NEIL ABERCROMBIE
GOVERNOR

KATHRYN S. MATAYOSHI
SUPERINTENDENT

STATE OF HAWAI`I
DEPARTMENT OF EDUCATION
P.O. BOX 2360
HONOLULU, HAWAI`I 96804

Date: 02/10/2014

Committee: House Education

Department: Education

Person Testifying: Kathryn S. Matayoshi, Superintendent of Education

Title of Bill: HB 2457,HD1 (HSCR228-14) RELATING TO DENTAL HEALTH.

Purpose of Bill: Requires the Department of Health to establish or enter into partnerships or agreements to administer a dental sealant program in a high-need school. Appropriates funds. Effective July 1, 2014.

Department's Position:
The Department of Education (Department) supports HB 2457 HD1.

Establishing a dental sealant program in a high need demonstration school will greatly benefit low-income children who are at a greater risk of tooth decay. This program has the potential to assist many families in the state who do not have adequate access to dental care. We also support the provision that would allow the Department of Health to receive an appropriation to implement this measure since the Department does not have the means to do so under our current budget appropriation.

Thank you for the opportunity to present testimony on this measure.

NEIL ABERCROMBIE
GOVERNOR OF HAWAII

DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

House Committee on Education

H.B. 2457, HD1 RELATING TO DENTAL HEALTH

Testimony of David Sakamoto, MD, MBA
Deputy Director, Health Resources Administration

February 10, 2014

Department's Position: The Department of Health supports H.B. 2457, HD1 to improve the oral health of children through an oral health surveillance system, administering a demonstration school-based dental sealant program in a high-need school, and establishing a plan for a statewide school-based dental sealant program.

Fiscal Implications: Funding will be needed for the Department of Health to support the requirements of this measure. The public health dental program of the Department was eliminated as a result of the 2009 budget reductions and there is currently inadequate infrastructure to support full implementation.

Purpose and Justification: The importance of oral health is often understated; oral disease, primarily dental caries, is the most common pediatric disease and can lead to physical and psychological disabilities as well as significant diseases in adulthood. Tooth decay may result in pain and other problems that affect learning in school-age children including lost school time. The Task Force on Community Preventive Services recommends school sealant programs and issued a "strong endorsement" in 2001. In 2003, the Association of State and Territorial Dental Directors published a Best Practice Report. The report reviews the scientific evidence that school sealant programs work and

presents specific examples of practices in state programs. School-based sealant programs are especially important for reaching children from low-income families who are less likely to receive dental care.

The Department recognizes the need to rebuild the infrastructure necessary to provide public health leadership in regards to a comprehensive oral health system and to conduct critical public health surveillance, evaluation, planning and prevention functions. Planning has begun under the Department's Family Health Services Division. The Division is currently establishing an exempt dental director position and part-time support staff with funds from a small grant from the Centers for Disease Control and Prevention.

The Department is working with the Centers for Disease Control and Prevention and the Association of State and Territorial Dental Directors to provide technical assistance to rebuild the State's oral health surveillance system comprised of several data sources. The Department currently collects some of the data elements included in the National Oral Health Surveillance System (NOHSS) but is lacking others such as some of the children's oral health indicators. The Department has initiated discussions with the Department of Education to plan for a statewide oral health screening of third graders to collect the data needed to submit to participate in the National Oral Health Surveillance System. School-based activities included in this measure can facilitate the collection of this data.

The Department co-facilitates the Hawaiian Islands Oral Health Task Force with the Hawaii Primary Care Association. The Task Force is a group of over forty oral health stakeholders who represent private and Community Health Center Dentists, Hawaii Dental Association, Hawaii Dental Hygienists Association, Hawaii Dental Services, Hawaii Medical Services Association Neighbor Island oral health task forces and others. One of the Task Force's highest priorities is to address the need for improved oral health data. The Department is currently finalizing a report of existing oral health data developed in consultation with the Task Force and with technical assistance from the Association of State and Territorial Dental Directors.

The Department has initiated planning for a school based oral health prevention program that would include sealant application as part of a project supported by the Aspen Institute for Excellence in Public Health Law. The Department was selected to participate in the program and chose oral health as its focus. A team of key state policymakers is participating in the project including legislators, the Governor's Office, the Attorney General as well as the Department of Health.

The Department will require funding to conduct the school based oral health surveillance as well as staffing to conduct the demonstration dental sealant program and develop a statewide plan. Currently, there are at least two community-based dental sealant programs being conducted that represent different methods of service delivery. Staffing would facilitate a dedicated effort to partner with the community providers and the Task Force to document and evaluate best practices that may be replicated in other high need schools. The Department will also be able to access technical assistance from national experts including the Centers for Disease Control and Prevention Oral Health program regarding best practices for school based sealant programs based on the experience of other states.

Thank you for the opportunity to testify.

STATE OF HAWAII
STATE COUNCIL
ON DEVELOPMENTAL DISABILITIES
919 ALA MOANA BOULEVARD, ROOM 113
HONOLULU, HAWAII 96814
TELEPHONE: (808) 586-8100 FAX: (808) 586-7543
February 10, 2014

The Honorable Roy M. Takumi, Chair
House Committee on Education
Twenty-Seventh Legislature
State Capitol
State of Hawaii
Honolulu, Hawaii 96813

Dear Representative Takumi and Members of the Committee:

SUBJECT: HB 2457 HD1 – RELATING DENTAL HEALTH

The State Council on Developmental Disabilities (DD) **SUPPORTS HB 2457 HD1.** The bill requires the Department of Health (DOH) to establish or enter into partnerships pr agreements to administer a dental sealant program in a high-need school and appropriate funds.

Access to dental care services for individuals with DD is a priority of the Council and is addressed in our 2012-2016 State Plan through partnerships with dental hygienists, the University of Hawaii School of Nursing and Dental Hygiene, the Maternal Child Health Leadership in Neurodevelopmental and Related Disabilities program, and Special Olympics to do in-service training on preventive oral health care for families and other caregivers. Children and adults with DD face increased oral health challenges coupled with their disability. Dental sealants would be a proactive step in improving the oral health and increasing access to dental services. We understand that the application of dental sealants is quick, simple, and painless with demonstrated effectiveness in preventing tooth decay and providing access to dental services amongst children.

The Council defers to DOH regarding the staff and fiscal resources needed to carry out the activities described in the bill.

Thank you for the opportunity to submit testimony **supporting HB 2457 HD1.**

Sincerely,

Waynette K.Y. Cabral, M.S.W.
Executive Administrator

J. Curtis Tyler
Chair

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Pew Children's Dental Campaign
The Pew Charitable Trusts
Shelly Gehshan, Director

Testimony Submitted to the Hawaii House of Representatives
Committee on Education in support of H.B. 2457 HD1

February 10, 2014

Chairman Takumi, Vice Chairman Ohno, and members of the committee, thank you for holding this hearing and for your commitment to improving oral health in Hawaii. The following are written remarks respectfully submitted by the Pew Children's Dental Campaign in support of H.B. 2457 HD1.

Members of this committee may be familiar with Pew's work as a result of policy reports released over the past four years. In both 2010 and 2011, the Pew Children's Dental Campaign graded all 50 states on children's dental health, relying on eight evidence-based policies that cover prevention, financing, and workforce issues. In 2013, Pew released a similar report focusing solely on prevention that included whether a state allows the use of dental sealants for children without a prior dental exam, an evidence-based practice that can increase access to preventive treatment. Unfortunately, Hawaii received an F for its policies on dental sealants.

Sealants Protect Teeth

The dental health of Hawaii's children has slowly and steadily improved over the past decades, but there are still many communities in the state with unnecessarily high rates of tooth decay. Research shows that decay and other dental-related problems undermine children's ability to attend and perform well in school. This bill is a meaningful first step towards addressing this issue by creating a program to place dental sealants on children's teeth.

Sealants have been recognized by both the American Dental Association (ADA) and the Centers for Disease Control and Prevention (CDC) as one of the best strategies to protect children who are at a increased risk for developing cavities.[1] Sealants are clear plastic coatings that act as a barrier against decay-causing bacteria when applied to the chewing surfaces of molars—the most cavity-prone teeth. Research also shows that sealants can prevent tooth decay from worsening if applied during the early stages of decay.[2] Although sealants can sometimes break or fall off, studies show that the formerly sealed teeth are not at a higher risk of decay than those which were never sealed.[3]

In addition to preventing decay, sealants can potentially save taxpayers and families money by preventing the need for more costly procedures to address untreated decay. On average, a sealant is one-third the cost of filling a cavity.[4] Preventing decay also reduces the number of children whose toothaches or other decay-related problems might otherwise lead them to seek care in a hospital emergency-room. In 2006, tooth decay was the primary reason for more than 330,000 dental-related trips to emergency rooms across the U.S., at a total cost of nearly $110 million.[5]

Bringing the Care to the Children: School-Based Programs

The key challenge for all states, including Hawaii, is to get sealants to low-income children, as these kids are the most likely to benefit from them and the least likely to receive them. Children aged 6 to 11 who live in poverty are almost twice as likely to develop cavities in their permanent teeth as more affluent kids.[6]

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There is strong and growing evidence that school-based sealant programs are effective at increasing sealant use and reducing cavities. A study of Wisconsin's school-based sealant programs published in January of this year estimated that the state's sealant programs averted more than 10,000 cavities over nine years [7]. For a child who does not regularly see a dentist, a cavity represents pain and the possibility of infection, often requiring expensive treatment options. For Colorado, this reduction in cavities translated into a significant return on investment for its school-based sealant programs: for every dollar the state spent, it saved two[8].

Better Utilizing the Dental Workforce

While H.B. 2457 is a significant step towards improving children's oral health in Hawaii, it should be strengthened by a simple provision that would make better use of Hawaii's existing dental workforce. Early last year, Pew expressed its support for a similar bill considered in the Hawaii legislature, S.B. 343, which called for the creation of sealant programs in which dental hygienists could place sealants without a prior exam from a dentist.

Over 30 states already allow hygienists in school-based sealant programs to apply sealants without having to wait or incur the costs to arrange for a dentist to examine the child first.[9] Unfortunately, Hawaii currently still requires such an exam before a hygienist can apply sealants—a rule that adds unnecessary delays and costs to sealant programs, and results in fewer children who receive this proven strategy.

While a dentist's diagnosis is required before many dental treatments, a scientific consensus has determined that in school-based programs, is it not necessary before the placement of sealants. Only a visual assessment by a hygienist is needed to determine whether the tooth can be sealed and whether a cavity is present[10]. Early stages of tooth decay can be arrested by placement of sealants. However, when a hygienist detects a cavity, the child can be referred to a dentist for the necessary care. Moreover, sealant placement is a reversible procedure that easily allows a dentist to administer additional care and treatment strategies, such as placement of a filling or crown, if needed.[11]

Ending the prior exam requirement would be consistent with the ADA's guidance on sealants. In 2009, CDC recommendations published in the *Journal of the American Dental Association* stated that sealants should be provided to children even if follow-up care by a dentist cannot be assured.[12] A possible lack of comprehensive care following a visit to a school-based sealant program is not a reason to deny preventive services to children who are most at risk of tooth decay.

Additionally, ending the prior exam requirement can bring down program costs. In Virginia, a 2011 pilot study found that eliminating the prior exam requirement in a school-based sealant program decreased the per-child program cost by 20 percent[13]. After seeing the initial results, the Virginia Dental Association advocated for the passage of legislation to make the pilot program a permanent statute.

Maryland ended its prior exam requirement in 2008. A recent study release by the Maryland Department of Health and Mental Hygiene showed that where the law has been implemented, the number of children screened and given sealants has increased, and program costs have decreased[14]. In addition, the number of dentists receiving referrals of children screened in these programs who need further treatment has increased.

By approving H.B. 2457, Hawaii can strengthen its ability to reach more children with sealants. Adding a provision to the bill that would eliminate the prior exam requirement in school-based programs would make the measure more effective and allow more children to be served.

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Sources

[1] "Dental Sealants," Centers for Disease Control and Prevention, September 2, 2009, http://www.cdc.gov/oralhealth/publications/factsheets/sealants_faq.htm; "Evidence-based clinical recommendations for the use of pit-and-fissure sealants," Journal of the American Dental Association, March 2008, Vol. 139, 257-268, http://www.ada.org/sections/professionalResources/pdfs/report_sealants.pdf.

[2] S.O. Griffin et al., "The Effectiveness of Sealants in Managing Caries Lesions," *Journal of Dental Research*, (2008), Vol. 87, No. 2, 169–174, http://jdr.sagepub.com/content/87/2/169.abstract.

[3] S.O. Griffin, S.K. Gray, D.M. Malvitz and B.F. Gooch, 2009. "Caries risk in formerly sealed teeth," *Journal of the American Dental Association,* 2009, Vol. 140, No. 4, 415–423, http://jada.ada.org/cgi/content/full/140/4/415.

[4] The national median charge among general practice dentists for procedure D1351 (dental sealant) is $40 and national mean charge for procedure D2150 (two-surface amalgam filling) is $145. See: "2007 Survey of Dental Fees," American Dental Association, 2007, 17.

[5] Of the 330, 757 ER visits for dental-related causes, 330,599 (99.9 percent) did not require a hospital stay. See: R. Nalliah, V. Allareddy, S. Elangovan, N. Karimbux, V. Allareddy, "Hospital Based Emergency Department Visits Attributed to Dental Caries in the United States in 2006," *Journal of Evidence Based Dental Practice* (2010), Vol. 10, 212-222, http://www.jebdp.com/article/S1532-3382(10)00183-1/abstract.

[6] "Affluent" is defined as a family income of twice the federal poverty line. See: B.A. Dye, et al, "Trends in oral health status: United States, 1988-1994 and 1999-2004," *Vital Health Statistics*, (2007), Vol. 11, 1-92.

[7] J Public Health Dent. 2014 Jan 15. doi: 10.1111/jphd.12047

[8] "The Impact of Oral Disease on the Health of Coloradans." Colorado Department of Public Health and Environment, Oral Health Program (2005). http://www.chd.dphe.state.co.us/Resources/cms/pp/oralhealth/impact.pdf

[9] Pew Center on the States, May 2011, 24.

[10] Gooch, Barbara, et al. "Preventing Dental Caries Through School-based Sealant Programs: Updated Recommendations and Reviews of Evidence," *Journal of the American Dental Association* 140 (2009): 1356-1365

[11] B. Gooch et al. "Preventing Dental Caries Through School-Based Sealant Programs," *Journal of the American Dental Association,* 140 (2009):1256-1365. http://jada.ada.org/content/140/11/1356.full.pdf+html, accessed January 17, 2011.

[12] B.F. Gooch et al., (2009).

[13] Virginia Department of Health. (2011). "Final Report on Services Provided by Virginia Department of Health (VDH) Dental Hygienists Pursuant to a Practice Protocol in Lenowisco, Cumberland Plateau, and Southside Health Districts for FY 2012" Accessed November 1, 2013. http://leg2.state.va.us/dls/h&sdocs.nsf/fc86c2b17a1cf388852570f9006f1299/ab04b2114fa4d95785257aaf006e9e98/$FILE/RD318.pdf

[14] Levy, D. "Maryland Public Health Dental Hygiene Act: Impact Study." Maryland Department of Health and Mental Hygiene, Office of Oral Health. Baltimore, Maryland, 2013.

Good Beginnings Alliance
Voices For Hawai'i's Children

February 9, 2014

To: Chair Roy Takumi
Vice-Chair Takashi Ohno
Members of the House Committee on Education

From: Deborah Zysman, Executive Director
Good Beginnings Alliance

RE: Comments in **support of HB2457 HD1**: RELATING TO DENTAL HEALTH.

The Good Beginnings Alliance supports HB2457 HD1, which requires the Hawaii Department of Health to establish or enter into partnerships or agreements to administer a dental sealant program in high-need schools. Research clearly shows that tooth decay and other dental-related problems undermine a child's ability to attend and perform well in school. This measure seeks to improve the dental health of our state's children by requiring the DOH to increase its role in the prevention of tooth decay through a school-based dental sealant pilot program, and requiring the DOH to participate in the national oral health surveillance system managed by the Centers for Disease Control.

A recent report by the Pew Charitable Trusts, entitled *Falling Short: Most States Lag on Dental Sealants*, found that less than 25% of high-need schools in Hawaii have school-based sealant programs. These are schools with a significant proportion of children who are at higher risk of tooth decay and who are least likely to be able to afford dental services.

In addition to preventing decay, sealants can potentially save families and taxpayers money by preventing the need for more costly procedures to address untreated decay. On average, a sealant is one-third the cost of filling a cavity.[i] Preventing decay also reduces the number of children whose toothaches or other decay-related problems might otherwise lead them to seek care in a hospital emergency-room. In 2006, tooth decay was the primary reason for more than 330,000 dental-related trips to emergency rooms across the U.S., at a total cost of nearly $110 million.[ii]

We would also draw the Committee's attention to other states who have taken steps toward allowing dental hygienists to apply preventative sealants via 'remote supervision' (Virginia) or 'collaborative agreement' (South Dakota and West Virginia) (Attached). These approaches appear to provide appropriate and effective oversight of the professionals applying sealants

while ultimately improving the dental health of the patient, and may provide Hawaii with examples of safe and proven policies from which to build our own program.

The Good Beginnings Alliance (GBA) is a policy and advocacy organization focused on ensuring that Hawaii's young children are healthy, safe, and ready for school and therefore strongly supports the passage of HB2457 HD1.

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[i] The national median charge among general practice dentists for procedure D1351 (dental sealant) is $40 and national mean charge for procedure D2150 (two-surface amalgam filling) is $145. See: "2007 Survey of Dental Fees," American Dental Association, 2007, 17.

[ii] Of the 330, 757 ER visits for dental-related causes, 330,599 (99.9 percent) did not require a hospital stay. See: R. Nalliah, V. Allareddy, S. Elangovan, N. Karimbux, V. Allareddy, "Hospital Based Emergency Department Visits Attributed to Dental Caries in the United States in 2006," *Journal of Evidence Based Dental Practice* (2010), Vol. 10, 212-222, http://www.jebdp.com/article/S1532-3382(10)00183-1/abstract.

ENROLLED
COMMITTEE SUBSTITUTE
FOR
H. B. 4077

(By Delegates Perdue, Hatfield, Lawrence, Marshall, Moye,
Poore, Staggers, Ferns, Ellington, J. Miller and Rowan)

[Passed March 10, 2012; in effect ninety days from passage.]

AN ACT to amend §30-4-17 of the code of West Virginia, 1931, as amended, relating to activities that may be performed by a dental hygienist without a prior exam by a dentist; requiring a Public Health Practice permit; providing for the sealants to be placed pursuant to a collaborative agreement with a supervising dentist; and requiring a referral for a dental examination within six months.

Be it enacted by the Legislature of West Virginia:

That §30-4-17 of the Code of West Virginia, 1931, as amended, be amended and reenacted to read as follows:

ARTICLE 4. WEST VIRGINIA DENTAL PRACTICE ACT.

§30-4-17. Scope of practice; dental hygienist.

The practice of dental hygiene includes the following:

(1) Performing a complete prophylaxis, including the removal of any deposit, accretion or stain from the surface of a tooth
or a restoration;

(2) Applying a medicinal agent to a tooth for a prophylactic purpose;

(3) Taking a dental X-ray;

(4) Instructing a patient on proper oral hygiene practice;

(5) Placing sealants on a patient's teeth without a prior examination by a licensed dentist: *Provided,* That for this subdivision, the dental hygienist has a Public Health Practice permit issued by the West Virginia Board of Dental Examiners, and subject to a collaborative agreement with a supervising dentist and the patient is referred for a dental examination within six months of sealant application.

(6) Performing all delegated procedures of a dental hygienist specified by rule by the board; and

(7) Performing all delegated procedures of a dental assistant specified by rule by the board.

VIRGINIA ACTS OF ASSEMBLY -- 2012 SESSION

CHAPTER 102

An Act to amend and reenact § 54.1-2722 of the Code of Virginia and to repeal the third enactments of Chapters 99 and 561 of the Acts of Assembly of 2009, as amended by Chapter 289 of the Acts of Assembly of 2011, relating to dental hygienists' scope of practice.

[S 146]

Approved March 6, 2012

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2722 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2722. License; application; qualifications; practice of dental hygiene.

A. No person shall practice dental hygiene unless he possesses a current, active, and valid license from the Board of Dentistry. The licensee shall have the right to practice dental hygiene in the Commonwealth for the period of his license as set by the Board, under the direction of any licensed dentist.

B. An application for such license shall be made to the Board in writing, and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character, (ii) is a graduate of an accredited dental hygiene program offered by an accredited institution of higher education, (iii) has passed the dental hygiene examination given by the Joint Commission on Dental Examinations, and (iv) has successfully completed a clinical examination acceptable to the Board.

C. The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B of this section; (ii) holds a current, unrestricted license to practice dental hygiene in another jurisdiction in the United States; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) meets other qualifications as determined in regulations promulgated by the Board.

D. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection V of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.

A dentist may also authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. In its regulations, the Board of Dentistry shall establish the education and training requirements for dental hygienists to administer such controlled substances under a dentist's direction.

For the purposes of this section, "general supervision" means that a dentist has evaluated the patient and prescribed authorized services to be provided by a dental hygienist; however, the dentist need not be present in the facility while the authorized services are being provided.

For the purposes of this section, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have done an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.

The Board shall provide for an inactive license for those dental hygienists who hold a current, unrestricted license to practice in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

E. (Expires July 1, 2012) Notwithstanding any provision of law or regulation to the contrary, a dental hygienist employed by the Virginia Department of Health who holds a license issued by the Board of

Dentistry may provide educational and preventative dental care in the Cumberland Plateau, Southside, and Lenowisco Health Districts, which are designated as Virginia Dental Health Professional Shortage Areas by the Virginia Department of Health *Commonwealth under the remote supervision of a dentist employed by the Department of Health*. A dental hygienist providing such services shall practice pursuant to a protocol *adopted by the Commissioner of Health on September 23, 2010, having been* developed jointly by *(i)* the medical directors of each of the districts, *the Cumberland Plateau, Southside, and Lenowisco Health Districts; (ii)* dental hygienists employed by the Department of Health,*; (iii)* the Director of the Dental Health Division of the Department of Health,*; (iv)* one representative of the Virginia Dental Association,*;* and *(v)* one representative of the Virginia Dental Hygienists' Association. *Such protocol shall be adopted by the Board as regulations.*

F. A report of services provided by dental hygienists pursuant to such protocol, including their impact upon the oral health of the citizens of these districts *the Commonwealth*, shall be prepared and submitted by the medical directors of the three health districts *the Department of Health* to the Virginia Secretary of Health and Human Resources by January 1, 2012 *annually*. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene.

2. That the third enactments of Chapters 99 and 561 of the Acts of Assembly of 2009, as amended by Chapter 289 of the Acts of Assembly of 2011, are repealed.

State of South Dakota

EIGHTY-SIXTH SESSION
LEGISLATIVE ASSEMBLY, 2011
940S0076

HOUSE BILL NO. 1045

Introduced by: Representatives Haggar, Blake, Boomgarden, Gibson, Hickey, Jensen, Lucas, Magstadt, Munsterman, Romkema, and Stricherz and Senators Hunhoff (Jean), Bradford, Gray, Heineman, Holien, Kraus, Krebs, and Schlekeway

FOR AN ACT ENTITLED, An Act to authorize dental hygienists to provide preventive and therapeutic services to more persons under certain circumstances.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That chapter 36-6A be amended by adding thereto a NEW SECTION to read as follows:

A dental hygienist may provide preventive and therapeutic services under collaborative supervision of a dentist if the dental hygienist has met the following requirements:

(1) Possesses a license to practice in the state and has been actively engaged in the practice of clinical dental hygiene in two of the previous three years;

(2) Has a written collaborative agreement with a licensed dentist; and

(3) Has satisfactorily demonstrated knowledge of medical and dental emergencies and their management; infection control; pharmacology; disease transmission; management of early childhood caries; and management of special needs populations.

135 copies were printed on recycled paper by the South Dakota Legislative Research Council at a cost of $.075 per page. Insertions into existing statutes are indicated by underscores. Deletions from existing statutes are indicated by overstrikes.

Section 2. That chapter 36-6A be amended by adding thereto a NEW SECTION to read as follows:

A dental hygienist seeking to provide preventive and therapeutic services under collaborative supervision shall submit evidence, as prescribed by the board, of meeting the requirements of section 1 of this Act and a fee not to exceed thirty dollars. The board shall, by rules promulgated pursuant to chapter 1-26, establish the required fee, the minimum requirements for a collaborative agreement, the preventive and therapeutic services that may be performed, and the evidence required to demonstrate the active practice and knowledge required pursuant to section 1 of this Act.

Section 3. That chapter 36-6A be amended by adding thereto a NEW SECTION to read as follows:

A dental hygienist may only provide preventive and therapeutic services under collaborative supervision at a nursing facility, an extended care facility or by a home health agency serving the elderly or disabled, a public institution under the Department of Human Services, Social Services, Health, or Corrections, a federally qualified health center, a public health facility, a tribal or Indian health service facility, a mobile dental unit, or a public or nonpublic school, or

through a head start program or the Special Supplemental Nutrition Program for Women, Infants, and Children.

. Section 4. That § 36-6A-40 be amended to read as follows:

36-6A-40. Any licensed dentist, public institution, or school authority may use the services of a licensed dental hygienist. Such licensed dental hygienist may perform those services which are educational, diagnostic, therapeutic, or preventive in nature and are authorized by the Board of Dentistry, including those additional procedures authorized by subdivision 36-6A-14(10). Such services may not include the establishment of a final diagnosis or treatment plan for a

dental patient. Such services shall be performed under supervision of a licensed dentist. As an employee of a public institution or school authority, functioning without the supervision of a licensed dentist, a licensed dental hygienist may only provide educational services.

All A dental hygienist may perform preventive and therapeutic services may be performed under general supervision provided if all individuals treated are patients of record of a licensed dentist and that all care rendered by the hygienist is completed under the definition of patient of record. A dental hygienist may perform preventive and therapeutic services under collaborative supervision if the requirements of section 1 of this Act are met. However, no dental hygienist may perform preventive and therapeutic services under collaborative supervision for more than thirteen months for any person who has not had a complete evaluation by the supervising dentist.

Section 5. That § 36-6A-26 be amended by adding thereto NEW SUBDIVISIONS to read as follows:

"Collaborative agreement," a written agreement between a supervising dentist and a dental hygienist authorizing the preventive and therapeutic services that may be performed by the dental hygienist under collaborative supervision;

"Collaborative supervision," the supervision of a dental hygienist requiring a collaborative agreement between a supervising dentist and dental hygienist

ohno2-Rexie

From: mailinglist@capitol.hawaii.gov
Sent: Saturday, February 08, 2014 12:12 PM
To: EDNtestimony
Cc: teruyadt@att.net
Subject: Submitted testimony for HB2457 on Feb 10, 2014 14:00PM

HB2457
Submitted on: 2/8/2014
Testimony for EDN on Feb 10, 2014 14:00PM in Conference Room 309

Submitted By	Organization	Testifier Position	Present at Hearing
Darrell T Teruya	Individual	Comments Only	No

Comments: Chair Takumi, Vice-Chair Ohno. members of the House Committee on Education. Dental Health is vital to the well being of all and a pain free childwill make for a better student. A program which seeks to benefit an at risk (for dental decay) child is beneficial to society as a whole. This program is a step in that direction. Thank you for the opportunity to submit testimony in support of HB2457, HB1 Darrell Teruya, DDS Past President (2008) HDA

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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ohno2-Rexie

From: mailinglist@capitol.hawaii.gov
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HB2457
Submitted on: 2/7/2014
Testimony for EDN on Feb 10, 2014 14:00PM in Conference Room 309

Submitted By	Organization	Testifier Position	Present at Hearing
Javier Mendez-Alvarez	Individual	Support	No

Comments:

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HAWAI'I PRIMARY CARE ASSOCIATION

House Committee on Education
The Hon. Roy M. Takumi, Chair
The Hon. Takashi Ohno, Vice Chair

Testimony on House Bill 2457, HD1

Relating to Dental Health
Submitted by Robert Hirokawa, Chief Executive Officer
February 10. 2014, 2:00 pm, Room 309

The Hawai'i Primary Care Association, which represents community health centers in Hawai'i, supports the intent of House Bill 2457 to increase children's access to dental care by creating a school based dental sealant program.

The mouth, teeth, and gums are as essential to health as any other part of the body. In Hawaii, the rate of tooth decay in children is twice as high as that of children living on the mainland. As a point of reference, over 94 percent of mainland six year olds are entirely free from cavities, while only 19 percent of six year olds in Hawaii are cavity-free. Later in life, health care research points to associations between chronic oral infections and diabetes, heart and lung disease, stroke, and low-birth-weight births—conditions that are more complicated and costly to treat than effective, timely oral health care. It makes sense to invest in pediatric dental health, and a dental sealant program is an effective tool for such an investment.

Hawaii's community health centers have long been providers of, and advocates for, pediatric dental health programs in high-need communities, including dental sealant programs. We fully support the implementation of a statewide school based dental sealant program and we recognize the need for program collaboration while operating with a limited amount of resources. **We recommend the Department of Health partner with an existing program(s) to expeditiously allow children to access and benefit from a dental sealant program.** Community health centers serve the high-need communities and high-risk populations that the program in House Bill 2457 is targeting. In addition to familiarity with the target population, approximately half of community health center patients are covered by Medicaid, and Hawaii's state Medicaid benefit package covers pediatric dental services.

Thank you for the opportunity to testify.

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