Texas Dental Hygiene Educators' Association

Statewide Health Coordinating Council White Paper:
Innovative Primary Care Models to Improve Access and Outcomes

The School Dental Hygienist

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Summary of model proposed

The profession of dental hygiene was envisioned by Dr. Alfred C. Fones, the Founder of Dental Hygiene, as a distinct profession positioned in dental public health versus working solely in private dental practices. The purpose was to provide oral health education and preventive services to school children. Dr. Fones created the first school of dental hygiene in Connecticut in 1913. In 1914 he began a demonstration program to have dental hygienists provide educational services and preventive treatment in the Connecticut public schools, which successfully reduced oral disease rates of these children. The model suggested for Texas is this original model. Unsupervised public health dental hygienists practicing in schools can provide ongoing oral health education, oral prophylaxis (teeth cleaning), fluoride treatments, fluoride varnish, dental sealants, screening for oral disease, and referral for dental treatment. The safety and efficacy of such a program has been demonstrated with the original model that Dr. Fones created as well as with several programs in the U.S. where dental hygienists are able to establish independent or collaborative practices to provide preventive care for the untreated low-income children and establish referral programs for children who would not otherwise seek dental treatment. The funding for these programs comes from the ability of dental hygienists to file for Medicaid and other insurance to support the program. Referral relationships are established between the dental hygienist and dentists in order to provide diagnosis of disease and continuing care. Such a program would require a change of law and regulations. First, the supervision requirement would need to be changed to allow the dental hygienist in such a setting to practice unsupervised by the dentist. Second, the dental hygienist would need to be able to file for Medicaid and other insurance in order to generate funding for the program.

How would model improve outcomes without increasing health care cost?
The children who need preventive care the most would benefit from it. Research demonstrates that provision of cleaning, fluoride, sealants, and classroom oral health education, in combination, reduces disease in a population. Low income children do not have access to preventive care because of cost barriers. This program would bring preventive care to those who need it the most. The program can be paid for with Medicaid dollars and other insurance benefits that are now being used for more expensive examinations and treatment provided by dentists in private practice.

What process is in place to collect and analyze process and outcome measures?
The program itself would provide the process to collect and analyze outcome measures. Children would be screened annually to document lower disease rates, and number of children treated with fluoride varnish and sealants would be tracked.

Does your model emphasize standard treatment protocols (evidence-based practice guidelines) and patient instruction and reinforcement concerning self-care?
Yes. It is based on evidence-based practice for dentistry and dental hygiene and public health literature on school dental health programs. Oral health instruction in the classrooms provides the instruction and reinforcement necessary to motivate and reinforce appropriate self-care. Numerous studies have demonstrated that dental sealants, fluorides, and fluoride varnish prevent dental caries, and these treatments in combination provide greater benefits.

How will this model be used to create a "wellness model" rather than an "illness model"?
The program would emphasize the prevention of oral disease and referral for early treatment of disease to prevent more severe disease and loss of teeth.

What effect will your model have on the demand for health workforce in the future? (What numbers and types of health professionals will be needed?)
The model would utilize dental hygienists who are already in the work force. The state has an adequate number of dental hygiene programs to provide the work force. The excessive need for restorative services in the underserved community would be lessened and therefore ameliorate the problem of a shortage of dentists to treat these children.

How will the community be utilized to improve the health of the community? (Will lay people be trained as extenders?)
The community is utilized by placing the program in the public schools. Public school personnel would become aware of the need and be a part of encouraging and reinforcing good preventive oral care. Involvement of parent/teacher organization and other community leaders would help to empower the community.

How will your model improve the culturally sensitive delivery of health care?
All cultures are represented in the public schools. All children, regardless of cultural background, would benefit from the program. Lower SES is more prevalent among minority groups, and these children would benefit the most from this model.

How will your model improve health disparities and access to care?
All children will have equal access to preventive care to improve oral health disparities among children. The population that needs care the most, the lower SES children, would benefit the most.

How does or how could technology be utilized to improve the effectiveness of your primary care delivery model in terms of outcomes or cost?
The model includes the placement of dental sealants and fluoride varnish, which reflect current technology.

What are the barriers to implementing your model?
Current supervision laws limit the ability of dental hygienists to provide preventive care for the population who do not visit the dentist. Current law does not allow a dental hygienist to be employed by a school district to provide clinical preventive services. In addition, administrative code prevents dental hygienists from being awarded Medicaid "provider" status and from being reimbursed by other insurance programs.

What regulatory/legislative/reimbursement issues will be required to implement or expand your model?
Changes in supervision laws and reimbursement regulations for dental hygienists will be required to be able to implement the model.