Approved March 13, 1984
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Jan Meyers at
Chairperson

10 a.m./p.m. on March 1, 1984 in room 526-S of the Capitol.

All members were present except:

Senator Roitz, excused, and Senator Vidricksen

Committee staff present:

Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department

Conferees appearing before the committee:

Dr. Lois Scibetta, Kansas State Board of Nursing
Elizabeth Taylor, Kansas Dental Hygienists' Association
Jan Haun, Dental Hygienist, Overland Park
Pamela R. Overman, Division of Dental Hygiene, UMKC
Donna L. Osness, RN, Director of Health Education and Health Services, Shawnee Mission Public Schools, Shawnee Mission
Pamela Gaudreau, Dental Hygienist, Wichita
Allen Kelly, dentist, Lawrence
Mary Jo Nigg, Dental Hygienist, Wichita
Dr. Paul Hund, Leavenworth
Dr. Thane Frazier, dentist, Lyons, Kansas
Dr. Robert E. Menees, Jr., dentist, Mission
Debbie Pallazio, Wichita
Diane Bottorf, Kansas State Nurses Association

Others present: see attached list

SB 807 - Grounds for denial, revocation or suspension of license to practice nursing

Dr. Lois Scibetta testified in support of SB 807, and distributed testimony stating that this bill was requested by the Board of Nursing and has the full support of the Board. Dr. Scibetta said this bill would enable the Board to tighten up their disciplinary matters and enable examinees to pay their fee for examination directly to the examination service. (Attachment #1).

SB 806 - Scope of practice and requirements for licensure of dental hygienists

Elizabeth Taylor, speaking for the Kansas Dental Hygienists' Association, testified in support of SB 806, and distributed testimony stating that the changes proposed in this bill are not uncommon in other states and emphasizing that this bill is permissive and would only allow those dentists who wish to authorize their hygienist to perform under these changes may do so. (Attachment #2).

Jan Haun, Dental Hygienist, testified in support of SB 806, and distributed testimony stating that Kansas Dental Hygienists ask for approval of this bill so they may better augment existing capabilities within their profession to ensure that the consumers of Kansas receive the same kind of quality care that consumers in surrounding states have access to. (Attachment #3).

Pamela R. Overman, Acting Director, Division of Dental Hygiene, UMKC, testified in support of SB 806 and distributed testimony stating that the dental hygienist is a dental health professional with the primary focus of practice being the prevention of oral diseases. Since the Practice Act revision stipulates direct supervision, the dentist would always be in attendance to provide emergency care, if needed. (Attachment #4).

Donna L. Osness, RN, Ed. D., Director of Health Education and Health Services, Shawnee Mission Public Schools, Shawnee Mission, testified in support of SB 806, and distributed testimony stating that the expansion of the hygienist' role would enable more Kansans to be seen and screened for dental needs. (Attachment #5).

Pamela Gaudreau, RDH, BHS, testified in support of SB 806, and submitted testimony stating that many times dental hygienists are asked to volunteer time to do oral screenings and have to decline because of the Practice Act's limitations. She believes that general supervision would enable dental hygienists to serve the community and fulfill some dental needs that are not being met. (Attachment #6).

Dr. Allen Kelly, Lawrence, testified in support of SB 806, and said that this bill would allow nurses to go to nursing homes and deliver health care where it is needed. According to Dr. Kelly, health care needs are not being met in rural communities and among the elderly.

Mary Jo Nigg, RDH, Wichita, testified in support of SB 806, and submitted written testimony stating that only those hygienists who are educated, trained and licensed in the administration of local anesthesia and nitrous oxide analgesia by the Kansas Dental Board would be allowed to perform those functions. (Attachment #7).

Carl Schmitthenner, Kansas Dental Board, introduced Dr. Paul Hund, Leavenworth, who testified in opposition to SB 806, stating that this bill would allow hygienists to administer anesthesia and work under "general supervision" instead of "direct supervision". Dr. Hund said that any type of anesthesia is dangerous and should be administered only by properly trained individuals.

Dr. Thane Frazier, Lyons, testified in opposition to SB 806 and distributed testimony stating that a hygienist's training was never intended for treating patients without the direct supervision of a dentist, and with the number of well trained professionals available today, high quality care can be assured patients under the regulations of our present State Dental Law. (Attachment #8).

In answer to a question from the committee as to whether this bill would increase the cost of services, Dr. Frazier said he could not answer that precisely. He did point out that the KDA feels there is a need for increased care to residents of nursing homes. In answer to a question as to how the dentists feel about this bill, Carl Schmitthenner said he had no definite statistics on this, but estimated that 70% were opposed to the bill, and 30% supported it.

Dr. Robert E. Menees, Jr., Mission, testified in support of SB 806 and distributed testimony stating that a portion of quality oral health care may be provided by a dental hygienist in a cost effective manner, and certain uncared for dental problems may be recognized and referred on to dentists for treatment. Dr. Menees said this bill will allow Kansas to become consistent with dental practice acts in other states. (Attachment #9).

Debbie Pallazio, Wichita, testified in support of SB 806, and distributed testimony stating that dental hygienists are trained and qualified to be the dental team preventive specialist. Dental hygiene courses parallel dental students' courses in many respects, but hygienists concentrate on repair services. (Attachment #10). Ms. Pallazio said that they have a yearly continuing education program.

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S, Statehouse, at 10 a.m./~~p.m.~~ on March 1, 1984

Diane Bottorf, KSNA, testified in support of SB 806, and submitted testimony stating that while this bill does expand the practice of dental hygienists, it does require that certain standards are met and that supervision is given in accordance with the level of the function being performed. (Attachment #11). In answer to a question from the committee, Ms. Bottorf said that a dental hygienist has a college program to prepare her for practice, while a medication aide has about 1½ weeks.

Written testimony was submitted by Carl Schmitthenner, KDA, stating their opposition to SB 806 on the basis that no benefit to the citizens of Kansas will result from the changes, and in some cases the health care of Kansans would be adversely affected. (Attachment #12).

Elizabeth Taylor distributed a packet to the committee containing a detailed report of the curriculum, goals and objectives of the Johnson County Community College Dental Hygiene Program, along with letters of support for SB 806. (Attachment #13).

Senator Ehrlich moved that the minutes of February 20, 21, and 22, 1984, be approved. The motion was seconded by Senator Bogina and it carried.

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-1-84

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Gregory H. Scott	KDHE
Jim McKenzie	United Way of Topeka
Sandy Praeger	KPTL/K
Roberta Wellmeier	KDHE
Dr Lois Rich Scibetta	KS BON
Cynthia Barrett	KS Dental Bd
[illegible]	Budget Div.
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Nevin Watkins	Olathe Chamber of Commerce
GARY D Newman	KS Dental Assn.
Dr. Ann Harris RDH	Ks. Dental Hygienist Assn
Linda Zaun the RDH	KS Dental Hygienist Assoc.
Pamela Bumgarner RDH	KS. Dental Hygienist Assoc.
Margaret Mary Dillon RDH	Ks. Dental Hygienist Assoc.
Dee Pokorny	Wichita Dental Hygiene Student
Debbie Palacioz	Wichita Dental Hygiene Student
Barb M. Gichler	Wichita State U. Dental Hygiene
Sandra L. Peters	Ks Dental Hygienists Assoc.
Jamie B. Menees	Ks Dental Hygienists' Association
Carla D. Wright	Ks. Dental Hygienists Assoc
Mary Jo Kugler	Ks Dental Hygienists Assoc.
Cris Ewing	KS Dental Hygienist
Ellen [illegible]	Kansas Dental

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-1-84

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Carol Clemons Overbrook	Kansas Dental Association
Thomas Gregson	Kansas Dental Association
Paul Klug D	Kansas Dental Assn
Jerry Norsman	Individual
Pamela Quarnstrom KDH	Kansas Dental Hygienists Assn.
Joy Hawes, R.D.H.	" " " "
Marilyn Bradt	Kansas for Improvement of Nursing
Ronald Bottorff	Kansas State Nurses' Assn.
Carl Schmidtheuser	Ks Dietetic Assn
Ken Schatzmeyer	KS Pharmacist Assn.
Sheila Schmidt	Ks. Pharmacists Assn.
Dick Morse	Ks. Pharmacists Assn.
Gary Robbins	Ks Optometric Assn

#1 - 3-1-84

KANSAS STATE BOARD OF NURSING

BOX 1098, 503 KANSAS AVENUE, SUITE 330
TOPEKA, KANSAS 66601
Telephone 913/296-4929

TO: The Honorable Jan Meyers, Chairman
Public Health and Welfare Committee

FROM: Dr. Lois Rich Scibetta LRS
Executive Administrator

DATE: March 1, 1984

RE: Senate Bill 807

Thank you Madam Chairman for the opportunity to respond to Senate Bill 807. The Board wishes to thank the Committee for introducing this legislation.

This Bill was requested by the Board of Nursing and has the full support of the Board.

The Bill would enable the Board to tighten up our disciplinary matters regarding inter-state findings and requests for continuance of hearings. These changes were made after consultation with our attorney.

Secondly, the Bill would enable the examinees to pay their fee for examination directly to the examination service. This would not effect the current licensure fee of sixty dollars ($60.00). The procedure for direct payment to the examination service was approved by the Board of Nursing in its regularly scheduled meeting in October 1983.

I will be happy to answer any questions which the Committe may have.

LRS/cap

Att. 1

#V- 3-1-84

The Kansas Dental Hygienists' Association

Constituent of The American Dental Hygienists' Association

kdha

TESTIMONY IN SUPPORT OF SENATE BILL 806

SENATE PUBLIC HEALTH and WELFARE COMMITTEE
March 1, 1984

Madam Chairman and Committee Members:

CHANGES BEING PROPOSED BY 806:

1- Allowing a dental hygienist to perform dental hygiene under "general" supervision rather than "direct" supervision. The definition of general supervision being that the dentist must personally diagnose, and personally authorize each procedure to be performed on each patient but does not have to be on premises where the procedure will be performed. The change from current law is simply that the dentist does not have to be on premises. K.D.H.A. is seeking this change so that hygienists may provide greater access to the citizens of Kansas. Many segments of our society are not receiving preventive dental care particularly children, the handicapped, and the elderly.

Dental Hygienists are trained professionals and are not asking to perform any functions that they are not trained to perform. You have in the packet before you a specific outline of curriculae from each of the Kansas schools offering dental hygiene programs and also from UMKC's Dental Hygiene Program. We have with us an instructor from UMKC who is familiar with the educational programs. Therefore, I will defer any further comments on the quality of the educational programming to her testimony.

2- Allowing a dental hygienist to administer local anesthesia and nitrous oxide analgesia. The administration of these must be performed under the direct supervision of the dentist. Again, the hygienists are not asking to perform anything that they are not trained to perform. We have also qualified this provision with certification on the hygienists license upon the meeting of regulations to be devised by the Dental Board.

3- Upon employment by an public institution or facility, school, etc., a hygienist may perform dental hygiene under the authority of the governing body of that facility. The intent here is to provide a means for the hygienist to provide preventive dental care to those who are not being seen by a dentist. It is estimated that only 50% of our school children are seen by a dentist each year. If a hygienist were allowed to educate these children, we are sure their long-range dental health would be vastly improved. With the ability to screen, these children would be referred to a dentist earlier, again improving their future dental health.

The need for oral health care in nursing homes is not currently being met. Here again, if a hygienist were

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allowed to perform in a nursing home, we would not see the emergency nature of care that we see today. Seldom is a nursing home patient seen by a dentist unless the dental situation is deteriorated. This not only causes greater pain for the patient, but it also causes the cost of dental care to greatly increase. Many patients in nursing homes, institutions and extended care facilities are not able to care for their daily dental needs in order to prevent further deterioration. Dental Hygienists are trained to be the dental prevention provider and should be allowed to do so in this state.

4- The last provision is the requirement that all dental hygienists be able to perform CPR, as all health care professionals should, unless there is good cause shown to the Board that the individual cannot perform such.

OPPOSITION TO THESE CHANGES

We are finding opposition to these changes primarily coming from the Executive Committee of the Dental Association. We are concerned, however, that this opposition is not representative of the dentists across the state. In a survey conducted last summer by hygienists one-on-one with dentists, we found that roughly 70% of those dentists surveyed were in favor of our proposed changes. The percentage is much higher among those dentists who employ a hygienist. We estimate that we surveyed 25% of those dentists licensed in Kansas and have broken down the particular percentages with respect to each change proposed in the packet that you have. Due to the time restrictions today I will not innumerate them all, but I would encourage all of you to look these over as they are quite significant. Some interesting conclusions, other than the wide support, were found in this survey. (a) We found that most of the dentists opposing our changes were those who do not employ a hygienist (particularly in rural communities where "cottage-dentistry" is still practiced), and (b) that most of the dentists supporting our changes were those who are more recent graduates of dental programs (ages 45 and under).

ARGUMENTS AGAINST THESE CHANGES

Several arguments are being used against these changes that must be addressed:

1- the argument that we are seeking changes primarily to expand the job market. ACCESS FOR KANSANS is the reason we are seeking these changes. This is supported by similar changes in the Colorado statues not substantially expanding the dental hygiene job market.

2- the fear that dentists will not have control over functions performed on their patients. Under the definition of general supervision, the dentist must personally authorize each procedure on each patient. We must also recognize that this bill is permissive in nature and does not mandate any unauthorized performance. If the dentist is unconfortable with his hygienist performing while he is not on premises, he simply will not authorize her to perform while he is away. The same is true with the administration

of local anesthesia and nitrous oxide under his presence. If he does not authorize his hygienist to administer these, she will not be doing so.

3- the concern that hygienists are not qualified to perform as they are asking. Again, hygienists are extensively trained in all of these areas. Please check the detailed curriculae enclosed.

4- some dentists are concerned that these changes may result in a loss of income. We feel that, in contrast, these changes would result in more citizens having access to dental care, particularly through the screening of patients not currently receiving care and thus more citizens would be visiting their dentists. We can foresee also that these changes would result in the lower long-range dental cost to the consumer since PREVENTION is the focus.

SUPPORT OF THESE CHANGES

We are finding support for these changes among many segments of our population including dentists, nurses, nursing homes, schools, and particularly consumers.

Again, due to time restrictions, many who would like to testify today will not have a chance to be heard. We have enclosed numerous letters of support from dentists, school administrators, hygienists, and consumers. Please look these over when you have a chance.

In closing, I would like to point out that the changes we are asking for are not uncommon in other states. 32 states allow for general supervision defined much the same as we have proposed; 16 states allow for the administration of nitrous oxide analgesia; 12 states allow for the administration of local anesthesia. Also, please keep in mind that this bill is PERMISSIVE and would only allow those dentists who wish to authorize their hygienist to perform under these changes may do so. Our aim is MORE CARE FOR MORE KANSANS in order that we may all have healthier smiles.

Thank you for your consideration.

Sincerely,

Elizabeth

Elizabeth E. Taylor
Legislative Consultant-KDHA
513 Taylor
Topeka, Ks. 66603
913-354-1605

~~#4~~ - 3-1-84
#3

'UBLIC HEALTH AND WELFARE COMMITTEE
/ENATE BILL 806

Good morning, I am Jan Haun, RDH, and I am here to speak in favor of SB 806. Specifically I will be addressing the issue of local anesthesia and will be speaking both as an individual and a representative of the Kansas Dental Hygienists.

I am a private practice dental hygienist and for two years I have been participating in the administration of local anesthesia. I live in Kansas but practice dental hygiene across the state line in Missouri, one of the three states surrounding Kansas that allows dental hygienists to administer local. Although I am in a general practice setting, I consistantly treat three to five patients per day who have gum problems and require local anesthesia for comfort and to better assure that my treatment is not altered or compromised because of patient discomfort.

You will be hearing a letter from my employer who totally supports the concept of hygienists extending this courtesy to the patients in our office. This does not interrupt the continuity of the treatment of his patients for him to come to my patient, administer the local, return to his patient, and possibly have to return a second or third time if the first efforts were not effective enough to comfort the patient. This is a very positive consideration for all concerned; the patient, the dentist, and the hygienist.

In the two years that I have been actively administering anesthesia, I have not had one incident of any complication, the patient acceptance has been tremondously positive, and never has there been any issue or concern on the patients behalf questioning my qualifications before or after treatment. In fact, numberous patients question why my injections do not hurt. The bottom line in safety to the patients for this procedure is PREVENTION. A thorough health history review is imperative and if there is a systemic problem, complications will occur regardless of WHO administers the anesthesia. Under

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direct supervision, the dentist will be in consultation with the hygienist on the health history and current medical condition of each patient to avoid any complications -- thus making administration of local anesthesia a safe procedure for hygienists to perform.

It is a fact that insurance companies handling liability insurance DO NOT consider local anesthesia a risk procedure for hygienists or dentists. Additionally, premiums are not altered or increased for hygienists administering local anesthesia over those who do not.

There are no significant law suits regarding dental hygienists and local anesthesia even though local has been legal in some states as long as 18 years. (Oregan, 1966)

In closing, the KDental Hygienists believe that all of our testimony, written and verbal, indicates local anesthesia administration by dental hygienists to be safe and in the best interest of the dentist, the dental hygienist, as they continue to work together in the tradition of dentistry to provide the highest standards of care possible to the consumer. We ask for approval not to pursue a NEW direction , but so we may better augment EXISTING capabilities within our profession to ensure the sunsumers of Kanaas receive the same kind of quality care the consumers of the surrounding states have access to. The bottom line is that we have a responsibility to deliver what is best for the residents of Kansas. Our purpose for making this request is to meet that responsibility.

I thank you for your time and honest consideration of our proposal.

Jan Haun, RDH, BS

Private Practice Dental Hygienist
Kansas Dental Hygienists

3-1-84
#4

TESTIMONY IN SUPPORT OF SENATE BILL 806
Kansas Dental Hygienists' Association
Pamela R. Overman, Acting Director
Division of Dental Hygiene
University of Missouri-Kansas City

The intent of the currently proposed legislation is to allow dental hygienists to provide certain traditional dental hygiene functions, oral hygiene instruction and cleaning of the teeth, under the general supervision of the dentist. This would allow the dental hygienist to become a "dentist extender", allowing dental hygiene care to be given to those whose needs are currently not met.

Are dental hygienists qualified to provide dental hygiene care under this type of supervision arrangement? The dental hygienist is a dental health professional with the primary focus of practice being the prevention of oral diseases. They are the only dental professionals educated primarily to provide preventive dental care to the public.

The University of Missouri-Kansas City offers an educational program which prepares dental hygienists at the Baccalaureate Degree level. The program is two academic years in length and students entering the program must have completed two years of pre-professional college course work prior to entry. The program is fully accredited by the Commission on Dental Accreditation, a specialized accrediting body recognized by the Council on Post-secondary Accreditation and the United States Department of Education. The Commission's responsibility is to monitor and continually evaluate all dental hygiene and dental programs in order to maintain quality dental education.

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In compliance with the educational standards set forth by the Commission on Accreditation, dental hygiene students complete course work in basic sciences, dental sciences and dental hygiene sciences.

Dental hygiene students at UMKC spend approximately 750 hours in clinical dental hygiene, learning and mastering the skills necessary to provide comprehensive oral prophylaxis (cleaning) and preventive services. This is a greater number of clock hours than dental students devote to oral prophylaxis and preventive services. It seems ironic that upon graduation, dentists must supervise these procedures.

At the completion of the program, the dental hygiene students must take licensure examinations. A comprehensive written National Board Examination is given. After successful completion of the National Board, the graduates must take a clinical examination in the states in which licensure is sought. These examinations are usually two days in length and require that complete dental hygiene services are provided and evaluated by State Dental Examiners. Within the defined scope of dental hygiene care, all dental hygienist must demonstrate minimal competence to obtain licensure. It is time to rationally question whether current supervision requirements fully recognize the competence of today's licensed dental hygienist.

Another aspect of the currently proposed legislation will allow educated dental hygienists to provide local anesthesia and nitrous oxide-oxygen analgesia under direct supervision. Since these functions are legally delegatable in the State of Missouri, dental hygiene students at the University of Missouri-Kansas City

receive training in them. It is interesting to compare dental hygiene students' instruction to dental students' instruction in pharmacology and anesthesia.

COMPARATIVE CLOCK HOURS

Dental Hygiene Students	Dental Students
Pharmacology 45	Pharmacology 30 Therapeutics 15
Local Anesthesia 15 Lecture	Local Anesthesia 15 Lecture
Nitrous Oxide Analgesia 6	Nitrous Oxide Analgesia 6

Dental hygiene students must demonstrate clinical proficiency in administration of local anesthesia and nitrous oxide during their course work. After completion of the courses in local anesthesia and nitrous, students incorporate these pain control procedures into their clinical practice. Although complications from the use of local anesthesia and nitrous are rare, they do occur. Dental hygiene students are trained to deal with unexpected adverse reactions and all are certified in Cardio Pulmonary Resuscitation.

Since the Practice Act revision stipulates direct supervision, the dentist would always be in attendance to provide emergency care, if needed. Allowing properly trained dental hygienists to use modern techniques of pain control will certainly not detract from the quality of care given to Kansans. It will only enhance it. Thank you.

#5 - 3-1-84

Shawnee Mission Public Schools
Mohawk Instructional Center
6649 Lamar
Shawnee Mission, Kansas 66202
Telephone 913-384-6800

Division of
Instruction

Educating for Life

February 28, 1984

To Whom It May Concern:

As director of Health Services and Health Education for the Shawnee Mission School district, I would like to encourage you to seriously consider relaxing the Dental Hygienist practice act to require general supervision. This expansion of the hygienist' role would enable more Kansans to be seen and screened for dental needs. The availability of dental hygienists to our school-age children would enhance the preventive dental health programs that we now provide for our young people by offering a screening option such as those in the areas of hearing, vision and scoliosis.

As the supervisor for our school nurses, I am repeatedly reminded of the need for more and better dental health efforts. Please recognize this opportunity to improve the quality and quantity of our dental programs for school children.

Sincerely,

Donna L. Osness

Donna L. Osness, R.N., Ed. D
Director of Health Education
and Health Services
Shawnee Mission Public Schools
6649 Lamar
Shawnee Mission, Kansas 66202

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#6- 3-1-84

February 29, 1984

To the Members of the Senate Public Health and Welfare Committee:

I support the changes in the dental practice act.

I would like to address general supervision.

I have worked in various practice settings including private practice but primarily in public health settings such as the Wichita-Sedgwick County Department of Community Health as a dental health educator, U.S.D. 259 and the National Preventive Dentistry Demonstration Program as a dental hygienist and educator, and Wichita State University Department of Dental Hygiene as a clinical instructor and lecturer.

I have been able to do oral screenings and dental prophylaxis due to dental screening permits from the Kansas Dental Board as an employee of the State of Kansas.

I have reached the conclusion that there is a high need for oral screenings and oral prophylaxis in nursing homes, hospitals, school systems, and other settings I have visited because many people who need dental care and dental education are not obtaining or receiving it.

Many times dental hygienists are asked to volunteer time to do oral screenings and have to decline because of the practice act's limitations. I believe that general supervision would enable dental hygienists to reach out and serve the community and fulfill some dental needs that are not being met.

Thank you for your consideration.

Sincerely,

Pamela Gaudreau

Pamela Gaudreau, R.D.H.,B.H.S.

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H 7- 3-1-84

SUPPORT TESTIMONY SB 806
Public Health And Welfare Committee

by Mary Jo Nigg, R.D.H.
Wichita, Kansas

This testimony is presented in support of SB 806, which will change the Kansas Dental Practice Act to broaden the scope of practice of the dental hygienist.

I am a registered dental hygienist and have been practicing in Kansas for more than eight years; two years in general dentistry, and the past six years in the specialized dental practice of periodontics. I am also a clinical dental hygiene instructor at Wichita State University.

Specifically, I would like to address the portion of the bill allowing the administration of local anesthesia and nitrous oxide analgesia by the dental hygienist. The focus of dentistry has long been on caries (decay) prevention. This has been very successful. Through education and fluoridation, there has been a 30% to 70% reduction of decay throughout the United States. But periodontal disease is also a national epidemic. 90% of American adults have some form of periodontal (gum) disease, and 70% of adult tooth loss is caused by periodontal disease. The focus of dentistry should shift to the treatment and prevention of periodontal disease. Universal treatment of periodontal disease centers on root planing, both in preventive and maintenance care. This modality is already in the scope of practice of the dental hygienist, who is obviously the most qualified member of the dental team to deliver treatment for periodontal disease in its early stages. But to be effective, the administration of local anesthesia and/or nitrous oxide analgesia is necessary. This would insure patient comfort through anxiety and pain control, thus allowing the hygienist to be more thorough and to enhance the quality of care rendered to each patient. Only those hygienists who are educated, trained and licensed in the administration of local anesthesia and nitrous oxide analgesia by the Kansas Dental Board would be allowed to perform

Atch. 7

these additional functions.

I am asking for your support of this portion of the bill, and I ask your favorable and serious consideration of SB 806. Thank You.

Mary Jo Nigg

#8- 3-1-84

Senator Myers and Members of the Committee:

My name is Thane Frazier and I live in Lyons, Kansas, where I have practiced general dentistry for the past 32 years. I have employed a dental hygienist in my practice for the past seven years.

Working together with my hygienist has made these years the most enjoyable of my entire professional career and Carol fully realizes the respect and confidence which I have in her abilities and her valuable contribution to the oral health and the dental education of our patients. She has been a joy to me and our patients love her, as I do, for all she has done for my practice and for our community.

Because of my high regard for my dental hygienist and for her many friends in the Kansas Dental Hygienists Association it is not easy for me to speak in opposition to their support of Senate Bill #806.

If we look back over the past 100 years in which dentistry has been regulated in Kansas, we find the purpose of the law and the regulations enforced by the Kansas Dental Board have been for the protection of the public and assure the care delivered to Kansans will be the very finest.

Our laws require persons licensed to treat patients to have educational backgrounds to qualify them to provide that care. The legislature has required that all candidates for licensure in Kansas shall be graduates of an accredited dental school and shall successfully pass the Kansas Dental Board examinations.

My hygienist told me her training and education to become a dental hygienist was always with the clear understanding the dentist would oversee her work, as well as providing her advice and assistance. The cirriculum of study established to train dental hygienists does not train them to recognize and diagnose dental lesions. Their training was never intended to train them to treat patients without the direct supervision of a dentist.

Fortunately our state continues to have a good supply of dental and dental hygiene graduates. Dental care services and the quality of that service available to Kansans is as fine as in any state in the union.

With the number of well trained professionals available today, we can continue to provide and assure this high quality of care to our patients under the regulations of our present State Dental Law.

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#9- 3-1-84

Testimony on Senate Bill #806

Robert E. Menees, Jr., D.D.S.

I am writing in support of Senate Bill #806. It is "high time" for the Kansas Dental Practice Act to modify the duties and supervision of the dental hygienist.

The quality care for dental hygiene procedures includes the need for the control of anxiety and pain for my dental patients. The avaliability of a dental hygienist with approved skills in local anesthesia in my office would not only allow the dental hygiene patient an uninterrupted procedure appointment but allow that same courtesy for the patient in my chair.

Having just completed my certification in CPR, I am reminded of the need for everyone to have current updating of these procedures. The need for all members of the dental team to possess these life saving skills is, in my estimation, mandatory.

Finally, my schedule does not allow time away from the office to provide the on going service many of the Kansas elderly and handicapped require for optimal oral health. A portion of quality oral health care may be provided by a dental hygienist in a cost effective manner and certain heretofore uncared for dental problems may be recognized

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by such dental hygienist and referred on to dentists for treatment. This will provide an increase in income to the dentist and an increase in tax revenues to the state while keeping the individual cost down and reaching uncared for persons. The oral health of these citizens is compatable with total body wellness and these individuals should not be made to suffer this lack of care needlessly.

As a concerned Kansas Dentist, I am supportive of the changes described in Senate Bill #806 which will allow Kansas to become consistent with dental practice acts in other progressive states. Let's not let Kansas lag behind.

Robert E. Menees Jrs

March 1, 1984

#10 - 3-1-84

Senate Public Health and Welfare Commitee
February 28, 1984

RE: S B 806

Members of the Commitee:

You have in your packet a very detailed report of the curriculm, goals, and objectives of the Johnson County Community College Dental Hygiene Program. In consideration of your time, let me highlight a few items of particular interest.

Dental hygienists are trained and qualified to be the dental team preventive specialist. The main thrust of their schooling is educating, motivating, and assisting the patient in keeping their teeth the rest of their life. Dental hygiene courses parrallel dental students' courses in many aspects, however, dental hygienists concentrate on preventive and prophylactic services while dental students concentrate on repair services. Yet after some 750 hours of patient contact, our practice act says the hygienist cannot pick up a mouth mirror and look into a child's mouth or give a special care to a geriatric patient in a nursing home without a dentist on the premise.

Our students, as in all dental hygiene programs, are required to extend a variety of preventive dental hygiene services to the public in hospitals, extended care facilities, homes for exceptional children, schools for handicapped, and public school systems. They must demonstrate competance and expertise in these services and are evaluated on process as well as end product. And yet, once graduated, these fully qualified licensed professionals cannot continue these preventive services to the 50% of the residents of Kansas who have no dental care, unless they can find a dentist who is willing to leave his private practice and be on the premise while the hygienist performs her services.

General supervision is not a new and innovative idea - 42 of the exsisting states have some form of general supervision now. Aren't the residents of Kansas deserving of these services that dental hygienists spend over 2,000 clock hours learning to provide? Aren't they deserving of the expertise of a preventive professional who can concentrate on specialized home care an individualized attention? Why can we only reach half of the residents of Kansas with our present practice act?

It is impossible to say general supervision will LOWER dental costs to Kansans, however, isn't prevention less expensive than repair?

Dental hygiene graduates have an unending capability for creativeness in patient education and motivation and a genuine concern for the "special" patients--don't kill that potential by keeping Kansas among the very few states that do not allow these licenced professionals to extend their proven talents to more of our residents.

Atch. 10

A 11- 3-1-84

KSNA

the voice of Nursing in Kansas

Statement of Kansas State Nurses' Association
by Diane Bottorff, R.N., Assistant Director
before the Senate Public Health & Welfare Committee

March 1, 1984

In support of SB 806 Scope of Practice & Requirements for Licensure of Dental Hygienists

Madam Chairwoman and members of the committee, I am Diane Bottorff, an Assistant Director of the Kansas State Nurses' Association. KSNA speaks in support of SB 806.

The provisions of this act expand the scope of practice of the dental hygienist. While doing this, SB 806 does clearly spell out the relationship of the hygienist to the dentist in terms of supervision of varying levels of functioning. In addition, this bill sets certain requirements which the dental hygienists would be required to meet in order to include in their practice the administration of local anesthesia or nitrous oxide. This ensures that only those who can meet the standards set for this additional area of practice will be allowed to carry it out.

In expanding the practice, lines 0128-0136 describe certain situations in which the dental hygienist may practice without the personal direction of the dentist. Permitting this would make dental services available to certain segments of the population which tend to be underserved by dentists.

The provision in this bill requiring dental hygienists to have completed a course in cardiopulmonary resuscitation for licensure is commendable. Other health care professionals should be encouraged to follow the lead of the dental hygienists in requiring this.

In summary, we ask you to act favorably on SB 806 because while it expands the practice of dental hygienists, it does require that certain standards are met and that supervision is given in accordance with the level of the function being performed.

Atch. 11

#B - 3-1-84

KANSAS DENTAL ASSOCIATION

SENATE BILL #806

The Kansas Dental Association is opposed to the passage of SB #806 on the basis that no benefit to the citizens of Kansas will result from the changes and in some cases the Health Care of Kansans would be adversely affected.

The KDA is opposed to allowing Hygienists to practice under general supervision for the following reasons:

The Educational Program has not prepared the Dental Hygienist for practice without supervision.

Dentists are trained to recognize and diagnose oral diseases the untrained eye may miss. Oral disease might not be recognized and a patient, believing that he is receiving sufficient dental care, might go untreated.

Dentists supervising Hygienists would still be legally responsible for the work of the Hygienists even though it may have been performed while the dentist is away.

The KDA is opposed to allowing the Hygienist to administer anesthesia.

The administration of local anesthesia is a dangerous procedure. Because of the skill required, the administration of local anesthesia, which is a procedure which takes only a few minutes should be performed by the Dentist. In most cases, patients may be scheduled conveniently to allow the dentist to administer anesthesia without interrupting treatment of other patients.

What about oral health care in nursing homes? Couldn't the dental hygienist be of help there? The answer is yes. The dental hygienist plays an important role--along with the dentist--in providing complete oral health care to all patients. The Kansas Dental Association would like to see dental hygienists in nursing homes--screening patients, teaching nursing home personnel how to help care for patients' oral health on a daily basis and providing nutritional instruction. These are <u>preventive</u> services which may be provided under the current statute. We would also like to see dental hygienists provide oral hygiene care to nursing home patients--but we emphasize strongly that this intraoral treatment should take place only when a dentist is present to evaluate the treatment provided and to respond to emergencies. This is important for all dental patients, but it is vital for nursing home patients, who are among the highest risk groups when receiving dental treatment due to chronic debilitating disease and complex medication. We cannot stress enough the importance of complete dental care for these patients, including the availability of diagnostic skills, treatment of tooth, gum, denture and other oral conditions.

5200 Huntoon
Topeka, Kansas 66604
913-272-7360

#19 - 3-1-84

Hugh H. Bruner, Jr., D.D.S.
Diplomate, American Board of Periodontology
Bel-Air Proffessional Association • 5600 West 95th Street • Overland Park, Kansas 66207 • (913) 649-0166

10 January 1984

Mr. Phil Kline
Member
House Public Health & Welfare Committee
Representative 19th District
State Capitol
Topeka, Kansas 66612

Dear Mr. Kline:

My father entered a Nursing Home in November, 1982. Part of the Nursing Home's contractual obligation includes his dental care. The primary deliverence of that dental care is accomplished by the Nursing Staff. Those same persons who make his bed, cut his fingernails, change his clothes and give him his medication are also responsible for his dental health.

My father is a dentist who is suffering from the sequalae of a stroke. My father is partially paralyzed; he cannot use his left arm, and is bed-fast and chair-fast. He is dependent upon others. But he has an alert mind. He was frustrated with the assistance he was given concerning his dental maintenance. Just the simple act of brushing his teeth was difficult. And, interestingly enough, part of this difficulty was not just his physical impairment. He ran into difficulties from the Nursing Staff that was a result of their mentality.

The Nursing Staff is simply reacting to my father, and to other patients, from the basis of their own intelligence, education, experience, training, and attitudes. Which means that from a dental management aspect, it is subjective and sometimes inadequate.

My personal experience with dentists and dental hygienists leads to generalizations. One generalization that I can offer is that the dental hygienists, that I work with, are as qualified as dentists when it comes to toothbrushing guidance, plaque control and dental health maintenance. Another generalization is that these dental personnel know more about dental care than do Nurses (and physicians for that matter.)

Con't

There is at least one drug that is given to my father that may affect his life or death. This medication is given to my father on the orders of a physician. However, this physician is rarely physically present when the medication is administered. If you wish to use the term, "General Supervision" to define the relationship between the nurse and the physician, then do so.

Just think about this for a moment. It is all right for a nurse to administer to the life and death needs of a patient; but (under our current law) it is not all right for a dental hygienist to administer to the prosaic dental needs of a patient.

Any reasonable, non self-serving person would have to agree that this is nonsense.

It would be in the best interest of society and the citizens of the State of Kansas to allow dental hygienists to be able to perform their services under the definition of "General Supervision."

In a personal note, such a Public Policy would be marvelous for my father.

Respectfully Submitted,

Hugh H Bruner, Jr., D.D.S.

HHB/kmf

Leo F. Bieser, D.D.S.
Chartered
Johnson County Medical Building
6300 Glenwood
Overland Park, Kansas 66202
432-6226

L. F. Bieser, D.D.S.

February 10, 1984

I am writing in support of portions of the changes in the Dental Practice Act, as proposed by the Dental Hygienists of Kansas.

As a part-time instructor in the Johnson County Community College Dental Hygiene Program, and a private practicing dentist who employs a hygienist, I feel qualified to state that Dental Hygienists are qualified to extend care to more patients under a well defined "general supervision" designation.

The proposal for administration of local anesthesia under "direct supervision", after a defined educational qualification, is also recommended for approval.

The certification in CPR as a requirement for initial and annual licensure should be in the Dental Practice Act for all licensed health practitioners.

Sincerely,

Leo F. Bieser

Leo F. Bieser, DDS

John W. Adams, D.D.S., P.A.
909 East Wayne
Salina, Kansas 67401
913—825-1659

January 19, 1984

Dear Sirs:

I have been a licensed practicing Dentist for the past nine years in Salina, Kansas. I have employed a Dental Hygienist full time for eight of those years. In my opinion, the hygienists I have worked with are highly trained, competent individuals who are skilled in many areas of Dentistry.

I feel it would be a service to the patient as well as cost effective, if certified personnel were allowed to work under general supervision as proposed in this legislation. It is inconsistent that these skilled professionals who have been trained in anesthetic are denied this procedure, while an LPN can administer drugs parenterally with less formal education and training.

Specifically, a hygienist who was trained and experienced in local dental infiltration should be allowed to administer local anesthetic under direct supervision and to do routine proplylaxis and x-rays under general supervision.

I do support my hygienist being able to administer local infiltration anesthetic under direct supervision and support her doing routine dental hygiene procedures under general supervision.

Sincerely,

John W. Adams, D.D.S., P.A.

JWA: sa

RODGER L. SUCHMAN D.D.S.
3907 Crackerneck
Independence Missouri 64055
(816) 373-3101

February 10, 1984

I feel the State of Kansas would be wise to adopt legislation allowing qualified dental hygienists to administer local anesthesia.

For the past two years, Jan Haun, our office hygienist, has utilized local anesthesia for appropriate patients in accordance with the Missouri Dental Practice Act. This procedure saves time and results in lower fees for our patients, because the treatment does not have to wait for another individual (the dentist) to come into the treatment room and anesthetize the area to be treated.

Dental hygienists can and are being trained to administer local anesthetic safely and expertly.

It is my considered opinion that it would be advantageous to the people of Kansas if the practice act were ammended to allow trained dental hygienists to utilize local anesthesia.

Sincerely,

Rodger L. Suchman DDS

Rodger L. Suchman, DDS, PC

March 1, 1984

TO WHOM IT MAY CONCERN:

I support the passage of Bill #806. I strongly feel that had I received the care of a well trained Dental Hygienist in past years, I would not now be wearing dentures.

Sincerely,

Mrs. Burton Edson

Mrs. Burton Edson

WICHITA STATE UNIVERSITY
PHONE 689-3614
WICHITA, KANSAS 67208

COLLEGE OF HEALTH RELATED PROFESSIONS
DEPARTMENT OF DENTAL HYGIENE

February 27, 1984

Senate Public Health and Welfare Committee
State House
Topeka, KS. 66612

Dear Committee Members:

I am Mary Martha Stevens, Chairperson of the Department of Dental Hygiene at Wichita State University, writing in support of changes in the Dental Practice Act relating to dental hygienists in the State of Kansas. I urge passing of this entire bill. I am writing specifically to one portion of this proposal, which supports changes in the Dental Practice Act permitting dental hygienists to work under the general supervision of dentists in the provision of oral care to clients.

There are three specific reasons why I support these changes:

1. There is a need for services of dental hygienists by thousands of currently unserved or underserved Kansans.

2. Dental hygienists are trained and tested to perform these services.

3. Current Kansas state law does not permit dental hygienists to perform without direct or indirect supervision of a dentist.

Let me expand briefly on these points.

First, thousands of Kansans are without adequate daily maintenance of oral hygiene care. Many of these people are in our long term care institutions for the aged or the handicapped. These are people who cannot care for their own oral hygiene, and who do not receive full oral care from their nurses and other allied health professionals. Currently, institutional staffs are not properly trained to provide oral hygiene care, and many are not interested in providing these services.

Secondly, the essentials for accreditation of dental hygiene programs, as set by the American Dental Association, require that dental hygiene students have experience in extended care facilities for the provision of community dental health and dental health education. Students at Wichita State University learn to work with clients in community settings, for instance, those from Head Start, the Veterans Administration Hospital, public schools in Wichita and surrounding

areas, the Wichita-Sedgwick County Public Health Department, the Indian Center, and the Kansas Elks Training Center for the Handicapped. Our graduates, like those of other dental hygiene programs in the nation, are experienced in working with physically, mentally and emotionally handicapped clients.

In Kansas, graduates who have completed a two-year program in Dental Hygiene must pass extensive examinations in order to be licensed. These exams include a one-day written and two-day clinical performance examination. These examinations are longer and more extensive that those required for most other allied health professionals who perform under general supervision (e.g., nurses, physical therapists, respiratory therapists, etc.). Students must be knowledgeable about community dental health to pass these examinations. Currently, however, passage of the examination does not allow the graduate to legally practice in these practice settings.

This leads me to the third point, that of the amount of supervision required for practice. Dental hygienists in Kansas are not currently permitted, upon state licensure, to work in extended care facilities without the direct or indirect supervision of a dentist. This essentially prevents dental hygienists from working in these settings because dentists are not physically present to provide supervision. The effect of this state restriction is frustrating for dental hygienists who see the needs, yet are unable to provide services required by a vast unserved population.

As a dental hygiene educator, I urge you to effect changes in the Dental Practice Act which would allow dental hygienists to work under the general supervision of a dentist. This would allow clients in settings where dentists do not normally practice, (e.g., long term care settings or public schools) to receive the preventive and therapeutic oral hygiene care they need. It would also permit dental hygienists to use the skills which they have acquired. In effect, passage of these changes to the Dental Practice Act would allow "more care for more Kansans".

Sincerely,

Mary Martha Stevens

Mary Martha Stevens, Chairperson
Dental Hygiene Department

cc: Dean Rodenberg

lh

JEANNE CLARK

My mother, bedfast in a local nursing home, was in need of a dental check up to determine whether dentures would be feasible. Because of a lack of a dental care program at the care center, I took my mother, wheel chair and all to the office of Dr. Menees.

His receptionist was kind enough to leave her desk, meet me in the parking lot and assist me in seating my mother in the wheel chair and on leaving helped me seat mom in the car. This was an examination could easily have been performed at her place of residence.

Jeanne Clark

Public Health and Welfare Committee
February 28, 1984

Dear Committee Members:

The Kansas Dental Hygienists are requesting administration of local anesthesia as an expanded function for dental hygienists to benefit both the consumer and the profession. We feel it is important to discuss the benefits as applied to three specific groups -- the consumer, the dentist, and the dental hygienist. Some points may seem repetitive, but only indicate that some of the benefits apply to more than one of the groups concerned.

BENEFITS TO THE CONSUMER:

1. The discomfort that patients often experience during a hygiene procedure is reduced or eliminated.
2. The patients' anxiety, apprehension, fear, and stress levels are lessened when the discomfort is reduced.
3. The actual pain caused by the injection itself can be lessened when the hygienist takes adequate time to administer slowly.
4. Patients' attitudes toward the dental profession are more positive.
5. Patients can receive uninterrupted treatment by the hygienist.
6. The consumer can receive a more thorough cleaning without discomfort therefore, need not compromise quality for comfort-they can get both.
7. Hoepfully, dental care costs incurred by the patient can be kept down through improved, efficient, preventive care.
8. The consumer can associate a higher confidence level in the hygienist if the hygienist who provides the treatment can also provide the comfort.
9. The consumer does not have to wait on the dentist who is in the process of treatment with another patient to come into the treatment room, exchange introductions, scrub his/her hands, adjust the chair, position himself, position the patient, and then administer the anesthetic.

BENEFITS TO THE DENTIST:

1. Time allotted to the dentists' patients would be uninterrupted by the hygienist requesting the dentist to leave and administer to her patient - thus enabling the dentist to provide continuous care to his patients.
2. Better time utilization on the part of the dentist and the hygienist.
3. Increase production level of the dentist and the hygienist.
4. Be able to provide more services to his patients.
5. Project a more professional imagery in the talents of his staff.
6. Avoid the stress to the dentist by having the constant demand on his time to jump from one patient to another.
7. Patients will appreciate the dentist having this service available for their comfort.

RE: SB 806

BENEFITS TO THE HYGIENIST:

1. The hygienist would have the opportunity to utilize their professional skills.
2. Time now spent waiting for the dentist to inject a patient could be used for actual instrumentation and direct patient care.
3. The hygienist could provide more thorough care: she/he need not compromise because of patient discomfort, reluctancy to ask the dentist for anesthesia, or shortened amount of production work time.
4. Management of the patient would be easier - patients are more cooperative and appreciative of the care they are receiving if they are not in pain.
5. All of these benefits create a job that is less stressful and less frustrating for the hygienist. This in turn leads to a more enthusiastic, efficient, attitude in all phases of the hygienist's responsibilities as a part of the dental team.

Obviously we are concerned with the safety of this procedure. Dentists and hygienists carry malpractice insurance and in communicating with these companies we found that claims regarding local anesthesia are not significant In number and the companies DO NOT consider local anesthesia an insurance risk for either the dentist or the hygienist.

Currently there are twelve states which delegate the administration of local anesthesia to dental hygienists. They include three of the four states surrounding Kansas - Missouri, Colorado, and Oklahoma.

Jan Haun, RDH, BS

JOHNSON COUNTY COMMUNITY COLLEGE • 12345 College at Quivira • Overland Park, Kansas 66210 • 913-888-8500

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE:

Testimony in support of Kansas Senate Bill #806

Its been said that individuals who have their natural teeth can expect to live 10 years longer than individuals with dentures. Studies show, however, that only 50 percent of the population are regular dental patients. Why? Could it be the cost of dental care?

I am writing this letter in support of the Dental Hygienist's proposed changes in the Dental Practice Act. One of these changes will allow licensed dental hygienists to perform those functions allowed by law (through the authority of the Kansas Board of Dental Examiners) and which are prescribed and authorized by the dentist as part of the individual patient's dental plan under the "general supervision" of the dentist. This change to "general supervision" from "direct supervision" allows the hygienist to extend care to those citizens who may otherwise not have access to quality oral health care.

The dental industry, like the accounting industry, needs to adjust with the times in order to service the population.

Specifically I support these needed changes in the Dental Practice Act as they provide greater comfort to patients and greater accessibility to many Kansans otherwise without access.

Sincerely,

Roger W. Mayhugh

Roger W. Mayhugh
Certified Public Accountant

RWM/srm

JOHNSON COUNTY COMMUNITY COLLEGE • 12345 College at Quivira • Overland Park, Kansas 66210 • 913-888-8500

KANSAS PUBLIC HEALTH AND WELFARE COMMITTEE

Testimony in Support of Kansas Senate Bill #806

The following testimony has been compiled in support of Senate Bill Number 806 by the Dental Hygiene instructors at Johnson County Community College. The Dental Hygiene Program at JCCC provides students with the opportunity to provide care and education to patients of all ages and backgrounds at the clinic located on campus. Students also participate in classroom and clinical learning experiences in a science-based curriculum and become involved in the community by providing care at the program's extended campus sites including the VA Hospital, Lake Mary School for Exceptional Children and Kansas School for the Deaf. The Dental Hygiene Program strives for excellence and quality education in preventive dental health care.

Johnson County Community College dental hygiene graduates:

1) Perform services needed within various health care delivery systems,

2) Possess the professional attributes of a caring, empathetic, problem-solving individual,

3) Internalize and demonstrate professional characteristics, and,

4) Integrate current educational experiences to be adaptive to future practice settings and life-long learning.

Our science based curriculum not only prepares the students for current dental hygiene practice but also provides a foundation for continued formal education, and professional growth. (Refer to Exhibit #1, JCCC Program Curriculum)

The General Education courses within the curriculum prepare students to communicate effectively with the general public, patients, dentists, and other health care professionals. The students also develop the assessment skills necessary to provide individual oral health instruction to their patients as well as participate in community group health programs.

Basic Science and Dental Science courses provide the necessary background information for assessing patient health needs, and developing and providing patient care.

The Dental Hygiene Science aspect of the curriculum includes such courses as:

....Clinical Dental Hygiene

....Developmental Dentistry

....Dental Radiology

....Pathology/Periodontology

....Community Dental Health

....Dental Therapeutics and

....Dental Materials

These courses enable each student to perform clinical and health education functions as an integral member of the dental care team. (Refer to Exhibit #2, Dental Hygiene Science Courses - Content and Skill Development) Learning experiences and practice time for all clinical procedures assures each student the opportunity to develop their competence in performing primary preventive functions.

Faculty members, including licensed dental hygienists and supervising dentists, are present during all clinical sessions to supervise, evaluate, and assist students with the integration of curriculum courses. They are also available to provide consultative and referral recommendations.

Our evaluation system assesses and evaluates both the process and end product of each student's performance in clinical practice.

The performance by JCCC dental hygienists on both national written board examinations and clinical dental hygiene board examinations have maintained high levels of achievements. Upon completion of our two year dental hygiene program, the students are awarded an associate degree and are eligible for licensure. Our graduates are very marketable and are well known and recognized in the dental community for their professionalism and preventive expertise.

Our dental hygiene clinic on campus not only serves as an educational facility to our students, but also serves over 2,000 active recall patients in our community. Patient feedback reveals recognition of the quality care provided to them by our students and staff.

Therefore, if Bill 806 is passed, the graduates of Johnson County Community College's Dental Hygiene Program will have the opportunity to provide preventive dental care to more Kansans (under general supervision) who otherwise may not have access to care. In addition, better quality and more comprehensive preventive dental health services (i.e., local anesthesia and nitrous oxide analgesia) can be provided to more Kansans.

Renee Byczek, R.D.H., M.S.
Toni Cannon, R.D.H., M.S.
Margaret Cerra, R.D.H., M.S.
Elizabeth Matthews, R.D.H., M.S.
Recie Pennell, R.D.H., B.S.
Sally West, R.D.H., M.S.

Exhibit #1
Johnson County Community
College Dental Hygiene
Program Curriculum

NDH 7252 Clinical Dental Hygiene I
NLS 5057 Gen. Head & Neck Anatomy
NDH 7253 Developmental Dentistry
NDH 7254 Clinical Dental Hygiene II
NDH 6266 Dental Radiology
NDH 7255 Periodontics
NDH 7256 Dental Health Education
NDH 7257 Clinical Dental Hygiene III
NDH 7258 Pathology/Periodontology
NDH 7259 Dental Therapeutics
NDH 5250 Dental Materials
NDH 7260 Community Dental Health
NDH 7261 Clinical Dental Hygiene IV
NPS 6634 Priniciples of Chemistry
NLS 6152 Nutrition
NLS 5593 Microbiology
SS 1068 Psychology
NLS 1144 Physiology
CEN 7612 Composition I
SS 3404 Sociology
CSP 4950 Interpersonal Communications

Exhibit #2
Dental Hygiene Science Courses
Content & Skill Development

1) NDH 7252 Clinical Dental Hygiene I Basic Skills:

Handwashing, Ultrasonic Cleaner, Autoclave, Equipment Maintenance, Sanitation of Cubicle, Patient/operator Position, Blood Pressure Detection.

NDH 7252 Clinical Dental Hygiene I Patient Assessment Skills

Health History, Oral Inspection (extraoral/intraoral), Gingival Conditions, Periodontal Charting, Restorative Charting, Occlusal Classification, Deposit Charting/Patient Classification, Treatment Planning.

NDH 7252 Clinical Dental Hygiene I Instrumentation Skills

Supragingival Instrumentation, Subgingival Instrumentation, Polishing.

Instruments: Mouth mirror, explorers (cowhorn, #17, Shephard's Hook) probe, sickle 204S, sickle H6/H7, Universal Curet (Columbia 13/14) Gracey Curet P1/Ps, Gracey Curet 11/12, Gracey Curet 13/14.

Selected Skills: Fluoride Treatment, cleaning removable appliances, self disease control.

2) NDH 7254 Clinical Dental Hygiene II - All of the above listed in NDH 7252 plus:

Record keeping, treatment planning, preventive strategies/ diet counseling, Alginate Impressions, pouring and trimming study models.

3) NDH 6266 Radiology - Exposing, processing and interpreting the following radiographic projections:

bitewings, max anterior radiographs, max canine radiographs, max premolar radiographs, max molar radiographs, mand. anterior radiographs, mand. canine radiographs, mand. premolar radiographs, mand. molar radiographs, occlusal radiographs, and panelipse.

4) NDH 7256 Dental Health Education - Table Clinic development, critique of dental literature, presentation development, special populations, communication, problem solving.

5) NDH 7257 Clinical Dental Hygiene III-Items listed in NDH 7252 and NDH 7254 plus:

Root planing, soft tissue curettage, ultrasonic scaling, pulp vitality testing, desensitization procedures,

removal of overhanging margins, phase microscope/oral cytology.

6) NDH 7259 Dental Therapeutics - Introduction to basic nomenclature, drug action and interactions, routes of administration, drugs associated with common systemic disorders. Also all factors necessary to properly administer local anesthesia.

7) NDH 5250 Dental Materials - Finishing and polishing restorations, placing and removing rubber dams, sealants.

8) NDH 7260 Community Dental Health - Biostatistics, community/classroom presentation development, planning and evaluation mechanisms, eqpidemiology.

9) NDH 7261 Clinical Dental Hygiene IV - Items listed in NDH 7252, NDH 7254, and NDH 7257, and including administration of local anesthesia, pit and fissure sealants and the finishing and polishing of amalgam restorations.

SUPPORT TESTIMONY SB 806

by MARK A. MOXLEY, D.D.S.

This written testimony is presented in regards to proposed changes in the Kansas Dental Practice Act. The dental hygienists of Kansas would like to broaden the scope and function of their practice by being allowed to administer local anesthesia and Nitrous Oxide - oxygen analgesia. I support this portion of their proposal and would ask your serious consideration.

I am a practicing periodontist who has had broad exposure to dental hygiene education in four dental hygiene schools in the state of California and I am presently on the faculty at Wichita State University Department of Dental Hygiene. Dental hygienists in the state of California are allowed to be trained and examined in the proper administration of local anesthesia and Nitrous Oxide - oxygen analgesia as part of their curriculum. I have participated in both the didactic and clinical aspects of this training. I have found that with well designed instruction, dental hygiene students and registered dental hygienists can safely and properly administer local anesthesia as well as nitrous oxide oxygen analgesia. The Kansas Dental Board should be reminded that they will have full control of the training and examination criteria.

In my opinion, utilization of local anesthesia and nitrous oxide oxygen analgesia by dental hygienists can greatly benefit the public and the practice of Dentistry in the state of Kansas. In general, these modalities of anesthesia and analgesia are necessary parts of patient management, anxiety control and pain control. It is clear to me that the utilization of these modalities by highly trained and qualified people can lead to improved quality of dental care. This is certainly true for the functions of a dental hygienist.

adha American Dental Hygienists' Association
444 North Michigan Avenue, Suite 3400
Chicago, Illinois 60611 (312)440-8900

Sara Dunham, RDH, President
Marjorie J. Sharpe, Executive Director

Senate Public Health and Welfare Committee
February 24, 1984

RE: SB 806

Members of the Committee:

My name is Lorraine Gaul. I am currently the District VIII Trustee of the American Dental Hygienists' Association. My district includes Kansas, Missouri, Nebraska, Iowa, and Illinois.

As District Trustee, I have the opportunity of meeting and conversing with many dental hygienists throughout the United States. Each state's dental board of examiners and legislators are very conscientious and protective of their consumer's health and welfare. But those dental boards and legislators are also concerned about the public's access to quality care. This, too, is your concern in consideration of SB 806.

First, let me talk about quality care.

Quality care for dental hygiene procedures includes the need for pain and anxiety control. By allowing hygienists to administer local anesthesia and/or nitrous oxide analgesia, that hygienist can provide non-painful therapeutic and preventive treatments that will improve the oral health of the patient. Patient's who have access to treatments that are enjoyable, are more likely to seek out the necessary care they need for maintaining optimal oral health.

But the licensed dental hygienists of Kansas (including myself) are not asking to preform these expanded responsibilities without any regulations. They are willing to ask for certification requirements in CPR for license renewal. The Kansas Dental Board of Examiners will establish the educational criteria necessary before granting certification for all these expanded responsibilities. The quality of care to patients will also include the educational quality of the dental hygienist provider.

Second, I wish to speak to the issue of general supervision.

Today's society shows a great interest in prevention of all diseases. A national concern of the dental profession is the lack of dental care to various populations. ADHA is currently hosting several Hearings on Needs to determine the extent of dental care needed and why people are not receiving dental care. With this information, better access to care can be provided. And due to the background and education of a dental hygienist in preventive dental procedures, a dental hygienist could be utilized to educate and treat the public in these preventive procedures in a variety of alternate practice settings.

Therefore, it would seem to follow that a dental hygienist could be employed by schools, governmental agencies, hospitals, or nursing homes to

provide preventive care for their people. From my own personal experience with dental care to nursing homes, I found dental care very limited. But the nurses and staff were very receptive to my expertise in how to help their patients and how to provide dental care for the patients. Why not let dental hygienists, who are the trained, licensed, preventive dental professional, provide those dental services rather than nurses and aids who are untrained in dental care. Hygienists could also teach school children how to care for their teeth, and free the teachers to do their job of education.

In conclusion, I would encourage you to consider the quality and quantity of dental care available from licensed dental hygienists and the need for this bill to allow hygienists to provide that care to all your constituents.

Sincerely,

Lorraine Gaul, RDH

Lorraine Gaul, R.D.H.
ADHA District VIII Trustee

cc: KDHA

FACTS...

ABOUT DENTAL HYGIENISTS

1 A dental hygienist is a licensed preventive health professional who provides educational, clinical and therapeutic services and promotes total health through the maintenance of optimal oral health.

2 The education of the dental hygienist emphasizes the basic sciences which includes microbiology, chemistry, pathology, anatomy and physiology. Other components of the curriculum develop the clinical skills of the dental hygienist which ultimately prepares the hygienist to provide preventive dental health services to the public. A dental hygienist is eligible for licensure after graduation from an educational program accredited by the American Dental Association Commission on Dental Accreditation and successful completion of both a written National Dental Hygiene Board Examination and a clinical examination. The licensed dental hygienist practices in accordance with the requirements of individual State Dental Practice Acts. The purpose of licensure is to protect the public. In many states, a dental hygienist must take continuing education courses to renew his/her license.

3 A dental hygienist is that member of the dental team who is responsible for providing treatment that helps to prevent oral disease such as dental caries (cavities) and periodontal disease (gum disease) and for educating the patient to maintain optimal oral health. This professional is especially knowledgeable about the preventive aspects of dental disease.

4 Although legal dental hygiene functions vary from state to state, some of the functions routinely performed by a dental hygienist include, but are not limited to:

- monitoring of patient's health history, including blood pressure;

- thorough examination of the teeth and oral structures, including a soft tissue exam;
- removal of calculus, stain, and plaque (hard and soft deposits) from above and below the gumline;
- application of caries-preventive agents, such as fluorides and fissure sealants;
- plaque control instruction and development of individualized oral hygiene programs for home care;
- dietary analysis and counseling;
- exposure, processing and interpretations of dental x-rays;
- placement of temporary fillings and periodontal dressings, removal of sutures, and polishing and recontouring amalgam fillings;
- educating the individual patient, the general public and special population groups (e.g., minority groups, geriatric, mentally/physically handicapped persons) about the importance of good oral hygiene habits;
- oral cancer and blood pressure screenings;
- designing and implementing community dental health programs;

In some states, with additional education a hygienist may provide other services such as administering local anesthetics and nitrous oxide/oxygen analgesia, placing and carving of filling materials, and also additional periodontal procedures.

5 A dental hygienist may work in such practice settings as:

- Private dental offices and dental clinics.
- Federal, state and local health departments or associated institutions.
- Hospitals and nursing homes.
- School districts or departments of education.
- Educational programs for dental, dental hygiene and dental assisting students.
- Private business/industry.
- Correctional facilities.
- Private and public centers for pediatric, geriatric and other individuals/groups with special needs.
- Health maintenance organizations.

Prepared by the ADHA Council on Dental Hygiene Practice

adha

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12/82

The Kansas Dental Hygienists' Association

Constituent of The American Dental Hygienists' Association

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The Kansas Dental Hygienists' Association

Constituent of The American Dental Hygienists' Association

K.D.H.A. COMPOSITION

The Kansas Dental Hygienists' Association membership consists of approximately 400 dental hygienists licensed under the Kansas Board of Dental Examiners in the state of Kansas.

K.D.H.A. PURPOSE STATEMENT

The Kansas Dental Hygienists' Association strives to improve the public total health by increasing the awareness of and accessibility to quality oral health care and to position the dental hygienist as the preventive oral health care professional.

K.D.H.A. LEGISLATIVE GOALS

The Kansas Dental Hygienists' Association is seeking to change the Dental Practice Act by:

- allowing dental hygiene to be performed under the "general supervision" of a licensed dentist. "General Supervision" means that the dentist personally diagnoses the condition to be treated, personally authorizes the procedures for each patient, and such procedures are carried out in accordance with the diagnosis and treatment plan for that patient established by the dentist, whether or not the dentist is present on the premises where such procedures are performed;

- allowing qualified dental hygienists to administer local anesthesia and nitrous oxide analgesia to patients under the direct supervision of a licensed dentist;

- requiring for licensure certification in the administration of Cardiopulmonary Resuscitation, unless physically unable to administer such; and

- allowing dental hygienists to perform dental hygiene in alternate practice settings such as schools, institutions, and adult care facilities.

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Periodontal Disease in America: a Personal and National Tragedy

A position paper prepared for the American Association of Public Health Dentists by the AAPHD Subcommittee on Preventive Periodontics, October 24, 1981

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Introduction

Countless papers, surveys, and statistics attest to the magnitude of the American periodontal disease problem. In a review of the economic and social impact of the disease, Ingle[1] stresses the insidious and painless nature of the process, which only in its later stages becomes "a personal and national tragedy." He estimated in 1969 that the total cost of prevention and treatment of periodontal disease, including costs for extractions and full denture replacement was $2.33 billion.

Periodontal disease is the leading cause of tooth loss. The 1960-62 National Health Survey considered the 75 percent rate of periodontal disease among adults 18-79 to be underestimated because 20 million persons in the survey population were excluded because they were completely edentulous. Chilton and Miller[2] summarized the well-known discouraging scope of the national periodontal disease problem:

> *The prevalence of periodontal disease is world-wide. It occurs from early in the first decade of life right through to old age. It accounts for over 50% of missing teeth in adults and results in tremendous economic and social burdens, both upon the individual and upon the society. The effect of missing teeth or a totally edentulous mouth upon the nutritional status of an individual can only be estimated, but it is surely well beyond that of slight inconvenience. Prevention is the only answer. Numerous studies support the fact that the world's population of dentists is inadequate to meet even a fraction of the need, much less the demand. Preventive programs are long overdue, and even more affluent nations like the United States have failed to place periodontal disease on the head of the list of chronic diseases to be eradicated.*

Background

In responding to its charge from the Executive Council, the AAPHD Subcommittee on Community Preventive Periodontics has attempted to bring into focus a number of disparities between what is known concerning periodontal disease and the lack of any widespread, coordinated effort to control it.

The 16 member Subcommittee is made up of epidemiologists, dental public health administrators, periodontists, dental hygienists, and public health practitioners. This group has shared a profound sense of concern that sharp imbalances exist between programs for controlling dental caries and periodontal disease. These imbalances can be better understood in the context of fluoridation:

- For over 35 years, increasingly widespread and successful efforts at community fluoridation have provided a classical, efficient, and cost-effective basis for controlling a major dental disease.
- Fluoridation, with its well-documented predictability, has provided a sound concept upon which those concerned with public health could "hang their hats." Understandably, then, caries became the target for a concentrated, universal effort rather than periodontal disease. Although equally ubiquitous, periodontal disease simply does not respond to the same classic, single-agent, community preventive approaches. Moreover, it is insidious and painless until the advanced stages, and not well-understood by a public which has been educated to perceive dental disease as caries exclusively.
- And last, there are increasing indications that fluoridation's dramatic effect in reducing caries is affecting the nature of dental practice.[3,4] Scholle,[5] in commenting on the combined protective effect of fluoridation, topical fluorides, and sealants, suggests an alternative to the frustration of increased concern over decreased "busyness":

> *As we become increasingly free from the rigors of restoring the destructive effects of dental decay, there will be unrestrained opportunity for new achievements. For example, earlier and better prevention, detection, and treatment of periodontal disease is a major challenge for us all.*

So forthrightly, in fact, have caries control and fluoridation moved from the research arena into widespread implementation that caries might be regarded increasingly as an administrative [political also—ed.] rather than as a scientific problem. Clearly, militant efforts to expand fluoridation benefits must continue and this Subcommittee does not advocate either an abandonment or diminution of effort in this regard. Recently, Faine[6] and our sister AAPHD Committee on Fluoridation[7] have described strategies to combat a formidable new generation of sociopolitical obstacles to fluoridation which will certainly demand such intensified and innovative responses.

Nevertheless, the hard evidence of fluoridation success should allow appropriate, concerned agencies to reassess the nature of the national oral disease threat. Indeed, the American Association of Public Health Dentists itself is an organization which should be affected critically by such a timely examination. We advocate this position while recognizing that ours is an organization whose very birth and development has paralleled that of fluoridation itself. Within our membership and archives are enshrined the distinguished pioneers of fluoridation—dedicated and visionary dental scientists who have left a splendid legacy to the children of the world.[8]

An unforeseen and unfortunate by-product of this dramatic success story has been a tunnel-vision approach to public health dentistry. A simple survey of 19 years of the *Journal of Public Health Dentistry* reveals only 35 papers devoted primarily to periodontal disease, out of some 350 published. Th ng suggests that, historically, ublic health dentistry may have become primarily caries-oriented rather than concerned with oral health on a broader, more comprehensive scale. Timely reappraisal, however, of the AAPHD organizational objectives relative to periodontal diseases can have a major positive impact on the oral health of the nation, as well as on the continued relevance and vitality of the Association itself.

Subcommittee Approach to Periodontal Literature and Base of Knowledge

The Subcommittee has reviewed and shared a considerable number of individual papers related to all aspects of preventive periodontics. The immensity of the task of a thorough review, however, has necessitated a concentration on several international workshops and symposia dealing with the subject.[9-16] Each of these documents comprises a series of important position papers, including extensive literature reviews, critical analyses, summaries, and recommendations. The Subcommittee has been impressed with the quality of these resources. They form a significant body of scientific knowledge which can be brought to bear on national strategy to control periodontal disease. Furthermore, directions are clearly available in their various recommendations for research, education, dental practice, and public health program development.

Jackson[17] studied the recent scientifically conducted longitudinal evaluations of the preventive and therapeutic procedures in periodontics. His comprehensive review provides an accurate and valuable state-of-the-art summary of what is known:

1. Gingivitis can almost be eliminated by either daily oral hygiene [measures] alone or a combination of daily oral hygiene [measures] and prophylaxis.
2. Periodontal and gingival health seem to improve and the loss of periodontal attachment seems to diminish as the number of prophy-

laxes and oral hygiene appointments increases up to four per year, but age, dental disease activity, economics, and practicality may influence the clinician to choose less-frequent recalls with little compromise in periodontal health.

3. Any type of treatment is beneficial, but the maximum benefit is obtained by combining subgingival deposit removal by the therapist with intensive, enthusiastic oral hygiene instructions.
4. The value of periodontal treatment, including scaling, root planing, and surgical procedures in preventing or slowing down the rate of epithelial migration is proven both in patients with initial periodontal disease and in patients with advanced periodontal disease.
5. The foregoing is valid only if the patient can maintain a plaque-free or relatively plaque-free dentition.
6. Patients unable to accomplish good oral hygiene [status] should not be subject to periodontal surgical procedures because such procedures will, in all likelihood, increase the rate of destruction.
7. Regeneration of bone in intraosseous defects can occur with a high degree of predictability in the presence of low plaque levels.

Listgarten[18] and many other investigators also acknowledge that enough knowledge is available to prevent most forms of periodontal disease, and the difficulty of applying this information to the implementation of effective preventive programs.

Heifetz and Suomi[19] and others[20] have appraised the value of plaque-control methods in public health programs and are plainly skeptical. They think that successful programs for caries and periodontal disease control must operate "independently of the patients' performance and cooperation." Obviously, fluoridation rather than plaque control provides the direction in the case of caries. These papers suggest the pressing need to develop an effective chemotherapeutic agent to prevent periodontal disease, especially since behavioral modification technology to attain compliance in personal plaque-control procedures is not well-developed.

Sheiham[21] cautions that the American public interest in oral cleanliness is indicated by over one billion dollars in sales of oral hygiene devices and should not be underestimated. Unfortunately, even most adult consumers think that they are controlling caries and their plaque-control efforts generally are not good enough to prevent periodontal disease. Nevertheless, oral cleanliness, for whatever motivation, seems to be a reasonably integral part of the culture. It remains to be sufficiently exploited to produce a universal, significant effect on controlling periodontal disease.[22]

The North Carolina Studies[16,23,24,25]

More than any studies in recent years, the documents associated with the North Carolina Dental Studies have served to focus attention on a population's increasing periodontal disease problem while caries prevalence is being reduced dramatically and steadily. The studies are significant for several reasons:

- The impressive collaborative project represents the combined efforts of the North Carolina Dental Society, the dental section of the state health department, the North Carolina State Board of Dental Examiners, the University of North Carolina (Schools of Dentistry and Public Health and Health Services Research Center), the Research Triangle Institute, the Kellogg Foundation, and the Dental Foundation of North Carolina.
- Extensive surveys of dental health status in North Carolina were conducted in 1963 and 1977, allowing data comparison and analyses of the 14-year trends.
- The North Carolina findings should provide directions for other states and agencies concerned with national oral health problems. They have significant implications for dental education, community programs, and research. The major findings of the studies are:

1. Caries prevalence in all age groups 30 years and younger was significantly lower in 1977 than in 1963. The investigators attribute the reduction to 20 years of community fluoridation, and predict continuing steady declines as the effects of a statewide children's preventive program are felt.
2. Fewer caries were left untreated in 1977 compared to 1963, and it is estimated that present dental manpower could restore all the new carious lesions occurring in the population each year.
3. Periodontal disease increased significantly since 1963, especially in children, young adults, and blacks.
4. Oral hygiene scores were worse in 1977 than in 1963.
5. General practitioners in North Carolina spend less than two percent of their time treating periodontal disease.

North Carolina authorities regard periodontal disease as rampant, having significantly worsened in 14 years. Thus, periodontal disease is firmly established as North Carolina's major dental public health problem.

National Priorities in Oral Health

Fluoridation and dental health were identified among 15 priority areas for health improvement in the 1979 Surgeon General's Report on Health Promotion and Disease Prevention.[26] In 1980, specific objectives necessary to attain those health improvement goals within this decade were described in a subsequent federal document, *Promoting Health/Preventing Disease: Objectives for the Nation.*[27] Although the report was weighted toward fluoridation and considered periodontal disease the second most

prevalent disease, the specific objectives for periodontal health improvement "by 1990 or earlier" included:

a. Decreasing prevalence of gingivitis in children six to 17 years to 18 percent, from 23 percent in 1971-74.
b. Decreasing prevalence of gingivitis and destructive periodontal disease in adults to about 20 percent, down from 24 percent recorded for adults aged 18 to 74 years in 1971-74.
c. At least 75 percent of adults should be aware of the necessity for both thorough personal oral hygiene and regular professional care in the prevention and control of periodontal disease. In 1972, only 52 percent were aware of the importance of oral hygiene and only 28 percent were concerned about regular professional care.

The 1980 report further stated a basic assumption that organized dentistry as well as a broad range of state and local health agencies will "increase their concern for and expand their activities to support fluoridation, school-based prevention-oriented dental programs, and periodontal health promotion."

The Subcommittee thinks that any major new thrust in periodontal disease prevention should be based on official identification of periodontal disease by government agencies and dental professional organizations as the ranking national oral disease priority. Its prevalence, the relative absence of effective public health preventive measures, and the socioeconomic impact of the disease justify this priority. Such recognition will have an important bearing on federal dental research efforts, on undergraduate and continuing dental education, on practice, on strategies for community-based preventive approaches, and, of course, on the health of citizens.

The General Dentist and Periodontal Practice

Because it is universally acknowledged that periodontal diseases do not yet respond to mass medication with specific vaccines or chemotherapeutic agents, professional personnel resources must be assigned an especially critical role in preventive efforts. These roles include personnel for health education and for all levels of prevention, diagnosis, and treatment.

The general dental practitioners should be regarded as the pivotal elements in the broad scheme of preventive and therapeutic periodontal programming. Whether in the private sector, public health, military, or institutional setting, virtually all patients seeking dental services must flow through them. In terms of efficient and effective patient management, they may refer patients with noncomplex, early disease to their hygienists for primary care. The large proportion of patients with intermediate stages of disease are appropriately their own responsibility for therapy. They may exercise another option for patients with advanced disease: referral to or consultation with a specialist-level periodontist.

It is at this critical point, however, where the literature reveals that the dental generalist has become, by default, part of the problem rather than part of the solution to periodontal disease. Bellini[28] observed that periodontal therapy represents less than three percent of the total dental service rendered to the U.S. population. A 1980 survey by the U.S. Department of Health and Human Services revealed that regardless of 20 variables analyzed, the amount of time the general dentist devoted to periodontal treatment remained constant at five percent, with restorative procedures (44 percent) and prosthodontics (22 percent) accounting for the majority.[29] The statistics are consistent with Douglass and Day's analysis[22] of dental costs in the United States. Their data reveal that patient expenditures for general practitioners' services amounted to only 7.67 percent for preventive services (94 percent prophylaxes) and only 0.78 percent for periodontal treatment. Crown-and-bridge services have become the nation's largest single expenditure for dental care—about 35 percent of all dental care expenses. The investigat[illegible]ld that "the increased cost-e[illegible]e-ness (in terms of disease control and teeth saved) of these services over the basic corrective types of care is not known."

Perhaps the most disconcerting finding in the previously mentioned North Carolina studies was that the state's general practitioners report that they spend less than two percent of their time treating periodontal disease. In commenting on this observation Bawden[23] wrote:

> It seems to me that our graduates have adequate backgrounds and clinical experiences in periodontics, and that failure to become involved very much in the treatment of periodontal disease is a matter of attitude on their part and the part of their patients. . . . It is time for the students to be oriented to the fact that periodontal disease is the most serious dental health problem in the state and that much more of their efforts should be directed to the management of the problem.

In North Carolina, however, "Project 80" is underway, as a joint response by the state dental society and the UNC Department of Periodontics to the manpower study findings.[25] Project 80 is a multiphasic community demonstration project aimed at intensifying education in periodontal disease awareness, prevention, and treatment for citizens and general dentists alike. Like the original studies, this follow-on effort may provide a model for similar projects on a national scale.

There are many possible explanations for periodontal noninvolvement by general dentists. Generally, they lack confidence in periodontal diagnosis, treatment planning, and therapeutic procedures. Many do not understand or fully appreciate modern concepts of periodontal disease control and cure. Virtually all practitioners are more comfortable, more intrigued, and more challenged by traditional reparative styles of practice, including the associated economic aspects. Unless they become peri-

odontally oriented, however, these traditionalists—the majority—may not be able to survive from an economic standpoint as the effect of fluoridation on caries-related dental practice increases. Research exploration of dentists' attitudes toward periodontal disease, their knowledge and technical deficiencies, their periodontal practice-management skills, and mechanisms to retain and remotivate them should carry a high priority. The entire approach to periodontal diagnosis and treatment must be simplified for both student and practitioner so they will not be awed by the process.

The responsibilities of practice aside, the nonmanagement of periodontal disease for those in society who seek care is a national disaster. Eventually, legal pressures and consumer militancy may force an improvement sooner than internal professional monitoring can correct the situation.

Consumer advocacy for improved dental service was heightened with publication of a dentist directory, including guidelines for selection of a dentist, by a Washington-based organization, the Public Citizen's Health Research Group.[30] The comprehensive directory provided recommendations and patient-consumer expectations for health assessments, plaque-control programs, radiation safety, and descriptions of a periodontal examination which might have appeared in a dental text:

> *PERIODONTAL EXAMINATION (gum examination)*
>
> *The dentist should make note of any areas of bleeding gums, tooth mobility or unusual colorings or the presence of bad breath. He should also use a tapered thin instrument (periodontal probe) to examine the depth of the space between the gum and the tooth as an indication of the health of your gums and supporting structures. The measurement of the periodontal pocket depth (normal is 0-3 mm. or ⅛ inch) plus a standardized oral hygiene index should be included in your dental record. Ask your dentist what your pocket depth is and your plaque index (oral hygiene index). (Remember 67.9% of those between 12-17 years had some form of gum disease and 70% of the teeth lost after 40 are due to periodontal disease).[1] Bleeding gums are not healthy and [are] an indication of disease!*

It is apparent that building a "constituency" in support of periodontal disease prevention can have a potent negative impetus as well as the better-known positive, professionally sponsored variety. Organized dentistry's perception of consumer power must be considered unclear at this time.

Cohen has been one of the most eloquent and persistent critics of the generalists' minimal dedication to the periodontal needs of the population. At the 1981 National Conference on Dental Education,[31] he suggested that the phenomenon is a reflection of the traditional emphasis of most dental curricula, where restorative, prosthodontic, and oral surgery departments are dominant.

Focusing on the growing consumer alarm over professionally neglected periodontal disease, Cohen states:

> *It is tragic to learn of the large numbers of patients who have been receiving care on a regular basis, only to find out that they are suffering from advanced periodontal disease. It may surprise a reader of the litigation section of the* Journal of the American Dental Association *to learn that there are more than 300 malpractice suits pending in the State of California alone, initiated by patients with chronic periodontal destruction against dental hygienists and dentists who were responsible for their maintenance care.*

Wade[32] found that plaque scores and plaque control of dentists [themselves] were worse than those of patients. When such depressing information is coupled with the aforementioned indicators of negative dentist attitudes toward periodontal disease, it becomes obvious that the dentist is something less than a dependable resource in the preventive periodontics cam

Dental Hygienist or Preventive Periodontal Therapist?

The Subcommittee has indicated previously, that in the global scheme of preventive periodontics, the general dentist—for better or worse—is the *pivotal* element. Searching analysis of both literature and practice, however, will reveal that it is the dental hygienist—of all those in the dental professional hierarchy—who is the *critical* element in that same scheme.

Because of a complex of social, political, legal, and economic factors, however, the full potential of the hygienist resource has not been brought to bear optimally on the nation's primary oral health problem. Current evaluations of the hygienist's role are frequently overshadowed by the issue of independent practice—a natural, predictable outgrowth of improved education, expanded responsibility, and enhanced professionalism.

O'Leary, Koerber, and Catherman[33] compared specially trained dental hygiene students with senior dental students in a variety of "periodontally expanded functions." The hygienist-trainees were significantly better than the future dentists in periodontal examination, probing accuracy, tooth mobility and plaque assessments, and root planing. Root planing, in particular, is the basis for all phases of periodontics: prevention, treatment, and maintenance. Cohen[31] considers root preparation to be the most difficult technic to master in the entire dental repertoire.

With these skills, then, coupled with the dentists' well-documented abdication from periodontal responsibilities, it is logical to regard the dental hygienist as the primary preventive therapist in periodontics.[34] Indeed, there may be as much merit in increasing the hygienists' training and influence in periodontics as there may be in exhortations to general dentists to increase their periodontal activity—a minicapitulation to their strong reparative heritage. Corollary to this proposition is a realization that efforts to expand the hygienist's role in *restorative*

rather than periodontal disciplines are misdirected.

Schallhorn[35] describes in considerable detail the importance of maintenance therapy as "the most critical aspect of dental treatment." He provides a comprehensive review of both hygienist and dentist responsibilities in all phases of preventive periodontics, including a minute-by-minute procedure analysis of a typical preventive recall appointment. Few papers in the recent literature have highlighted the transcendent role of the hygienist as effectively. The number of practicing dental hygienists has increased tenfold during the past 30 years, from 3,190 in 1950 to 32,200 in 1977. Unfortunately, however, there may be as many hygienists not practicing as there are those in practice. This great pool of trained therapists could possibly be reactivated by new strategies in periodontal disease control, and by facilitation of reentry into practice for working parents. The number of trained hygienists will likely continue to increase throughout this decade.[36] They should be given [seek—ed.] an increased role in the control of periodontal disease in both the public as well as the private sector, free from unnecessarily restrictive provisions in dental practice acts. The dental profession must acknowledge eventually that dental hygienists are even more appropriately trained to provide preventive periodontal therapy than dentists.[33] This is especially true in view of the fact that the economics of preventive periodontal therapy as provided by the hygienist are favorable not only to the patient and to the hygienist but to the dentist and the public health administrator as well.

Strategies for a National Program

The growing realization of the primacy of the American periodontal disease problem evokes a natural interest in developing a broad strategy for preventing the disease, or controlling it sufficiently to lessen its impact on society. Unfortunately, in addition to the recognized lack of a specific preventive agent, the absence of a universal, powerful constituency for periodontal disease eradication presents a formidable barrier to progress.

Many targeted, federally supported health programs have been initiated because of the lack of an adequate knowledge base to identify potential preventive interventions in the disease process. Kidney disease, diabetes, and sickle-cell anemia have benefited from such informational deficiencies, but the common factor in the initiation of these programs seems to have been the political influence of a large and vocal group of people who are affected by the disease or condition, either directly or indirectly.

In the instance of periodontal disease, the constituency vacuum is complicated. The public does not seem aware that a serious oral health problem exists. Moreover, only a fraction of the half of the American population who may seek other than just episodic dental care have had their periodontal needs diagnosed and treated. In the absence of a massive simultaneous effort to motivate *dentists* toward periodontal involvement, intensive campaigns to encourage people "to see their dentists" seem almost thoughtless.

Neither the professional public health community, the federal government, nor the dental research and educational sectors have realistically contributed to the type of constituency necessary for society-wide periodontal disease control. To get things going, this Subcommittee has developed an interest in exploring the concept of a "National Periodontal Disease Program." Rather obviously, a model exists in the National Caries Program, which serves to coordinate and amplify a wide range of anticaries initiatives in addition to fluoridation. Without a constituency, however, such an approach is probably inopportune.

Short of the "task force" approach, however, the Subcommittee feels that progress can be made through realignment—toward the periodontal disease problem—of overall emphasis, staffing, and budgets within the federal and state dental agencies. Furthermore, through improved coordination—internally, and externally with other organizations—some progress may be anticipated through such initiatives by the AAPHD example, the American Associa... of Public Health Dentists should stimulate development of a permanent Committee on Public Health within the American Academy of Periodontology, while it strengthens its own programs in periodontics. Such organizational cross-fertilization is vital in building an information exchange system.

The Subcommittee is emphatic that the major thrust of preventive periodontics programs in public health be directed toward children and youth. Recognizing the early insidious onset of periodontal disease in the teens and early adulthood, efforts should be directed towards improving the periodontal health of the young. Some dental public health programs shun supervised brushing and flossing in school programs because of their lack of evidence in reducing caries incidence significantly. Nevertheless, it is the only means of plaque removal which can be done on a daily basis. Clinical studies should be conducted to ascertain the impact of plaque control, as used in the supervised classroom setting, upon the incidence and severity of periodontal disease in school-age groups.

Cons,[37] describing the dental health program for the State of New York Department of Health, comments on the statistics of the National Health Surveys relating to periodontal disease in children. While the statistics reveal that 68 percent of youth ages 12-17 have periodontal disease, only 5.8 percent have destructive periodontal disease characterized by pockets, and the remainder have only relatively mild gingivitis associated with a few teeth. This same report indicates that 39 percent of children 6-11 have periodontal disease and one out of 125 has evidence of chronic, destructive periodontal disease characterized by pockets. Forty percent of this age group had some degree of gingivitis, mild in severity and limited to only a few teeth. Unfortunately, the report comments that periodontal disease to most youths is not perceived as an imminent threat.

While concentrating on the preventive approach for the young,

care must be taken not to neglect the adults who are presently experiencing the results of the lack of prevention and care in their early years. Whatever public thrust is designed to bring home the message of prevention of periodontal disease must include some direction for the current sufferer. As a profession, we should be prepared to shoulder the task of alleviating or, at least, slowing down the onslaught of periodontal destruction in the adult population.

New Strategies in Periodontal Disease Control

Many old beliefs about dental disease control must at last be put to the scientific test if much improvement is to be achieved in the periodontal health of the population. Dental health education in the form of plaque-control instruction has frequently been found ineffective in public health clinical trials. The problem here may not be the objective but the unacceptability of the plaque-control methods that were offered as a means of reaching the objective and the age-group at which they were directed. It is possible to interpret the literature to show that ideal brushing and flossing may be unreasonably difficult skills for all but a few compulsive individuals to master. Other methods of oral hygiene must be evaluated. Among these are antibacterial rinses and subgingival cleaning devices such as toothpicks and flexible points.

Recent advances in preventive periodontal theory which may provide needed new therapeutic strategies center on the work of Löe, Loesche, Keyes, and Listgarten.[38-41] These investigators and others have focused clinician attention on specific target organisms in the oral microflora and evaluated chemomechanical treatment regimens designed to suppress or eliminate them. The continuing search for an acceptable antibacterial agent has recently begun to focus on low concentration stannous fluoride compounds which offer previously established anticariogenic benefits along with strong antimicrobial effects.[42] It is necessary to develop such an agent which could be used daily in combination with simple mechanical cleansing technics to control both crown and root caries as well as disease of the periodontium. This combination is particularly needed if we are to realize an effective preventive periodontics program suitable for implementation as a public health measure.

It is now evident that caries is being brought under control not by toothbrushing but by fluoride compounds in drinking water, dentifrices, gels, and rinses. By contrast, it seems that the control and prevention of periodontal disease will not be accomplished so much by means of the toothbrush and dental floss as by antibacterial agents, microscopic bacterial monitoring, and simple-to-use subgingival and interproximal cleansing devices. These latter methods could be utilized by dentists and hygienists in either the public health or the private practice sectors. It is possible to foresee public dental clinics and private practices exclusively devoted to the diagnosis, prevention, and control of dental diseases. In the past, such practices would not have been technically or economically feasible, yet today they may become a reality as competition in the dental marketplace intensifies and as innovative forms for the provision of dental care emerge.

Thus, an understanding of the historical neglect of periodontal disease by general dentists and dental public health specialists alike can provide, at least, a logical basis for productive, timely new partnerships. For example, massive public health promotional efforts, coupled with public health-managed clinics for periodontal disease screening and detection, can be coordinated with extraordinary referral initiatives involving the private sector. Whereas these partnerships obviously challenge and serve dental professionals, they probably provide the best hope for widespread periodontal control for the nation until the scientific research gap is closed.

Conclusions

1. Caries is responding so dramatically to preventive and tre measures in society, especially community fluoridation, that periodontal disease should now be recognized and established as the principal oral disease threat in the nation.
2. Private general practitioners and dental public health programs at all levels have neglected periodontal disease.
3. There is an impressive body of knowledge that can be brought to bear on the diagnosis, prevention, and treatment of periodontal disease, which is widespread in society without an effective preventive system.
4. Research in periodontal disease may not be directed or targeted efficiently.
5. There is enough knowledge available to prevent most forms of periodontal disease. There is, however, a critical need for coordination of research, administrative, and health care efforts to control/prevent periodontal disease at the organizational, state, and national levels.
6. There is a need for a powerful, efficient, and sustained public health educational and promotional program to enhance awareness of periodontal disease in the public at large as well as in practitioners of dentistry.
7. The most critical research needs identified are:
   a. the development of effective and acceptable chemotherapeutic agents to prevent periodontal disease,
   b. determination of the role of professional and patient behavior in the maintenance of periodontal health,
   c. investigation of the role of inadequate nutrition in enhancing susceptibility to periodontal disease,
   d. design and evaluation of the effectiveness of improved dental health care systems on the periodontal health of communities, and
   e. studies on how effectively to educate and motivate the general dental practitioner to recognize and treat periodontal disease in its early stages.

Recommendations

1. The American Association of Public Health Dentists should adopt the position that periodontal disease is the greatest oral threat to health of the American people. The AAPHD should recommend to the ADA and APHA that they adopt a similar official posture.
2. The American Dental Profession needs to undertake an aggressive effort to bring the problem of periodontal disease in the United States under more effective control. Prevention of the disease should have the highest priority.
3. The American Association of Public Health Dentists should examine its internal organizational structure to determine if its present resources and philosophical orientation are directed sufficiently toward the prevention of periodontal disease.
4. The American Association of Public Health Dentists should assume leadership in establishing an interorganizational committee to coordinate and act as a clearinghouse for national preventive periodontics matters: research, demonstration projects, public information, and continuing education. participation should include the American Dental Association, The American Academy of Periodontology, The American Dental Hygienists' Association, The Academy of General Dentistry, and elements of appropriate federal health agencies.
5. The American Association of Public Health Dentists should initiate planning for a major, multimedia health education program to inform the public of the threat that periodontal disease poses to the oral health of every citizen.
6. The American Association of Public Health Dentists should assign a high priority to establishment of oral health programs in elementary, junior, and senior high schools. Such programs would include oral health education and promotion as well as preventive caries and periodontal disease programs. Plaque-control programs should be explained, conducted, and targeted, as much as possible, to the prevention of periodontal disease.
7. The American Association of Public Health Dentists should establish a major workshop to explore ways to build a broad-based national constituency dedicated to prevention of periodontal disease. participants should include representatives from consumer-advocate groups; federal health agencies; federal and state legislatures; national education and parent-teacher associations; third-party payment industry; national communications media; marketing, advertising, and public opinion survey organizations; labor unions; and the dental profession.
8. The American Association of Public Health Dentists should establish lines of communication with elements of the North Carolina Dental Manpower Project, including a special liaison team. this initiative should assess the impact of the North Carolina studies on other state populations and explore the development of state and national demonstration projects dedicated to periodontal disease awareness and prevention.
9. The American Association of Public Health Dentists should assign a special task force to study the feasibility of establishing a national periodontal disease program.

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=*DH*=

FREQUENTLY ASKED QUESTIONS ABOUT PROPOSED LEGISLATION

Why is KDHA seeking these changes?

- to provide greater access to quality oral health care to those Kansans currently without access.

Is it not to expand the potential job market?

- These changes may provide for an expanded job market, but our main concern is expanded accessibility since nearly 50% of the nations population will not be seen by a dentist this year.

Do the dental hygienists really want to have independent practice?

- No! The dental hygienists seek to offer preventive oral health care as a part of the dental team.

How do the dentists feel about these changes?

- The KDA is opposing these changes; however, in a one-on-one survey conducted by dental hygienists to dentists (random sampling of approximately 25% of licensed dentists) an average of 65% of those surveyed favored "general supervision" (84% of those dentists surveyed who employ a hygienist favored "general supervision); 69% of those dentists surveyed favored allowing the hygienists to administer local anesthesia under the direct supervision of the dentist (96% of those dentists surveyed who employ a hygienist favored this position); 65% of the dentists surveyed favored allowing the hygienist to administer nitrous oxide analgesia (91% of those dentists surveyed who employ a hygienist favored this provision); 72% of those dentists surveyed favored the opportunity for hygienists to offer regular preventive services (i.e. Prophylaxis, Oral hygiene instruction, Flouride treatments) to adult care facilities, institutions and school systems (99% of those dentists who employ a hygienist favored this provision).

How do other states stand with respect to these provisions?

- 12 states currently allow for the administration of local anesthesia by dental hygienists (some have special qualifications); 16 states currently allow for the administration of nitrous oxide analgesia (some with qualifications); 32 states allow for General Supervision as defined much the same way as we have defined it in the proposed legislation.

What will these changes do to the cost of oral health care?

- We cannot say that the cost of visiting the dentist will decrease but we do anticipate that the cost will increase much more slowly. Since these changes increase the prevention of dental disease, we can also foresee a long-range reduction in the overall cost of oral health care to citizens.

What educational requirements are placed on dental hygiene applicants?

- In order for a dental hygiene applicant to receive a license she must have a two or four year degree from an accredited dental hygiene program and pass State, Regional and National Board examinations. These exams are both written and clinical and cover such areas as oral inspections, radiographs, providing diagnostic aids, prophylaxis, applying topical agents, supportive treatment services, and emergency assistance.

Under these provisions, who would receive payment for dental services?

- The method of payment would not change.

What happens to liability under these provisions?

- Liability would remain much the same as it is now. Dentists, as well as hygienists, carry insurance. The dental hygienist in any practice setting is under the authority of either the dentist or an appropriate governing body under these proposed changes. Please remember that this bill is permissive; if the dentist feels unsure of his liability or of his hygienists' abilities, he does not have to authorize his hygienist to perform dental hygiene without his presence.

How are dental hygienists qualified to administer local anesthesia and nitrous oxide analgesia?

- Educational requirements in this area include head and neck anatomy, oral physiology, pharmacology, local anesthesia and pain control, chemistry, and microbiology. At the University of Missouri at Kansas City, for example, the dental hygiene student must take 750 hours of clinical time in order to receive their degree.

Plan A Curriculum

FIRST YEAR

Fall

DH3100	Oral & Medical Microbiology	3
DH3065	Head & Neck Anatomy	3
DH3160	General & Oral Histology	2
DH3000	Dental Morphology & Occlusion	2
DH3030	Introduction to the Preventive Practice of Dental Hygiene	3
DH3080L	Preventive Dental Hygiene Techniques	3
DH3040	Dental Assisting	2
		18

Winter

DH3054	Biochemistry & Nutrition	3
DH3070	Oral Physiology	3
DH3200	General & Oral Pathology	3
DH3020	Dental Radiology	2
3260	Principles of Periodontics	2
3280C	Preventive Dentistry Clinic I	3
H3285	Comprehensive Preventive Therapy I	2
		18

SECOND YEAR

Summer

DH3240	Applied Nutrition	3
DH3320	Dental Health Education	2
DH4000	Periodontal Therapy	1
		6

Fall

DH3220	Dental Materials	2
DH4100	Pharmacology	3
DH4020	Local Anesthesia and Pain Control	2
DH4080	Introduction to Research Design	3
DH4220	Dental Health Education Practicum	3
DH4605	Comprehensive Preventive Therapy II	2
DH4060C	Preventive Dental Clinic II	4
		19

Winter

DH4240	Ethics & Jurisprudence	2
DH4210	Practice Management and Seminar	2
DH3340	Principles of Public Health	2
DH4120C	Preventive Dentistry Clinic III	4
Electives (select one or more)		
DH4380	Research Practicum	3
DH4340	Community Dentistry Practicum	3
DH4320	Institutional Care Practicum Practice Management	3
DH4660	Independent Study in Dental Hygiene	2-4
		13 +

Financial Information

Approximate expenses for these dental hygiene programs are listed below. This does not include room and board or expenses for personal items. Tuition and incidental fees are subject to change without notice.

Resident	$647.00/semester	323.50/summer
Non-Resident	1823.00/semester	911.50/summer
Instruments & Supplies	$600.00/entire program	
Textbooks	600.00/entire program	
Uniforms, labcoats, etc.	100.00/entire program	
Laboratory fees	100.00/entire program	
National, Regional and State licensure fees	350.00	

An advance deposit of $50.00 is required upon admission to this program. This payment shall be credited to the student's incidental fee upon enrollment. THIS FEE IS NON-REFUNDABLE except by special order of the Dean of the School of Dentistry.

Assistance

The University of Missouri-Kansas City offers several forms of financial aid to help qualified students finance their education. For further information concerning financial assistance contact:

University of Missouri-Kansas City
The Financial Aid Office
4825 Troost
Kansas City, Missouri 64110

816/932-4422

Housing

Students may live at home, in off-campus housing or in the UMKC Residence Hall. For housing information, contact:

UMKC Residence Hall Housing Office
5030 Cherry
Kansas City, Missouri 64110

816/276-1413

Application

For additional information or to obtain application materials, mail the coupon to:

UMKC School of Dentistry
Division of Dental Hygiene
650 East 25th Street
Kansas City, Missouri 64108-2795

I am interested in additional information about the UMKC Dental Hygiene Program.

NAME _____

ADDRESS _____

CITY _____ *STATE* _____

ZIP _____

UMKC School of Dentistry
Division of Dental Hygiene
650 East 25th Street
Kansas City, Missouri 64108-2795

Bachelor of Science Program

DENTAL HYGIENE

UNIVERSITY OF MISSOURI-KANSAS CITY SCHOOL OF DENTISTRY

Dental Hygiene

Dental Hygiene is a rapidly growing and increasingly dynamic profession for qualified persons who wish to participate as an active member of a health profession. Service to mankind is the primary purpose of health professions and the dental hygienist with a baccalaureate or master's degree may accomplish this objective through a variety of challenging and rewarding professional opportunities.

The dental hygienist is the only dental health team member, other than the dentist, licensed to provide direct services to the patient while working under the supervision of a licensed dentist. Professional training consists of a minimum of two years in an accredited dental hygiene program before eligibility for licensure, thus enabling one to practice in the profession.

The University of Missouri-Kansas City offers a Bachelor of Science Degree in Dental Hygiene. The qualified student who has completed two academic years of liberal arts courses at any accredited community/junior college, college or university may enter the professional dental hygiene program. This program prepares men and women for a challenging career as a health care provider through the profession of dental hygiene.

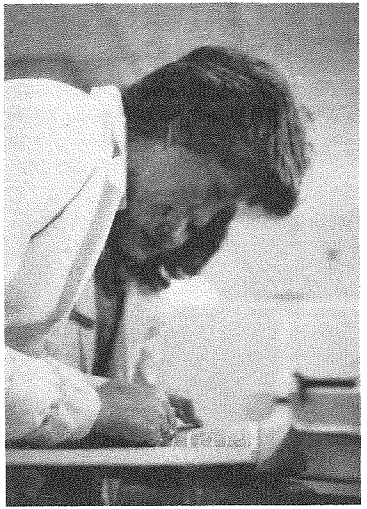
The primary goals of the Bachelor of Science Degree Program in Dental Hygiene (Plan A) are to prepare dental hygienists to perform competently in private dental offices and to assume responsibilities in one or more of the following: community dental health program planning, institutionalized patient care, practice management and research.

Plan A Program

The Plan A Program is designed for students who have completed approximately two years of liberal arts course work.

Formal applications for admission to the Dental Hygiene Program must be submitted no later than February 1 preceding the academic year for which the student desires admission. Classes formally begin in the fall of each year. Basic requirements and credentials are as follows:

1. *Graduate of an accredited high school or its equivalent.*
2. *Satisfactory completion of approximately two academic years of college (60 semester hours). The 60 semester hours must satisfy the general education requirements specified. It is required that all the general education requirements be completed prior to entrance into the Dental Hygiene Program.*
3. *A cumulative college grade point average of at least 2.50.*
4. *Personal interviews with at least two members of the Dental Hygiene Admissions Committee. Interviews will be scheduled after February for those students who have met admissions criteria.*
5. *Application to the University of Missouri-Kansas City.*
6. *Application for admission to the Division of Dental Hygiene.*
7. *High School Transcript.*
8. *College transcripts of all college work.*
9. *Three evaluation and reference forms.*



Education Requirements

The following courses must be completed prior to the Dental Hygiene Program:

Communication Skills, 9 hours (English Composition, 6 hours; Public Speaking, 3 hours);

Humanities, 9 hours (Appreciation courses in art, music, theatre, etc. Philosophy, foreign language and/or literature. These courses may be taken in any combination desired);

Social studies, 9 hours (Sociology, 3 hours; The remaining six hours may be taken in American history, government, social science, economics, etc);

Physical Science, 5 hours (Chemistry, 5 hours);

**Biological Science, 7-11 hours (Biology or Zoology, 3-5 hours; Anatomy and Physiology, 4-6 hours);*

Mathematics, 3 hours (College Algebra, 3 hours);

Behavioral Science, 3 hours (General Psychology, 3 hours);

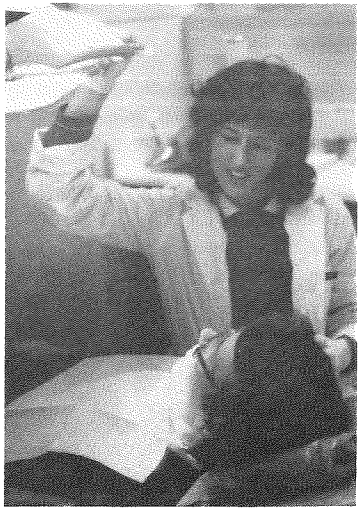
Electives Credit will be granted for courses taken at other institutions which are substantially equivalent to those offered at the University of Missouri-Kansas City provided a grade of C or above was received.

**Credit hours in science courses will vary from institution to institution.*

The major responsibilities of the dental hygienist are preventive in nature. In the private dental office, the dental hygienist may be responsible for patient education, exposing and processing dental radiographs, conducting head and neck examinations, providing a thorough oral prophylaxis, soft tissue curettage, local infiltration anesthesia, diet analysis and other functions as delegated by the licensed dentist. In some large offices, the dental hygienist may serve as a manager of office procedures. Dental hygiene functions may vary from state to state according to the laws of that state which govern the practice of dental hygiene.

In public health and/or community agencies, the dental hygienist is concerned with the oral health of the community being served. Major responsibilities may be assessing the oral health of a given population and developing and implementing a dental health program. In hospitals and nursing homes the dental hygienist may function as a health educator, clinical operator, and resource person. In some instances, hygienists are employed for clinical and descriptive research projects.

The Dental Hygiene Program at University of Missouri-Kansas City offers an opportunity to learn from professionals and to share in all the advantages of a University Dental School and stimulating educational community. Clinical and classroom experiences for dental hygiene students are provided on campus in the UMKC School of Dentistry. The School of Dentistry is located on Hospital Hill where Truman Medical Center, Children's Mercy Hospital, and University of Missouri-Kansas City Schools of Medicine and Nursing are now located.



Statement of Human Rights

The Board of Curators has committed itself and the University of Missouri-Kansas City to the policy that there shall be no discrimination on the basis of race, creed, color, sex, age, national origin, handicaps or veteran's status. This policy pertains to educational programs, admissions, activities, and employment practices. Pursuant to and in addition to this policy, the University abides by the requirements of Title VI and VII of the Civil Rights Act of 1964. Revised Order No. 4, Executive Orders 11246 and 11375, Sections 799A and 845 of the Public Health Service Act, Title IX of the Education Amendments of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973. Section 402 of the Vietnam Era Veterans' Readjustment Act of 1974, and other federal regulations and pertinent acts of Congress. The Director of Affirmative Action is responsible for all relevant programs.

college of health related professions wsu undergraduate program 182

Wichita State University

H 12 A

BACHELOR OF HEALTH SCIENCE...DENTAL HYGIENE (BHS)
(for students entering under the 1983-1984 catalog)

General Requirements: total hours for graduation 124 minimum overall GPA 2.0 minimum GPA for major 2.0

REQUIREMENTS FOR A MAJOR

Completion of the two-year professional core courses, including:

Biol	105G	The Human Organism (4)	____
Chem	103Q	General Chemistry (5)	____
Eng	101	College English (3)	____
Psych	111Q	General Psychology (3)	____
either Speech	111	Basic Public Speaking (3)	____
or Speech	112	Basic Interpersonal Communication (3)	____
Soc	211Q	Introduction to Sociology (3)	____
Biol	120Q	Introduction to Microbiology (4)	____
	225-226	Human Anatomy (3) and Human Physiology (3)	____ ____
DH	101	Preclinical Dental Hygiene (5)	____
	104	Clinical Radiology (3)	____
	201-303A-304A	Clinical Hygiene Seminar I & III & IV (1-1-1)	____ ____
	202-302-323 -324	Clinical Dental Hygiene I & II & III & IV(2-2-3-4)	____ ____ ____ ____
	206	General and Oral Pathology (3)	____
	290	Embryology, Histology and Oral Anatomy (3)	____
	301	Dental Materials and Expanded Functions (3)	____
	305	Periodontics (3)	____
	307	Ethics and Jurisprudence (2)	____
	309	Community Dental Hygiene (1)	____
	311	Dental Health Education (2)	____
	409	Introduction to Research for the Health Professions (1)	____
HS	301	Pharmacology (3)	____
	315	Head and Neck Anatomy (2)	____
	331Q	Nutrition (3)	____
RT	102	Cardiopulmonary Resuscitation (1)	____

plus additional courses to complete the General Education Program (see reverse side)

plus 24 hours in education or administration chosen in consultation with a dental hygiene adviser:

*** DH	420	Course Development and Methods of Teaching in D. H. Education (3)	____
	430	Curriculum Development in Dental Hygiene Education (3)	____
	462	Special Problems in Dental Hygiene (3)	____
***	405	Concepts and Principles of Dental Hygiene Administration (3)	____
	455	Personnel Management in Dental Hygiene (3)	____
	465	Research in Dental Hygiene (3)	____
	481	Cooperative Education (1-6)	____
*HAE	501	Health Education Curriculum Development (3)	____
**	503	Organization and Administration of the Health Care System (3)	____
*	506	Teaching and Learning Strategies in Health Sciences (3)	____
**	507	Health Planning (3)	____
Phil	300G	Science and the Modern World (3)	____
	327	Philosophy of Health Care (3)	____
Psych	342Q	Psychology of Motivation (3)	____
	347	Social Psychology (3)	____
	361	Child Psychology (3)	____
	365	Psychology of Aging (3)	____
	375	Psychology of Personality (3)	____
	510	Psychology of Illness (3)	____
MGMT	360	Concepts of Administration (3)	____
	462	Leadership and Motivation (3)	____
Nurs	332Q	Dimensions of Self-Care (4)	____
Soc	338Q	Health and Lifestyle (3)	____
	513	Sociology of Aging (3)	____
	538	Medical Sociology (3)	____
Spch	312Q	Nonverbal Communication (3)	____
WS	388Q	Women in Society: Social Issues (3)	____

* Required for the education track
** Required for the administration track
*** Required for the administration or education track

Mary Martha Stevens

Ms. Mary Martha Stevens, Chairperson
Department of Dental Hygiene
689-3614
263 Health Sciences Building

Sidney D Rodenberg

Dr. Sidney D. Rodenberg, Dean
College of Health Related Professions

ERAL EDUCATION PROGRAM IS TO PROVIDE A LIBERAL EDUCATION THAT RESULTS IN (1) KNOWLEDGE OF OUR BASIC C

Wichita State University — GENERAL EDUCATION PROGRAM — 1983-1984 Catalog

I. BASIC SKILLS: 12 hours. English 101___(3) and 102___(3) Speech 111___(3) or 112___(3)(or equivalent)
Math 109(2)(3) or 110(5) or 111(3) or 112(5) or 211(3)___(or equivalent) ACT, AP, CLEP, CRE____

II. GENERAL EDUCATION: 30 hours, distributed as follows:
DIVISION A: HUMANITIES AND THE FINE ARTS.....9 hours in at least three departments (excluding studio/performance/techniques/creative writing courses, etc.)
DIVISION B: SOCIAL AND BEHAVIORAL SCIENCES.....6 hours in at least two departments
DIVISION C: NATURAL SCIENCES AND MATHEMATICS.....6 hours in at least two departments
ELECTIVES.....9 hours of any "G" and/or "Q" courses
Limitations: All coursework must be designated as "G" or "Q" courses.
Nine hours must be taken in General Studies Courses ("G" courses).
No more than 6 hours may be counted in any one department.
No courses can be counted in the student's major department.

NOTE:
"G" courses are the most comprehensive and they serve as an overview for students NOT majoring in the field.
"Q" courses serve majors AND non-majors. They tend to be more specialized and often are foundation courses.

DIVISION A: HUMANITIES AND THE FINE ARTS — AP, CLEP, CRE____

DEPARTMENTS	"G"		"G"
American Studies		Music Education	
Art Education		Music Performance/Applied	
Art History		Musicology-Composition	
Dance		Philosophy	
English		Religion	
German/Russian (excluding 111-112)		Romance Language (excluding 111-112)	
Graphic Design		Speech Communication	
History		Studio Arts	
Interdisciplinary LAS		Women's Studies	
Linguistics			

DIVISION B: SOCIAL AND BEHAVIORAL SCIENCES — CLEP, CRE____

DEPARTMENTS	"G"		"G"
Accounting		Management	
Administration of Justice		Marketing & Small Business	
Anthropology		Medical Record Administration	
Business Education		Military Science (Army ROTC)	
Communicative Disorders & Sciences		Minority Studies	
Economics		Personnel Services (Educ)	
Finance, Real Estate & Decision Sciences		Physical Education	
Geography		Political Science	
Gerontology		Psychology	
Health Administration & Education		Social Work	
Instructional Services (Educ)		Sociology	
Journalism		Urban Affairs	

DIVISION C: NATURAL SCIENCES AND MATHEMATICS — AP, CLEP, CRE____

DEPARTMENTS	"G"		"G"
Aeronautical Engineering		Industrial Education	
Basic Emergency Medical Care		Industrial Engineering	
Biological Sciences		Mathematics	
Chemistry		Mechanical Engineering	
Computer Science		Medical Technology	
Cytotechnology		Nurse Clinician	
Dental Hygiene		Nursing	
Electrical Engineering		Physical Therapy	
Engineering, General		Physician's Assistant	
Geology		Physics	
Health Sciences		Respiratory Therapy	

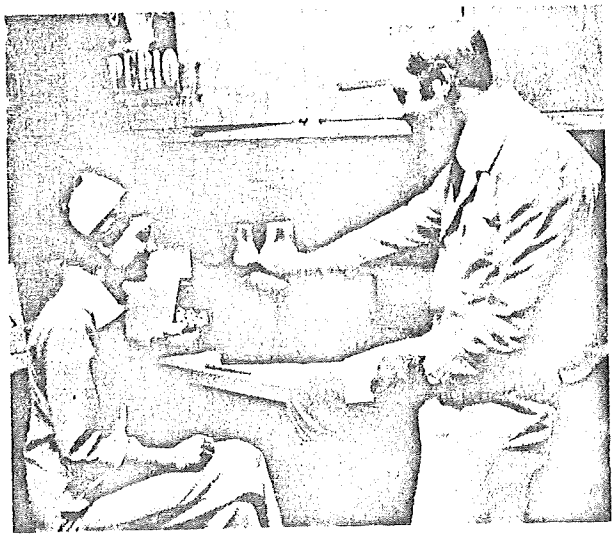
OF A COLLEGE EDUCATION: TO PRODUCE GRADUATES WHO KNOW SOMETHING, WHO CAN THINK CRITICALLY AND WHO HAVE THE DESIRE TO CONTINUE LEARNING ONCE THEY LEAVE.

AL HERITAGE; (2) COMPETENCE IN USING THE METHODS OF THOUGHT FOUND IN THE NATURAL SCIENCES, THE SOCIAL SCIENCES AND THE HUMANITIES; (3) COMPETENCE IN

COMMUNICATING, AND (4) A CONSCIOUS COMMITMENT TO A SET OF VALUES. ALL OF THESE CONTRIBUTE TO THE MAIN OBJECTIVE

DENTAL HYGIENE

The dental hygienist, as a member of the dental health team, is qualified by education and licensure to provide direct service for maintenance of oral health and prevention of disease. The Dental Hygiene Program is fully accredited by the American Dental Association, Commission on Dental Accredition. The program consists of two full academic years and one summer session. The dental hygiene clinic is located on campus. It is used to develop students' efficiency in clinical techniques, under the supervision of a licensed dentist and registered dental hygienists. In addition, learning experiences are arranged so students can assist in raising the dental health standards throughout the community. The application packet for the Dental Hygiene Program, available in the Admissions/Records Office, includes information about deadlines, admission, and options for meeting academic criteria. Deadline for application for admission for fall is Feb. 15.



Suggested Sequence of Courses **Credits**

First Semester

NDH	7252	Clinical Dental Hygiene I	6
NLS	5057	Genral Head/Neck Anatomy	4
NDH	7253	Developmental Dentistry	3
NPS	6634	Principles of Chemistry	5
		TOTAL HOURS	**18**

Second Semester

NDH	7254	Clinical Dental Hygiene II	5
NDH	6266	Dental Radiology	2
NLS	6152	Nutrition	3
NLS	5593	Microbiology	3
NDH	7255	Periodontics	1
NDH	7256	Dental Health Education	1
SS	1068	Intro. to Psychology	3
		TOTAL HOURS	**18**

Third Semester (Summer)

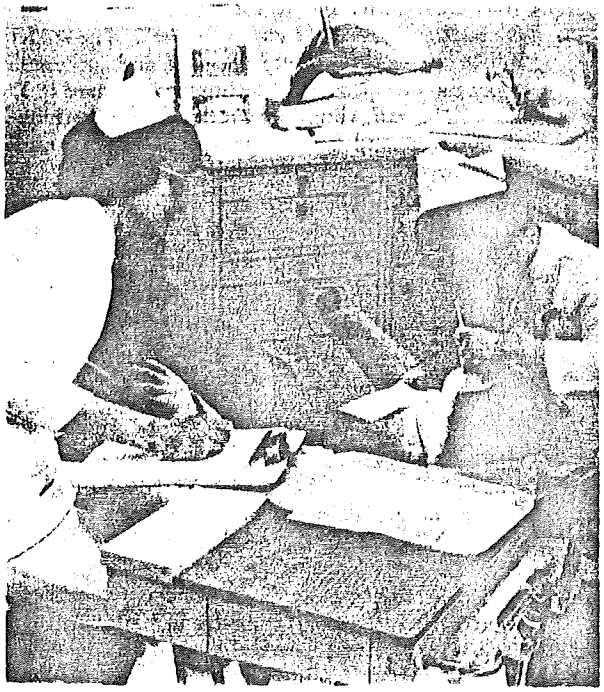
NLS	1144	Human Physiology	3
CEN	7612	Composition I	3
SS	3404	Sociology	3
		TOTAL HOURS	**10**

Fourth Semester

NDH	7257	Clinical Dental Hygiene III	7
NDH	7258	Pathology and Periodontology	3
NDH	7259	Dental Therapeutics	3
NDH	5250	Dental Materials	2
NDH	7260	Community Dental Health	2
		TOTAL HOURS	**17**

Fifth Semester

NDH	7261	Clinical Dental Hygiene IV	7
CSP	4950	Interpersonal Communication	3
		TOTAL HOURS	**10**



NDH 7256 DENTAL HEALTH EDUCATION 1CR
Prerequisite: NDH 7252, NDH 7253, NLS 5057, NPS 6634 and no grade below a "C." Corequisites: NLS 1144, NLS 6152, NDH 6266, NDH 7255, NDH 7254. A study of the principles of educational methods and their use in health education as they apply to both individual and group development, with particular attention to psychological, social and economic factors. Class meets two hours a week. Lab only.

NDH 7257 CLINICAL DENTAL HYGIENE III 7CR
Prerequisites: NDH 7256, NDH 7252, NDH 7254, NLS 5057, NDH 6266, NDH 7253, NDH 7255, NLS 1144, NLS 6152, NPS 6634 and no grade below a "C." Corequisites: NDH 7258, NDH 7259, NDH 7260, NDH 5250. Continued development of proficiency in clinical techniques including preparation and application of dental hygiene treatment plans and expanded functions. Class meets eighteen hours a week, including two hours of lecture and sixteen hours of clinic.

NDH 7258 PATHOLOGY AND PERIODONTOLOGY 3CR
Prerequisites: NDH 7252, NDH 7254, NLS 5057, NDH 6266, NDH 7253, NDH 7256, NDH 7255, NLS 1144, NLS 6152, NPS 6634 and no grade below a "C." Corequisite: NDH 7257, NDH 7259, NDH 7260, NDH 5250. Description of periodontal treatment and therapy with emphasis on root planing and soft tissue curettage. Basic pathological processes and identification of common oral conditions, their etiology and treatment. Class meets three hours a week. Lecture only.

NDH 7259 DENTAL THERAPEUTICS 3CR
Prerequisites: NDH 7256, NDH 7252, NDH 7254, NLS 5057, NDH 6266, NDH 7253, NDH 7255, NLS 1144, NLS 6152, NPS 6634 and no grade below a "C." Corequisites: NDH 7258, NDH 7257, NDH 7260, NDH 5250. An introduction to basic principles of drug actions, interactions, practical application and familiarization and appropriate selection of professional products. Although the course will emphasize dental-related therapeutics, it will also provide information related to drugs associated with common system disorders. Also included is the study of factors which are necessary to properly administer local anesthesia. Class meets three hours a week. Three hours of lecture (one hour of lab for eight weeks).

NDH 7260 COMMUNITY DENTAL HEALTH 2CR
Prerequisites: NDH 7252, NDH 7254, NLS 5057, NDH 6266, NDH 7253, NDH 7256, NDH 7255, NLS 1144, NLS 6152, NPS 6634 and no grade below a "C." Corequisites: NDH 7257, NDH 7258, NDH 7259, NDH 5250. Study of public health agencies and their functions, application of basic statistical procedures in critiquing scientific literature, identification of dental needs of people of different ages, socioeconomic backgrounds and mental and physical abilities, application of dental indices. Recognition of factors involved in planning dental health education programs within school systems. Field experience is included. Class meets four hours a week, including one hour of lecture and three hours of lab.

NDH 7261 CLINICAL DENTAL HYGIENE IV 7CR
Prerequisites: NDH 7252, NDH 7254, NDH 7257, NLS 5057, NDH 7253, NDH 7256, NDH 7260, NDH 7255, NDH 7258, NDH 7259, NDH 6266, NDH 5250, NLS 1144, NLS 6152, NPS 6634 and no grade below a "C." Continued development of proficiency in clinical techniques and current procedural practices of the dental hygienist with emphasis on self evaluation. Principles of dental hygiene ethics and jurisprudence, methods of efficient dental office management and current dental hygiene issues are included. Class meets eighteen hours a week, including two hours of lecture and sixteen hours of clinic.

NDH 5250 DENTAL MATERIALS 2CR
Prerequisites: NDH 7252, NDH 7254, NLS 5057, NDH 6266, NDH 7253, NDH 7256, NDH 7255, NLS 1144, NLS 6152, NPS 6634 and no grade below "C." Corequisites: NDH 7257, NDH 7258, NDH 7259, NDH 7260. Components of restorative, prosthetic and preventive materials utilized in dentistry with emphasis on manipulation and utilization. Expanded functions in the laboratory. Class meets four hours a week, including one hour of lecture and three hours of lab.

NDH 6266 DENTAL RADIOLOGY 2CR
Prerequisites: NDH 7252, NLS 5057, NDH 7253, NPS 6634 and no grade below a "C." Corequisites: NDH 7254, NLS 6152, NLS 1144, NDH 7255, NDH 7256. Theory of exposing, processing, mounting and evaluating oral radiographs. Paralleling and bisected angle techniques. Emphasis on radiation protection for patient and operator. Class meets four hours a week, including one hour of lecture and three hours of lab.

DENTAL HYGIENE

NDH 7252 CLINICAL DENTAL HYGIENE I . . . 6CR
Prerequisite: Admission to Dental Hygiene Program. Corequisites: NLS 5057, NPS 6634, NDH 7253. History, development, current status and future implications of dental hygiene profession. Introduction to dental hygiene techniques and instrumentation, patient evaluation, primary preventive treatment, auxiliary procedures and aseptic techniques. Class meets thirteen hours a week, including two hours of lecture and eleven hours of lab.

NDH 7253 DEVELOPMENTAL DENTISTRY . . 3CR
Corequisites: NLS 5057, NPS 6634, NDH 7252. Study of embryology, oral histology and dental morphology and occlusion. Description of normal and abnormal growth and development of the face, oral cavity and related structures. Identification and description of deciduous and permanent dentitions. Utilization of dental nomenclature in identification and classification of occlusion. Explanation of protective function and forms of teeth and supporting structures and description of dental anomalies. Class meets four hours a week, including three hours of lecture and one hour of lab.

NDH 7254 CLINICAL DENTAL HYGIENE II . . 5CR
Prerequisites: NDH 7252, NDH 7253, NLS 5057, NPS 6634, and no grade below a "C." Corequisites: NDH 6266, NLS 6152, NLS 1144, NDH 7255, NDH 7256. Clinical application of dental hygiene techniques and instrumentation, oral physiotherapy, patient motivation and education techniques, diet analysis and counseling. Emergency procedures for medical and dental emergencies which may be encountered in the dental office. Class meets ten hours a week, including two hours of lecture and eight hours of clinic.

NDH 7255 PERIODONTICS 1CR
Prerequisites: NDH 7252, NDH 7253, NLS 5057, NPS 6634 and no grade below a "C." Corequisites: NDH 6266, NLS 6152, NLS 1144, NDH 7254, NDH 7256. Description of the inflammation process and its relationship to the pathogenesis of periodontal disease. Recognition and identification of the various periodontal diseases, their etiology, signs and symptoms. Lecture only. Class meets one hour a week.

PROPOSED

PROPOSED DENTAL HYGIENE DISTRIBUTION REQUIREMENTS FOR ASSOCIATE OF SCIENCE DEGREE

Suggested Sequence of Cources	Credits
Summer	
NPS* 6634 Principles of Chemistry	5
CEN* 7612 Composition I	3
SS* 3404 Sociology	3
	11
First Semester (Fall)	
NDH 7252 Clinical Dental Hygiene I	6
NLS 5057 General Head and Neck Anatomy	4
NDH 7253 Developmental Dentistry	3
SS* 1068 Introduction to Psychology	3
	16
Second Semester (Spring)	
NDH 7254 Clinical Dental Hygiene II	5
NDH 6266 Dental Radiology	2
NLS* 6152 Nutrition	3
NLS* 5593 Microbiology	3
NDH 7255 Periodontics	1
NDH 7256 Dental Health Education	1
Elective Health/Physical Development	1
	16
Third Semester (Summer)	
NLS* 1144 Human Physiology	4
Elective Humanties/Fine Arts	3
Elective Mathematics/Logic	4
	11
Fourth Semester (Fall)	
NDH 7257 Clinical Dental Hygiene III	7
NDH 7258 Pathology/Periodontology	3
NDH 7259 Dental Therapeutics	3
NDH 5250 Dental Materials	2
NDH 7260 Community Dental Health	2
	17
Fifth Semester (Spring)	
NDH 7261 Clinical Dental Hygiene IV	7
CSP* 4950 Interpersonal Communications	3
	10

*Recommended before admission into the program

Total Curriculum Hours - 70