



Ohio

Dental Hygienists' Association

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Ohio Dental Hygienists' Association
House Finance Committee
Senate Bill 332 proponent testimony
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Chairman Smith and members of the committee, my name is Beth Bielecki and I am the President of the Ohio Dental Hygienists' Association. I appreciate the opportunity to provide supportive comments on Senate Bill 332 and the goal that it seeks to accomplish.

The Ohio Dental Hygienists' Association supports the efforts behind the bill. As we are all aware, the Department of Health has identified Ohio as one of the worst states in the nation for infant mortality. Part of the issue is babies are being born pre-term or prior to the 39th week of pregnancy. Research has shown that expectant mothers who receive routine dental cleanings during pregnancy can reduce the risk of pre-term births and increase the birth weight of the newborn child. Attached is one of the many articles and studies on the connection of the oral health of the mother and the impact on the fetus. We applaud the effort to require enhanced care management services for both pregnant and non-pregnant women in the most high-risk neighborhoods as a strategy to improve the health status and future birth outcomes. We believe that the state should consider requiring, or at least encouraging, dental cleanings for all expectant mothers covered by Medicaid to help improve this important health indicator. I am attaching a summary of a recent study that states that women who are pregnant are likely to have moderate to severe gingivitis and may need regular care to maintain their oral health and help avoid adverse pregnancy outcomes.

Additionally, there is language in Senate Bill 332 that requires certain licensing boards to consider race and gender-based disparities in health care treatment decisions. Our regulatory body, the Ohio State Dental Board (OSDB), is among the licensure boards identified and required to participate under the bill. The OSDB

would be charged with reviewing the curricula and experiential learning opportunities offered by the applicable health care professional schools, colleges and other educational institutions. The Ohio Dental Hygienists' Association is supportive of this effort.

I am proud to tell you that our educational institutions are in the process of meeting the requirements in the bill. The Commission on Dental Accreditation (CODA), the body that oversees curriculum and guidelines for schools to follow to teach the next generation of dental hygienists has included cultural competency in its manual of current accreditation standards for dental hygiene education programs. Below is the language from item 2-15 from the CODA standards manual:

“2-15 Graduates must be competent in interpersonal and communication skills to effectively interact with diverse population groups and other members of the health care team.

Intent:

Dental hygienists should be able to effectively communicate with individuals, groups and other health care providers. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental Hygienists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).

Examples of evidence to demonstrate compliance may include:

- student projects demonstrating the ability to communicate effectively with a variety of individuals, groups and health care providers.
- examples of individual and community-based oral health projects implemented by students during the previous academic year
- evaluation mechanisms designed to monitor knowledge and performance”

Additionally, our national partner organization, the American Dental Hygienists' Association, has recently issued a white paper on the future of dental hygiene education and practice. The paper entitled, “*Transforming Dental Hygiene Education and the profession for the 21st Century*” states,

“The CODA Standards are the guidelines and requirements for accredited dental hygiene educational programs. The current CODA Standards include some essential content areas that provide key foundations for future dental hygiene practice. Examples of these content areas include health promotion, disease prevention, clinical practice and community service. With changes in societal needs, advances in technology, new research highlighting the oral-systemic link and the

growing complexity of the health care delivery system, current educational standards and curricular content will need augmentation.² **Curricula may need to expand beyond a primary focus on clinical expertise to include a broader focus on primary care, public health service delivery, population wellness, cultural and linguistic awareness, and health literacy (emphasis added).**

Specifically, more focus on disease prevention and health promotion related to the oral- systemic link, the role of inflammation, and the use of new technology to determine risk levels would enhance current guidelines. Additional curriculum time could be made available for physical, head, neck, and oral cavity assessment and diagnosis through the use of chair- side diagnostics, salivary testing, nanotechnology, genomic mapping, telehealth, and other state-of-the-art methodologies.^{7, 8} (p. 5-6)

The report further states:

“A myriad of societal factors and new research support the need for dental hygiene’s growth and expansion. Demographic trends indicate that the U.S. population is changing, with an increase in underserved patients and demographic groups that are underrepresented in both patient and practitioner populations. Many of the underserved populations will present with complex health care needs including complications that far exceed oral concerns. **Behavioral, financial, cultural and medical issues will have to be addressed, as they often cannot be separated from oral health needs. All of these trends will be instrumental in defining future dental hygiene roles, as meeting societal needs will require oral health care providers from more backgrounds, in more roles, and in more settings than just the traditional private practice dental office (emphasis added).**” (p. 8)

We believe this is a positive development for our profession as we look to better serve the unmet needs of people in our community. Senate Bill 332 is a good bill that makes positive steps toward solving a critical problem in our state. The Ohio Dental Hygienists’ Association commends Senators Jones and Tavares for their efforts on this bill and urge the Ohio House to pass Senate Bill 332.

Thank you for the opportunity to share these perspectives.

7. Davies K. The \$1,000 Genome. New York, NY. Free Press. 2010.

8. Glick M. The Oral-Systemic Health Connection: A Guide To Patient Care. Chicago, IL. Quintessence Publishing Co, Inc. 2014.



IADR study: Is gingivitis likely in pregnant women?

By Tony Edwards, Editor in Chief

June 28, 2016 -- Women who are pregnant are likely to have moderate to severe gingivitis and may need regular care to maintain their oral health and help avoid adverse pregnancy outcomes, according to a new study.

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The researchers also found that gingivitis is relatively stable in the late first and second trimester. The study was presented on June 23 at the International Association for Dental Research (IADR) meeting in Seoul, South Korea, by Michael Reddy, DMD, dean of the school of dentistry at the University of Alabama at Birmingham (UAB).

"There exists compelling evidence based on epidemiologic, microbial, and intervention studies suggesting an association between pregnancy gingivitis and adverse pregnancy outcomes," Dr. Reddy told *DrBicuspid.com* in an email. "Pregnancy gingivitis is the most common form of periodontal disease in pregnant women and yet the data are limited on potential demographic, social, and gestational age effects."

Gingivitis prevalence

Sources estimate that fewer than 40% to almost 80% of pregnant women have gingivitis. Given the ubiquity of the condition, this multicenter study attempted to focus on the need for better oral healthcare during pregnancy.

The researchers sought to evaluate the effect, if any, of gestational age, study site, and demographic factors on first- and second-trimester pregnancy gingivitis. Working with trained examiners, they identified more than 600 pregnant women (between eight and 24 weeks of gestation) with at least 30 gingivitis bleeding sites. The examiners also measured whole-mouth gingivitis scores at up to 168 sites using a four-point clinical index, the Loe Silness GI.

Participant characteristics

Mean gestational age	17.1 weeks
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Mean maternal age	27.8 years (range: 18-46)
Mean gingival inflammation	51.2 sites (range: 30-144)

The researchers found that study site and maternal age were significant factors in gingival bleeding during the first two trimesters of pregnancy, but that gestational age and ethnicity were not. They also found that younger women, in general, had higher measured gingival inflammation.

Dr. Reddy said this study overturned some of the conventional wisdom about gingival inflammation as pregnancy progresses.

"The conventional wisdom indicates that gingival inflammation increases progressively throughout pregnancy and returns to baseline levels postpartum," he said. "In this study we found that the level of pregnancy gingivitis was the same for women at eight weeks of gestation as it was for 24 weeks with no significant difference in the first or second trimester."

Age-related issues

Which patients experienced gingival inflammation was another surprising result.

"The gingival inflammation was more significant for young women, whereas most periodontal diseases tend to escalate in severity associated with age," Dr. Reddy said. "This may represent a lack of exposure to certain microbes in the younger mothers-to-be."

He said that all dentists should be aware of the potential issues posed by gingivitis during pregnancy.

"Pregnancy gingivitis may not be a harmless oral finding, and intervention may be important for the patient's oral health and for the well-being of the fetus," Dr. Reddy said.

As for the next steps, he said that further study is needed to clarify which women are at greater risk.

"Pregnant women should not be considered as a homogenous group," he said. "Further study of the demographic, social, environmental, microbial, and genetic aspects will enable us to add precision and to use a personalized approach to dentistry during pregnancy."

He said the data presented in Seoul are part of an ongoing randomized controlled clinical trial to evaluate the effect of late-first- to midsecond-trimester introduction of advanced daily oral hygiene on gingivitis and maternity outcomes.

“Pregnancy gingivitis may not be a harmless oral finding, and intervention may be important for the patient’s oral health and for the well-being of the fetus.”

Dr. Reddy was joined in the current study by co-authors from UAB, the University of Alabama, the University of Pennsylvania, and Procter & Gamble.

Study disclosures

This study was funded by a grant from Procter & Gamble, and three of the researchers are employees of the company. All funds received were used to support research endeavors and not for personal gain, according to the authors.

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