NEIL ABERCROMBIE
GOVERNOR

KATHRYN S. MATAYOSHI
SUPERINTENDENT

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

Date: 02/20/2014

Committee: House Finance

Department: Education

Person Testifying: Kathryn S. Matayoshi, Superintendent of Education

Title of Bill: HB 2457,HD1(hscr417-14) 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.

House Committee on Finance
The Hon. Sylvia Luke, Chair
The Hon. Scott Y. Nishimoto, Vice Chair
The Hon. Aaron Ling Johnson, Vice Chair

Testimony on House Bill 2457, HD1

Relating to Dental Health
Submitted by Robert Hirokawa, Chief Executive Officer
February 20. 2014, 12:00 pm, Room 308

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.

ADD 735 BISHOP STREET, SUITE 230 HONOLULU, HI 96813 TEL 808.536.8442 FAX 808.524.0347 WEB WWW.HAWAIIPCA.NET

THE PEW CHARITABLE TRUSTS

2005 Market Street, Suite 1700
Philadelphia, PA 19103-7077
215.575.9050 Phone
215.575.4939 Fax

901 E Street NW, 10th Floor
Washington, DC 20004
www.pewtrusts.org
202.552.2000 Phone
202.552.2299 Fax

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

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

February 19, 2014

Chairman Luke 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.

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, specifically dental sealants. The report graded states on four evidence based measures, including how many children in each state had access to school-based sealant programs, and whether a state allows hygienists to apply dental sealants for children without a prior dental exam. Unfortunately, Hawaii received an F for its policies on dental sealants.

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, particularly among low-income children. Unfortunately, it's this very group – young children who live in poverty – that is almost twice as likely as more affluent kids to have cavities in their permanent teeth.[i] This bill is a meaningful first step towards addressing this issue by creating a program to place dental sealants on children's teeth.

School-based Sealant Programs: Return on Investment

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, and a fraction of the cost of more intensive restorative care, such as crowns.[ii] The sealant program proposed in H.B. 2457, which targets high-need schools where many children receive Medicaid or CHIP benefits, could play a crucial role in bringing down expenditures related to preventable dental treatments. Many school-based sealant programs have been able to demonstrate significant return on investment by reducing the need for fillings, crowns, and other restorations:

- **Colorado.** The Colorado Department of Public Health and Environment estimated that the 2006-07 sealant program provided sealants to 2,530 students, avoiding 2,200 cavities and saving $212,000 in the treatment costs associated with single-surface amalgams.[iii] They further estimate that for every dollar spent in a school sealant program, two dollars are saved in treatment costs, a 200 percent return on investment.[iv]

- **Wisconsin.** Seal-A-Smile, Wisconsin's school-based sealant program, averted an estimated 25,091 cavities in the 2011-12 school year with dental sealants. Taking into account Medicaid reimbursements, the state of Wisconsin paid $40.22 to avert a cavity[v]. Given that research shows that the lifetime cost of treating one cavity can be over $2,000, sealants represent a huge savings for both private payers and a state's Medicaid program[vi].

- **Oregon.** In southern Oregon, La Clinica, a low-cost dental provider, operated a privately-funded oral health program for children in high-needs schools for over 20 years. In analyzing their sealant program, La Clinica determined that over 20 years, they protected 13,858 teeth and averted an estimated $16,491,400 in restorative dental costs, including fillings, crowns, and crown replacements. When compared with the $1.16 million investment the group received over that time period, this savings represented a return on investment of 1,313 percent. [vii]

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.[viii]

Reduce Spending by Eliminating the Prior Exam Requirement

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 and bring down the cost of sealant programs. 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. Ending the prior exam requirement would be consistent with the American Dental Association's guidance on sealants. In 2009, CDC recommendations published in the *Journal of the American Dental Association* stated that visual assessment, which a hygienist is trained to perform, is all that is necessary to determine whether to place a sealant, and that sealants should be provided to children even if follow-up care by a dentist cannot be assured. The evidence to support this provision is clear.

- **Virginia**. 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[ix]. After seeing the initial results, the Virginia Dental Association advocated for the passage of legislation to make the pilot program a permanent statute.

- **Maryland.** 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[x]. 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, and reduce spending on preventable dental treatments. Adding a provision to the bill that would eliminate the prior exam requirement in school-based programs would make the measure more cost-effective and allow more children to be served.

---

[i] "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.

[ii] 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.

[iii] T. Anselmo, , et al. "Expanding school-based sealant programs to realize treatment cost savings in Colorado." *Journal of Dental Hygiene* . (2007). 82(4):81-88.

[iv] Colorado Department of Public Health and Environment, Oral Health Program (2005). The Impact of Oral Disease on the Health of Coloradans. [Retrieved May 31,2010: link]

[v] "Wisconsin Seal-A-Smile Program Improves Health Outcomes in 2011-12." Children's Health Alliance of Wisconsin (2012).

[vi] "The True Cost of a Cavity." Delta Dental Insurance. [Accessed on February 18, 2014: link]

[vii] "Study of School-Based Dental Prevention Efforts for 2004-2011." Happy Smiles Report from La Clinica (2011). [Retrieved February 12, 2014: link]

[viii] 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.

[ix] 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

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

Testimony in Support of **HB2457-HD1**, Relating to Dental Health

Ellie Kelley-Miyashiro, RDH, BS

President – Hawaii Dental Hygienists' Association

February 18, 2014

Dear Respected Members of the Finance Committee:

The Hawaii Dental Hygienists' Association (HDHA) applauds your efforts to help solve the problem of inadequate oral health care for Hawaii's children. We, as I'm sure many of you on your respective committees, were appalled at the results of the most recent PEW report Falling Short: Most States Lag on Dental Sealants. With grades from A to F, Hawaii was one of 5 states and the District of Columbia to receive an F in providing a proven and simple technique to prevent tooth decay–-the placement of dental sealants. Obviously, we feel Hawaii could do more to prevent oral disease; cavities in particular, among its school aged population.

At the end of 2012, the US Health Resources and Services Administration estimated that 30.6 million people in the country were "unserved" by dental care, primarily because they live in areas with few providers, racial factors, low education or they have inadequate income and are unable to afford proper dental care. Hawaii is in line with this alarming and unfortunate trend.

In an increasing effort to solve this disparity, over 30 states have looked to hygienists as a lower-cost way to expand access and to connect more families to regular dental care. According to the Association of State and Territorial Dental Directors, numerous states and territories have done this by implementing programs for dental sealants, and several states have school-based sealant placement programs as part of their health-related initiatives. (The report is available here: Best Practice Approach: School-Based Dental Sealant Programs

According to the CDC, "Sealants prevent cavities and reduce associated dental treatment costs, especially among high-risk children, where sealants applied to permanent molars have been shown to avert tooth decay over an average of 5-7 years." Without access to regular preventive dental services, dental care for many children is postponed until symptoms, such as toothache and facial abscess, become so acute that care is sought in hospital emergency rooms. This frequent consequence of failed prevention is not only wasteful and costly to the health care system, but it rarely addresses the problem, as few emergency departments deliver definitive dental services. As a result, patients

typically receive only temporary relief of pain through medication and in some acute cases, highly costly, but inefficient surgical care. The CDC estimates that inpatient emergency department treatment costs on average $6,498 versus preventive treatment costs of $660. This reveals that on average, the cost to manage symptoms related to dental caries on an inpatient basis is approximately 10 times more than to provide preventive dental care for these same patients.

As the largest association representing Hawaii's licensed dental hygienists', HDHA strongly **supports** the intent of **HB2457-HD1** to address the prevention of dental disease among Hawaii's children. Dental hygienists possess the education and training to fulfill the goals of the pilot program described in this bill, as well as, its greater implementation statewide. We look forward to working toward our common goal of increased oral health care and decreased dental decay for Hawaii's children.

Thank you for your time and consideration.

Re: HB 2457, HD1 RELATING TO DENTAL HEALTH
Committee on Finance

Representative Sylvia Luke, Chair
Representative Scott Y. Nishimoto, Vice Chair
Representative Aaron Ling Johanson, Vice Chair

Date: February 20, 2014
Time: 12:00pm
Place: House Conference Room 308

Dear Honorable Representative Luke, Chair; Honorable Representative Nishimoto, Vice Chair, Honorable Representative Johanson, Vice Chair, and Members of the Committee on Finance:

This testimony is in **support** of **HB 2457, HD 1**.

My name is Diane Brucato-Thomas, RDH, EF, BS, FAADH. I have been a practicing Dental Hygienist in good standing on the island of Hawaii since 1992. I live in Pahoa and have practiced in Kona and Hilo. It has been my privilege to present numerous preventive education programs in grade-school classrooms and participate in countless health fairs over the years, providing preventive dental education to the public in the areas of early childhood caries, periodontal disease, root caries, systemic links, xylitol as a preventive agent, oral piercing, and, of course, halitosis. In addition to my participation at health fairs, in the last few years, I have worked to develop and implement a successful, entertaining, hands-on power point program for the lay public on oral health and prevention. This program, titled "Sweet Kisses/Sweet Truth" has been very well received by numerous audiences of various ages within the community. In 2011, I received the ADHA Institute for Oral Health Rosie Wall Community Spirit Grant to continue this program.

One of the reasons I began my quest to educate the public was because it breaks my heart when I see so many beautiful children smile with silver teeth, or worse, badly decayed teeth that are untreated, often painful, and certainly a risk to their systemic health. Hawaii is known to have a very high rate of Early Childhood Caries. This is shameful, when you consider the fact that caries is a preventable disease.

To clarify, dental "caries" is a bacterial infection. Tooth decay or "cavities" are the result of a caries infection. According to the Center for Disease Control:

- Early Childhood Caries is the most prevalent chronic disease in America.
- Early Childhood Caries is the most prevalent infectious disease on the planet.
- 40% of Children have Cavities by age five.
- CARIES INFECTION IS PREVENTABLE!

The formula chain for tooth decay is:

- Bacterial infection + sugar = acid
- Acid + tooth = decay

This chain can be broken at various links, such as:

- Daily removal of bacterial biofilms from teeth (brushing and cleaning between teeth)
- Remove sugar from diet
- Neutralize acids with water or saliva stimulated with xylitol gum or candy
- Strengthening/hardening tooth surfaces with fluoride or calcium/phosphorus agents
- Using sealants to create a barrier that protects susceptible tooth surfaces

According to the *"Executive summary of evidenced based clinical recommendations for the use of pit-and-fissure sealants: A report of the American Dental Association Council on Scientific Affairs"* , JADA, 2009, (Beauchamp, Caufield, Crall, et. al.):

- Sealants should be placed in pits and fissures of **children's** primary teeth when it is determined that the tooth, or the patient, is at risk of developing caries
- Sealants should be placed on pits and fissures of **children's** and **adolescents'** permanent teeth when it is determined that the tooth, or the patient, is at risk of developing caries
- Sealants should be placed on pits and fissures of **adults'** permanent teeth when it is determined that the tooth, or the patient, is at risk of developing caries
- Pit-and-fissure sealants should be placed on early (non-cavitated) carious lesions in **children**, **adolescents** and **young adults** to reduce the percentage of lesions that progress

HB 2457 provides an important step toward tooth decay prevention in Hawaii's youth by attempting to break the chain of caries process. This bill serves to lay the groundwork to establish and administer a school based dental sealant program in a high-need demonstration school. I urge you to please pass HB 2457 and consider that dental hygienists are a cost-effective, qualified resource for prevention programs. Utilizing dental hygienists for the placement of sealants makes good sense, as this is clearly within their scope of practice of as educated, licensed prevention specialists. Please know that there are dental hygienists willing to facilitate the implementation of this bill. Thank you for your consideration.

Sincerely,

Diane Brucato-Thomas, RDH, EF, BS, FAADH
d.bt@live.com (808) 937-7282
Immediate Past President, American Academy of Dental Hygiene
Past President, Hawaii Dental Hygienists' Association
ADHA/Hu-Friedy Master Clinician Award 2008
Sunstar/RDH Award of Distinction 2002

Jill Rethman, RDH, BA
Kaneohe, HI 96744
grethman@hotmail.com

Testimony in **Support** of HB2457 HD1 - Relating to Dental Health

Jill Rethman, RDH, BA
Past President – Hawaii Dental Hygienists' Association
Regulations & Practice Chair - Hawaii Dental Hygienists' Association
Editor in Chief – Dimensions of Dental Hygiene
Adjunct Instructor in Periodontics/Preventive Dentistry, University of Pittsburgh School of Dental Medicine
Adjunct Assistant Professor, Division of Dental Hygiene, The Ohio State University

Date of Hearing: Thursday February 20 at 12:00 pm

House Committee on Finance
Representative Sylvia Luke, Chair
Representative Aaron Ling Johanson, Vice Chair
Representative Scott Nishimoto, Vice Chair

Dear Esteemed Members of the House Committee on Finance,

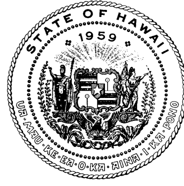
Thank you for bringing much needed attention to the unacceptable oral health situation faced by Hawaii's children. As evidenced by the recent PEW Report, Falling Short: Most States Lag on Dental Sealants, it's obvious that Hawaii could do much better to prevent oral disease, in particular dental caries, among its population. On a scale of A to F, Hawaii (along with 5 other states and the District of Columbia) received an F in providing a proven and simple technique to prevent tooth decay – the placement of dental sealants. This is particularly troubling because those who could benefit the most from sealant placement, children at high risk for decay, are the ones least likely to receive this preventive measure. According to the Association of State and Territorial Dental Directors, numerous states and territories have programs for dental sealants, and several states have school-based sealant placement programs as part of their health-related initiatives. (The report is available here: Best Practice Approach: School-Based Dental Sealant Programs)

In addition to supporting a school-based sealant program for the state of Hawaii, I fully support the legislature's initiative in putting a primary focus on oral healthcare by requiring the Director of Health to participate in the database managed by the Centers for Disease Control and Prevention and the Association of State and Territorial Directors. This intent of HB2457 will enable Hawaii to compare itself to other states in terms of implementation and standards for preventive oral healthcare measures, ensuring that the people of Hawaii receive appropriate evidence-based and needs-based care.

"Prevention is better than cure." This common axiom applies to not only systemic maladies but oral ones as well. As the prevention specialists in oral healthcare, dental hygienists would welcome the opportunity to help improve the health of Hawaii's most vulnerable population – underserved children at risk for decay. HB2457 takes Hawaii a step closer to preventing oral disease in the most needy and underserved of its population.

Thank you for your time.

NEIL ABERCROMBIE
GOVERNOR OF HAWAII



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

DIRECTOR OF HEALTH

LATE

In reply, please refer to:
File:

House Committee on Finance

H.B. 2457, HD1 RELATING TO DENTAL HEALTH

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

February 20, 2014

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

5 **Fiscal Implications:** Funding will be needed for the Department of Health to support the requirements
6 of this measure. The Department suggests appropriating for FY 2015-16 the sum of $450,000 for this
7 purpose, provided that it does not replace or adversely impact priorities indicated in our Executive
8 Supplemental Budget.

9 **Purpose and Justification:** The Department recognizes the need to rebuild the infrastructure necessary
10 to provide public health leadership in regards to a comprehensive oral health system and to conduct
11 critical public health surveillance, evaluation, planning and prevention functions. Planning has begun
12 under the Department's Family Health Services Division.

13 The Department is working with the Centers for Disease Control and Prevention and the
14 Association of State and Territorial Dental Directors to rebuild the State's oral health surveillance

1 system. The Department has also initiated discussions with the Department of Education to plan for a
2 statewide oral health screening of third graders to collect the data needed for the National Oral Health
3 Surveillance System. School-based activities included in this measure will facilitate the collection of
4 this data.

5 The Department has also initiated planning for a school based oral health prevention program
6 that would include sealant application.

7 Thank you for the opportunity to testify.

LATE

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 20, 2014

The Honorable Sylvia Luke, Chair
House Committee on Finance
Twenty-Seventh Legislature
State Capitol
State of Hawaii
Honolulu, Hawaii 96813

Dear Representative Luke and Members of the Committee:

SUBJECT: HB 2457 HD1 – RELATING DENTAL HEALTH

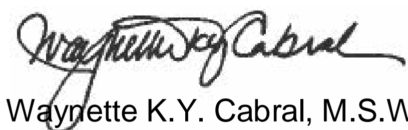
The State Council on Developmental Disabilities (DD) **SUPPORTS HB 2457 HD1.** The bill requires the Department of Health (DOH) to establish or enter into partnerships or agreements to administer a dental sealant program in a high-need school and appropriate funds.

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, III
Chair

Good Beginnings Alliance
Voices For Hawai'i's Children

LATE

February 18, 2014

To: Chair Sylvia Luke
Vice-Chair Scott Nishimoto
Members of the House Committee on Finance

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.

---

[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.

West Virginia

Enrolled Version - Final Version

OTHER VERSIONS - Introduced Version |

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 1 provide preventive and
2 therapeutic services to more persons under certain circumstances.
3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:
4 Section 1. That chapter 36-6A be amended by adding thereto a NEW SECTION to read as
5 follows:
6 A dental hygienist may provide preventive and therapeutic services under collaborative
7 supervision of a dentist if the dental hygienist has met the following requirements:
8 (1) Possesses a license to practice in the state and has been actively engaged in the
9 practice of clinical dental hygiene in two of the previous three years;
10 (2) Has a written collaborative agreement with a licensed dentist; and
11 (3) Has satisfactorily demonstrated knowledge of medical and dental emergencies and
12 their management; infection control; pharmacology; disease transmission;
13 management of early childhood caries; and management of special needs
14 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.

1 Section 2. That chapter 36-6A be amended by adding thereto a NEW SECTION to read as
2 follows:
3 A dental hygienist seeking to provide preventive and therapeutic services under
4 collaborative supervision shall submit evidence, as prescribed by the board, of meeting the
5 requirements of section 1 of this Act and a fee not to exceed thirty dollars. The board shall, by
6 rules promulgated pursuant to chapter 1-26, establish the required fee, the minimum
7 requirements for a collaborative agreement, the preventive and therapeutic services that may be
8 performed, and the evidence required to demonstrate the active practice and knowledge required
9 pursuant to section 1 of this Act.
10 Section 3. That chapter 36-6A be amended by adding thereto a NEW SECTION to read as
11 follows:
12 A dental hygienist may only provide preventive and therapeutic services under collaborative
13 supervision at a nursing facility, an extended care facility or by a home health agency serving
14 the elderly or disabled, a public institution under the Department of Human Services, Social
15 Services, Health, or Corrections, a federally qualified health center, a public health facility, a
16 tribal or Indian health service facility, a mobile dental unit, or a public or nonpublic school, or

17 through a head start program or the Special Supplemental Nutrition Program for Women,
18 Infants, and Children.
19 . Section 4. That § 36-6A-40 be amended to read as follows:
20 36-6A-40. Any licensed dentist, public institution, or school authority may use the services
21 of a licensed dental hygienist. Such licensed dental hygienist may perform those services which
22 are educational, diagnostic, therapeutic, or preventive in nature and are authorized by the Board
23 of Dentistry, including those additional procedures authorized by subdivision 36-6A-14(10).
24 Such services may not include the establishment of a final diagnosis or treatment plan for a

1 dental patient. Such services shall be performed under supervision of a licensed dentist.
2 As an employee of a public institution or school authority, functioning without the
3 supervision of a licensed dentist, a licensed dental hygienist may only provide educational
4 services.
5 All A dental hygienist may perform preventive and therapeutic services may be performed
6 under general supervision provided if all individuals treated are patients of record of a licensed
7 dentist and that all care rendered by the hygienist is completed under the definition of patient
8 of record. A dental hygienist may perform preventive and therapeutic services under
9 collaborative supervision if the requirements of section 1 of this Act are met. However, no
10 dental hygienist may perform preventive and therapeutic services under collaborative
11 supervision for more than thirteen months for any person who has not had a complete evaluation
12 by the supervising dentist.
13 Section 5. That § 36-6A-26 be amended by adding thereto NEW SUBDIVISIONS to read
14 as follows:
15 "Collaborative agreement," a written agreement between a supervising dentist and a dental
16 hygienist authorizing the preventive and therapeutic services that may be performed by the
17 dental hygienist under collaborative supervision;
18 "Collaborative supervision," the supervision of a dental hygienist requiring a collaborative
19 agreement between a supervising dentist and dental hygienist