
Clarke County Public Health
131 W. Jefferson
Oncle, VA 22959
615-347-3444
Fax 615-347-3605



FREE Animations for your email [Click Here!](#)



Public Health
Prevent. Promote. Protect.

Clarke County Public Health

134 West Jefferson
Osceola, IA 50213
Phone: 641-342-3724
Fax: 641-342-2603
Email: clarkeph@iowatelecom.net

June 7, 2013

Members of the Iowa Dental Board,

I am a public health care nurse in Clarke County, Iowa. I am writing this letter in support of the current public health supervision rules for dental hygienists. As a public health nurse in a rural county, I have seen firsthand the benefit of public health supervision dental hygienists and the I-Smile™ program in our rural community. Many families are on Medicaid and there is currently not one dentist that takes Medicaid clients on a regular basis. There are also no pediatric dentists in our county and traveling to Des Moines is not an option for many families. I see many benefits in the current programming.

For many of the children seen by the hygienist, is it their first experience with dental care. The experience of having a screening and fluoride done by someone in a setting such as WIC is always a positive and non-threatening start to dental care. The education and tools that are provided help to develop a lifetime of healthy habits.

The fluoride varnish and sealant programs provided by a dental hygienist with a public health supervision agreement in our communities provide direct services children may otherwise not receive. I know a number of children were found to be in need of dental care and the hygienist was able to help coordinate visits to dentist for these children to have care. Without services like these, many children would still be suffering from dental decay.

One of our local dentists has become a big proponent of the program and has agreed to take on some clients after referral from hygienist following a screening.

Please consider the implications of your decision to make changes. Your decision could create barriers to the program, which would have a huge negative impact on the dental health of numerous rural children in Iowa.

Thank You,

Kelly Bailey, RN

Johnson, Melanie [IDB]

From: Emily Boge [ereinert@hotmail.com]
Sent: Sunday, June 09, 2013 9:17 PM
To: Johnson, Melanie [IDB]
Subject: Iowa Dental Board - Opinion - Emily Boge

Hello Ms. Johnson,

I am writing to comment on a couple of topics coming before the Iowa Dental Board. The first of which is the topic of eliminating public health supervision. These hygienists are a much needed asset in both the education and treatment modalities of disease prevention for the Iowa population. Please do not eliminate this opportunity for Iowans to serve Iowans. Although I am a private practice hygienist in Manchester, I have seen and heard the many great things these dental hygienists do for our citizenship.

Secondly, I am writing to comment on dental hygienists being denied the ability to perform expanded functions as a dental assistant if they had been a registered dental assistant prior to obtaining their dental hygiene license. Speaking with both students and licensed hygienists that find benefit in this possibility, I do not understand why this is not allowed. In my opinion, it is similar to telling someone with a motorcycle license that they can no longer ride a bicycle. Many hygienists have the ability to complete these tasks, and would be happy to pitch in by helping with EFDA tasks during dental hygiene downtime (failed or cancelled appointment times).

I kindly thank you for your time, and your service as a public administrator in Iowa.

Emily

—*Emily Boge, RDH, BS, MPA(c)*

13151 Kramer Road

Farley, IA 52046

319.231.1193

ereinert@hotmail.com

toothfairymelanie@hotmail.com

Johnson, Melanie [IDB]

From: Jodene DeVault [JodeneD@co.warren.ia.us]
Sent: Tuesday, June 18, 2013 8:49 AM
To: Johnson, Melanie [IDB]
Subject: Dental Board Input
Attachments: BOH letter to Dental Board 061413.pdf

Melanie,

I have attached a letter signed by the Warren County Board of Health chair regarding the Board of Health's stance on the Public health supervision requirements being addressed by the Iowa Dental Board. Thank you for passing this information along to the Dental Board.

Jodene

Jodene DeVault RN BSN

Administrator

Warren County Health Services

301 N. Buxton, Suite 203

Indianola, IA 50125

P: 515.961.1074 F: 515.961.1083

jodened@co.warren.ia.us

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June 14, 2013

Iowa Dental Board Members,

On behalf of the Warren County Board of Health, I thank you for the opportunity to provide input on the oversight of public health supervision (PHS) activities.

In spite of modern innovations such as water fluoridation, tooth decay continues to be the single most common childhood disease nationwide and continues to be five times as common as asthma and seven times more common than hay fever. Children of lower socioeconomic status are more than twice as likely to have cavities as their more affluent peers. Children are missing more than 51 million hours of school each year due to dental-related illness. These are the same children that may one day be the leaders of our country.

Although the federal government requires each state to provide oral health services to children through Medicaid programs, the shortage of dentists who will treat Medicaid recipients remains a major barrier to care. Through the help of dental hygienists with public health supervision agreements, fewer children and their families suffer from dental decay and its impact on the basic functions of eating, speaking and learning.

Public health supervision has been a tremendous resource in our community. In 2012, 1,283 Medicaid-enrolled children in Warren County, ages zero through fourteen, received a dental or oral health service. In 2006, when the I-Smile™ program was just getting started, only 769 children in the same age groups received a dental or oral health service. This data alone shows the great improvements public health supervision has made in the future of our youngest residents. Statewide, more than 135,000 children received a dental or oral health service in 2012 – a 13 percent increase from 2011 and 1.6 times as many children than those seen in 2006!

The statistics show that public health supervision is working well. In fact, public health supervision has been working well for the citizens of Iowa for a decade now. The number of dental hygienists with public health supervision agreements has grown from 24 agreements in 2004 to 96 in 2012. In the 8 year history of the agreements, there has never once been a complaint about a dental hygienist working under a public health supervision agreement, a service provided or the I-Smile™ program itself. This shows that current oversight of the agreements is clearly sufficient.

The rule changes that you are proposing would significantly alter the public health category of supervision. This is rather concerning to dental hygienists that work under public health supervision agreements, to the programs that rely on these collaborative agreements and to us, who rely on such programs to serve the citizens of our communities.

We believe the I-Smile™ program and dental hygiene public health supervision is working so well that considerations should be made to possibly expand the program. With current agreement oversight from supervising dentists and the Iowa Department of Public Health, these dental hygienists could do so much more for the children at highest risk within our communities! Changing something that is working so well does not make sense!

We understand the importance of quality healthcare and feel that dental hygienists with public health supervision agreements are able to provide that. Please thoughtfully consider this very important matter!

Sincerely,


Dr. Dennis Zachary, Chair
Warren County Board of Health

Johnson, Melanie [IDB]

From: Marla Janning [MJanning@newopp.org]
Sent: Tuesday, June 18, 2013 3:42 PM
To: Johnson, Melanie [IDB]
Subject: In support of Public Health Dental Hygienists

Dear Melanie:

I work in a Community Action Agency that has a large Public Health component. We do I-Smile, Maternal Health, Child Health, Family Planning, WIC, Childhood Lead Poisoning Prevention, hawk-I Outreach, and all of the various components that are a part of these fine programs. I cannot imagine not having the dental component if we did not have Dental Hygienists. They are an integral part of our comprehensive Public Health programming.

Specifically, the following is a list of services that they are providing, all of which are valuable services to our communities, and in support of helping families establish Dental Homes:

They visit Head Start Classrooms, some are only Head Start children, some are a mix of Head Start and non-head start children in the school systems. They provide 3 sessions of fluoride varnish, dental screenings and referral to dentists in support of establishing Dental Homes.

They visit the WIC clinics, giving oral hygiene instruction to the children and moms, providing fluoride varnish and distributing oral hygiene supplies. They help the family make dental appointments and provide transportation to appointments as needed. They look for alternative sources of payment for dental services for families with that need.

When schools request it, they give dental presentations and delivery oral hygiene supplies and instruction to students.

They participate in community activities that promote organ hygiene awareness and provide oral hygiene information and supplies.

They provide school audits, going to every school in the area to collect school screening forms for every 9th grader and Kindergartener in the state. They refer students and their families to dentists, again, in support of establishing a Dental Home. They collect data that is used by the State of Iowa to evaluate Dental needs.

Thank you for the opportunity to comment.



Marla Janning, CCAP
New Opportunities, Inc.
23751 Hwy 30
PO Box 427
Carroll, IA 51401

Voice: 712-792-9266 X804
Fax: 712-792-5723 or 712-792-1457

* Email to: mjanning@newopp.org

Website: www.newopp.org

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Johnson, Melanie [IDB]

From: Cora Mondloch [cwillhoft@yahoo.com]
Sent: Wednesday, June 19, 2013 6:41 AM
To: Johnson, Melanie [IDB]; Steve Burds
Subject: Public health supervision

Dear Melanie, of Iowa Dental Board, and Dr. Burds,

I just wanted to send a quick email to the IDB, and my public health supervising dentist, Dr. Steve Burds, D.D.S. Thanks for your support of public health supervision in Iowa!

Ever since I spent a semester working with the Geriatric Mobile Unit , at U. of Iowa, (many years ago), I have wanted to visit nursing homes and provide preventive oral care on site.

Now , all these years later, my dream has come true!

Dr. Burds and I have planned for well over a year, to establish a program at Wesley Acres, on Grand Avenue, in Des Moines, Iowa.

The dentist provides the oral evaluation. Then I go and provide the cleanings, on site. Wesley Acres even has an exam room, that we use. This Friday, another hygienist is joining me. Also, I just talked to a hygienist yesterday, who really wants to clean residents teeth on site, at the nursing home. As you can see, this idea/project is exciting , and is catching on! What a great service to residents of nursing homes, who have great difficulty traveling to a private dental practice.

I found a specialized pillow, that attaches to the back of any wheelchair. It was designed by a dentist. It helps a lot!!!

It is a really fun, and rewarding service. The residents really like getting their teeth cleaned , and it feels good to make a difference in their quality of life. I want to say thanks again for supporting public health supervision in Iowa! It is a really good idea.

Please feel free to come and observe our nursing home project anytime! I will be at Wesley Acres this Friday, the 21st, from 9:30 to approx. noon, if you want to come see our equipment, and our routine. Each resident is first screened by Dr. Burds, before any work is done.

Please feel free to call Craig Thomes, nursing home administrator at Wesley Acres, if you have any questions, or Amber Umbreit, Director of Nursing.

It is a fun project, thanks for leaving public health supervision the way it has been written. Also, many thanks to Dr. Burds for all his time and help spent on this project. I feel confident that Dr. Burds would be happy to talk to the IDB also, if you have further questions.

Sincerely, Cora Mondloch, RDH. cora@mondloch.com (515)981-0091 8590 Arthur Trail,
Cumming, Iowa 50061

Johnson, Melanie [IDB]

From: Anita Siddall [anita3marie@gmail.com]
Sent: Wednesday, June 19, 2013 9:19 AM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision

Public Health Supervision

should remain as it is written. I have been a practicing Dental hygienist for 28 years and I have witnessed first hand too many examples of dependent adult abuse in the form of oral neglect in hospitals and care centers due to lack of oral care. It is my opinion that moderate to severe oral disease is the "norm" in Care Centers and Hospitals due to lack of medical caregiver's knowledge of oral care in medically compromised patients and these patient's unique oral complications. Medical workers also are not proficient in recognition of oral pathology and they are burdened with often difficult oral access & poor intra-oral working environment. It is my opinion that not only should there NOT be any additional restrictions on hygienists work but they should be encouraged to work in long term healthcare facilities.

It is my opinion that the population with the most critical oral needs are not receiving adequate care and if legislators place more restrictions on the oral professionals that are best trained in disease prevention, the hygienists, this population will be very negatively affected.

Anita Siddall RDH

319-310-6335

cprandtheworks@gmail.com

Johnson, Melanie [IDB]

From: Becky Lang [beckylang@mchsi.com]
Sent: Wednesday, June 19, 2013 10:45 AM
To: Johnson, Melanie [IDB]
Subject: Support for Public Health Dental Hygienists

To the State of Iowa Citizens;

As a current Registered Dental Hygienist, past Public Health Hygienist and now University Professor in Health Promotion I support, 110%, public health supervision as it now stands. As a nation, state and community, with the current state of our health status, we want to encourage and enhance prevention services not diminish. Changing the status of dental hygiene supervision would do just that, diminish services to those who so desperately need the care.

What complaints have been filed? I understand there have been no complaints. We, in the state of Iowa, need Dental Hygienist to be working in public health settings as they have in the past, There is no need to change the supervision wording at this time.

Please vote to support public health supervision as it now stands, there is no need for a change.

Thank you-

Becky

Dr. Rebecca Lang, EdD, RDH, MCHES
Motivational Interviewing Network of Trainers (MINT member) Professor, Health and Physical Education
Grand View University Des Moines, IA beckylang@icloud.com
515-778-4764

Johnson, Melanie [IDB]

From: Nancy Adrianse [adriansen@iowapca.org]
Sent: Wednesday, June 19, 2013 4:35 PM
To: Johnson, Melanie [IDB]
Cc: 'Mary Kelly'; 'Slach, Nancy A'
Subject: Public health Supervision

Ms. Johnson and the Iowa Dental Board,

I am sending requested input on Public Health Supervision of Dental Hygienists. This type of supervision has greatly increased the ability of Iowans to receive much needed oral health preventive services. I see no reason to make changes to the rule by adding additional oversight for the contracting dentist, changing the existing agreements that the dentist and dental hygienist enter into or the reporting requirements. Each dentist and dental hygienist that enters into these contracts can make those changes within their contract if so desired. I believe that the board has never had to investigate any of the existing contracts so I wonder why the board sees the need to change the existing contracts. Please continue to allow dentists and dental hygienists the option to set up contracts that work best for them and the communities they serve.

Thank you,

Nancy Adrianse, BSDH
3210 SW 33rd Street
Des Moines, Iowa 50321
515-490-7412
nadrianse@gmail.com

Johnson, Melanie [IDB]

From: Knudsen, Kathleen [kknudsen@cbcsd.org]
Sent: Wednesday, June 19, 2013 4:52 PM
To: Johnson, Melanie [IDB]
Subject: Public Health Oversight

Ms. Johnson,

Please consider this email support of the present supervisory rules and regulations regarding Dental Health, and with special regard to the I-Smile Program and other dental screening programs.

With our in-school clinic this spring, we had over 100 students experience their initial screening, cleaning and other work, in addition to a direct connection with a dentist for follow up. I believe Ms. Linda Meyers ensured that every student in our clinic had an appointment for follow up.

The only thing I know for certain about more government intervention/oversight/rule-making is that it means less people will be taken care of due to qualifications & rules, or it will become so cumbersome that they will give up and then, again, less people will be taken care of. 82% of our students come from poverty and the manner in which the aforementioned programs/clinics/grants have helped is *working*. Please do not change the rules just for the sake of changing them, or so that someone is able to garner some sort of power they currently do not have. It is my understanding that there have been no complaints about the programs as they currently exist.

We had hygienists via I-Smile the past two years, and this year in our in-school clinic who were WONDERFUL with our students, and, again, who provided much needed care under good supervision from their dentist or their teachers and directors. I think the question ought to be: *Are there children and families who have been screened who would not ever have been screened without these programs?*; instead of *Who gets to be the boss of the program?*

While an healthy review of practices is a necessary and prudent piece, it would seem to me that, once the review indicates there have been no complaints and much success, that one might want to keep what is working.

Thank you for your time, and please share this at the testimony on June 28th.

Sincerely,

Kathleen E. Knudsen

--

Kathleen E. Knudsen
School Administrative Manager
Carter Lake Elementary School
(712) 347-5876

*We may not reach the ending, but we can start
Slowly but truly mending, brick by brick, heart by heart
Now, even now, we'll start learning how
We can Build a Beautiful City*
~ Steven Schwartz

Johnson, Melanie [IDB]

From: Catherine Venzke [cathyvenzke@gmail.com]
Sent: Wednesday, June 19, 2013 7:58 PM
To: Johnson, Melanie [IDB]
Subject: KEEP PUBLIC HEALTH SUPERVISION FOR DENTAL HYGIENISTS!

Greetings,

My name is Cathy Venzke, I am a registered dental hygienist currently working in private practice. However, I was previously a dental assistant working with the Smile Squad and School Smiles programs in Des Moines.

In my work with these programs I have seen first hand how many children fall through the cracks of the system. PATIENTS ENROLLED IN MEDICAID ARE GENERALLY EMPLOYED IN JOBS THAT ARE NOT PAYING THE BILLS AND DO NOT OFFER PAID TIME OFF. MISSING TIME AT WORK MEANS LOSS OF INCOME AND POSSIBLY THE LOSS OF THEIR JOB ALTOGETHER. THAT IS WHY WE HAVE TO MAKE CARE MORE EASILY ACCESSIBLE TO THIS POPULATION THROUGH PUBLIC HEALTH SUPERVISION. Dental hygienists are necessary to provide treatment in settings such as schools so that children whose parents have limited income and time off of work can receive treatment which they would likely not receive otherwise.

In private practice I have listened to many heartbreaking phone calls of Medicaid patients calling to ask if they or their children can be seen in our office and our office manager has to turn them away because we do not see Medicaid patients in the office due to the low reimbursement rates and the tendency of patients to fail appointments due to the reasons previously mentioned.

Dental Hygienists are very well qualified to provide the treatments necessary to screen for disease and provide preventive services such as sealants, fluoride treatments, and prophylaxis.

Patients in need of more extensive treatment are referred to local dental providers which can address further needs. All patients are always encouraged to see a dentist and find a dental home where they can get comprehensive care. MOST DO NOT due to the reasons previously mentioned.

Prophylaxis in elderly populations can greatly reduce the likelihood of patients developing aspiration pneumonia which is a huge concern in nursing homes. Fluoride varnish can reduce risk of root caries in aging populations who are in failing health and would be difficult to treat for restorative needs in a clinical setting.

Children and elderly adults are in need of care that dentists in the area simply can not or refuse to provide.

Services provided are agreed upon explicitly in each public health supervision contract between each dentist and hygienist. There have been no complaints thus far regarding treatment received in these settings.

As a dental hygienist I know that the services being provided are all services we are well trained for. We are taught how to recognize treatment needs including screening for decay, determining prophylaxis needs, determining need for fluoride needs, and placing sealants. There is no reason not to continue and even expand the scope of services provided under public health supervision!

Discontinuing this option will leave many disadvantaged children and adults with no options to receive care that they desperately need.

Respectfully,

Johnson, Melanie [IDB]

From: Steve Burds [steveburds@gmail.com]
Sent: Wednesday, June 19, 2013 11:50 PM
To: Cora Mondloch
Cc: Johnson, Melanie [IDB]
Subject: Re: Public health supervision

Cora,

I am glad to help out. I am also talking to Wesley Acres about providing an in-service education for their CNAs on how to do oral care for their residents. It will be interesting to see the outcomes of increased oral care assistance done on a daily basis. I hope that we can apply this new preventive model of nursing home oral care to other facilities in our community.

Dr. Burds

On Wed, Jun 19, 2013 at 6:41 AM, Cora Mondloch <cwillhoft@yahoo.com> wrote:
Dear Melanie, of Iowa Dental Board, and Dr. Burds,

I just wanted to send a quick email to the IDB, and my public health supervising dentist, Dr. Steve Burds, D.D.S. Thanks for your support of public health supervision in Iowa!

Ever since I spent a semester working with the Geriatric Mobile Unit , at U. of Iowa, (many years ago), I have wanted to visit nursing homes and provide preventive oral care on site.

Now , all these years later, my dream has come true!

Dr. Burds and I have planned for well over a year, to establish a program at Wesley Acres, on Grand Avenue, in Des Moines, Iowa.

The dentist provides the oral evaluation. Then I go and provide the cleanings, on site. Wesley Acres even has an exam room, that we use. This Friday, another hygienist is joining me. Also, I just talked to a hygienist yesterday, who really wants to clean residents teeth on site, at the nursing home. As you can see, this idea/project is exciting , and is catching on! What a great service to residents of nursing homes, who have great difficulty traveling to a private dental practice.

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It is a really fun, and rewarding service. The residents really like getting their teeth cleaned , and it feels good to make a difference in their quality of life. I want to say thanks again for supporting public health supervision in Iowa! It is a really good idea.

Please feel free to come and observe our nursing home project anytime! I will be at Wesley Acres this Friday, the 21st, from 9:30 to approx. noon, if you want to come see our equipment, and our routine. Each resident is first screened by Dr. Burds, before any work is done.

Please feel free to call Craig Thomes, nursing home administrator at Wesley Acres, if you have any questions, or Amber Umbreit, Director of Nursing.

It is a fun project, thanks for leaving public health supervision the way it has been written. Also, many thanks to Dr. Burds for all his time and help spent on this project. I feel confident that Dr. Burds would be happy to talk to the IDB also, if you have further questions.

Sincerely, Cora Mondloch, RDH. cora@mondloch.com [\(515\)981-0091](tel:(515)981-0091) 8590 Arthur Trail, Cumming, Iowa 50061

--

Steve Burds
(515) 971-9826

Johnson, Melanie [IDB]

From: sarah.marie.rdh@gmail.com
Sent: Saturday, June 22, 2013 12:12 PM
To: Johnson, Melanie [IDB]
Subject: Public health dental hygiene supervision

Hello Melanie,

I am writing you in regards to the upcoming discussion on public health supervision for dental hygienists.

I am currently working as a clinical hygienist in a busy three soon to be four doctor office with about 11 other hygienists. Although I work in a traditional office, my true passion is for public health. I am just at the 3 year mark where I am now able to get my public health supervision agreement to be able to treat patients in need that would otherwise go untreated. I believe there is no need to change the current laws as there has been no complaints from patients being treated or any others. There are so many programs in Iowa that would go away if public health supervision was taken away such as the I-Smile program which helps children in all Iowa counties with screenings, fluoride treatments, sealants and helping families to find a dental home that will take them. Also, the Smile Squad, part of the Des Moines Health Center is a excellent example of what public health hygienists do. Here is a list of achievements in 2010.

- 5468 screenings
- 3,066 teeth sealed
- 3,123 fluoride varnish applications
- 897 children received dental services in the Mobile Dental Clinic

Please take into consideration these facts when making the decision on the current public health supervision laws. Thank you for your time.

Sincerely,

Sarah Petersen RDH

Johnson, Melanie [IDB]

From: Carol Van Aernam [cvanaernam@aol.com]
Sent: Sunday, June 23, 2013 8:34 PM
To: Johnson, Melanie [IDB]
Subject: RE: Oversight of Public Health Supervision
Attachments: Dear Dental Board Members.docx

Ms. Johnson,
I have attached my letter in support of Public Health Supervision.
Thank you.

Carol Van Aernam
cvanaernam@aol.com

June 23, 2013

Melanie Johnson, Executive Director

Iowa Dental Board

400 S.W. 8th Street, Suite D

Des Moines, IA 50309-4687

Re: Request for Input RE: Oversight of Public Health Supervision

Dear Ms. Johnson and Members of the Iowa Dental Board,

Please do NOT add additional oversight, rules and reports to the Public Health Supervision Agreement.

You are charged with protecting the health of the citizens of Iowa. If you add additional reports and requirements you will be endangering the well-being of many Iowans.

We only had 59 dentists and 76 hygienists in 2012 with active PHS Agreements. Since Dr. Fuller's proposal has been presented, some dentists have terminated their agreements. Fewer agreements mean less dental care for many underserved Iowans. Delmonte Driver died in 2007 due to lack of dental treatment, his mother did not know he needed treatment. In Iowa, in 2012, we had over 6000 Urgent Care Referrals to dentists and over 65,000 residents received open mouth screenings. There has never been a complaint raised against a dentist/hygienist/agreement. This is an extremely effective and successful program. Did we save someone from Delmonte's fate?

We have a great need to get hygienists into nursing homes. You need to be proactive and make it possible for additional oral care, screenings and dental treatment to be made available for our elderly. Hygienists should be able to place temporary restorations under PHS, this would help reduce pain and infection for many Iowans.

Aspiration Pneumonia has been reduced by 50% in nursing homes with good daily oral care.

If you have Periodontal Disease you could be at a greater risk for Heart Attacks, Strokes and Uncontrolled Diabetes.

Please do not make it impossible for many Iowans to receive oral health services through PHS by adding more rules, conditions and reports, which will reduce or eliminate most of the PHS Agreements. These agreements are entered into by a Licensed Dentist and Licensed Hygienist, the Licensed Dentist has total control over the agreement, he can ask for more oversight or reports if he feels it is necessary. We trust the dentist to decide if a patient needs an extraction or fillings or etc., but we do not trust his good professional judgment to decide what can or should not be done under PHS?

Please protect the health of Iowans by allowing greater access to care.

Thank you,

Carol Van Aernam RDH, BA

411 Madison Place

Indianola, Iowa 50125

Johnson, Melanie [IDB]

From: Hillis, Jan [jhillis@iwcc.edu]
Sent: Monday, June 24, 2013 11:30 AM
To: Johnson, Melanie [IDB]
Subject: DH Public Health Permit

I am writing to you in support of the Iowa Dental Hygiene Public Health Permit. I have been working under the permit for the last year under the supervision of a local dentist. The dentist and I met on two occasions to write the parameters of the permit and make sure that each of us understood the agreement. At the end of the year, I reported my statistics to the dentist. I was able to help many homeless people here in western Iowa that cannot afford dental care. The Public Health Permit system is currently working well, serving the underserved, and needs to continue. Thank you.

*Jan Hillis, RDH, MA
Professor and Program Chair, Dental Hygiene
Iowa Western Community College
(712) 325-3738
1-800-432-5852 x 3738*

Johnson, Melanie [IDB]

From: Pat Alden [p.alden@mchsi.com]
Sent: Monday, June 24, 2013 5:17 PM
To: Johnson, Melanie [IDB]
Subject: Public health supervision

To the Iowa Dental Board:

I am contacting the Iowa Dental Board concerning the proposed changes to the current Public Health Supervision Agreement.

I have been a licensed, registered dental hygienist in Iowa for over 33 years. Over these years, I have witnessed the detrimental dental health problems affecting Iowa's underserved. Hygienists have been dedicated to serving and improving quality of life for those who can't always speak for themselves. Numerous programs, such as the ISmiles, school sealant and nursing home programs have been successfully implemented for over 10 years under the current Public Health Supervision agreement. I feel that adding oversights and regulations to this agreement will only reduce and possibly limit future agreements and greatly decrease access to care for these underserved individuals.

I support the current agreement and urge the Board to do the same.

Thank you for your consideration.

Pat Alden, RDH, BS

Johnson, Melanie [IDB]

From: Brenda Platz [bplatz25@gmail.com]
Sent: Tuesday, June 25, 2013 6:44 AM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision Proposed Changes

Iowa Dental Board,

I am writing in opposition of the proposed Public Health Supervision changes.

Current reporting requirements are more than sufficient in providing the summary of services provided under Public Health Supervision Agreements. The proposed changes create unnecessary reporting that would reduce valuable direct patient care time. The current contract review requirements are also sufficient.

I understand one of the proposed changes states a dental hygienist working under Public Health Supervision must file a report with the names of clients who have been referred for treatment. I have serious concerns about patient confidentiality should this proposal be approved.

There has been a 62% increase in services provided to Medicaid recipients ages 0-12 by a dentist between 2005 and 2012 thanks to the work of dental professionals working under Public Health Supervision Agreements. Additionally, there have been no complaints filed against providers working under Public Health Supervision since its inception in 2004. Let's keep this healthy momentum going by continuing current reporting requirements and not bogging down our Public Health providers with unnecessary reporting requirements.

Sincerely,

Brenda Platz, RDH
503 Plum Street
Solon, Iowa 52333
bplatz25@gmail.com
C) 319.530.4582

Johnson, Melanie [IDB]

From: Iowa Dental Board [IDB]
Sent: Tuesday, June 25, 2013 6:58 AM
To: Johnson, Melanie [IDB]
Subject: FW: support public health supervision as currently written

Christel Braness, Program Planner
Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

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-----Original Message-----

From: Polan, Dorothy [<mailto:dpolan@iwcc.edu>]
Sent: Monday, June 24, 2013 3:56 PM
To: Iowa Dental Board [IDB]
Subject: support public health supervision as currently written

Dear Iowa Dental Board,

I strongly support the public health supervision as it is written. It is vital to continue to allow the current public health supervision to help the citizens of Iowa.

The dental needs of the children and adults that are covered by Medicaid are not currently being met by private dental offices.

The majority of private dental practices do not accept Medicaid patients. It is getting more and more difficult to find providers to care for these patients.

It is through the utilization of the public health providers that the needs of these children and adults are met. The oral systemic link is one more reason that adequate dental care is vital for all the citizens of Iowa.

As a Dental Hygiene Educator, I have seen how important public dental health supervision is in providing access to care for these individuals.

Please support the public health supervision as it is currently written.

Thank you for all you do for the health of all Iowans.

Sincerely,
Dorothy J. Polan, B.S.,R.D.H.
Iowa Western Community College
2700 College Road
Council Bluffs, Iowa 51503

Johnson, Melanie [IDB]

From: Iowa Dental Board [IDB]
Sent: Tuesday, June 25, 2013 7:00 AM
To: Johnson, Melanie [IDB]
Subject: FW: Public Hearing on January 8, 2013, adding day care centers to list
Attachments: National Call To Action To Promote Oral Health.docx

Christel Braness, Program Planner

*Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov*

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From: Mary Ann White [<mailto:merryannwhite@gmail.com>]
Sent: Sunday, June 23, 2013 4:27 PM
To: Iowa Dental Board [IDB]
Subject: Fwd: Public Hearing on January 8, 2013, adding day care centers to list

SUBJECT: public health supervision agreement- DEAD LINE Friday, June 28, 2013
Dear Iowa Dental Board:

I have taken much time to state the truth as it relates to my personal experience with my Public Health Supervision Agreements. I find much of my inspiration to volunteer hundreds of hours from: *National Call To Action To Promote Oral Health A Public-Private Partnership under the leadership of The Office of the Surgeon General* (attached).

*There has never been a complaint delivered against a hygienist or dentist under Public Health Supervision- which has been in effect since 2004.

*If its not broken, why fix it?

*The dentist is in complete control of the agreement. Changing the regulations will make it even more difficult to **VOLUNTEER.**

I admire the fact that I have been afforded the opportunity to provide this valuable information for you.

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

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.

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

Table of Contents

- Introduction
- Partnering for Progress
- Vision and Goals
- The Actions
 - Action 1: Change Perceptions of Oral Health
 - Action 2: Overcome Barriers by Replicating Effective Programs and Proven Efforts
 - Action 3: Build the Science Base and Accelerate Science Transfer
 - Action 4: Increase Oral Health Workforce Diversity, Capacity, and Flexibility
 - Action 5: Increase Collaborations
- The Need for Action Plans
- Next Steps
- Appendix 1: Partnership Network Members
- Appendix 2: What People Said

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⁽¹⁾. 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^[2], 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

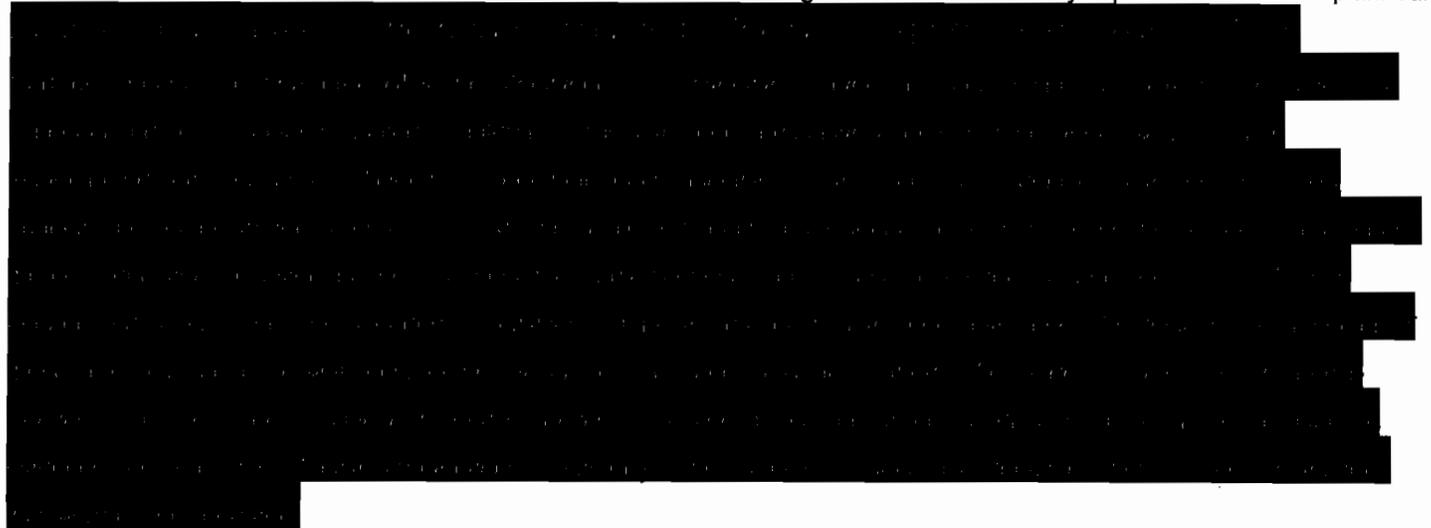
- Enhance oral health literacy.
- Develop messages that are culturally sensitive and linguistically competent.
- Enhance knowledge of the value of regular, professional oral health care.
- Increase the understanding of how the signs and symptoms of oral infections can indicate general health status and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



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⁽⁶⁾. 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.... The mouth and face act as a mirror 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*.

[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]

From: Piper, Renee [Piper@iowacentral.edu]
Sent: Tuesday, June 25, 2013 9:27 AM
To: Johnson, Melanie [IDB]

I support the Public Health supervision as it stands today.

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]

From: Cindy DeWall [insurasmile@gmail.com]
Sent: Tuesday, June 25, 2013 12:31 PM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision

Please accept this e-mail in support of Public Health Supervision as it is currently stands now. It is a joy to be able to serve the public with sealants in school settings and to give access to many Iowans that are under-insured to improve their oral health.

Thank you for your time,
Cindy DeWall, RDH

Johnson, Melanie [IDB]

From: Marilyn Corwin [corwin.marilyn@gmail.com]
Sent: Tuesday, June 25, 2013 4:54 PM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision

Melanie,

As a past Iowa Dental Board Member, practicing dental hygienist and dental hygiene educator I write in support of the current public health supervision available for dental hygienists and dentists. It has been instrumental in making screening or treatment available to thousands of Iowa children who would otherwise not be served. It eases my mind that if I enter a nursing home, care will be available. There have been no complaints filed so it seems wasteful of the Board's time debating this non issue. Thank you for consideration of my opinion.

Marilyn K. Corwin, R.D.H., B.A.
10989 Hawthorn Dr.
Clive, IA. 50325

515-224-2323

Johnson, Melanie [IDB]

From: lepeau@mchsi.com
Sent: Wednesday, June 26, 2013 7:33 AM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision of Dental Hygienists Rules and Regulations
Attachments: Public Health Supervision DH Rules & Regs.pdf

Melanie,

Attached is a modified copy of my two-page letter to the members of the Board of Dentistry. The modified copy has my name on each page while the first copy only had my name on the second page.

If you have not already sent my first copy to the Board, please substitute this new copy.

Thank you for your assistance.

Nancy Sisty LePeau

To: Members of the Iowa State Board of Dental Examiners
From: Nancy Sisty LePeau, RDH, MS, MA
Date: June 25, 2013
Re: 65—10.5 (153) Public health supervision allowed
Public Health Supervision of Dental Hygienists Rules and Regulations

I am a retired dental hygienist who practiced dental hygiene for nearly 50 years. The majority of my career was spent in Iowa. My work experience included dental hygiene education and research at the University of Iowa (1971-1991), clinical practice (1984-1991 and 2001-2011), and public health practice (1991-2011). Additionally, I served as a member of the Iowa State Board of Dental Examiners (1994-2000). Due to my long-time practice experience in a variety of settings, I am acutely aware of the unmet oral health needs of Iowa children in low-income families.

The 2012 Iowa Health Survey Report completed by the Bureau of Oral Health Delivery Systems in the Iowa Department of Public Health shows that 24.8% of 3rd graders are enrolled in Medicaid, 5.3% in hawk-I, 14.9% have no insurance, and 26.4% have no dentist of record. This same survey of 3rd graders shows that 18% of low SES children had untreated decay versus 11% of those of higher SES. In 2010, only 54% of 3rd graders with Medicaid had been to the DDS in the last 6 months compared to 81% of children with private pay.

During my tenure as the dental hygienist in the WIC program at the Johnson County Department of Public Health, I found the parents to be grateful for information regarding their children's oral health needs, including oral screenings, oral health instructions, fluoride varnish applications, information about Medicaid dental benefits, and referrals to the dentist. The majority of the parents were anxious to take their child to the dentist. The major barriers for dental visits were cost for those ineligible for Medicaid, transportation, and the high number of dentists who refused Medicaid patients. Many of the dentists who did accept Medicaid had met their designated quota of such patients they accepted in their practice, usually a low number.

I strongly support the 2003 IBODE Public Health Supervision Rule that allows dentists to supervise dental hygienists in a variety of public health settings in order to meet some of the unmet oral health needs of the children of Iowa. The rules are carefully formulated to ensure that services provided by hygienists are within their scope of practice and provide safeguards to protect the public. The Board maintains authority over all aspects of the agreements made between the supervising dentist and the public health dental hygienist. The dentist and dental hygienist utilize specific protocols that meet the needs and requirements of the public health setting in which the hygienist is employed. Having worked on several committees to formulate rules for practice, I know what an arduous task it is to make rules that are carefully crafted to provide excellent oral health care to the public while ensuring their safety. I believe that the current rule, as formulated, meets all of the criteria. These rules address the regulatory barriers involving the high failure rate of Medicaid patients, their lack of understanding of the importance of prevention and good oral health, and their problems with access to preventive services and treatment. The rule also safeguards the children who do not receive a dental examination by limiting the services the dental hygienist can provide at subsequent visits. The agreement with the supervising dentist worked very well in the WIC program in which I was employed.

The Bureau of Oral and Health Delivery Systems within the Iowa Department of Public Health further enhanced meeting unmet oral needs of children from low-income families with the initiation of the I-Smile program in 2005. The goal was to place dental hygienists in all of the IA Title V MCH Agencies

to increase access of Iowa’s children to oral health assessment, preventive treatment and referral. The current 24 regional dental hygiene Oral Health Coordinators cover 99 counties. They refer to MCH Agency Staff, dentists, primary care providers, school nurses, WIC staff, Public Health Agencies, Head Start, Boards of Health, and Empowerment Boards to strengthen and improve children’s access to a permanent dental home and to oral health preventive care and treatment.

Comparing information about the type and amount of oral health care children between the ages of 0 to 20 years from low-income Iowa families received prior to and since the public health rule was promulgated is proof of the efficacy of this rule. Review of the yearly Service Reports of Public Health Supervision of Dental Hygienists to the Iowa Department of Public Health revealed the following data:

Service Reports of Public Health Supervision of Dental Hygienists					
Clients 0 - 20					
Year	DH with DDS Agreements	Assessments	Referrals to DDS	% Increase Assessments	% Increase Referrals
2004	12	11,472	3,229		
2006	24	22,546	11,171	97%	246%
2007	56	32,071	19,513	42%	75%
2009	65	57,845	33,780	80%	73%
2011	76	59,445	37,061	3%	10%
2012	96	63,899	41,861	7%	13%

During the 2011-2012 year, the number of Public Health Dental Hygiene Agreements markedly increased to 96 DH who saw children ages 0 to 20 and made 63,899 assessments and 41,861 referrals. The referral data included 5,975 children for urgent dental care and 35,886 for regular care. These same dental hygienists provided 30,630 dental sealants, 44,115 fluoride applications, and 21,489 individual educational interventions. It is obvious from the reports that the dental hygienists in public health settings are providing important oral health services to Iowa children from low-income families.

I firmly believe that the IBODE initiated an excellent change in 2003 by developing and promulgating the rules and regulations for public health supervision for dental hygienists in Iowa. The Iowa system has been copied in other states where private practice and public health dentistry have teamed up to improve the oral health status of children in their states. Low-income families and their children are very well served by this progressive step to improve their oral health status. Marked increases in the number of dental hygienists employed in public health settings, dentists entering into public supervision agreements, and preventive and referral services provided to the children of low-income families in Iowa is proof of the efficacy of the public health supervision rule for dental hygienists in Iowa. The Board should do everything possible to facilitate rather than hinder increased numbers of public dental hygiene agreements between dentists and dental hygienists.

Sincerely,

Nancy Sisty LePeau, RDH, MS, MA
 114 S. Mount Vernon Drive
 Iowa City, IA 52245
 (319) 354-2304

Johnson, Melanie [IDB]

From: Thompson, Nancy J [nancy-thompson@uiowa.edu]
Sent: Wednesday, June 26, 2013 3:47 PM
To: Johnson, Melanie [IDB]
Cc: Brenda Platz (bplatz25@gmail.com)
Subject: Proposed revision of public health dental hygienist supervision rule
Attachments: Driver story-Norris.pdf; IBODE NJT FINAL.docx

Importance: High

Dear Melanie,
Sorry, sent the draft before the final one in the previous email. THIS email has the final draft.
Let me know that you will be using the FINAL edition.
Thanks
Nancy

Dear Melanie,
Am sending a letter to counter proposed changes of the public health dental hygiene supervision rule.
This letter should also include the PDF attachment called the Driver story.
Let me know if you have any problems in printing. I will not be in the office tomorrow but will be back on Friday.
Nancy Thompson

Community and Behavioral Health
N412 CPHB
105 River Street
Iowa City, IA 52242
319 384 4137 Phone
319 384 4106 Fax
nancy-thompson@uiowa.edu

"The Unfolding of my life is not an issue of competence or control. It is an issue of faith." Anne Wilson Shaef



To: Iowa State Board of Dental Examiners
From: Nancy Thompson
Date: June 26, 2013
Re: Proposed revision of the public health dental hygienist supervision rule

It has come to my attention that there are proposals to tighten supervision of the state's public health hygienists and to mandate the acquisition of additional information about referral outcomes. In my opinion, these proposals would not improve the delivery of oral health care to Iowans by public health hygienists either because the additional bureaucracy would cost more than it is worth or because it is currently unrealistic to impose them.

First, I would like to remind the Board of Dental Examiners that the system is currently doing much to expand oral health care services to low-income children in Iowa. In the last 8 years of the I-Smile Program, for each hygienist added to the program, an additional 460 new referrals were generated; an overall increase of approximately 1300% referrals. Use of dental hygienists in this manner is consistent (including their measurement of outcomes) with the newly established system established in Maryland in response to the unnecessary death of Deamonte Driver which was heavily implicated by the lack of responsiveness of that state's dental care system to the unmet oral health needs for low income children in Maryland. (see attachment)

Proposal #1 Renew agreements annually with IDPH

It is my understanding that each dentist/hygienist team must review their agreement biennially with the option of allowing the supervising dentist to review it more frequently. I do not see the need to impose an additional review by the Iowa Department of Public Health which is already short of resources for attending to assigned responsibilities. The existing arrangement was established to ensure that services provided by hygienists are within their scope of practice and that The Board of Dental Examiners maintains authority over all aspects of the agreements made between the supervising dentist and the public health dental hygienist. The importance of client responsiveness to referrals is reflected by limiting the services the dental hygienist can provide at subsequent visits.

Proposal #2 Annual reports from the hygienist to IDPH must be signed by the dentist prior to submission

Again, it is my understanding that the existing protocol requires the participating dentist and public health hygienist to agree on the content of the annual report submitted by the public health hygienist. Requiring the dentist to sign the report could easily be done but, again, the need for it and the benefit to the process from adding this step are minimal.

Proposal #3 Report from hygienist must identify the names of clients who have been referred identifying those who did not seek treatment with a plan for achieving compliance

Knowing more about the outcome of referrals and assuring that all referrals lead to meeting unmet oral health needs are desirable goals. However, this information is not attainable given a host of barriers imposed by forces beyond the control of the public health hygienists' programs. Before listing some of these barriers, the Board should note that these hygienists go above-and-beyond to facilitate compliance with referrals. This includes providing transportation and making appointments which consume a considerable amount of time and effort.

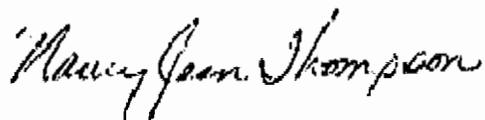
Ideal information on the goal of meeting unmet needs among Medicaid Eligible Children is currently impossible to attain for many reasons including: HIPAA policies regarding confidentiality; unwillingness to voluntarily share information among providers, insurers and governmental agencies; and language barriers. An attempt to establish such a system was attempted in Dubuque but was unsuccessful due to difficulties obtaining information on completed treatment in dental offices by staff of the Dubuque Visiting Nurse Association. This unwillingness is not without rational bases. Unmet dental need resolution often requires multiple visits. Further, patients are often transient. Finally, there is the need to protect the 70 participating dentists' practices from being forced to assume the responsibility of becoming any particular patient's dental home.

In the absence of better ways to measure the resolution of unmet needs, numerous proxy measures have been or could be utilized. The proxy measure used by the I-Smile program is change in the number of Medicaid-enrolled children who submit a claim for services received from a dentist. Other sources of data which may be available and could be used are those collected by schools, Head Start and the Women, Infants and Children (WIC) Program. At one point in time the parents of school children were asked to indicate if the child had a dentist and the date of their last appointment. Perhaps these data are still collected. Head Start has been becoming more aggressive in assessing and following up on the oral health of children enrolled in that program. WIC personnel are required to ask when the child last saw the dentist. These data could be put in the computerized data system and could be kept longitudinally for children seen multiple times in the clinic.

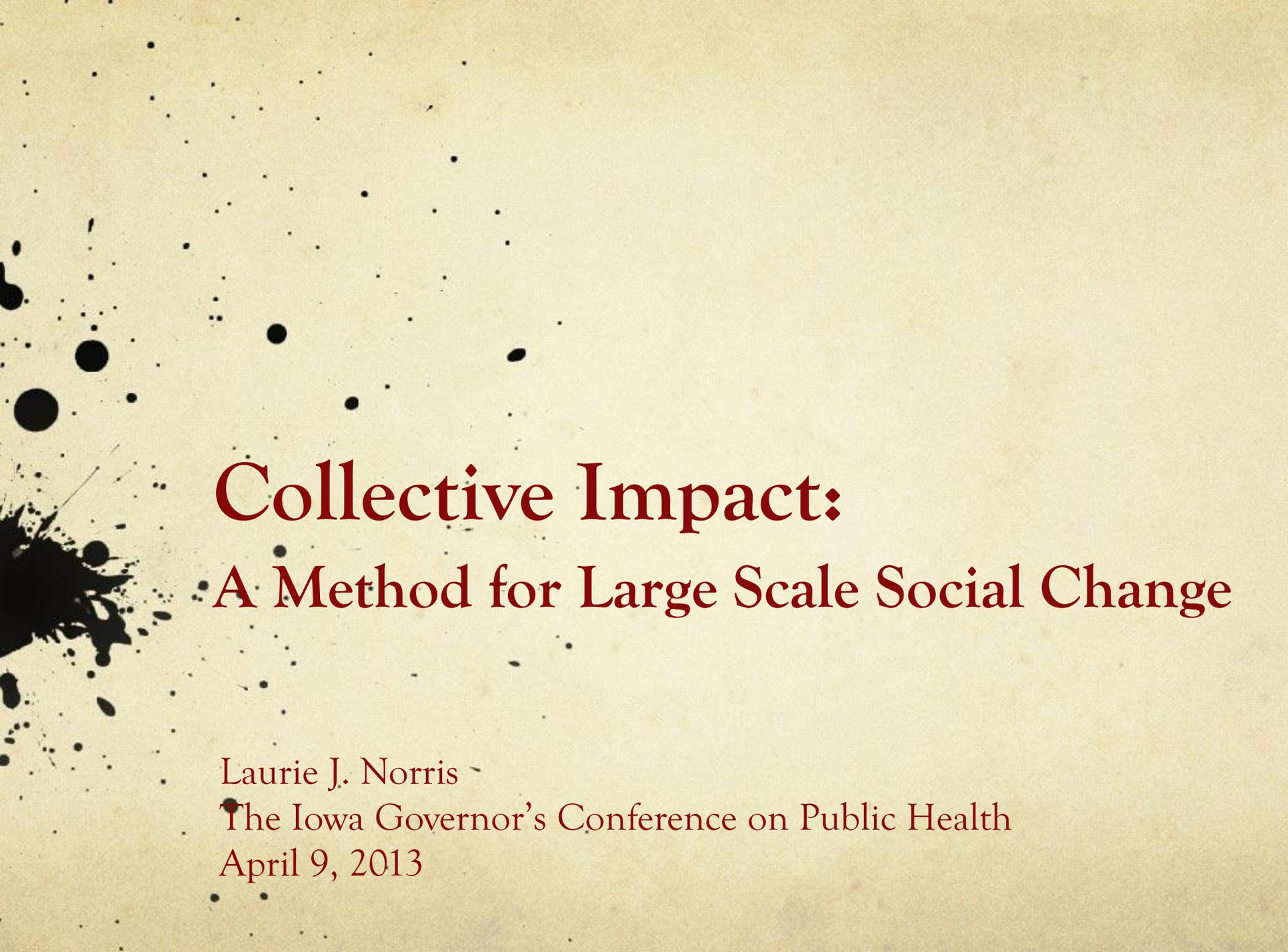
Besides barriers to accessing the data, the time to track individuals until any unmet needs have been met, would not be an efficient use of public health hygienists' time. This task could well require the employment of a half-time clerical person to do all of the follow-up calls to parents (which require numerous attempts), and dental and other providers.

Imposing the requirement that public health hygienists' programs comply with this third proposal would reflect a discriminatory attitude towards public health dental hygienists. No such requirement is being proposed for referrals made by public health dentists.

These are my personal views and do not necessarily reflect those of The University of Iowa or its College of Public Health.



Nancy Thompson, RDH, PhD Associate Professor
The University of Iowa, College of Public Health
(see attachment- Collective impact: a method for large scale social change)



Collective Impact:

A Method for Large Scale Social Change

Laurie J. Norris

The Iowa Governor's Conference on Public Health

April 9, 2013

Our Path Today



A Process for Creating Social Change



One Family's Tragic Story



A State's Response



Here and Now in Iowa



A Process for Creating Social Change

Two Kinds of Problems

Technical Problems

- Well-defined, answer known before solving begins, solution can be implemented by one organization.

Adaptive Problems

- Complex, just understanding the problem requires many different players to learn, then they must develop a common agenda and change their behavior.

Two Approaches to a Solution

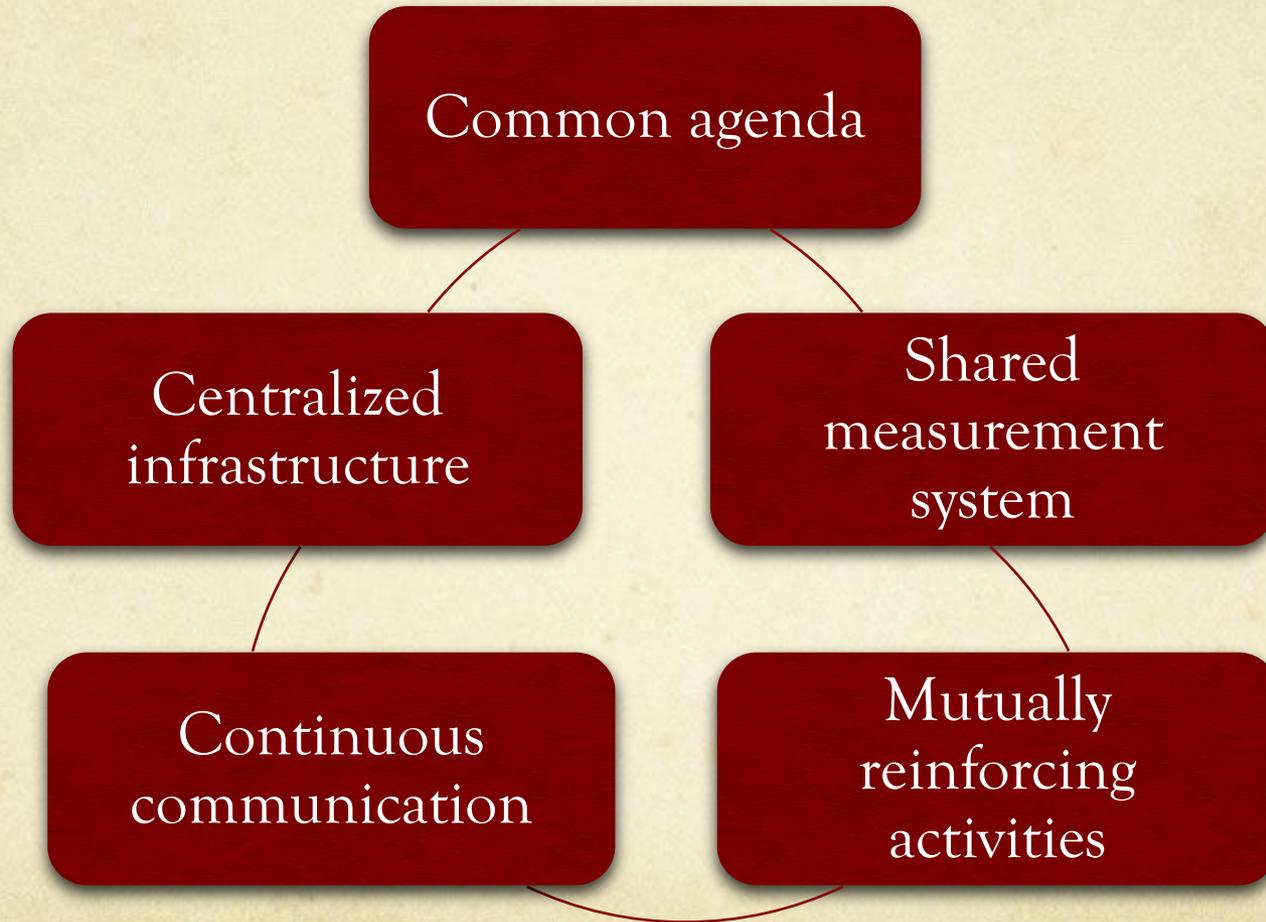
Isolated Impact

- Find and fund a solution embodied in a single organization; hope it can be replicated or scaled up.

Collective Impact

- Systemic approach, shared objectives, behavior change by participating organizations, common indicators to measure progress.

5 Conditions for Collective Impact



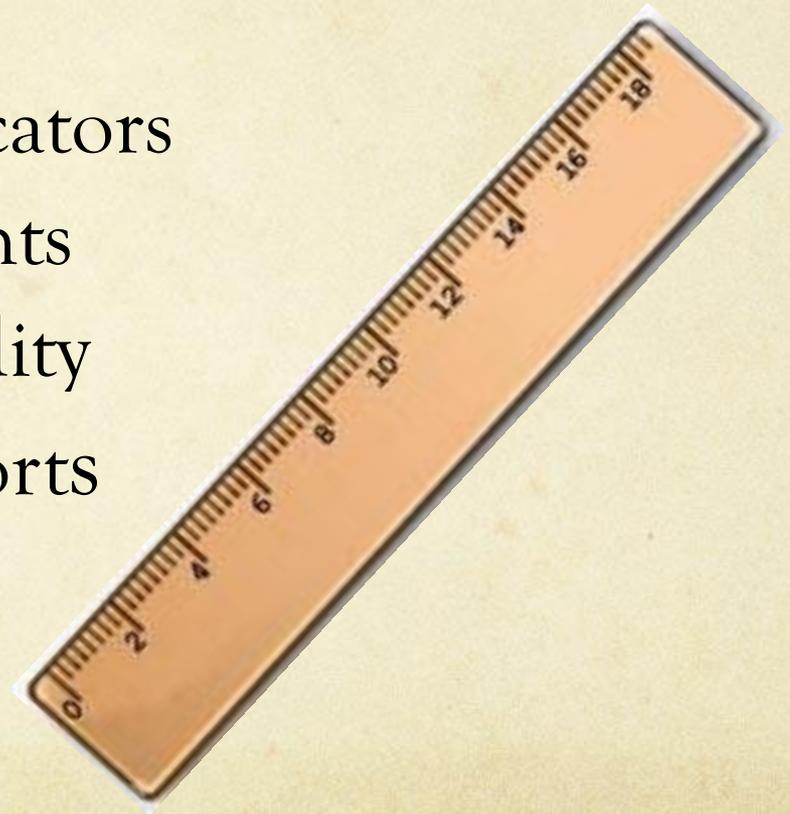
1. Common Agenda

- Shared vision of change
- Common understanding of the problem
- Joint approach to a solution
- Agreed-upon activities or actions



2. Shared Measurement

- Common list of indicators
- Used by all participants
- Promotes accountability
- Aligns everyone's efforts



3. Mutually Reinforcing Activities

- Each organization pursues activities at which it excels.
- Activities are coordinated across organizations
- Through a mutually reinforcing action plan.



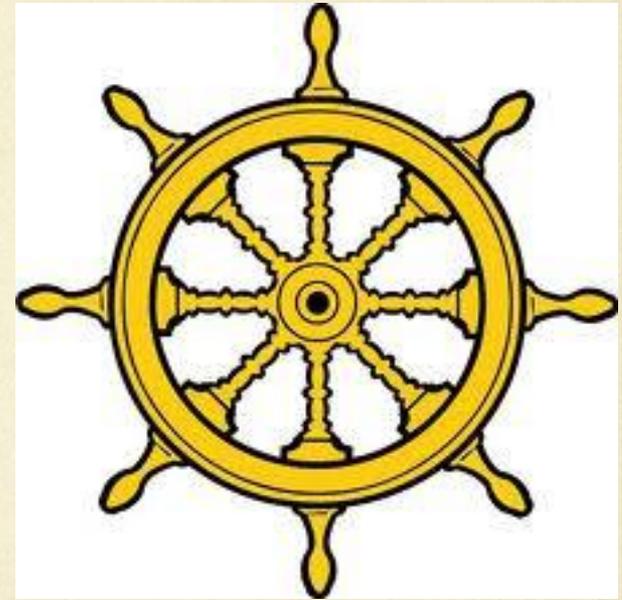
4. Continuous Communication

- Develops and sustains trust across sectors.
- Creates a common vocabulary.
- Frequent in-person meetings at the CEO level.



5. Centralized Infrastructure

- Create a “backbone” organization to support the collective effort.
- Facilitation, communication, logistics, data analytics, administration.
- Embody the principles of adaptive leadership.



Other Types of Collaboration

- Funding Collaboratives
- Public-Private Partnerships
- Multi-stakeholder Initiatives
- Social Sector Networks



Successful Collective Impact



Reducing childhood
obesity



Watershed
restoration



Economic
improvement



Education
reform

One Family's Tragic Story

Photo courtesy of Alyce Driver



DaShawn's Story

Photo courtesy of The Megaphone Project



Deamonte's Story

Photo courtesy of Gina James



Deamonte's Story

Photo courtesy of The Washington Post

Tragic Consequences

Tragic Consequences



For Want of a Dentist

Pr. George's Boy Dies After Bacteria From Tooth Spread to Brain



A State's Response

Maryland's Story



Martin O'Malley
Governor



Elijah Cummings
Congressman
Maryland 7th District



John Colmers
Former Secretary
Health/Mental Hygiene

Maryland's Dental Action Committee

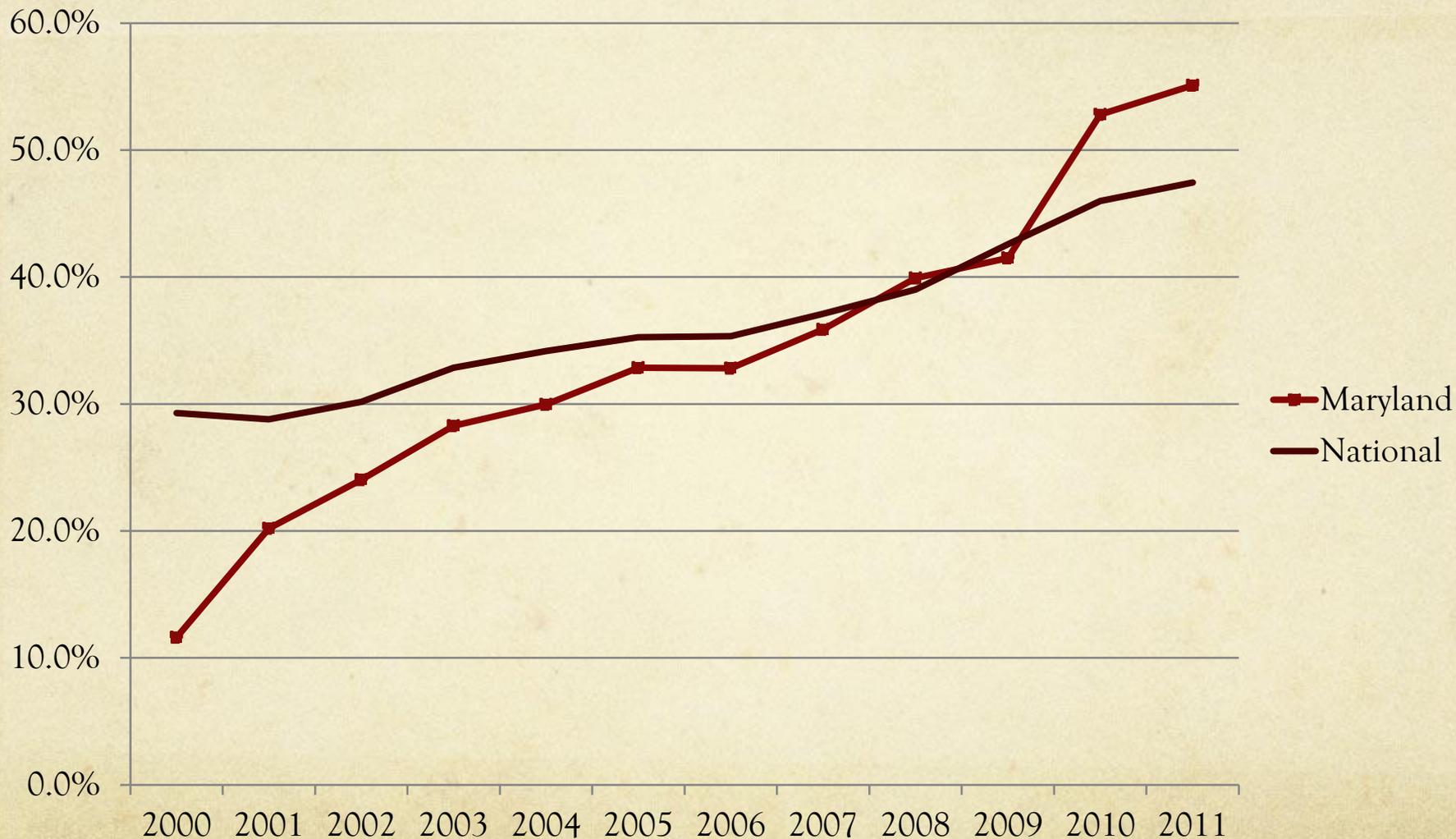
- Advocates for Children and Youth
- Carroll County Health Department
- Doral Dental, USA
- Head Start
- Maryland Academy of Pediatrics
- Maryland Academy of Pediatric Dentistry
- Maryland Assembly on School Based Health Care
- Maryland Association of County Health Officers
- Maryland Community Health Resources Commission
- Maryland Dental Hygienists' Association
- Maryland Dental Society
- Maryland Medicaid Advisory Committee
- Maryland Oral Health Association
- Maryland State Dental Association
- Maryland State Department of Education
- Medicaid Matters! Maryland
- Mid-Atlantic Association of Community Health Centers
- Morgan State University
- National Dental Association
- Parent's Place of Maryland
- Priority Partners MCO
- Public Justice Center
- United Healthcare MCO
- University of Maryland Dental School

Dental Action Committee Recommendations

1. One statewide Medicaid dental administrative services vendor.
2. Over 3 years, increase dental payment rates to ADA 50th percentile.
3. A public dental clinic in every county.
4. Pass law to create “public health” dental hygienist role.
5. Institute school-based oral health screenings.
6. Train general dentists in pediatric dental care.
 - 6a. Train pediatricians, family physicians, and nurse practitioners to do oral health assessments and apply fluoride varnish.
7. Launch an oral health literacy campaign targeted to parents, providers, and policy makers.

Improvement in Maryland

Percentage of children age 1-20 in Medicaid who received any dental service FY 2000- FY 2011



Source: FY 2000-2011 CMS-416 reports, Line 1, Line 1b, 12a

Note: FY 2011 data for Idaho, Kentucky and Ohio are not yet available and was substituted with FY 2010 data when calculating the national estimates for FY 2011.



The Driver Family Today

Did Maryland's Dental Action Committee Qualify as a Collective Impact Effort?

1. Common agenda
2. Shared measurement system
3. Mutually reinforcing activities
4. Continuous communication
5. Centralized infrastructure
- ~~~~~

6. Funding



Here and Now in Iowa

What Is Iowa's Story?



What public health problem seems ripe for collective action? Why?



What would need to change for a collective approach to have an impact on this problem?



Is there a first step you could take to explore a collective impact approach to this problem?

Harvesting Your Ideas



- What topic, theme, or idea emerged in your dyad?
- Report in one sentence.

Photo courtesy of Marilyn Norris

Resources

- For more information about collective impact, see *Collective Impact* by John Kania and Mark Kramer, Stanford Social Innovation Review, Winter 2011.
- For more information about Deamonte's story see *For Want of a Dentist*, by Mary Otto, Washington Post, February 28, 2007.
- To learn more about Maryland's Dental Action Coalition, go to www.mdac.us

Johnson, Melanie [IDB]

From: Linda Rowe [lkrowerdh@gmail.com]
Sent: Wednesday, June 26, 2013 8:07 PM
To: Johnson, Melanie [IDB]
Subject: PHS input

Having practiced dental hygiene in Iowa for over 30 years, the PHS agreements are one of the best things that the IDB has done to assist more Iowan to access oral care. While I have not had enough free time in my schedule to help, I do work with and know several hygienists using the PHS, mainly for school screenings. If this is the student's first contact with an oral health provider, how wonderful that it can be with someone who can encourage good habits and seeking continued care.

I would actually encourage the IDB and all licensed providers to take advantage of this opportunity and "fan out" to other facilities besides schools that have the mandate for screenings. My family life has been such that I spent many hours visiting in an excellent long term care facility this past winter. When residents (and some staff) learned I am a dental hygienist the press for information from me was unexpected. Even though this particular facility has a dentist who actively treats the residents, if the needs have not been identified at the initial intake or have changed since that time, I see where a dental hygienist visiting with and reassessing needs periodically could go far to insure the comfort of Iowa's elders. The common attitude I experienced during my casual visits was the residents "didn't want to be a bother".

Please retain this valuable tool for us to help Iowa's under-served. Please also consider encouraging MORE hygienists to look around their community and see how this tool could help them help the vulnerable.

Linda K (Moe) Rowe, RDH, MS

(One never knows when a life change can happen. This link is to the story of a dental hygienist educator, who had a stroke, is in long term care and during the initial years of the treatments received no significant oral care. It could be any Iowan. http://www.adha.org/resources-docs/71010_Irene_Woodall_Trust.pdf)

Johnson, Melanie [IDB]

From: Angie Kelley [akelleyrdh@gmail.com]
Sent: Wednesday, June 26, 2013 9:37 PM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision Comments

Dear Ms. Johnson,

I work in a general practices located in Council Bluffs. Up until the last 2 years, we accepted new Medicaid patients, now we only see our existing ones(or their family members) As they drop from our office, we do not add new Medicaid. We had to quit seeing new ones because we could NOT handle the load. Everyday, several times a day, we get phone calls for Medicaid patients. Some of these calls are coming from outside the Council Bluffs area. They are desperate to find a dentist that accepts Medicaid.

I personally do not have a public health supervision agreement but I do know that those hygienists that are willing to sign one, are special hygienists. They serve a special part of Iowa's population. A population that does not have access to, for whatever reasons, the traditional means of receiving care. The programs that are in place now, are doing an awesome job. They are doing something.

Adding more additional rules and regulations could hamper the wonderful services (and sites available) for these special target populations to receive care. I also think it would make more dentists not want to get into the PHS agreements because of the hassle. Some dentist already feel the pressure from some of their peers for participating or wanting to, which in the end only hurts the underserved.

Please do not allow added restrictions to the PHS. It is heart breaking enough to turn Medicaid patients away from our office. To think more citizens of Iowa would lose their only access to care (the ones that use the PHS sites) seems cruel and unnecessary.

Thank you for taking the time and consideration with this important matter.

Angie Kelley, RDH, BS
712-326-9088 cell
712-328-0708 work

Johnson, Melanie [IDB]

From: michelle bjokne [michellebjokne@gmail.com]
Sent: Wednesday, June 26, 2013 10:56 PM
To: Johnson, Melanie [IDB]
Subject: Michelle Bjokne

Hello Ms. Johnson,

This is Michelle Bjokne from Minnesota. I have some questions that I am hoping you will be able to help me with. I went to Century College in White Bear Lake, Minnesota. I received my diploma from the Dental Assisting program this spring. I have plans to go to Faith Baptist Bible College in Ankeny Iowa. I want to work as an Assistant while I am at school. I was wondering how my Minnesota training would transfer to Iowa. I was hoping that you would be able to tell me what I need to do to so I can be an Assistant in Iowa.

Thank you for your time,

Michelle Bjokne

9432 Jergen PL
Cottage Grove MN
55016

(651) 315- 3786

Johnson, Melanie [IDB]

From: Doug Rose [alrdwr@aol.com]
Sent: Thursday, June 27, 2013 5:04 AM
To: Johnson, Melanie [IDB]
Subject: Supervision for RDH's

Sent from AOL Mobile
To the Iowa Dental Board:

I wish to voice my concerns regarding a change in public health supervision of dental hygienists. I have worked in small Iowa towns for twenty two years and have seen first hand the lack of access to dental care. Some of my patients who received XIX benefits would drive for more than hour to get dental treatment. The dental office I worked in was the only one in the area that would accept "new" XIX patients. I feel that many of the qualified patients ultimately gave up seeking dental care. I feel that screening and preventative care provided by hygienists are a way to fill the gap for those that are unserved. It just makes sense that preventive measures are so much better for the young and nursing home-bound patients, and that hygienists can provide screening and preventive care efficiently and cost effectively. I urge you to maintain the current public health supervision guidelines for dental hygienists. It just makes sense for the under and unserved as well as the taxpayers.

Sincerely ,
Anne Rose, RDH

Johnson, Melanie [IDB]

From: Iowa Dental Board [IDB]
Sent: Thursday, June 27, 2013 6:44 AM
To: Johnson, Melanie [IDB]
Subject: FW: Public Health Supervision Agreement
Attachments: letter to IDB on public health supervision review.docx

Christel Braness, Program Planner

Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309

Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

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From: Miriam Burk [<mailto:burkmiriam@yahoo.com>]
Sent: Wednesday, June 26, 2013 11:06 PM
To: Iowa Dental Board [IDB]
Subject: Public Health Supervision Agreement

Hello there Melanie. I have attached my letter to the IDB in support of Public Health Supervision Agreements. Please pass this along. Thank you.

Miriam Burk, RDH
President
Iowa Dental Hygienists' Association

June 24, 2013

Melanie Johnson, Executive Director
Iowa Dental Board
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687

Via email: Melanie.johnson@iowa.gov

Re: Request for Input RE: Oversight of Public Health Supervision

Dear Ms. Johnson:

On behalf of the members of the Iowa Dental Hygienists' Association (IDHA), I am writing to provide our association's input regarding the review of the public health supervision program which the Iowa Dental Board is currently conducting. IDHA welcomes this review, and we enter this discussion with the belief and hope that all who enter will be open to a full range of possible outcomes as it relates to public health supervision in Iowa.

IDHA believes that if this review demonstrates that the current level of oversight is posing risk to patients receiving care under public health supervision, then additional oversight is warranted. However, IDHA also believes that if instead this review demonstrates that public health supervision is improving access to quality oral health care without posing an additional risk, we hope that all engaged in this review will commit to looking for opportunities to significantly expand the number of dentists and dental hygienists participating in public health supervision agreements so that more Iowans can have access to care in public health settings.

A review of the current existing data available on public health supervision clearly indicates that it is accomplishing the goal of expanding access to quality oral health care while not posing additional risk to patients. That data comes from the state of

Iowa's I-Smile program, which could not operate without the existence of the Dental Board's public health supervision rules.

According to the 2012 I-Smile report, the number of Medicaid enrolled children ages 0-12 in Iowa receiving services from a dentist totaled 114,950 in 2012 up from 71,193 in 2005. This is a 61% increase. The 2012 data also indicates that children participating in this program tend to receive care from dentists-114,950 received care from dentists, almost four times as many as the 29,405 children receiving care (i.e. screenings or fluoride varnish) from a title V contractor. This data is an important reminder that, despite the fears of some, public health supervision has not resulted in a replacement of services by a dentist with services provided by another provider.

So clearly public health supervision, under its current rules, has improved access to quality oral health care. Has the risk to patients also increased? IDHA believes that the only way to measure patient risk in an unbiased, in-depth method is to review the number of investigations and resulting disciplinary actions brought against dentists and dental hygienists for work performed by the hygienist while operating under a public health supervision agreement.

IDHA believes that the Dental Board staff should have the ability to review the investigation history since public health supervision has been in place, and should be able to share with the public, in a way that does not violate confidentiality requirements, statistics related to public health supervision related complaints and disciplinary actions taken by the Dental Board. IDHA also believes, based on our years of monitoring closely the work of the Dental Board, that this review will show that public health supervision poses no greater risk to the patient than work performed by dental hygienists under other types of supervision.

If this review demonstrates that the current public health supervision rules improve access to care and pose no additional risk to patients, then IDHA believes the Dental Board should not pursue rule changes for this program. As has been said in the past, "If it isn't broken, don't fix it." Otherwise, pursuing rule changes when none are clearly needed would clearly result in burdensome regulation in which we know that no one on the Dental Board has interest, and also clearly is not consistent with Iowa Governor Terry Branstad's goal for boards and commissions to reduce burdensome regulations, not create more.

Instead if this review produces the improved access, no risk conclusion that IDHA expects, we would hope that all who are interested in this issue will join with us in committing to expanding the number of Iowans who receive benefit of public health supervision by expanding the number of dentists and dental hygienists who participate in the program.

Sincerely,

Miriam Burk, President

Iowa Dental Hygienists' Association

Johnson, Melanie [IDB]

From: Iowa Dental Board [IDB]
Sent: Thursday, June 27, 2013 6:45 AM
To: Johnson, Melanie [IDB]
Subject: FW: Public Health Supervision Agreement, deadline June 28, 2013

Christel Braness, Program Planner

Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309

Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

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From: Dr. Decker [<mailto:drdecker314@hotmail.com>]
Sent: Wednesday, June 26, 2013 5:39 PM
To: Iowa Dental Board [IDB]
Subject: Public Health Supervision Agreement, deadline June 28, 2013

Dear Iowa Dental Board:

It is my privilege to 100% endorse and approve Public Health Supervision agreements as currently enforced.

It has worked well since 2004.

There has never been a complaint delivered against a hygienist or dentist regarding this subject.

I currently have a Public Health Supervision agreement which has worked extremely well for over a year. It allows our community to provide services to the Long-term Care Facility residents whom normally would not be seen.

Respectfully,
Stephen M. Decker, D.D.S.

Johnson, Melanie [IDB]

From: Rachael Patterson-Rahn [rprahn27@gmail.com]
Sent: Thursday, June 27, 2013 8:37 AM
To: Johnson, Melanie [IDB]
Cc: Iowa Dental Board [IDB]
Subject: Input Regarding Oversight of Public Health Supervision
Attachments: Input Regarding Oversight of Public Health Supervision.docx; Inside I-Smile 2012.pdf

Good Morning,

Please see attached comment and referenced report regarding the future oversight of Public Health Supervision activities.

Thank you,

Rachael Patterson-Rahn, RDH

June 26, 2013

Dear Iowa Dental Board Member:

I am writing to provide input on the future oversight of public health supervision (PHS) activities. Overall, the program is very well designed and is achieving the intended results. Since the ability of hygienists to provide direct services in public health settings and the implementation of I-Smile™, Iowa has made marked improvements in the number of underserved children accessing care from a dentist. For example, in 2012, more than 1 ½ times as many Medicaid-enrolled children ages 0-12 saw a dentist for care than in 2005. The Inside I-Smile™ 2012 report which contains this as well as other data along with success stories and testimonials is attached. Fortunately, RDHs working in public health settings are well trained on removing barriers to care such as language and transportation, so receiving care at a dental office can become a reality for these families.

I feel the current data collected annually by the Iowa Department of Public Health is sufficient and is often shared with the supervising dentist. However, it may be in the Board's best interest to require a copy of the current data collected annually be provided to the supervising dentist. More detailed reporting would only impose barriers on both the RDH and supervising dentist – something I would recommend avoiding. Furthermore, with Medicaid paid-claims data readily available, manually tracking any additional data truly seems frivolous.

I greatly appreciate the opportunity to help the underserved and hope to be able to continue linking them with caring dentists. Thank you for your time on this matter.

Sincerely,

Rachael Patterson-Rahn, RDH

RECEIVED

JUL 1 2013

IOWA DENTAL BOARD

June 26, 2013

Dear Iowa Dental Board Member:

I am writing to provide input on the future oversight of public health supervision (PHS) activities. Overall, the program is very well designed and is achieving the intended results. Since the ability of hygienists to provide direct services in public health settings and the implementation of I-Smile™, Iowa has made marked improvements in the number of underserved children accessing care from a dentist. For example, in 2012, more than 1 ½ times as many Medicaid-enrolled children ages 0-12 saw a dentist for care than in 2005. The Inside I-Smile™ 2012 report which contains this as well as other data along with success stories and testimonials is enclosed. Fortunately, RDHs working in public health settings are well trained on removing barriers to care such as language and transportation, so receiving care at a dental office can become a reality for these families.

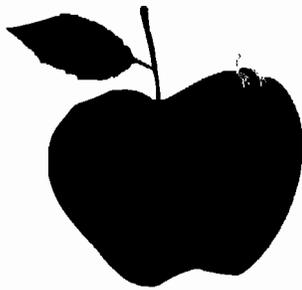
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I greatly appreciate the opportunity to help the underserved and hope to be able to continue linking them with caring dentists. Thank you for your time on this matter.

Sincerely,

A handwritten signature in black ink that reads "Rachael Patterson-Rahn". The signature is written in a cursive, flowing style.

Rachael Patterson-Rahn, RDH



Inside I-Smile™ 2012

Annual Report on Iowa's Dental Home Initiative for Children
Iowa Department of Public Health · Bureau of Oral and Health Delivery Systems

RECEIVED

JUL 1 2013

IOWA DENTAL BOARD

Prepared by:
Tracy Rodgers, RDH, CPH
Shaela Meister, MPA
Kevin Wooddell
Bob Russell, DDS, MPH



Inside I-Smile™ 2012

Annual Report on Iowa's Dental Home Initiative for Children
Iowa Department of Public Health · Bureau of Oral and Health Delivery Systems

Oral Health Center · 321 E 12th Street · Des Moines, IA 50319 · 1-866-528-4020

www.ismiledentalhome.iowa.gov

www.idph.state.ia.us/ohds/oralhealth.aspx

www.facebook.com/ISmileDentalHomeInitiative

January 2013



December of 2011 marked five full years of implementation for Iowa's I-Smile™ dental home initiative. The overall goal of I-Smile™ is to ensure that Medicaid-enrolled children have a dental home; yet we are finding in 2012 that the program's impact is stretching well beyond that measure.

As I-Smile™ was being developed in 2006, the intended outcome was an integrated service delivery system that would identify disease risk early, prevent tooth decay, improve care coordination, and strengthen parental involvement. And with each year of I-Smile™ activities, the numbers of at-risk children receiving services increase, improvements are made to the quality of dental care coordination services, and more parents and other stakeholders understand the importance of children's oral health.

Twenty-four I-Smile™ coordinators work within the state's Title V child health system helping Iowa families to access dental care as well as to understand the importance of oral health. In order to develop local I-Smile™ referral systems, coordinators rely on many partners which include dentists, medical professionals, civic organizations, businesses, schools, and other government programs such as Head Start and WIC (Special Supplemental Nutrition Program for Women, Infants, and Children).

In the end, the benefits of I-Smile™ are indeed helping to keep Iowa children healthy. This report reflects results from SFY2012.

TESTIMONIAL #1

"I feel that the I-Smile™ program has been very beneficial for our community. Through the I-Smile™ coordinator, many children who are in need of care have been sent to local dentists for care and some have found dental homes. Our I-Smile™ coordinator has also served as a valuable resource for other community projects involving dentistry."

- Eastern Iowa Dentist



Successes



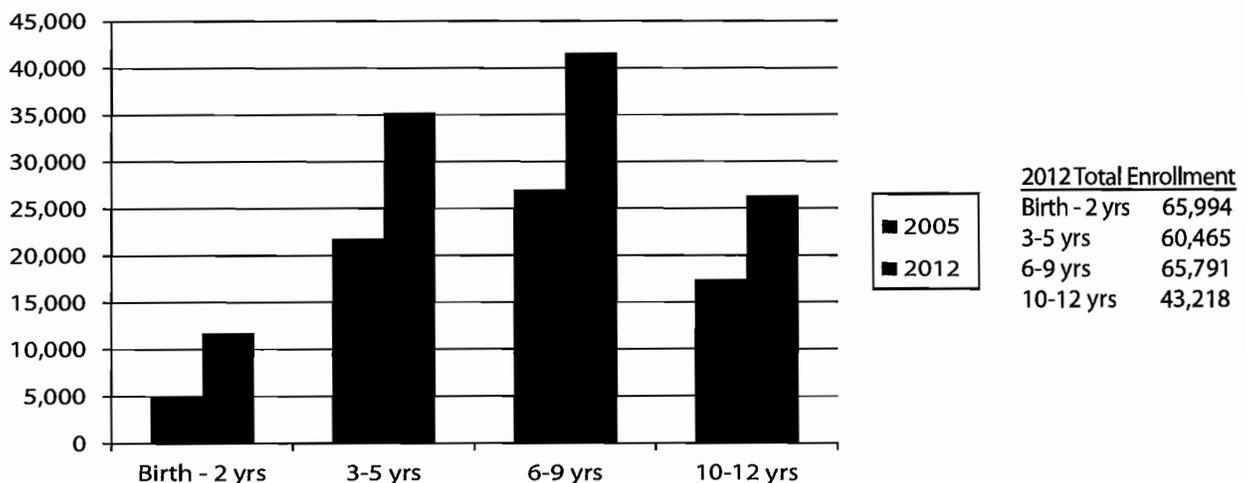
In 2012:

- MORE THAN 1½ TIMES AS MANY CHILDREN AGES 0-12 SAW A DENTIST FOR CARE THAN IN 2005
- NEARLY FOUR TIMES AS MANY CHILDREN AGES 0-12 RECEIVED CARE FROM A HYGIENIST OR NURSE WORKING FOR A TITLE V AGENCY THAN IN 2005
- 61% OF CHILDREN AGES 3-12 SAW A DENTIST

Based on SFY2012 Medicaid paid claims, Iowa Department of Human Services

Although the I-Smile™ dental home includes many provider types and settings, dentists play a critical role. A key strategy for I-Smile™ coordinators is building strong relationships with local dentists to encourage their willingness to accept referrals and be part of the I-Smile™ initiative. As a result, dental offices are seeing more Medicaid-enrolled children than ever before - 5 percent more than in 2011, and a remarkable 62 percent more than in 2005. (Figure 1)

Figure 1: Number of Medicaid-enrolled Children Receiving Dental Care from Dentists, 2005 and 2012



The Title V program, within which I-Smile™ operates, incorporates direct services only when needed to fill gaps in care. Because of access issues to dental care for low-income children, most Title V contractors have provided some gap-filling dental services for many years. Through I-Smile™, contractors have greatly expanded the number of gap-filling services that they provide to low-income children, in particular. For example, all I-Smile™ coordinators are required to ensure that children ages 2 and younger at WIC clinics receive screenings and fluoride varnish applications.

Several coordinators also facilitate preventive care at Head Start centers and preschools. In addition to the direct services, parents are being taught how to care for children's teeth, the importance of early and regular care, and are also offered assistance in setting up appointments with dental offices. Over half of I-Smile™ coordinators are also involved in administering school-based dental sealant programs for children ages 6-13 in schools with a large number of students at risk for tooth decay.

Other important partners are pediatric and family practice physicians, physician assistants, and nurse practitioners. In addition to oral health anticipatory guidance provided to parents, some are also applying fluoride varnish applications to Medicaid-enrolled children as part of the I-Smile™ dental home.

Another way that I-Smile™ is helping to increase the number of children who receive dental care is through health promotion and messaging. I-Smile™ coordinators conduct outreach and promotion activities, such as a statewide hospital project targeting new parents and the celebration of National Children's Dental Health Month in February. This year also included the launch of the I-Smile™ Facebook page, as well as I-Smile™ sponsorships on public television and radio spots, in order to reach parents with children's oral health messaging.

This multi-layered method of providing children preventive, diagnostic, and restorative dental care and building the awareness of parents and other community stakeholders will result in less dental disease and reduced costs to the health care system over time.

Challenges

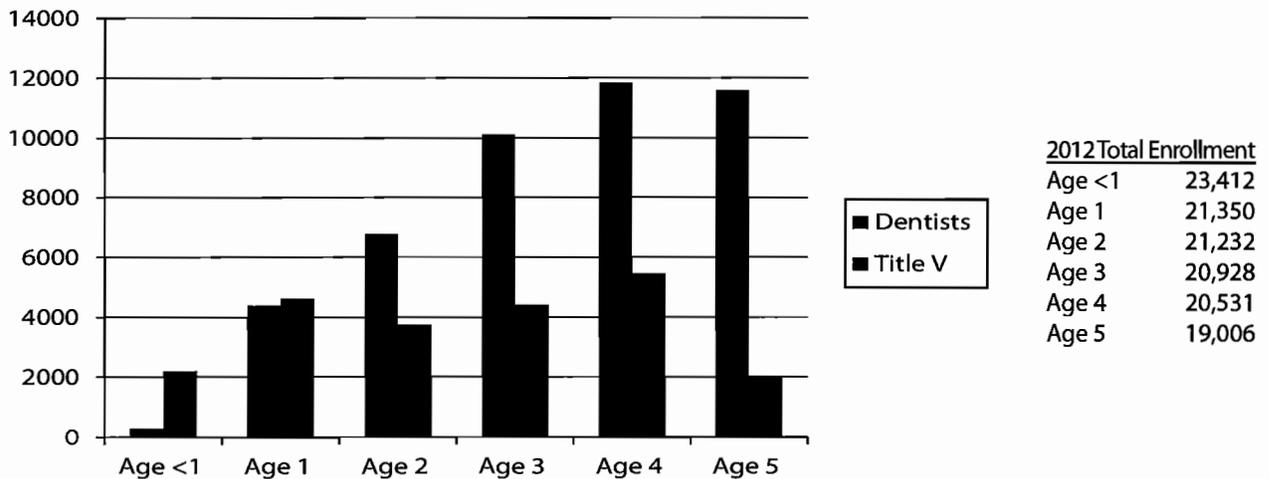
Although children younger than 3 are receiving more dental services than prior to I-Smile™, there are still too many who are not seen at all. It is critical that we work toward a system that includes the very young children in order to prevent tooth decay and decrease costs both now and in the future. Gap-filling care will continue through the Title V program, and dental offices will be encouraged to see very young children - with an emphasis on the first visit by the age of one.

In 2012:

- JUST 18% OF CHILDREN YOUNGER THAN AGE 3 SAW A DENTIST
- LESS THAN 300 CHILDREN YOUNGER THAN 3 YEARS OLD RECEIVED PREVENTIVE FLUORIDE DURING A MEDICAL WELL-CHILD EXAM
- THE NUMBER OF IOWA DENTISTS WHO SEE MEDICAID-ENROLLED CHILDREN IS STATIC (1,132 IN 2011 VS. 1,134 IN 2012)

Based on SFY2012 Medicaid paid claims, Iowa Department of Human Services

Figure 2: Number of Medicaid-enrolled Children Ages 0-5 Receiving a Dental Service from Dentists and Title V Agencies by Year of Age in 2012



Incorporating dental screenings and fluoride applications as part of well-child exams has not yet become standard of care for medical practitioners in Iowa. In 2012, 32 medical professionals provided fluoride varnish applications to just over 260 Medicaid-enrolled children younger than 3 years of age. I-Smile™ coordinators are required to contact pediatric and family practice medical practitioners to offer training, promote children's oral health and promote the age 1 dental visit. Yet this appears to be an area where we have not found the best means to build and nurture this component of the dental home for Medicaid-enrolled children.

Past efforts have focused on encouraging medical providers to include dental screenings and fluoride varnish applications during well-child exams. Future efforts will emphasize promoting referrals to I-Smile™ coordinators for children younger than 3. This may then increase the likelihood of children receiving preventive care in public health settings and completion of the referral process to a dentist for a diagnostic exam and treatment if needed.

The number of dentists providing care for Medicaid-enrolled children increased by just two in 2012, indicating that those who do see them are taking on more. In order to reduce the risk of overwhelming the limited number of dental practices seeing Medicaid patients, it will be necessary to continue to recruit pediatric dentists to the state, as well as to retain more dentists in rural communities. I-Smile™ coordinators must continue to foster these relationships and referral systems.

Audits of Iowa's dental screening requirement prior to kindergarten and ninth grade also reflect the need for involvement of dental hygienists and nurses to ensure that children receive a screening. Thirty-five percent of screenings last school year were done by non-dentists, indicating the existence of workforce issues and the need for non-traditional providers to play a role in children's access to routine and comprehensive dental services.

Another challenge facing some Iowa families is that some community water systems are opting to no longer fluoridate their water supplies to a level that is known to effectively prevent tooth decay. The I-Smile™ initiative is helping educate those involved about the benefits of fluoridation and the additional steps families must take to increase their exposure to topical fluoride when it is no longer concentrated in water supplies. Local and state partnerships will continue to be critical to prevent further attrition of this public health measure.

Next Steps

The future of I-Smile™ includes maintaining the gains already made and seeking to overcome existing and future barriers.

We must:

- Consider ways to increase medical professionals' involvement in the I-Smile™ dental home, such as seeking Medicaid policy changes to reimburse physicians for dental screenings and providing physicians with a standardized fax referral form to assist and encourage referrals of Medicaid-enrolled families to the I-Smile™ coordinator
- Ensure that the I-Smile™ strategies of prevention, risk assessment, and care coordination are included as part of the changes to the health care delivery system (i.e. Accountable Care Organizations and health home implementation)
- Continue regular training opportunities for I-Smile™ coordinators to maintain program consistency, quality assurance, and ensure the professional development of the public health workforce
- Seek ways to further evaluate the program for sustainability and possible replication to additional at-risk populations (e.g. elderly Iowans)

As I-Smile™ progresses, in addition to more children receiving dental care, we anticipate that Iowa children will be healthier – better able to speak properly, eat, grow, and thrive. Iowa children will be better prepared to learn in school, more parents will be aware of the importance of children's oral health, and community partners will know that I-Smile™ coordinators are available to assist families in accessing dental care.

These results will be integral to Iowa's goal of becoming the healthiest state.

TESTIMONIAL #2 *"I-Smile™ provides a safety net for those populations that have nowhere else to turn. The coordinators facilitate a solution to the problem, (transportation, screenings, assistance, appointments at providers). It is a great thing Iowa has done and colleagues from around the country speak so highly of the program and are using this model! Keep up the great work!"*

- Community Stakeholder



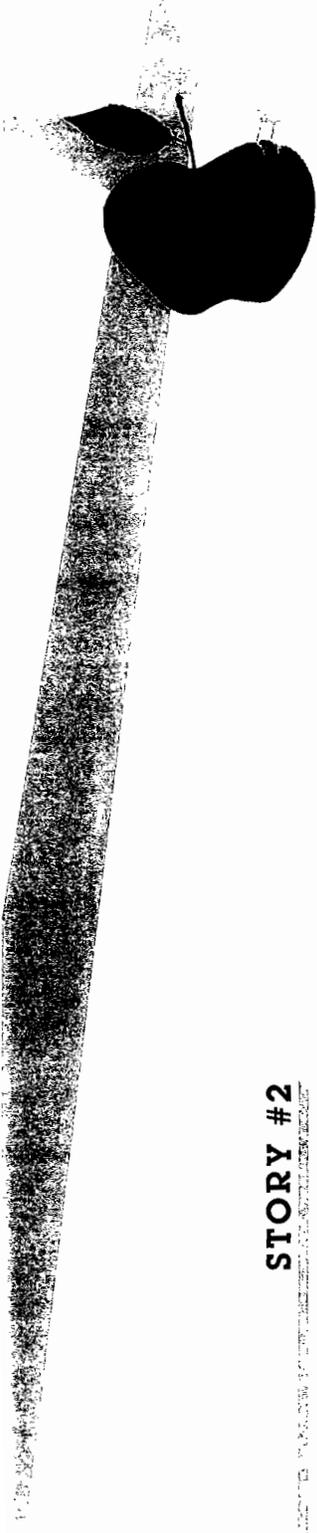


Table 1: Number of Medicaid-enrolled Children Ages 0-12 Receiving a Dental Service from Dentists

	Ages 0-2		Ages 3-5		Ages 6-9		Ages 10-12		Ages 0-12	
	Baseline	Current	Baseline	Current	Baseline	Current	Baseline	Current	Baseline	Current
	2005	2012	2005	2012	2005	2012	2005	2012	2005	2012
Number of children receiving a service	4,901	11,816	21,832	35,176	26,994	41,597	17,466	26,361	71,193	114,950
Total enrolled	48,573	65,994	40,396	60,465	43,981	65,791	30,726	43,218	163,676	235,468
Increase in number:	6,915		13,344		14,603		8,895		43,757	
Percent increase:	↑ 141%		↑ 61%		↑ 54%		↑ 51%		↑ 62%	
Rate of increase:	2.4 times		1.6 times		1.5 times		1.5 times		1.6 times	

Table 2: Number of Medicaid-enrolled Children Ages 0-12 Receiving a Dental Service from Title V Contractors

	Ages 0-2		Ages 3-5		Ages 6-9		Ages 10-12		Ages 0-12	
	Baseline	Current	Baseline	Current	Baseline	Current	Baseline	Current	Baseline	Current
	2005	2012	2005	2012	2005	2012	2005	2012	2005	2012
Number of children receiving a service	3,104	11,706	3,246	12,949	1,010	3,547	503	1,203	7,863	29,405
Total enrolled	48,573	65,994	40,396	60,465	43,981	65,791	30,726	43,218	163,676	235,468
Increase in number:	8,602		9,703		2,537		700		21,542	
Percent increase:	↑ 277%		↑ 299%		↑ 251%		↑ 139%		↑ 274%	
Rate of increase:	3.8 times		4.0 times		3.5 times		2.4 times		3.7 times	



I-Smile™ Success Stories

STORY #1

The mom of a 7-year-old called me (the I-Smile™ coordinator) because her son's stainless steel crown had come off for the second time. They'd had it resealed at a pediatric practice in another county once, but couldn't afford to do that again as they were going through bankruptcy. Mom had called two local providers who accept Medicaid, but neither would do a crown on a child. Mom was very frustrated and asked for help to get an appointment somewhere close. I told her if it had to be further away, our agency may be able to offer a gas voucher. She was thrilled with that little bit of helpful information.

I called another local dentist and explained the situation and was able to schedule an appointment for the following week. When I called mom back, she was so appreciative to have somewhere to turn for help! That same afternoon, I got a call from the dental office where I'd scheduled the boy for the next week. They'd had a cancellation that day and had called mom to see if they could come in. Mom made it work and got the crown placed that day.

She was so thankful to have the child's tooth protected once again. Without our ability to make the appointment for her, it's hard to say how long it would have been for the child to have that already weakened tooth vulnerable and exposed in his mouth.

STORY #2

A newly-single dad found himself suddenly responsible for arranging health care for his children. He was referred to I-Smile™ through a link on a school website, and called to request help finding a dentist for his children that would accept their Medicaid coverage. The I-Smile™ coordinator helped him set up an appointment with a local dentist.

Dad soon found out that his 12-year-old son had some complex problems with an upper front tooth that would require a root canal by an endodontic specialist to save it. If this wasn't possible, the tooth would have to be extracted to eliminate infection. Dad did not want to see his son lose the tooth at such a young age and be embarrassed by his smile. Unfortunately there was no endodontist accepting Medicaid in the county where they live. Dad called the I-Smile™ coordinator again.

A few months previously, the I-Smile™ coordinator had sent a mailing to local dentists to tell them about the challenges families face in getting dental care for their children and also highlighted the need for endodontists to accept Medicaid-enrolled families. One endodontist responded to the letter, and although he indicated he was not comfortable billing Medicaid, he volunteered to be available for a pro bono case if needed. The I-Smile™ coordinator called to schedule the child for a root canal with that endodontist. Dad was grateful that his son would be able to continue smiling with confidence.

STORY #3

Although many families may have some awareness their child needs to see a dentist, they sometimes don't know who to call or what to do. So they do nothing. This was the case for a mother of four kids, ranging in age from 3-9 years. She lives in a small town that is at least 45 minutes from any specialty dentists. The family only has one car, which her husband drives to work every day – so transportation has always been a barrier when trying to get medical or dental care. And the children have Medicaid coverage for their health care.

The two youngest children received screenings and fluoride varnish applications at their preschool through I-Smile's collaboration with the local Early Childhood Iowa program. Neither child had ever seen a dentist, and the 5-year-old had obvious decay. After the I-Smile™ coordinator's first phone conversation with mom, it was apparent that she understood the importance of getting her kids to the dentist, but was very overwhelmed in how to get it done.

Mom also told the I-Smile™ coordinator that her two older children hadn't seen a dentist for awhile. She knew that one had cavities, but didn't know who to call. The I-Smile™ coordinator helped to make dental appointments for the family and arranged transportation services. The two with known decay were seen by a pediatric dentist in another county within a week. Both needed restorative treatment in a hospital under general anesthesia. The other two children were able to be seen by a closer local general dentist.

A few months after all the kids' dental work was completed, Mom told the I-Smile™ coordinator that since the kids have been cavity-free they are eating much better and are able to eat things, like apples, they couldn't eat before. Mom is also much more aware of the importance of good oral health and the things that contribute to dental problems. She now gives her kids fruit as a snack, knowing it is a healthier choice than candy – which she knows contributed to their cavities. She has also noticed improved behavior in the 5-year-old, that she is less "whiny". She and their teachers have also recognized that their concentration has improved. Mom is grateful for the assistance she received from I-Smile™ and said "I want to share my story because there may be someone else out there just like me that needs assistance."

TESTIMONIAL #3

"As a former foster parent, I was well-aware of the difficulty in finding dental care for kids with Iowa Medicaid. In my current work, I often refer to I-Smile™ to assist parents in finding dental homes. I very much appreciate this service, as it alleviates the often time-consuming process for parents."

- Registered Nurse



STORY #4

This story spans over the past 11 years. We started seeing this boy when he was an infant at the WIC program and have followed him through our preschool fluoride varnish program, school dental sealant program, and requests for assistance from the school nurse. His parents were divorced and his mother had full custody. We tried multiple times to establish a dental home for this child, but mom would repeatedly miss appointments and not follow through on his routine care. The mother would only come to us when it was an emergency situation. About a year ago, Dad received full custody of this child. We saw him again at our community-based clinic, because other dental offices were hesitant to schedule him due to several past missed appointments and transportation was also a concern for Dad.

Appointment day came, and Dad and child arrived early for the appointment. The dental hygienist found that he had a probable abscess and severe decay on multiple teeth. We could get him an emergency appointment at the dental college, but transportation to Iowa City was a problem. The local mini-bus and the new DHS transportation do not provide emergency service on short notice. Dad could use his mother's car but there was no money available for gas. Our agency care coordinator worked with the family to get funding for gasoline, and a dental appointment was made for that afternoon. An emergency extraction was done and follow-up appointments were made for treatment and space maintainers at the dental college. Preventive care was completed at the community clinic.

Fast forward six months, and this child was ready for his recall appointment at the community-based clinic. Dad and child arrived early again - there were no apparent signs of any clinical decay and Dad had gotten his son to all of the follow-up and space maintainer appointments at the dental college. This child will now be able to go to local providers for routine and regular care. And better yet - the child is no longer that quiet little boy that we saw only when he was in pain. He has become a very outgoing, happy child whom dad states is doing much better in school too!

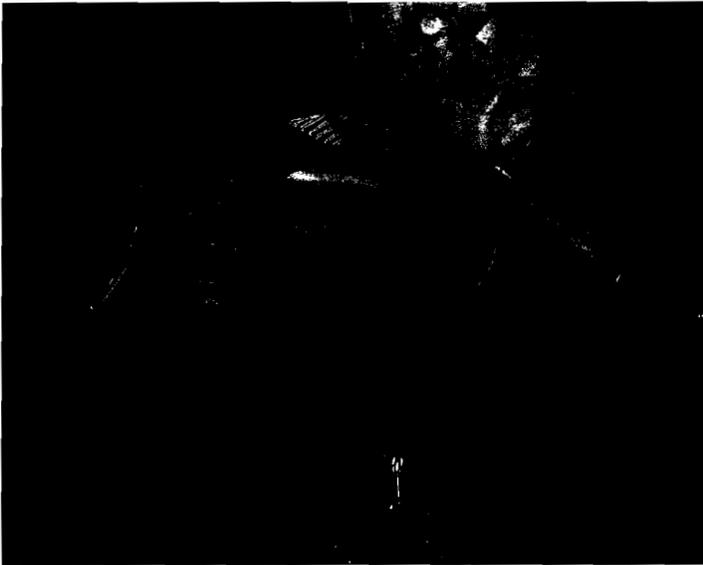


TESTIMONIAL #4

"I had made so many calls on my own and gotten turned down because of our insurance. I was frustrated!! A dental office that told me they couldn't help me gave me (the I-Smile coordinator's) number to call. She was able to schedule an appointment for me. Without her, I don't know what I would have done to get my child seen."

- Parent





STORY #5

A year ago, a second grader with Down Syndrome participated in our school-based dental sealant program. Just one sealant was placed, due to behavior issues and also dental decay that was found. The child's consent form indicated that the child had never been to a dentist and was covered by Medicaid. The I-Smile™ coordinator contacted the child's father and told him about the areas of concern that were identified during the screenings and the urgent need for the child to see a dentist. The father felt that due to the child's special health needs and behavior issues, they had never taken him to the dentist and they were not aware of any dentist that would accept Medicaid.

The coordinator assisted the family in finding a pediatric dentist that would accept new Medicaid patients and would be able to handle the child's special needs. The pediatric dentist provided the restorative treatment and a dental home was established. The family is now aware that they can take their child to a dentist and have a positive outcome, which they didn't think was possible due to their son's special health care needs.

TESTIMONIAL #5

"The I-Smile™ coordinator and program in this area of the state do a fine job of overseeing oral health concerns for all of our residents. It truly is a coordination of education and service."

- Western Iowa Dentist



I-Smile™



Johnson, Melanie [IDB]

From: Maranda Hollins [mhollins@slandchc.com]
Sent: Thursday, June 27, 2013 11:36 AM
To: Johnson, Melanie [IDB]
Subject: PHS Input
Attachments: IDB Letter PHS.doc

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June 26, 2013

Iowa Dental Board Members,

On behalf of the Siouxland Community Health Center, I want to thank you for your time and the opportunity to provide input on the oversight of public health supervision activities of dental hygienists.

Public health supervision has been wonderful in our community. Just recently I-Smile teamed up with the Council for Sexual Assault and Domestic Violence, which shelters approximately 10 women and their children in their facility at any given time. We have agreed to do twice monthly screenings in their facility and have had 2 screening dates completed so far. At each visit, we have referred at least one child for urgent dental care with severe caries and possible abscesses. The leader of this program, as well as the mothers that stay there, are very appreciative of the services we are providing them and were eager to team up with the I-Smile program.

This is just one example of the great things that the I-Smile program provides for the state of Iowa. The rule changes that are being proposed would greatly affect the community outreach that helps the highest risk populations in the state.

We understand the importance of quality healthcare and feel that dental hygienists with public health supervision agreements are qualified and able to provide that. Please keep these important services and children in mind when considering this matter.

Sincerely,

Maranda Hollins, RDH
Siouxland Community Health Center

Johnson, Melanie [IDB]

From: Beasler, Marijo A [marijo-beasler@uiowa.edu]
Sent: Thursday, June 27, 2013 11:53 AM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision of Dental Hygienists

Dear Iowa Dental Board,

I would like to voice my support of maintaining Public Health Supervision of dental hygienists as it currently is stated. It is an agreement between practicing dentists and hygienists that is appropriate in the public health setting.

The dentist controls every aspect of the agreement. The hygienist is essentially his employee.

There have been NO complaints filed against a hygienist or supervising dentist since 650-10.5 was written.

Many preventive programs in the communities, schools, and nursing homes, within the state of Iowa could be in jeopardy.

I know of no other programs currently available in the state that could have treated the number of needy Iowans that have been seen since this type of supervision has initiated.

With the scrutiny that other licensing boards are currently undergoing I feel that changing the supervision issue which would limit community outreach programs would not be looked upon kindly by many government watchdog agencies.

Please leave 650-10.5 as it is currently written.

Thank you for your time,

Marijo Beasler, RDH, BS

Johnson, Melanie [IDB]

From: Iowa Dental Board [IDB]
Sent: Thursday, June 27, 2013 2:18 PM
To: Johnson, Melanie [IDB]
Subject: FW: Public Health Supervision Agreement

Christel Braness, Program Planner

*Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov*

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From: Manson, Janice [<mailto:jmanson@Broadlawns.org>]
Sent: Thursday, June 27, 2013 12:12 PM
To: Iowa Dental Board [IDB]
Subject: Public Health Supervision Agreement

To Whom It May Concern:

I want my voice to be known as a supporter of the Public Health Supervision Agreement. I work at Broadlawns Medical Center and see everyday Iowans that have had no access to care because of a number of reasons;

1. Dental Offices do not take Medicaid patients or such a limited number that it really can not counted as seeing the "Medicaid population"
2. No one wants to go into the nursing facilities to see our elderly patients because of cost to the dentist, staff availability and just the toll on the physical being offering care. We service 2 nursing facilities and it is unacceptable that those patients that are unable to access a dental office get absolutely NO CARE from the dental community

I Smile, WIC and School sealant programs work!!! The Des Moines community has a large population of immigrant families as well as long time citizens and those programs are the initial contact for many families. Hygienists have made over 36,000 referrals to dentists in the year 2012 and over 6000 were for urgent care. These numbers come from 76 hygienists and 59 BRAVE DENTISTS (that also see a need) who have signed agreements. Can you tell me this program does not work with numbers like this? NO, it does work and we need more dental hygienists and concerned dentists to get on the band wagon to provide access to care.

The dental community should be ashamed of how we neglect the dental care for our elderly in the nursing homes and those disabled! It is hard for private offices to see that sitting in their operatories, but one really should step out of their box and open their eyes to the dental needs.

We, as hygienists, are trained to face the lack of access to care and try to make it better! Power or perceived lack of that is what motivates people to question safe, effective practices. We should all get off our high horses and look at what is happening to our communities. We ALL should be united to tackle the access to care issue, not continue putting up road blocks.

I sincerely ask that you not put more restrictions on the Public Health Agreement, but let's move forward in a positive manner for our citizens, especially those who need a voice; the elderly and children.

Thank you.

Regards,

Jan Manson RDH,BS
Program Director
Department of Oral Medicine
Broadlawns Medical Center
1801 Hickman Rd.
Des Moines, IA 50314
jmanson@broadlawns.org
515.282.2421. Ext. 2907

Johnson, Melanie [IDB]

From: Iowa Dental Board [IDB]
Sent: Thursday, June 27, 2013 2:19 PM
To: Johnson, Melanie [IDB]
Subject: FW: Public Health Supervision

Christel Braness, Program Planner

Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309

Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

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From: Lori Millard [<mailto:lorimillard@gmail.com>]
Sent: Thursday, June 27, 2013 10:23 AM
To: Iowa Dental Board [IDB]
Subject: Public Health Supervision

Iowa Dental Board,

I would like to express my concerns about oversights and restrictions regarding the Public Health Supervision for Dental Hygienists. As a former I-Smile dental Hygienist, I can assure you, the need is there. I provided dental screenings, education, fluoride varnishes, but most importantly, referrals to Dental offices so these children would have dental homes. Under the supervision, we do not provide any service that is beyond our scope of practice. The hygiensists report to a Dentist and have agreements as to what services can be provided and where. By being able to do this, we reach populations that otherwise might not get any dental care until there is serious problem. Providing education and information is so important.

Please allow us to continue to serve these children in need.

Thank you for your consideration,

Lori Millard, RDH

Johnson, Melanie [IDB]

From: Amanda Godfrey [asgodfrey85@yahoo.com]
Sent: Thursday, June 27, 2013 3:07 PM
To: Johnson, Melanie [IDB]
Subject: Dental Hygiene Public Health Supervision

Dear Melanie,

I may be new to the Dental Hygiene aspect, but as an Assistant for several years I have been able to see first hand the lack of care for those who are less fortunate. The overwhelming amount of providers that accept Medicaid in the Iowa region that are not accepting new patients is incredible. I would call for patients that came in for care and we had to turn them away for not being a provider, and there was only one office I could find accepting new Medicaid patients. The care is being neglected and preventative issues are turning into emergency situations. I fully support Public Health Supervision to help those who can't help themselves. The links between health issues and the state of the oral cavity show a correlation that can't be ignored. When going to a retirement home for a presentation while in school, I was able to see that in that specific setting oral health is next to none. This was an Alzheimers unit that would sit a toothbrush with toothpaste in front of a resident and leave. This is ridiculous and sad to know that people who can't help themselves can't be allowed the help of Dental Hygiene to come in and give them the health they deserve. Public Health and Dental Hygiene should not even be an option, it should be a mandate. If we are able to help lives then I can't see how Public Health and Dental Hygiene coming together should be an issue.

Thank you for your time,

Amanda Godfrey RDH

Johnson, Melanie [IDB]

From: Nadine DeVoss [ndrdh@yahoo.com]
Sent: Thursday, June 27, 2013 3:41 PM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision Agreement

I support the Public Health Agreement as written and see no need for changes that require additional supervision or reporting requirements.

The existing agreement provides adequate oversight and reporting requirements. The licensed dentist is completely in control of the agreement with the licensed dental hygienist and it is customized to the public health setting being served. Any changes can be requested by the supervising dentist.

Very few dentists in my area of Council Bluffs take Medicaid patients making it difficult for children to even receive screening appointments. That over 63,000 Iowa children have received screening or treatment is a testament to the effectiveness and need for Public Health preventive services.

I urge the Iowa Dental Board to leave the Public Health Supervision Agreement as it stands and to make no changes.

Nadine DeVoss, RDH BS
President-elect, IDHA

Johnson, Melanie [IDB]

From: David Miller [dnmiller@myomnitel.com]
Sent: Friday, June 28, 2013 3:18 AM
To: Johnson, Melanie [IDB]
Subject: Input for oversight of PH Supervision
Attachments: Letter to IDB - PH Supervision.docx

Hello Ms Johnson,

Please include my letter in the discussion on Public Health Supervision of dental hygienists. Could you let me know if this was submitted on time?

Nancy Miller, RDH

Nancy Miller, RDH, BS
1898 Zinnia Avenue
Rockford, IA 50468

June 27, 2013

Melanie Johnson, Executive Director
Iowa Dental Board
Melanie.Johnson@iowa.gov

RE: Testimony for oversight of Public Health Supervision of RDHs working in public health settings

Dear Ms. Johnson:

I am writing in support of the existing model of how public health dental hygienists are supervised in the public health settings where they are employed. I understand the very important role that the Iowa Dental Board plays in protecting the public from the inappropriate practice of dental personnel. Have complaints been filed against dental hygienists working under public health supervision? When I review the annual reports of the Iowa Department of Public Health, I only see the successes of specifically the ISMILE program which has helped thousands of Iowa children receive dental care, each year increasing since its inception in 2006. Not only have these children had screenings, fluoride varnishes, sealants, and oral health education, but the dental hygienists performing these services have referred many of these patients for needed dental care to dentists who will accept them.

I have worked in a Well Child Clinic in Muscatine which was an eye-opening experience for me after having only worked in private practice before that. I learned that these children come from very poor families – some having one parent, some only a guardian or grandparent. These “families” cannot afford treatment and many times do not even have transportation so they have difficulty seeking dental care traditionally. The Title V public health agencies are set up to meet these needs offering transportation and a list of participating dentists in the area (the public health RDHs being those persons establishing the DDS relationships). Many dental offices will not accept Medicaid eligible patients (which many of these patients are) who call directly to the office. I know specifically offices in my area who will accept patients referred from the public health agencies (the ISMILE RDH coordinator) because these patients are more likely to show up for appointments and follow through with the needed treatment. The numbers of these needy customers is only increasing with the depressed economy making the existence of these agencies, the public health RDHs, and the supervising dentists SO VERY IMPORTANT. Adding new rules and restrictions on already successful programs will only hamper their survival and increase the numbers of dentally underserved Iowans.

On the positive side of reviewing public health supervision, I would recommend expanding it to include homebound elderly and those in long term care facilities. In 2007, the list of facilities for dental hygienists to offer services was expanded to include long term care facilities but little has been done to accomplish this. A program like the ISMILE program for children could be set up for our very needy geriatric populations. Here are some facts presented at a Delta Dental workshop on November 30th of 2012:

- 1) Iowa is ranked #7 in the U.S. for the numbers of residents age 65+ (the ranking increases for 75+ and 85+.

- 2) Nearly 70% of adults 65+ will require long-term care at some point in their lives.
- 3) Medicare does not cover dental care and most older adults lose their dental insurance at retirement.
- 4) Many residents of long term care facilities are non-ambulatory and require transportation and a care center employee to accompany the resident to appointments – all very costly!
- 5) The Elderly Waiver program could be expanded for homebound customers qualifying for Medicaid who receive home and community-based services to include dental preventive services.
- 6) Evaluation of Medicaid claims from 2011 showed that 74% of homebound Elderly Waiver eligible adults did not receive a dental service that year.
- 7) 69% of Iowa Area Associations on Aging affiliates said obtaining dental services for their residents was very difficult.
- 8) A report from 2012 indicated that of approximately 24,000 Medicaid eligible care center residents, 25% experienced a dental incident in a 7 day period (cavity, broken tooth, ill-fitting or broken denture or partial denture).
- 9) A 2011 evaluation of claims for 65+ non-waiver Medicaid eligible residents, 84% did not receive a dental service.

In conclusion, one of the speakers at the workshop said that there is already a member of the dental team, the dental hygienist, who has attended an accredited educational program and passed a regulatory national exam and state licensing exam proving competency in performing screenings, education, and preventive services. In order to work in a public health setting, the dental hygienist must have three years of clinical experience.

For those dental hygienists already working in public health, they must submit an annual report to the Iowa Department of Public Health. The supervising dentist reviews this report and is in complete control of how the dental hygienist practices – requiring additional conditions and/or reports if he/she deems necessary.

Thank you for asking for input before making any decisions. I feel that the way public health hygienists are functioning has been a real success story for reaching dentally underserved children and I would like to see that very successful model expanded to include the homebound elderly and the residents of long term care facilities.

Respectfully submitted,

Nancy Miller, RDH, BS

Johnson, Melanie [IDB]

From: Shane and Patti Simon [spsimon@yousq.net]
Sent: Friday, June 28, 2013 7:05 AM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision

Ms. Melanie Johnson,

I am writing in support of public health supervision. I Smile, WIC, School Sealant, nursing home and many other programs that allow for access to dental care in Iowa is needed and I am asking for support of the board for this supervision as is. Public Health Supervision has worked well for Iowans since 2004. With Dental Hygienists and Dentists working together they have served the dental needs of thousands of Iowans. The Board of Dental Examiners should continue their support of public health supervision and be proud of their foresight that has helped to gain access for the dental needs of thousands Iowans with no complaints brought to the board.

Thank you for your consideration on this issue.

Patricia Lynch-Simon RDH.

Johnson, Melanie [IDB]

From: Terri Castle [castle@omnitelcom.com]
Sent: Friday, June 28, 2013 9:46 AM
To: Johnson, Melanie [IDB]
Subject: Public Health Supervision

Ms. Johnson,

This email is being sent to show my support for those Dental Hygienists who work in the Public Health setting.

I fully support Public Health supervision as it stands now.

These professionals are doing wonderful work serving those who cannot get their dental needs met.

A simple screening in 2012 served 63,000 children and put them on a path of wellness and prevention.

These professionals are only serving the population not harming them.

More restrictions and regulations, I feel, will only slow and hamper this valuable process.

Sincerely,

Trese Castle

Registered Dental Hygienist

Johnson, Melanie [IDB]

From: Suzanne Heckenlaible [SHeckenlaible@deltadentalia.com]
Sent: Friday, June 28, 2013 2:09 PM
To: Johnson, Melanie [IDB]
Cc: Ed Schooley, D.D.S.
Subject: REQUEST FOR INPUT RE: OVERSIGHT OF PUBLIC HEALTH SUPERVISION
Attachments: IDB PHS Letter 6-28-2013.pdf

Melanie –

Please find attached Delta Dental of Iowa's public comment in regards to the oversight of public health supervision. We appreciate the opportunity to provide our comments.

Suzanne Heckenlaible
Vice President, Public Affairs

June 28, 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 regarding the board's request for input on the future oversight of public health supervision activities. We encourage the board to ensure that any changes made to the public health supervision rules not place additional burdens upon either hygienists or dentists who provide care to underserved Iowans. The oversight should support the ability of public health hygienists and dentists to maintain a collaborative relationship to provide efficient, safe and effective oral health care.

In the Inside I-Smile Annual Report from 2012, it was indicated that dental offices saw 62 percent more Medicaid children ages 0-12 than before the program existed in 2005. This program is an example of how a partnership between public health and private practice dentists has been successful in providing care coordination, prevention and direct services in communities.

The Delta Dental of Iowa Foundation's 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. Public health supervision is a key component to achieving these long term goals. In fact, the opportunity to increase care coordination and preventive care in various settings can reach a broader underserved population to support and improve their oral health.

Sincerely,



Suzanne Heckenlaible, MPA
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]

From: Peggy Funk [pannfunk@icloud.com]
Sent: Friday, June 28, 2013 2:18 PM
To: Johnson, Melanie [IDB]
Subject: Public health supervision

IBODE

I support public health supervision as it stands now. Adding more rules and restrictions will only jeopardize the successful programs already in place and limit care for an ever-increasing population of undeserved Iowans. We have many dentists in north central Iowa who will see Title XIX for existing patients, however, they won't take any new Title XIX. The dentists that do take new XIX only take so many per month and we are now making appointments into November. We've also had many dentists decline seeing our pregnant Title XIX clients. It's very important for us to be able to help these women with oral health education and to get an appointment with a dentist.

We need to continue public health supervision as is for the benefit of Iowans.

Peggy Funk, BS RDH

Sent from my iPad

Johnson, Melanie [IDB]

From: Stephanie Chickering [stephaniec@co.warren.ia.us]
Sent: Friday, June 28, 2013 3:14 PM
To: Johnson, Melanie [IDB]
Subject: Request for Input Re: Oversight of Public Health Supervision
Attachments: Iowa Dental Board Letter.pdf

Melanie,

Please share my attached letter with the Iowa Dental Board.

Thank you!

Stephanie Chickering, BA RDH

I-Smile™ Coordinator
Warren County Health Services
301 N. Buxton, Suite 203
Indianola, IA 50125
Phone: 515.961.1074
Fax: 515.961.1083
stephaniec@co.warren.ia.us

June 28, 2013

Iowa Dental Board Members,

I am writing to you in opposition of the proposed rule changes that would greatly affect public health supervision agreements of dental hygienists. As a dental hygienist with a public health supervision agreement, I have serious concerns about the less than positive impact this will have on the children of Iowa.

Public health supervision has been working well for almost a decade now. Thousands of children and pregnant women are receiving services because of public health supervision. During this time, not one single complaint has been recorded in regards to public health supervision agreements, the services provided under a public health supervision agreements or the hygienist providing the services. In 2004, just over 11,000 oral screenings were provided by dental hygienists working under public health supervision and that number has grown to over 65,000 screenings in 2012. The overwhelming number of clients we successfully provide services to speaks well for the supervision agreements.

In my community and across the state, public health supervision dental hygienists have been making a difference in the communities in which we work. Not only are we helping children and their families find and receive services they need, but we are providing them with referrals to local dentists; thus increasing the amount of children and their family members seeking oral health care services from dentists. Dentists in the State of Iowa in 2012 saw more than 135,000 Medicaid-enrolled children in 2012 – a 13 percent increase from 2011 and 1.6 times as many children than those seen in 2006.

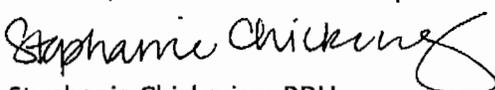
I believe the services that dental hygienists are able to provide to our communities because of public health supervision agreements are invaluable. Not only are we able to provide the tools to keep mouths healthy and increase the number of children visiting dental offices, but we provide them with the vital education for a lifetime of health. The time we are able to spend providing education to children and their families makes a huge difference in the oral health of our youngest Iowans, as the material tools are often not enough.

I feel that public health supervision is working so well that considerations should be made to possibly expand the services and locations of services provided. More and more children are getting in to see a dentist in the State of Iowa, but still too many go without seeing a dentist on a regular basis. By expanding the abilities of public health supervision dental hygienists, we would be able to do so much more for the children at highest risk within our communities.

Please thoughtfully consider the children and their families that may be affected by your proposed changes. Public health dental hygienists are playing an increasingly important role in the oral health of Iowa's children and would be unable to do so with the proposed changes.

Thank you for your consideration.

Sincerely,


Stephanie Chickering, RDH

Johnson, Melanie [IDB]

From: Mary Mariani [MMariani@davchc.com]
Sent: Friday, June 28, 2013 4:01 PM
To: Johnson, Melanie [IDB]
Subject: Oversight of Public Health Supervision
Attachments: Iowa Public Health Supervision Agreement Letter.docx

Hi Melanie,

Attached is a letter that lists some of the concerns that I have received about Public Health Supervision agreements. I realize the deadline is 5pm today.

Due to the time constraint, I was not able to vet this through the IDA Board of Trustees (they do not meet until August)

Therefore this letter is my opinion and not necessarily the opinion of the IDA although the complaints that I shared did come from membered dentists.

Please let me know if you have concerns about my letter.

Thanks

Mary

Mary L. Mariani DDS

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June 28, 2013

RE: Public Health Supervision Agreements

Dear Iowa Dental Board,

Per your request these are the main concerns that dentists have shared with me about the current public health supervision of dental hygienists in Iowa.

1. Misleading advertising of services: There have been several situations where the services have been advertised as being "free" only to find out that Medicaid is being billed.
2. The parent is not aware that their child's Medicaid Benefit has been used. They subsequently bring the child to the dentist appointment. The treating dentist is not aware that services were done until the claim is denied. This causes two problems. The child receives redundant care (possible overuse of fluoride that could cause harm) and the dentist does not get reimbursed and becomes more disenchanted with Medicaid and may choose to curtail the number of Medicaid patients seen.
3. There is no data bank that allows the dentist to see if the child's Medicaid benefit has already been used.
4. There have been concerns shared about quality assurance especially with the placements of dental sealants. In the clinic where I work, sealants are checked at the child's recall visit and replaced at no charge if they have fallen off. These are often checked by a dentist that did not place the original sealant so that there is quality control.
5. Dentists in our state work with other dental professionals and not by themselves. Concerns have been raised over whether these public health services are being provided with appropriate infection control. They are going into public schools and providing services often to the entire school. How are they preventing cross contamination? How are biohazard materials and instruments being transported? Who is responsible for making certain that these safety measures are in place?
6. Are there records being kept that indicates which services the child has received, results of screenings, who provided the care or whether the child was appropriately referred to a dentist for definitive care and a dental home? Where are these records being kept? Are they HIPAA compliant?
7. There are dental hygienists going to small towns , providing services to entire elementary schools then leaving without notifying the local dentist that they have been there much less following up on locating a dental home for the children.
8. Dental Malpractice companies are denying coverage to dentists who participate in these agreements because, despite the law, if there is an employee-employer relationship between the supervising dentist and the dental hygienist then the dentist may have liability.

Please understand that I am the supervising dentist for two agreements. As the director of a Federally Qualified Health Center our programs are heavily regulated by the federal government as well as the Joint Commission. We have programs in place to assure that there is not redundant

care... that children who are already being treated by a dentist are not receiving services from us and that HIPAA and Infection control standards are being met.

With the concerns that the Iowa Dental Association has received, I know that these standards are not being met statewide.

I truly believe that dentists, dental hygienists, dental assistants and members of the Iowa Dental Board have a common goal assuring that Iowa children are as healthy and as safe as possible. Public Health Supervision agreements allow oral health professionals to work together to improve the oral health of the children of Iowa.

I encouraged the Iowa Dental Board to address the problems that I have brought to your attention in this letter and find solutions that will make these arrangements as safe as possible for the children that receive services from them. Review of the required level of supervision provided by the sponsoring dentist seems to be a good place to begin.

Sincerely,

Mary L. Mariani DDS

Johnson, Melanie [IDB]

From: cbrumfield23@mchsi.com
Sent: Friday, June 28, 2013 4:25 PM
To: Johnson, Melanie [IDB]
Subject: Support of Public Health Supervision For Dental Hygienists

I support Public Health Supervision for dental hygienists as it is written. I do not think it should be changed. There have not been any complaints filed against this type of supervision and it is so very helpful for our communities in Iowa. Over 63,000 children have received screenings or treatment in 2012. This could be the only care some children receive.

Sincerely,
Carolyn Brumfield, RDH,BS
214 Essex Lane
Davenport, Iowa 52803
563-359-1249

Johnson, Melanie [IDB]

From: Erin Parker [erinmarie882@yahoo.com]
Sent: Friday, June 28, 2013 4:54 PM
To: Johnson, Melanie [IDB]
Subject: request for input-public health supervision
Attachments: letter to Iowa Dental Board.docx

June 27, 2013

Melanie Johnson, Executive Director
Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309

Dear Ms. Johnson,

I am writing in regards to the proposed changes to Public Health Supervision of dental hygienists. As a public health professional who has worked alongside the I-Smile program at both the state and local level, I have seen the great impact of this program, and I strongly feel that no changes are needed to the current structure.

As you know, the cost of poor oral health is great, and it can have a lasting impact on the overall health and wellbeing of a child. The current structure of public health supervision allows dental hygienists to be an integral part of the overall system of oral health care in Iowa, providing gap filling and preventive services to families who would not otherwise be able to access these services, and to identify any problems that, if left untreated, could become acute or even life threatening. These dental hygienists are an important partner in the dental system in this state, and the proposed changes would severely hinder a program that has become a model across the nation and has contributed greatly to the health of Iowans.

The current structure allows public health dental hygienists to provide preventive services and screening to many low income families who would otherwise not have access to these services. In no way are these services meant to replace regular dental care from a licensed dentist; in fact, one of the main goals of the program is to link families to a dentist for routine oral health care as well as treatment for any problems identified. These referrals are routinely given at the time of service, even if the family only requests a list of dentists in the area. Many families who have Medicaid insurance are not able to easily find dentists who will take their insurance, and others have no access to dental insurance, causing them to forego preventive care and only seek treatment once problems become acute or, in some cases, life threatening. In addition to educating the general public about the importance of good oral health, public health dental hygienists seek to connect these families to preventive services through a dental home.

On a more specific note, I have worked alongside a dental hygienist who builds excellent rapport with dentists, doctors, families, schools, and other community agencies to ensure that all children have access to preventive dental care. She works very well with the children to make dental screening as non-threatening as possible (and even fun!) She is able to provide fluoride varnish treatment or sealants that will help prevent problems down the road, as well as instructing children and parents on good oral hygiene. She has worked diligently with school nurses, child care agencies, and others to provide population-based screening so that parents who may be unaware of problems can then bring their children to see a dentist for treatment.

In short, the I-Smile program has flourished under the current structure and oversight. These proposed changes and cumbersome reporting requirements would effectively dismantle a program that has received much investment of time, effort, and taxpayer dollars. The current program and structure has experienced great success, and allows public health dental hygienists to be an integral part of the system of oral health care in Iowa. Thank you for your consideration of these issues.

Sincerely,

Erin Parker, MPH

Background Information

REQUEST FOR INPUT RE: OVERSIGHT OF PUBLIC HEALTH SUPERVISION

May 7, 2013

The **Iowa Dental Board** is seeking input from interested parties for ideas on the future oversight of public health supervision (PHS) activities. Board rules provide that a dentist may provide public health supervision to a dental hygienist if the dentist has an active Iowa license and the services are provided in public health settings.

The Board is interested in receiving comments about PHS including, but not limited to, the following topics:

- *Oversight of the public health supervision activities* – What works well? What could be improved? Any suggestions for strengthening oversight?
- *Public health supervision agreements* – Any suggested revisions to the minimum agreement requirements as set forth in Board rule?
- *PHS reporting requirements* – Is sufficient information collected and reported? If no, any suggestions?

➤ Link to current PHS rule:

<https://www.legis.iowa.gov/DOCS/ACO/IAC/LINC/5-1-2013.Rule.650.10.5.pdf>

Deadline for Written Comments: 5:00 p.m. on Friday, June 28, 2013

Ways to Submit Comments:

By e-mail to: Melanie.Johnson@iowa.gov

By U.S. Mail to: Melanie Johnson, Executive Director
Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309-4687

REPORT TO THE IOWA DENTAL BOARD

**DISCUSSION &
POSSIBLE ACTION**

DATE OF MEETING: March 28, 2013 (telephonic meeting)
RE: **Public Health Supervision Proposal**
SUBMITTED BY: Steven Fuller, D.D.S., Board Member
ACTION REQUESTED: Review of Public Health Supervision Proposal

Motion at 2/11/13 Telephonic Board Meeting re: Public Health Supervision

❖ MOVED by ROVNER, seconded by KELLY, to solicit information from interested parties for ideas on the future oversight of the public health supervision program for inclusion on the agenda of the next meeting of the Board. Motion APPROVED unanimously.

<u>Member</u>	<u>Bradley</u>	<u>Curry</u>	<u>Elmitt</u>	<u>Fuller</u>	<u>Kelly</u>	<u>McCullough</u>	<u>Meier</u>	<u>Slach</u>	<u>Rovner</u>
Yes	x	x	x	x	x	x	x	x	x
No									

Proposal for additional oversight of public health supervision agreements:

1. Agreements must be renewed and filed every year with IDPH.
2. Dentist must receive a report from the hygienist and file a signed report with IDPH.
3. Hygienist must file a report with the names of "clients" who have been referred for treatment. Report must be given to and signed by dentist.
4. Hygienist must file a report of non-compliant "clients" who were referred and did not seek further treatment. Report must be signed by the dentist.
5. Hygienist and dentist must have a plan to follow-up non-compliant "clients" and possible report to DHS by dentist.
6. Establish a proper place for storage of "clients" records and have dentist review them to insure the agreement has been followed. Make any necessary corrections to agreement
7. If the public health supervision hygienist ever receives authority to bill for services, the dentist must first exam the patient and complete a treatment plan for the hygienist to follow.
8. Dentists can have up to 5 collaborative agreements active.

Attached for Review

- ❖ Current PHS rule (650 IAC Rule 10.5)

650—10.5 (153) Public health supervision allowed. A dentist who meets the requirements of this rule may provide public health supervision to a dental hygienist if the dentist has an active Iowa license and the services are provided in public health settings.

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; child care centers (excluding home-based child 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.

10.5(2) *Public health supervision defined.* “Public health supervision” means all of the following:

a. The dentist authorizes and delegates the services provided by a dental hygienist to a patient in a public health setting, with the exception that hygiene services may be rendered without the patient’s first being examined by a licensed dentist;

b. The dentist is not required to provide future dental treatment to patients served under public health supervision;

c. The dentist and the dental hygienist have entered into a written supervision agreement that details the responsibilities of each licensee, as specified in subrule 10.5(3); and

d. The dental hygienist has an active Iowa license with a minimum of three years of clinical practice experience.

10.5(3) *Licensee responsibilities.* When working together in a public health supervision relationship, a dentist and dental hygienist shall enter into a written agreement that specifies the following responsibilities.

a. The dentist providing public health supervision must:

(1) Be available to provide communication and consultation with the dental hygienist;

(2) Have age- and procedure-specific standing orders for the performance of dental hygiene services. Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of dental hygiene services;

(3) Specify a period of time in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement; and

(4) Specify the location or locations where the hygiene services will be provided under public health supervision.

b. A dental hygienist providing services under public health supervision may provide assessments; screenings; data collection; and educational, therapeutic, preventive, and diagnostic services as defined in rule 10.3(153), except for the administration of local anesthesia or nitrous oxide inhalation analgesia, and must:

(1) Maintain contact and communication with the dentist providing public health supervision;

(2) Practice according to age- and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient;

(3) Provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs;

(4) Have each patient sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services; and

(5) Specify a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist, including where these records are to be located.

c. The written agreement for public health supervision must be maintained by the dentist and the dental hygienist and must be made available to the board upon request. The dentist and dental hygienist must review the agreement at least biennially.

d. A copy of the agreement shall be filed with the Oral Health Bureau, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

10.5(4) Reporting requirements. Each dental hygienist who has rendered services under public health supervision must complete a summary report at the completion of a program or, in the case of an ongoing program, at least annually. The report shall be filed with the oral health bureau of the Iowa department of public health on forms provided and include information related to the number of patients seen and services provided to enable the department to assess the impact of the program. The department will provide summary reports to the board on an annual basis.

This rule is intended to implement Iowa Code section 153.15.

[ARC 7767B, IAB 5/20/09, effective 6/24/09; ARC 0629C, IAB 3/6/13, effective 4/10/13]

Sherry Steinbach, RDH
627 Iliion Ave.
Chariton, IA 50049
June 25, 2013

Iowa Dental Board,

My name is Sherry Steinbach and I am a dental hygienist. I have worked in the dental profession since 1983, thirteen years as a dental hygienist. Under the public supervision agreement, I have been working with the I Smile program. I started on October 2012 and work in Chariton, Albia and Corydon.

Before working with the I Smile program, I had several questions regarding the public supervision agreement as well and if there was a need. I re-read the board rules, sent emails and spoke with fellow hygienists and public health individuals regarding my questions.

Under the current agreement, the dentist authorizes and delegates approved services to be provided by the hygienist. The dentist can request additional reports along with the required annual report.

I believe the supervising dentist has faith in and trusts that the hygienist is professional, ethical, and serves the good of the public. I have not heard of any complaints directed at hygienists that work within the public supervision agreement. I see no need to change the public supervision agreement as it now stands. The supervising dentist always has the option at the biennial date to re-evaluate the agreement and make changes based on the annual reports the dentist receives.

Since January of 2012, I have seen approximately 244 infants, children and pregnant mothers. Of those 244 approximately 194 were on Medicaid insurance with a large majority not having a dental home.

I recently saw a one-year-old girl at one of the WIC clinics. When I asked the mother if there were any concerns about her daughter's teeth, she stated she did not know what was wrong with her front teeth. When I checked the little girl's mouth, the maxillary four anterior teeth were decayed, with very little tooth structure left. When I asked her about sippy cups and bottle use, the mother stated that the child went to bed with milk in the cup or bottle. The mother and I discussed this ritual and her reply was "but milk is good for you". She was shocked when she heard that milk contains sugar. I asked the mother to replace the milk with water at bedtime.

Her next question was who will see my little girl to take care of her teeth. There are several dentists that will see children at such a young age and accept her Medicaid insurance. A couple of dentist names were given to the mother, as well as the contact number for the I Smile coordinator.

Each person I have seen is grateful for the advice and education. A young mother said that she wanted to learn at least one new bit of information a day, and thanked me for helping her understand why fluoride was important to her child's teeth. I have

always had positive feedback during an I Smile screening.

A major part of what I do with I Smiles is to educate parents on the importance of good oral hygiene and healthy nutritional habits. I discuss the problems associated with poor oral hygiene and how even though they are just “baby teeth” they can become infected and cause pain and premature loss of the tooth. Parents often state that they had never really thought about these things, other than that the teeth should erupt at a certain age.

Another important aspect of the I Smile clinic is to get the child and family established with a dentist. It is always stressed that the visit with I Smiles is just for screening (count the teeth), dental education, a fluoride varnish application, help answer dental questions and refer them to a dentist.

I look at the public supervision agreement as an extension of the dental office. We need and want to reach underserved areas of the state. The goal of a dental team is to help the public obtain good oral health and when we work together this can be accomplished. It should not matter if this is accomplished in a dental office or in the basement of a local church.

Please keep the existing public supervision agreement so we can all serve the needs of the public.

Respectfully submitted,
Sherry Steinbach, RDH