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**Ohio Dental Hygienists’ Association**

**Senate Health, Human Services, and Medicaid Committee**

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Chairman Burke, Vice Chairman Beagle, Ranking Member Tavares, and members of the committee my name is Kimberly Moore and I am of the President of the Ohio Dental Hygienists Association. I reside in Ashtabula County where I practice hygiene and actively volunteer. I am an adjunct faculty member at Cuyahoga Community College and Lakeland Community College. My dental hygiene degree is from Cuyahoga Community College and I received my BS from Youngstown State. I am working on my Master of Health and Human Services at YSU. Upon graduation with my Master's I would like to teach full time in a dental hygiene program teaching public health.

 I appreciate the opportunity to testify on behalf of my colleagues and to share some perspective on challenges that we see in Ohio’s dental health workforce and a possible piece of the solution. Total health and oral health are an integrated issue; when your oral health is good chances are your total health is good. If I see a patient with poor oral health, I immediately recognize that there may be more going on with this patient.

A little background information may be necessary for you to understand the challenge facing dental hygienists in Ohio. Ohio has 12 dental hygiene schools throughout Ohio and you approved the creation of a 13th in the last capital budget bill; a list of the schools is at the end my testimony. As of August 29, 2017, the Ohio State Dental Board issued by examination in FY 2017 313 dental hygiene licenses and licensed 8,720 dental hygienists in Ohio. As a frame of reference, they issued by examination in the same period 269 dental licenses and there are 7,404 dentists licensed in this state. Nationally, the demand for dental care services is projected to grow. Although the supply of the oral health workforce is also expected to grow, the growth in supply of dentists in 2025 will be smaller than that of demand, leading to significant unmet needs.

We know now that lack of oral health care has an impact on the overall health of Ohioans living in underserved communities. Poor oral health increases the risks associated with diabetes, leads to poor pregnancy outcomes, can increase the risk of cardiovascular disease and increased emergency room visits for dental pain and infection. New research being done by dental researchers is being released weekly about the connection of the receipt of oral healthcare and the prevention or identification of a corresponding health issue, including opiate addiction. In addition, Ohioans with poor oral health and missing teeth often have difficulty finding employment, creating a continued workforce issue.

Consider a dental hygiene impact on an issue that the Ohio Senate has invested a significant amount of time and resources. Research shows that low-birth weight rates in babies can be lowered if the mother receives a pre-natal dental exam. In Florida, this can now be performed in an OB-GYN office. In Colorado, 16 pediatrician offices have an exam room in their practice and employ a hygienist to “fill” a pediatric patient’s dental prescription from a dentist. You can see that Colorado is taking a comprehensive approach to access to oral health care and workforce development for dental hygienists through innovative scope of practice laws. It is the state’s practice environment that could be inviting our graduates!

The essential point is that an individual with a degree in dental hygiene and licensed by the state is an individual that has the education it takes to care for a patient in need of cleanings or preventative services. We have the knowledge to educate the patient. We understand the disease process and we know what to look for on x-rays and in the mouth for oral cancer, tooth decay, bone loss, and other abnormalities that require attention. We can avoid and know what to do in emergency situations.

Consider that new dentists, racked with debt from schooling, continue to set up practices in suburbs where they can serve a population that has insurance or the means to pay for care. Many times, they are focusing on and advertising for cosmetic dentistry services to people of means. It is simple economics that very few new dental school graduates can afford to go to the areas where the need is the greatest. It is time for Ohio to address the dental workforce issue by looking at new models that have been demonstrated to work, like changing the scope of practice for hygienists and allowing for new providers, called dental therapists and dental hygiene therapists to be added to the dental team. We cannot afford to wait to make these changes.

A Health Resources Services Administration report issued in 2015 looked at the supply of the dental hygiene workforce. Unlike dentists, the supply of hygienists is keeping up with demand. Nationally, it is projected that by 2025, that there will be more hygienists than the need—28,100 more practicing hygienists than the demand. What does that mean for Ohio? In Ohio, demand will increase slightly for hygienists, and there is projected to be a larger growth in supply, leaving approximately 821 more hygienists than demand.

The recognition of contributions of hygienists is not limited to the federal government. In 2014 the National Governors’ Association stated in a report entitled “The Role of Dental Hygienists in Providing Access to Oral Health Care” the “Bureau of Labor Statistics (BLS) reports that approximately 20 percent more dental hygienists are employed in the United States than dentists” and that “(e)xpanding the provision of affordable preventive services outside dentists’ offices might reduce the most serious consequences of limited access to dentists, and dental hygienists are potentially well suited to play an important role in expanding affordable access” (p.4). The report continues, “The services that are most effective in preventing serious dental disease are tasks that fall within dental hygienists’ normal scope of practice-professional prophylaxis, the application of fluoride, and the application of sealants” (p.4).

According to a survey of our members, Ohio hygienists are already dealing with issues of underemployment, with some hygienists only able to find part time work when they desire full time employment. ODHA, recognizing the current employment issues of its members and looking to the future, has endorsed the concept of a dental hygiene therapist and dental therapist to focus on workforce-based solutions to better serve the unmet oral health care needs of Ohioans. Current laws place unnecessary restrictions on hygienists to achieve these solutions.

Dental hygienists focus on prevention and have, for many years, championed the cause of dental care for the underserved. It is ironic to think of an “over supply” of hygienists when so many Ohioans need basic preventive and restorative care. Freeing up hygienists to work in communities under “remote” supervision of dentists can help to use the “surplus” workers while increasing access to care. This is one change that can use the existing workforce to provide much needed preventive services to communities that lack access to care.

There is also an economic impact when dental care is not available. Dental problems are among the highest number of expensive and avoidable visits to hospital emergency rooms. Untreated dental issues lead to lost work hours and missed school days.

Let me be clear: We believe that increased access to care by utilizing a mid-level provider does not mean a patient will receive a lower standard of care, but the utilization of a workforce degreed and licensed at a national standard determined by the Commission on Dental Accreditation (CODA). CODA is comprised of 30 members, 24 of whom are dentists, the remaining members are hygienists and certified dental assistants with 4 public members. This body is the same one that creates standards for programs that currently train dentists and hygienists, so it is logical for them to set standards for this mid-level provider. CODA Standard 2-15 states graduates must be competent collaborating with members of the oral health care team to support comprehensive patient care. Graduates of CODA accredited programs can evaluate, assess, and apply current and emerging science and technology. The core competencies focus on knowledge, experience, critical thinking, problem solving, procedural skills and professionalism. The curriculum for a dental therapy program **must** include 3 full academic years in full time education or an equivalent at a post-secondary college level.

Care provided by a dental hygiene therapist or a dental therapist is not substandard care, it is the opposite, it is the provision of standardized care from accredited schools while creating a dental home where one does not exist now. Allow me to dispel some misconceptions that are promoted about this bill. It is permissive. A dentist would have to actively hire a dental therapist or hygiene therapist in a practice. There is supervision through a practice management agreement initiated by the dentist to outline the duties of this practitioner. The bill limits the locations of where care can be provided, essentially creating a statutorily required pilot area program. Consider that there were 59 Dental Health Professional Shortage Areas (DHPSAs) in 2011, 85 DHPSAs in 2016, 88 DHPSAs in 2017, and just updated in January to 92 DHPSAs. Previous solutions brought forward by opponents of this concept are not working and the problem in problem areas continues to worsen. As other witnesses outline, dentists in other states that have embraced this concept have increased their practice profits and are creating new employment opportunities in communities of need.

We applaud Senators Lehner and Thomas’ efforts to examine the status quo in the oral health field and encourage the Senate to seriously consider this issue and engage in a deeper discussion on the topic. Oral healthcare is intertwined with all the large healthcare decisions you are reviewing.

I urge you to visit one of the 12 CODA dental hygiene programs, a dental clinic, or an office that serves exclusively Medicaid patients and observe the services patients receive that would otherwise go without care and see the truly good work that could be accomplished on a greater scale in Ohio.

Many of our dental hygiene schools and their educators are prepared to grow their programs to include CODA approved dental therapy and dental hygiene therapy training, including Owens, Rhodes State, and Sinclair Community Colleges and UC-Blue Ash. Just as this committee is charged to review the relationships of doctors and various levels of nurses, we believe that the relationship between dentists, dental hygienists and dental therapists is no different and warrants continued debate.You will hear testimony about the success and viability that is generated in other states.

Our Ohio-educated graduates are leaving the state to find opportunities in other states, soon as close a Michigan (a similar bill has passed one chamber). Attached is a map of where dental therapy laws are being considered. Professionally and economically, we must do better to keep them here. Thank you for the opportunity to share these perspectives. I will answer any questions you might have.

**Dental Hygiene Programs in Ohio**

**Columbus State Community College**

**Cuyahoga Community College**

**Lakeland Community College**

**James A. Rhodes State College**

**University of Cincinnati-Blue Ash**

**The Ohio State University**

**Owens State Community College**

**Shawnee State Community College**

**Sinclair Community College**

**Stark State College of Technology**

**Lorain County Community College**

**Youngstown State University**

**Hocking Technical College (approved for creation in 2016 state capital budget)**