JOINT
SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE
Friday, February 12, 2016

ATTACHMENT 11

02/12/16
Susanne Jamison

MISTER CHAIRMAN....MEMBERS OF BOTH THE HOUSE AND THE SENATE WELFARE COMMITTEES.
MY NAME IS SUSANNE JAMISON AND I AM THE EXECUTIVE DIRECTOR OF THE IDAHO DENTAL HYGIENISTS' ASSOCIATION.
FIRST, DENTAL HYGIENISTS ARE LICENSED HEALTH PROFESSIONALS WITH A WEALTH OF KNOWLEDGE AND SKILLS TO SHARE WITH IDAHO CITIZENS. THERE ARE OVER 1800 DENTAL HYGIENISTS AND OVER 1200 DENTISTS LICENSED IN IDAHO. THERE ARE FOUR DENTAL HYGIENE EDUCATION PROGRAMS IN IDAHO, ONE OF WHICH HAS A MASTER OF DENTAL HYGIENE PROGRAM THAT IS ONLINE.

I COME BEFORE YOU TODAY TO URGE YOU TO CONSIDER THE CREATION OF A DENTAL HYGIENE MIDLEVEL PRACTITIONER POSITION IN THE STATE OF IDAHO. MIDLEVEL PROVIDERS ARE COMMON IN OTHER HEALTH PROFESSIONS. NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS ARE EXAMPLES. DENTAL HYGIENE MIDLEVEL PRACTITIONERS EXIST IN OTHER STATES SUCH AS NORTH DAKOTA AND WASHINGTON. THEY PERFORM PREVENTIVE AND SIMPLE RESTORATIVE PROCEDURES SUCH AS CLEANINGS AND SEALANTS. THEIR EDUCATION IS ECONOMICAL BECAUSE DENTAL HYGIENISTS ALREADY HAVE A DEGREE, ARE LICENSED INDICATING COMPETENCY, AND WOULD NEED VERY LITTLE ADDITIONAL EDUCATION.

HERE ARE SOME QUICK ORAL HEALTH FACTS ABOUT IDAHO:

- 42 COUNTIES, OR ALMOST ALL OF IDAHO, IS DESIGNATED AS A DENTAL HEALTH PROFESSIONAL SHORTAGE AREA - THAT DOESN'T MEAN THERE'S A SHORTAGE OF DENTISTS IN ALL AREAS...IT JUST MEANS DENTAL PRACTICES TEND TO CONGREGATE IN POPULATED AREAS...WHILE OTHER AREAS GO UNSERVED.
- 21% OF CHILDREN 6 TO 9 YEARS OLD HAVE UNTREATED DENTAL DECAY
- 50% OF PREGNANT WOMEN HAVE BLEEDING GUMS, INDICATING INFECTION
- 65% OF PEOPLE WITH DIABETES HAVE HAD ONE OR MORE TEETH REMOVED
- 69% OF THOSE WITH CORONARY HEART DISEASE HAVE TOOTH LOSS
- 70% OF ADULTS 65 YEARS AND OLDER DO NOT HAVE DENTAL INSURANCE
- 55% OF 18 TO 24 YEAR OLDS DO NOT HAVE DENTAL INSURANCE AND
- AMONG IDAHO ADULTS 65 AND OLDER, ONE IN FOUR HAS LOST ALL THEIR TEETH.

IDAHO IS IN AN ORAL HEALTH CARE CRISIS...BUT THERE IS AN ANSWER...CREATION OF THE DENTAL HYGIENE MIDLEVEL PRACTITIONER.
AS THINGS STAND TODAY, THE DENTAL HYGIENIST IS ONE OF THE MOST UNDER-UTILIZED PROFESSIONALS IN OUR STATE. OTHER STATES HAVE FOUND THAT INCREASING THE RESPONSIBILITIES OF HYGIENISTS HAS RESULTED IN

INCREASED EFFICIENCES, IMPROVED ACCESS TO ORAL CARE AND LOWERED COSTS TO PATIENTS.

UNFORTUNATELY THERE ARE SOME POWERFUL FORCES THAT MIGHT OPPOSE THIS PROPOSED CHANGE BECAUSE NAYSAYERS SAY THIS MIDLEVEL PROVIDER IS UNNEEDED AND UNSAFE. HOWEVER, THERE IS NO EVIDENCE OF EVER HARMING A PATIENT BECAUSE OF THIS PROVIDER. IN FACT, NUMEROUS STUDIES HAVE SHOWN JUST THE OPPOSITE. ORAL CARE IS OF HIGH QUALITY AND CAN EVEN INCREASE REVENUE FOR DENTISTS, ORAL SURGEONS, PERIODONTISTS, AND VARIOUS OTHER MEDICAL PROFESSIONALS. IN MINNESOTA, THIS PROVIDER HAS INCREASED THE NUMBER OF MEDICAID PATIENTS SEEN, AND RAISED REVENUE WHILE DECREASING WAIT TIMES.
I HOPE YOU WILL AGREE THAT IT'S PERPLEXING WHY ANYONE WOULD OPPOSE A POTENTIAL SOLUTION THAT COULD PROVIDE SIGNIFICANT BENEFITS TO IDAHO CITIZENS. THE DENTAL HYGIENE MIDLEVEL PRACTITIONER EXISTS IN AT LEAST 14 STATES ALREADY, WITH OTHERS MOVING TOWARD THIS MIDLEVEL PROVIDER. A JOINT TASK FORCE OF ORAL HEALTH PROFESSIONALS AND OTHER STAKEHOLDERS COULD BE ASSEMBLED TO DEVELOP THE MODEL THAT WORKS FOR IDAHO. LET'S NOT LEAVE IDAHO CITIZENS BEHIND WHEN IT COMES TO ORAL HEALTH CARE, ESPECIALLY THE UNSERVED AND UNDERSERVED.

IN CLOSING HERE IS AN EXCERPT FROM THE 2014 GOVERNORS REPORT:

"Dental hygienists often are at the center of proposed strategies to increase access to oral health care. Such strategies include changing supervision rules and reimbursement policies so that dental hygienists are able to provide preventive services outside of dentists' offices or creating advanced-provider models that involve educating hygienists to perform under new titles with an expanded scope of practice and less supervision. Some of the barriers to access for underserved populations will be the same, regardless of whether services are provided by a dentist or a dental hygienist. Those barriers include low health literacy, low reimbursement rates for the publicly insured, and high administrative burdens for reimbursement from public payers."

RESOURCES

THE BURDEN OF ORAL DISEASE IN IDAHO 2014, IDAHO ORAL HEALTH PROGRAM, DEPARTMENT OF HEALTH AND WELFARE, DIVISION OF PUBLIC HEALTH.

THE NATIONAL GOVERNORS ASSOCIATION REPORT. THE ROLE OF DENTAL HYGIENISTS IN PROVIDING ACCESS TO ORAL HEALTH CARE. JANUARY 2014.

FACTS ABOUT THE DENTAL HYGIENE WORKFORCE IN THE UNITED STATES. AMERICAN DENTAL HYGIENISTS' ASSOCIATION, JANUARY 2016.

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Facts about the Dental Hygiene Workforce in the United States

Dental Hygienists are Primary Providers of Oral Health Care Services

The dental hygienist is the member of the oral health care team focused on preventing oral disease and identifying and treating oral disease while it is still manageable. Dental hygienists are primary care oral health professionals who administer a range of oral health services including prophylaxis, sealants, fluoride treatments, oral cancer screenings, oral health education, and in many states dental hygienists play an active role in placing restorations.[1]

Dental hygienists are licensed health care providers in each of the 50 states and the District of Columbia. In order to become licensed as a dental hygienist, an individual must graduate from one of the nation's 335 accredited dental hygiene education programs and successfully complete both a national written examination and state or regional clinical examination. The average entry-level dental hygiene education program is 84 credits, or about three academic years, in duration.[2] Approximately 6,700 dental hygienists graduate annually from entry level programs that offer a certificate, or an Associate's or Bachelor's degree. There are currently 21 Master's degree dental hygiene education programs in 16 states. In 48 states and the District of Columbia, dental hygienists are required to undertake continuing education as part of the licensure renewal process to maintain and demonstrate continued professional competence.[3]

Dental hygienists work in a host of settings to deliver clinical care and work under varying levels of supervision, depending on the state practice act. States are increasingly recognizing the importance of increasing direct access to dental hygiene services. In 1995, five states allowed direct access. Currently, 38 states have policies that allow dental hygienists to work in community-based settings (like public health clinics, schools, and nursing homes) to provide preventive oral health services without the presence or direct supervision of a dentist.[4] These states recognize that dental hygienists are primary care providers who are an essential entry point to the health care system.

Dental Hygienists' Impact on Access to Care

The dental hygiene profession with its continuing growth offers a cadre of competent and licensed providers who can deliver comprehensive primary care services in an increasing array of settings. Direct access to dental hygiene services is especially critical for vulnerable populations like children, the elderly, and the geographically isolated who often struggle to overcome transportation, lack of insurance coverage, and other barriers to oral health care. Today, 17 states (Arizona, California, Colorado, Connecticut, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, Oregon, Rhode Island, Washington and Wisconsin) recognize and reimburse hygienists as Medicaid providers.[5]

HRSA's National Center for Health Workforce Analysis developed the Dental Hygiene Professional Practice Index (DHPPI) to document the dental hygiene profession across the 50 states and assess the impact of dental hygienists on access to care for underserved

populations.[6] The findings of the study suggest that expanding the professional practice environment of dental hygienists improves access to oral health services, utilization of oral health services and oral health outcomes. Indeed, the study noted that "more can be done to increase the impact of these professionals [dental hygienists] on improved access and quality of care and reduced costs of care. More can be done to align DH [dental hygiene] scope of practice with demonstrated DH clinical skills and competencies."[7]

Dental hygienists throughout the country have demonstrated their ability to reach patients in alternative settings, thus drawing those who are currently disenfranchised from the oral health care system into the pipeline for care. In South Carolina, a school-based program brings dental hygienists directly to low-income students in 413 schools in 45 targeted school districts. Importantly, the program has 20 restorative partners, dentists who agree to see referred children in their private offices, thus promoting the receipt of comprehensive services. Data from the state has demonstrated that in the first five years the program was effectively in place; sealant use for Medicaid children increased while the incidence of untreated cavities and treatment urgency rates decreased for that population.[8] The 2007-2008 Needs Assessment showed that there were no disparities between black and white third grade children for sealant use in South Carolina.[9]

A program in Michigan, Smiles on Wheels, run by three dental hygienists, applied more than 1,360 sealants to children in schools in a one year period. The same program also brings care directly to patients living in nursing homes who are not able to travel for dental care.[10] For more than a decade, California has recognized "Registered Dental Hygienists in Alternative Practice" who provide unsupervised services in homes, schools, residential facilities and in Dental Health Professional Shortage Areas. A study of RDHAPs in California found that "alternative care delivery models such as RDHAP are *essential* to improving oral health and reducing health disparities."[11] These are just a few examples of innovative models and programs that maximize utilization of the experience, education and expertise of dental hygienists, many more can be found throughout the country.

Oral Health is Vital to Total Health and Most Dental Disease is Preventable

Research is continually emerging that demonstrates the link between oral health and total health. The Centers for Disease Control has noted the relationship between periodontal disease and health problems like diabetes, heart disease, and strokes.[12] The tragic death of 12 year old Deamonte Driver who died in 2007 as a result of complications from a brain infection that was brought about by an abscessed tooth was an unfortunate demonstration of the impact of untreated oral disease. In 2012, Kyle Willis, a 24-year-old father died from a tooth infection because he couldn't afford the antibiotics he needed, offering a sobering reminder of the importance of oral health and the serious-even fatal consequences- that people without access to dental care suffer. Lack of access to dental care forces too many Americans to enter hospital emergency rooms seeking treatment for preventable dental conditions, which emergency rooms are typically ill-equipped to handle.

Most oral diseases are completely avoidable with proper preventive care; however, in spite of this proven prevention capacity, oral disease rates among children and adults continue to climb.[13, 14] Preventing oral disease can positively impact total health and is also cost effective. Research indicates that low-income children who have their first preventive dental visit by age one incur dental related costs that are approximately 42 percent lower ($262 before age one, $449 between ages two and three) over a five year period than children who receive their first preventive between the ages of two and three.[15] Preventive care can diminish the need for more costly restorative and emergency care, saving valuable health care dollars in the long-run.

[1] American Dental Hygienists' Association, *Important Facts About Dental Hygienists*, Chicago, IL, 2009. http://www.adha.org/careerinfo/dhfacts.htm

[2] American Dental Hygienists' Association. *Dental Hygiene Education: Curricula, Program Enrollment, and Graduate Information.* American Dental Hygienists' Association [Internet]. 2014 Oct 21 [cited 2014 Feb 2]. Available from: http://www.adha.org/resources-docs/72611_Dental_Hygiene_Education_Fact_Sheet.pdf

[3] American Dental Hygienists' Association, *States Requiring Continuing Education for Licensure Renewal*, Chicago, IL, 2009. http://www.adha.org/resources-docs/7512_CE_Requirements_by_State.pdf

[4] American Dental Hygienists' Association, *Direct Access States Chart*, Chicago, IL, 2013. http://www.adha.org/resources-docs/7513_Direct_Access_to_Care_from_DH.pdf

[5] American Dental Hygienists' Association, *States Which Directly Reimburse Dental Hygienists for Services Under the Medicaid Program*, Chicago, IL, 2013. http://www.adha.org/reimbursement

[6] Health Resources and Services Administration, *The Professional Practice Environment of Dental Hygienists in the Fifty States and the District of Columbia, 2001*, National Center for Health Workforce Analysis, Bureau of Health Professions, Rockville, MD, 2004.

[7] *Ibid.*

[8] South Carolina Rural Health Resource Center, 2007-2008 South Carolina Oral Health Needs Assessment Data, 2008.

[9] *Ibid.*

[10] Smiles on Wheels Data, Jackson, Michigan. 2009.

[11] Mertz, E., "Registered Dental Hygienists in Alternative Practice: Increasing Access to Dental Care in California," University of California, San Francisco, Center for the Health Professions, May 2008, p. 44.

[12] U.S. Centers for Disease Control and Prevention. *Links between Oral and General Health*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2004.

[13] U.S. Centers for Disease Control and Prevention. *Links between Oral and General Health*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2004.

[14] Dye BA, Tan S, Smith V, Lewis BG, Barker LK, Thornton-Evans G, et al. National Center for Health Statistics. *Trends in oral health status: United States, 1988–1994 and 1999–2004. Hyattsville, MD. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2007.*

[15] Savage Matthew, Lee Jessica, Kotch Jonathan, and Vann Jr. William. *"Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs". Pediatrics 2004.*

[16] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2014-15 Edition,* Dentists, Washington DC, 2014. http://www.bls.gov/ooh/healthcare/dentists.htm#tab-6

[17] U.S Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2015. Rockville, Maryland, 2015.

[18] American Dental Hygienists' Association, Master File Data, Chicago, IL, 2008. http://www.adha.org/masterfile/index.html#3

[19] Paradise, J., "Oral Health Coverage and Care for Low-Income Children: The Role of Medicaid and CHIP," Kaiser Commission on Medicaid and the Uninsured, April 2009.

[20] National Governors Association, The Role of Dental Hygienists in Providing Access to Oral Health Care, Washington, D.C. , 2014. http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf

[21] ADHA Policy Manual [4S-09]. Chicago, Ill. American Dental Hygienists' Association. http://www.adha.org/resources-docs/7614_Policy_Manual.pdf

[22] ADHA Policy Manual [2-10]. Chicago, Ill. American Dental Hygienists' Association. http://www.adha.org/resources-docs/7614_Policy_Manual.pdf