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March 21st

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JOURNAL
of the California Dental Hygienists’ Association

Winter 2017

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This Journal is printed on 100% recycled paper
From the Editor’s Desk

A Call to Action . . .

At a recent Advisory Board meeting for Sacramento City College’s Dental Hygiene program, I was astounded, humbled and impressed by the learning tools now available to today’s dental hygiene students — computer simulations, video scenarios, at-home study materials and new diagnostic technology. Having graduated from a dental hygiene program 50 years ago at USC, I was struck with “learning” envy and thrilled at how far our knowledge and our profession have expanded.

It’s inspiring to see the transition of our profession and our ability to serve our patients. At the same time, we’re seeing challenges for RDHs in traditional dental office as well as the efforts of our RDHAP colleagues to reach the underserved. Conversations with practicing RDHAPs have exposed areas for concern, additional focus and action (see article on page 16). I’m looking forward to the Legislative Day, March 21st at the State Capitol, at which time we can, hopefully, address our concerns about the future of the dental hygienist practitioners to raise legislator’s awareness of the cost-effective preventive healthcare services we provide.

This issue also features dental hygienists who have taken their education and talents in directions outside the “traditional” clinical practice. I hope you’ll see what Barbara Baker-Ayares has done as the Tooth Fairy and Phyllis Martina has achieved in the corporate world. We also feature a Continuing Education course in Ethics — something that affects each practitioner daily, and a timely article on meeting the needs of limited-English patients. I hope all of these will be of value to you.

As always, we are here to serve you, our members, and our profession. Please let us hear from you . . . what do you want to see in your Journal and what topics do you need to have explored? Please contact me at editorcdha@gmail.com to let me know what you’re thinking and feeling.

With thanks to the incredible Journal Advisory team . . .

Liz Moore, RDH, MSEd
Editor

A Salute to an Extraordinary Person

There are a few extraordinary people who have the knowledge, character and desire to devote themselves to improving an entire society of people and who create a vacuum with their loss. Esther Wilkins, RDH, DMD was one of those people.

Nearly every student who has graduated from a dental hygiene program since 1960 learned their profession from her textbook Clinical Practice of the Dental Hygienist - the first of its’ kind. She faithfully updated that textbook every 4 years and was working with her editor on final revisions to the 12th edition at the time of her death at age 100.

Having earned her dental hygiene certificate at Forsyth School for Dental Hygienists in 1939, Dr. Wilkins went on to achieve a DMD degree from Tufts University School of Dental Medicine in 1948. Shortly after her graduation she was asked to start a dental hygiene program at the University of Washington. In developing and teaching the curriculum for this program, the concept of her now famous textbook was born. Her textbook codified and standardized the curriculum and practice of dental hygiene for generations to follow.

In 1964, Dr. Wilkins returned to Tufts where she taught for 45 years and was designated as Professor Emeritus in 2011. Throughout her career she provided over 600 continuing education programs, supported numerous charitable dental organizations and inspired multitudes of dental hygienists.

Her passing was noted on the CDHA website stating, “We will hold Esther in our hearts forever and thank her for all she meant to our profession and to the countless dental hygienists across the country.” With respect and profound appreciation . . .
Greetings from CDHA and Happy New Year!

It has been six months since CDHA entered independence and moved to a bipartite membership structure. With membership on the forefront, CDHA's central office staff along with the Membership Council have been working diligently reaching out to potential members through direct contact as well as developing new and enhanced membership benefit programs. Don’t be surprised if you receive a personal call from a CDHA past president seeking your continued support for the Association and all it does to protect, education and scope of practice. In addition to the Membership Councils efforts, the CDHA Student Relations Council continues to provide fun and interactive regional conferences that provide relevant information to future colleagues. This is an exciting time for California dental hygienists, and CDHA wants to make membership accessible to all. January 2017 now makes membership even more convenient by offering quarterly dues payments. Take advantage of this new opportunity to become a part of the CDHA dental hygiene family.

Since becoming an independent organization, the flow of communication has increased dramatically. We gained a full-time dedicated staff member, as Dr. Vickie Kimbrough stepped into the position of Executive Administrator. Our Central Office now has an experienced dental hygienist available to answer questions, and direct members appropriately for solutions in workplace and professional issues. Additionally, Central Office is in final negotiations for a member benefit package we expect will include liability insurance, disability insurance and other valued programs for our members. Keep an eye out for future updates!

Our Registered Dental Hygienists in Alternative Practice (RDHAP) have had a most challenging year. The Department of Health Care Services (DHCS), through Denti-Cal policy and reimbursement changes, has made it nearly impossible for RDHAPs who work in skilled nursing and intermediate care facilities to provide care and maintain a sustainable business. CDHA’s Alternative Practice Council has been working tirelessly to correct this situation. Their efforts have focused on developing coalitions and collaborations with various organizations and Advisory Committees. The Council’s goal is to elevate CDHA as a knowledgeable and capable Association, willing and able to partner in advancing and promoting a healthier California, while generating new professional opportunities for the dental hygienist and RDH in Alternative Practice.

The promotion of the dental hygienist as the preventive oral healthcare specialist is supported and shared by our AP Council as well as our Government Relations Council (GRC), Public Health Council (PHC), and Public Relations Council (PRC). Development of vital liaisons is a top priority, and the PHC continues reaching out to various oral health stakeholders advancing statewide community-driven priorities, supporting implementation efforts of the California Department of Public Health’s State Oral Health Plan, and to further identify CDHA as a leading voice as preventive oral healthcare specialists.

Just as it takes a village to raise a child, it takes collaboration within our organization to move the profession of dental hygiene forward. The focus of GRC, in tandem with CDHA’s legislative lobbyists Aaron Read and Associates, has been both legislative and employment based. A CDHA Legislative Day, planned in Sacramento on March 21st, will give our members the opportunity to speak with their legislators about dental hygienists and CDHA’s mission. These efforts are supported and promoted by the Public Relations Council (PRC) through press releases and social media updates. In addition, PRC has been assisting in the creation of press releases focused on “Periodontal Disease Awareness Month” and “National Children’s Dental Health Month” to further show CDHA leads preventive oral health professionals. Labor law and employee rights have also been addressed by GRC as they work to resolve workplace issues in California.

As you can see, CDHA has been working diligently to advance your profession. I am honored and humbled to be a part of this exciting transition. I invite you to get involved with both your local and state organization, as we need you to help move our profession forward. I hope to see all of you this June at our upcoming House of Delegates in San Diego, where you can let your voice be heard.

Thank you,

Julie Coan, RDH, MPH
CDHA President 2016-2017
Call her “THE” Tooth Fairy of the San Fernando Valley (the LA Times did), call her dedicated, call her determined and never afraid to ask you to support her goals and, if you want to reach out to school children and their parents in underserved areas...call her! “

Barbara Baker-Ayares, RDH, BS, was inspired to the profession of dental hygiene at age 7 by her wonderful Dental Hygienist – Marilyn. Now, 70 years later and still going strong, she is taking calls, booking teaching dates with schools months ahead and “letting the community know who we are and what we can do- that we dental hygienists are able and skilled.”

“It all came from CDHA”

A 1962 graduate of USC, Barbara has continuously practiced dental hygiene, having been a team member in the periodontal office of Dr. Alfred Penhaskashi (previously the office of Drs. Hyman and Mendelsohn) for 44 years. During all that time, she’s been a member of the San Fernando Valley component of CDHA where she credits such dental hygienists as Toby Segal, RDHAP, BS, Pam Hughes, RDH, MS, and many others for guiding, mentoring and supporting her throughout her career. She’s served her component as president 5 times, and held every position on their board because “the passion of being with colleagues of like mind was intoxicating.”

She feels CDHA is a bargain, saying it gave her goals and a catalyst to action. She learned from the members and was inspired by them, having been mentored while gaining friends. She adds, “you just can’t get the same kind of experiences that CDHA can give you.”

A life of service

Although happy with her practice life, Barbara was particularly struck by the dental health education needs in the Pacoima/San Fernando Valley. She saw too much ‘baby bottle’ tooth decay and wondered what she could do. When the 31st District PTA asked her to create educational programs for their students, she eagerly agreed and The Dental Hygiene Education and Prevention Program (DHEPP) was born. The United Way was the first to fund her efforts but she also went to colleagues such as Lori Gagliardi, RDH, EdD, and other friends in CDHA who could help with resources and product ideas, including donated toothbrushes from her component.

Bilingual in Spanish and English, she uses puppets she gathered in her travels from around the world, including Piranha Plaque, Cavity Cow and Super Tooth. The program started with Kindergarten, pre Kindergarten and special needs and branched out to early education centers. For the last 28 years, she has educated and entertained thousands — in her busiest year reaching 11,260 children, 1000 parents and 638 teachers!

Working in Title I schools with 99% Hispanic/minority student populations, Barbara designed 3-part programs to reach students, parents & teachers. She wants to reach the parents of each child to explain the need for healthy family nutrition as well as preventative dental care in both the home and the dental office. She shows teachers how to look for signs of problems as well as when to refer for care. All participants receive a resource catalogue of services, providers and ideas for the school’s personnel and parents.

Barbara is a force to be reckoned with. She increased her outreach by urging members of the community and her patients to support local clinics through contributions, both financial and in-kind products and services. As school principals learned of her programs, she received additional requests from other districts and areas.

In 2002, then City Council member Tony Cardenas and Assemblyman Alex Padilla coordinated their efforts to support her outreach to 10 additional schools in their larger geographic districts. Her many speaking engagements led to even more support, including a long term funding bequest from an appreciative friend, Joan Wismer. She even received a Kaiser Permanente grant and was featured on their calendar for the month of November stating, “I always wanted to be a calendar centerfold wearing a crown!”

She also contributed to the Emergency Immigrant Program, the First Five Program, Head Start, the Tooth Fairy Experience with the African American Museum (a collaboration with their theater department), as a media spokesperson for CDHA, and many, many others.

While very proud of her programs, Barbara is humbled by the wall of awards and commendations in her office, including Outstanding Component Member (4 separate times!) from the San Fernando Valley Dental Hygienist’s Society, the California Senate’s “Most Outstanding Community Award in the Field of Health,” and the “Outstanding Educator and Service to the Community Award” sponsored by Assemblyman Tony Cardenas.

Continued on Page 6
A Legacy for the Future

She urges us all to reach out to our communities and “don’t be afraid to ask - don’t take no for a final answer.” She urges students and recent grads to “find a need” and you’ll find your passion. Some of her ideas include: reach out to pregnant women to learn how to start their child’s dental health from neo-natal onward, look for retirement communities that could use your help and never forget your local schools.

“This has been my life and it’s been exciting and wonderful – I wouldn’t change a thing!” Thank you, Barbara, for all you’ve given your community and your profession.

CDHA Components and Students Reach Out to Communities

**Contributors:** Ellen Standley, RDH, Carol Lee, RDH, Laurel Bleak, RDH

CDHA Members and students volunteer their time and energy to provide dental care and education to their communities.

- In October, Los Angeles Component hygienists offered support and education at the International Thyroid Cancer Survivors’ Conference for patients suffering from severe salivary gland dysfunction and associated complications from dry mouth syndrome. Members emphasized the role Dental Hygienists play on interdisciplinary teams to manage oral health complications associated with thyroid treatment modalities and treatments associate with cervical surgery.

- Orange County members closed out October by providing dental care at the 6th Annual Free Dental Care event at the Cypress College Dental Clinic. Joined by participating local dentists, patients received preventative services including prophylaxis, screening, fillings and restorative options. Long Beach component assisted with this event by donating products. Teamwork on behalf of underserved populations!

- San Fernando Valley members teamed with West Los Angeles College students at the Los Angeles City Council District 6 Health Fair. Patients received screenings, varnish and oral hygiene instruction.

- Ventura County Dental Hygiene Association is doing “Make A Difference Day” at the Simi Valley Dental Free Clinic, Saturday April 8th from 9-12 seeing children from Ventura Area. X-rays, Prophylaxis, fluoride varnish, sealants and referrals for future treatment will be performed. Typically, VCDHA sees 70-80 children during this event.

- The Central Coast Component gives donations at the end of every year. 2016 donations were given to the Tolusa children’s clinic of Paso Robles, Children’s Resource Center and Prado. The component looks forward to the Give Kids a Smile event this spring.

- San Diego County Dental Hygienists’ Society has a number of activities and events for community outreach. In January they participated in the Los Angeles Care Harbor, Project Homeless Connect and North County Veterans Stand Down. February events are; Give Kids a Smile in various San Diego County locations and the KARAMU Festival in Spring Valley. The Oral Cancer Walk in Mission Bay will be an April event for SDCDHS. Component members will also be participating in the PLNU Festival of Health that same month.

Long Beach component members and Cypress College Students gathered for the Oral Cancer Foundation Walk in Fountain Valley in October. Those showing pride in the participation include: l to r - Leslie Setremlis RDH (LBDHS CE Events Chair), front row: Marie Benson, RDH (Student Relations), Shetal Nair, RDH (LBDHS President), Arlene Parker, RDH (VP CE and Membership Council Chair); back row L to R - Cypress College dental hygiene seniors Tonia Woods, Amy Tran, Lauren Bowesman, Yen Hoang, Aurica Brancov, Chris Pham, LBDHS members Michele Gray, RDH and Vanessa Saldana, RDH.
Members In The News

• South Bay Component volunteered at the January Care Harbor Event. In addition to helping facilitate the Care Harbor Event, South Bay member Mary Delehanty has created an successfully ongoing project which she dubs the “Resource Garage,” a garage which serves as a source of donated household and other items for those who are in need. Clients come from all areas of the community, including shelters, victims’ assistance programs, social worker referrals, group homes for the disabled, hospitals and emancipating foster teens.

• Long Beach Component members and students from Cypress College, Cerritos College, West Coast University, and Moreno Valley College participated in The Oral Cancer Foundation Walk in Fountain Valley. The 23 member Long Beach team raised nearly $1400 for the Foundation. Participants followed the walk by attending a lunch & learn. A perfect day – learning and serving together.

• Long Beach Dental Hygiene Society will be donating $4000 to the Children’s Dental Health Clinic at Long Beach Miller Children’s Hospital in February. In March they will be participating in “Kids in the Kitchen,” a healthy living and eating fair.

• Sacramento Valley Dental Hygienists’ Association and the students from University of Pacific and Sacramento City College provided much needed dental hygiene services to the underserved in several community sponsored events; Tzu Chi Foundation in Modesto, California CareForce in Stockton, and CDA Cares in Sacramento. SVDHA RDHs joined the VeteranForce Day effort held in Sacramento, providing care to veterans. Sacramento Valley hygienists participated in the Stockton Regional Transit District’s Fall Festival offering families of the community a fun-filled event. RDHs of Sacramento Valley co-sponsored The First5 San Joaquin County Town Hall conversation which was hosted by the Children’s Museum of Stockton.

All these CDHA members and participating students impacted their communities by their service and we salute them. Please let us know what you’re doing in your component.

University of the Pacific students lending enthusiasm and care at CDACares event in Stockton included l to r – (front) Elizabeth Goodyear; (second row): Yasin Assadi, Quynh Tran-Ta, Sherilyn Agsao; (third row): Bailey Peniz, Nicole Behiel, Shayna Latham; (fourth row) Melkon Avetisyan and Stephen Vardapetian.

Dear Colleagues,

Congratulations on continuing to grow the California Dental Hygienists’ Association (CDHA); #cdhastrong. California dental hygienists are caring, passionate and are the leading voice of dental hygiene. With your dedication to our Association, we are advancing the dental hygiene profession in California.

On May 5, 2017, CDHA will be hosting our Spring Scientific Session in Anaheim featuring:

• Olga Ibsen, RDH, MS (the author of many of our Oral Pathology books) will present Common and Unusual Oral Pathologic Lesions from 9 to Noon and a special Thursday May 4 evening course from 7-9 PM on Oral Pathology for the Dental Professional. We are honored that Ms. Ibsen will be available for a book signing on Friday, so please bring your Oral Pathology book.

• Heather Rogers, RDH, will provide CDHA with an informational course on Medical Marijuana with an update on its impact in California since its legalization.

As 2017 is now upon us, I wish you a happy, healthy, and prosperous New Year and I thank you for supporting CDHA.

Brenda Kibbler, RDH, RDHAP, BHSc
VP Membership & Professional Development
CE Course: Ethics in Review

Learning Objectives

- Identify foundation of Kantian ethical theory
- Define common ethic terminology
- Describe steps in the ethical decision-making model
- Discuss patient rights and provider responsibilities

Introduction

The term “professionalism” is widely used among licensed practitioners and those who abide by an oath or code guiding their profession. Professionalism is based on basic ethical principles that include conduct and qualities that tend to characterize the profession. Healthcare professionals make judgments on a daily basis as they interact with patients, colleagues and communities of interest throughout their careers. Judgments in our professional lives are likely based on morals, beliefs and behaviors begun in early childhood and influenced by parents, friends, religious practices, social norms, and perceptions. As such, moral beliefs are the foundation for developing ethical principles and abiding codes that guide professionals as they do what is right for each patient.

To obtain a dental hygiene license in California graduates, and those relocating from other states, are required to take and pass an ethics and law exam. The purpose of the exam is to protect the public, by stressing ethical practices, and adherence to standards of care. In December 2016, the Dental Hygiene Committee of California (DHCC) revealed low pass rates for those who attempted the California Law and Ethics Exam. From April 1 to November 10, 2016, of the 871 prospective dental hygiene licensees who attempted the exam, only 72% passed the exam. Statistics presented by DHCC did not separate California graduates from those relocating from another state. California dental hygiene programs contribute approximately 600 graduates each year. A fail rate of 28% leaves room for improvement in understanding ethics as regarding scope of practice. Healthcare providers must retain a thorough understanding of core ethical values to best serve the public and keep their best interests a priority.

For those who have enjoyed a lifetime career, or have only a few years as a practicing dental hygienist, or who are new graduates, one might perceive ethics as becoming inherent during the education process and years of patient care experience. Infusion of ethical principles begins in the first semester of hygiene school. Standard of care and fair treatment of patients are reinforced in all clinical experiences. Once graduated and working in the private or public health sectors, clinicians diligently approach each patient case in a systematic manner to ensure dental hygiene therapies are applied appropriately, fairly, and to best of their ability. Dental hygiene professionals are surrounded by ethical situations and decisions every day, yet may not realize how often or which ethical principles are present.

Foundation of Ethical and Moral Principles

Ethics, and acting ethically, are grounded in moral principles and views of right and wrong. Each person has his or her own moral compass, which begins to be shaped in early childhood. Actions deemed right and wrong are instilled in everyday life interactions. Stumbling blocks and questionable situations frequently arise, yet may not be immediately recognizable as ethical problems. Thomas Shanks provided examples that occur every day:

- “Is it right to keep my mouth shut, when I know the neighbor’s child is getting into trouble?”
- “How should I decide when my parent needs to be placed in a nursing home?”
- “Should I treat Harvey just as badly as he treats me?”
- “My next patient is always 15 minutes late for the appointment. - which procedures should I cut out of the appointment?”

Are basic ethical principles so common that we, as dental professionals, have forgotten basic ethical principles?

Ethics and ethical theories are numerous and span centuries of time. The following is a brief review of those most noted in dental publications. First, Utilitarian ethics originated from British philosophers John S. Mill and Jeremy Bentham. Utilitarian theory focuses on how one would act in certain situations such as keeping promises, or how one follows rules because it is required to act a certain way, such as polishing teeth even though there is some level of damage to tooth structure. Next, the science of Normative ethics stems from desirable attributes and has two theoretical
foundations. Deontology emphasizes duties, or an obligation regardless of consequences, i.e. telling the truth no matter what and Teleology, in which the consequences of actions are emphasized, i.e. would telling the white lie be better than telling the truth? Deontological theories focus on duties, just as the practice of dental hygiene does. Prima facie means “at first glance”. A prima facie duty is to address the most important thing that presents itself. An example in dentistry is treating a patient who presents with pain before treating the patient appointed for a routine appointment. The foundation of acting and thinking ethically seem obvious in these few examples when it comes to patient treatment and dental hygiene practice. Healthcare remains grounded in ancient structures of ethics and philosophies.

Another approach to ethical thinking falls into the theory of what is known as Kantian ethics. In the philosophy of 18th-century thinker, Immanuel Kant, ideas were focused on the individual’s rights to choose for himself or herself. Kant and other philosophers believed human dignity was to be respected. As a result, Kant’s theories revolved around rights: people had the right to choose, the right to the truth, to privacy, and the right not to be harmed. Kant’s theories are rooted in morality and include those that seem to be threaded in present day society.

The fairness and justice approach originated with Aristotle and relates to equality. “Equals should be treated equally,” if fairness and justice are to be imposed for all persons, favoritism and discrimination are unjust and wrong. Adding to Aristotle’s views, other philosophers such as Plato and Cicero advocated for the common-good approach. This 2,000 year old notion focuses on social policies, social systems, and environments that are of benefit to all communities. Present-day examples could include affordable health care, effective public safety, a just legal system, and a clean environment.

A final approach to ethics from Kant’s theories deals with virtues. Virtue ethics emphasizes character traits such as generosity, honesty, compassion, courage and more. Those having high virtues would develop habits within their character and naturally be disposed to act in certain ways under certain situations. If facing an ethical dilemma, virtuous characteristics would rise and direct the person toward the solution believed to be the in the best interest of both sides.

John Rawls, an American philosopher (1921-2002), built on Kant’s justice and fairness theory. He was well-known for elevating the concept of common good, along with justice and fairness, “having certain conditions that are equally to everyone’s advantage.” He believed that people in a society should reach agreements based on rational debate that they accept and enact. Rawls thought that people had to think impartially to reach a lasting agreement. For example, scientists can remain impartial and come to a conclusion once all the data is presented. Impartiality can be difficult for the average person who may have biased attitudes toward the economy, the legal system, politics and society. Recent issues reported by the media have shown social unrest in communities and among racial groups. Therefore, acting ethically for common good, justice and fairness, as Rawls theorizes, may cause a divide in how individuals approach ethical circumstances.

Rawls’s theories also point out that rights are not absolute. They can be revoked or suspended, as evidenced in actions by the justice system. Rights and privileges are not synonymous. Privileges are not guaranteed, rights are. Both can be denied based on circumstances and results of actions by individuals and communities. If a person wants to practice dental hygiene, he or she works to attain the education and licensure to do so. This is a privilege, since not everyone is guaranteed to earn the license. A current and prominent controversy is whether or not health care is a right or a privilege. The political arena remains divided on this topic, yet one might argue public consumers have a basic human need for healthcare despite their economic status.

The discipline of ethics consists of thoughts and ideas that are well-grounded in ancient philosophies. Kant’s theories emphasize duties and virtues while Rawls focuses on fairness and justice determined by society. Health care providers tend to enter their chosen profession to help others. In learning the art of medicine, dentistry, and dental hygiene, there are core values founded in morality and ethics and common to all health care providers.

Core Values and Ethics

Decisions and actions of dental professionals are guided by such values and based on the Hippocratic Oath or similar codes. Codes of ethics are developed from selected core values founded by ethical principles. Not only applicable to health care professions, many non-health organizations and professions, such as certified public accountants, educators, social workers, realtors, adopt codes of ethics. The following is a review of core values as related to the practice of dental hygiene.

Continued on Page 10
Autonomy: “Self-rule”- healthcare providers must respect a patient’s right to make decisions regarding his or her medical care. Competent, informed patients have the right to choose among treatment options and refuse unwanted medical interventions. By providing all treatment options and following patients’ wishes, providers demonstrate respect for autonomy. In developing the dental hygiene assessment, the clinician will present the case along with alternatives. For example, after evaluating the medical and dental history and collecting all clinical data, the clinician may recommend scaling and root planning. However, options for other types of treatment or no treatment should also be included so the patient can choose. Education on long-term effects of each choice is advisable so the patient is fully informed.

Beneficence: Providers must act in the best interests of the patient. Patients are vulnerable either because of illness and/or a lack medical expertise. Therefore, patients rely on the provider to offer advice and to place their well-being first. If patients lack decision-making capacity, they need to be protected from making decisions that are contrary to their best interests. Providers must put the interest of the patient ahead of their own or those of third parties such as insurers or managed care organizations.

A clinical application of beneficence: Providers are expected to refrain from causing harm, yet also have an obligation to help patients. Ethicists often distinguish between obligatory and ideal beneficence. Ideal beneficence constitutes extreme acts of generosity or attempts to benefit others on all occasions. Practitioners are not necessarily expected to live up to this broad definition of beneficence. However, the goal of health care is to promote the welfare of patients, and providers possess the skills and knowledge qualifying them to assist others. Due to the nature of the relationship between health care professionals and patients, providers have an obligation to 1) prevent and remove harms, and 2) weigh benefits against risks of an action. Beneficence can also include protecting and defending the rights of others, rescuing persons who are in danger, and helping individuals with disabilities.

Examples of beneficent actions: providing CPR, providing vaccinations for the general population, and encouraging a patient to quit smoking.7

Do no harm: The principle of non-maleficence directs providers to “do no harm” to patients. Practitioners must refrain from ineffective treatments or malicious actions. This principle, however, may be viewed as in conflict with treatment options since many beneficial therapies also have serious risks. One example is local anesthesia. There is a risk with administration techniques and the drugs themselves, yet it is necessary to provide dental hygiene therapies. The ethical issue is whether or not the benefits outweigh the risk.

A clinical application of non-maleficence: Clinicians should not provide ineffective treatments to patients if they bring risk and no possibility of benefit. Such action may harm patients. In addition, practitioners must not purposely harm patients unless that particular action/therapy is balanced by a benefit. Because many medications, procedures, and interventions cause harm in addition to benefit, the principle of non-maleficence provides little guidance in the care of patients. Non-maleficence is most helpful when it is balanced against beneficence. In this context non-maleficence assumes the risk of treatment (harm) is understood in light of the potential benefit. Ultimately, the patient must decide (autonomy) whether the potential benefits outweigh the potential harms.

Examples of non-maleficient actions: Stopping a harmful medication or refusing to provide an ineffective treatment that has not been shown to be effective.8

Justice (or distributive justice): Clinicians should treat similarly situated patients in a similar manner and allocate resources justly (fairly). Examples relate to equality and dealing with issues of treating patients equally. Standard of Care can be attributed to the justice principle. For example, in Dr. A’s office the treatment plan for any patient presenting with moderate to severe periodontal disease along with visible calculus, is likely to include scaling and root planing with possible adjunct therapies. If standard of care arches over the practice of dentistry then the same or similar treatment plan would occur should the same patient be evaluated in Dr. L’s office. If not, the patient may not be treated fairly or equally when presenting identical conditions to each practitioner.

Veracity: This is the legal principle that states a health professional should be honest and give full disclosure to the patient, abstain from misrepresentation or deceit, and report known deficiencies in standards of care to the proper agencies. Many dental professionals are faced with the following dilemma: My office staff members who do not follow OSHA mandates. If I report it, I will lose my job. Although a job may be lost, protecting the patient should take priority.
Confidentiality: Health professionals must maintain the confidentiality of health records information. Confidentiality respects patient autonomy and encourages them to disclose information that may affect health treatment recommendations. However, confidentiality can be overridden in order to protect third parties when there is the potential for serious, foreseeable harm to them. Practitioners may be conflicted when trying to determine what should and should not be kept confidential. One example where reporting outweighs confidentiality is reporting on child or elder abuse or domestic violence legally mandated.

How does one decide on the best solution when confronted with an ethical situation or dilemma? As a health care provider with strong core values and ethical standards, maintaining integrity is important. Critical thinking skills are tested daily as a dental hygienist. Clinicians want to ensure confidence both within themselves and from their patients. Patients appreciate and respect when providers keep their best interests in mind. The process for decision-making in ethical situations is not unlike the process for making decisions in other aspects of our lives and careers.

Ethical Decision-making

There are many models of ethical decision-making steps, yet most involve the same steps. When faced with a situation that requires a solution, Kimbrough and Lautar (2010) provide six steps in ethical decision-making (Table 1). With each situation, the first step in decision-making is identifying the problem. Problems are not always clear, and in order to determine how to solve them it is necessary to expose the root of the problem. The key is to ask questions that test ethical and core values are key. ‘Does this follow the standards of care?’ ‘Is this for the good of the patient?’

The second step is to gather all or as many of the facts as possible. For a dental hygienist, this might be talking with the patient, the dentist, a dental assistant, or family member to gather all relevant information.

Third is to list alternatives or pros and cons for one treatment modality over the other. Of course the first option is to do nothing. The second is to do something — but what will that be? Alternatives should take into consideration the concerns and obligations (rights and duties) of all those involved, should not ignore the interest or duty of one party, and should be a reliable solution.

Once alternatives are listed along with the pros and cons for each, selecting the course of action is required. Weighing the risks and benefits encompasses a broader spectrum: Will the selection best alleviate the problem? Will there be unintended consequences? If so, is this course of action still the best? Many questions like this still lead to the best solution.

Acting on the course of action or alternative is the fifth step. As health care providers the patient has placed their trust in our decision-making skills. Acting on the selected course of action is easy when it can be justified. However, sometimes there are risks in acting on the selection. One could lose a friend, or perhaps a job, even though the best outcome is sought to alleviate the ethical dilemma.

The last step is evaluating the action. Here is another opportunity to ask questions: If I had to go through this situation again, would I do it the same way? Could I have done something differently to achieve a better outcome? Evaluating and reflecting on a decision or action can lead to improved critical thinking and decision-making skills.

Using the ethical decision-making steps, what principles might need to be considered when developing a treatment plan for this patient?

A. Identify the problem: Untreated decay. Untreated decay can be a sign of child neglect by the parents, the responsible party.

B. Gather facts: The facts could be extensive. Ask about the family to understand the reason nothing has been done about the decay. Are there an economic or religious reasons? Does the parent not have the time due to work hours?

C. List alternatives: It is essential to explain and educate the parent on the consequences of no treatment as well as treatment. This is the parent’s decision. This is a mandated

Table 1. Decision-making steps

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<th>Step</th>
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<tr>
<td>A.</td>
<td>Identify the problem</td>
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<td>B.</td>
<td>Gather facts</td>
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<td>C.</td>
<td>List alternatives</td>
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<td>D.</td>
<td>Select course of action</td>
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<td>E.</td>
<td>Act on decision</td>
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<td>F.</td>
<td>Evaluate the action</td>
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Continued on Page 12
reporting situation; yet one alternative includes informing the parent about perceived neglect.

D. Select the course of action: This type of case should be a joint decision between the parent and the provider. Try to understand any limitations affecting the parents, such as finances, unemployment or transportation. This will help establish the course of action.

E. Act on the decision: Set up the next appointment, or determine how the case will be directed, based on the selected course of action.

F. Evaluate the action: Once all steps have been completed, evaluate whether or not this process resulted in expected outcomes. If not, which step might require modification in the future, in similar cases?

In Summary

Core values and ethical principles are the framework for the practice of dental hygiene. Professional and ethical behavior among dental hygiene practitioners is founded in a Code of Ethics which guides the profession. Acting ethically on behalf of patients, colleagues and community are viewed as characteristics of professionalism, thus as a profession. Comprehending and instilling the values of beneficence, veracity, justice, autonomy and confidentiality ensure high integrity of the clinician and develop confidence in those served. As licensed professionals faced with various situations each day, employing critical thinking and decision-making skills is necessary to keep the patient’s best interest on the forefront.

References


CASE Study for Ethical Decision-Making

During a routine dental hygiene recare appointment for an 8-year old female patient, you notice Class V decay along all posterior teeth. The lesions were noted in the patient’s record over nine months ago. The patient’s parent has indicated the child has not complained of pain, so she does not want to spend the money to fix the teeth since some are ‘baby teeth’ and will only fall out. You and the dentist have recommended the patient to a pediatric dentist, yet nothing has been done for nearly a year.

About the Author

Dr. Kimbrough has been in higher education for nearly 20 years in both teaching and administrative roles. She began as an adjunct instructor for Taft College dental hygiene and quickly rose to the Director of Shasta College. She has co-authored two textbooks for dental hygiene, including Ethics Jurisprudence and Practice Management for the Dental Hygienist. Her extensive teaching and administrative experience stems from health and career technical education in the community college system and her passion is mentoring faculty and students.

Dr. Kimbrough has a baccalaureate degree in biology, a Master’s in business administration and a PhD in Educational Leadership. Leadership roles have included President of California Dental Hygienists’ Association (CDHA) along with various roles with national associations such as the American Dental Education Association.

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1. Utilitarian theories on ethics includes which two of the following foundations:
   a. Bentham and Mills
   b. Kant and Rawls
   c. Deontology and Teleology
   d. Prima facie and Beneficence

2. Kantian ethical theories are rooted in which of the following?
   a. Greek and Latin
   b. Morality and fairness
   c. Privileges and rights
   d. None of the above

3. As a more recent philosopher, Rawls advocated for:
   a. Changes in laws
   b. Human rights
   c. Socialism
   d. Common-good and justice

4. Codes of Ethics can be found in
   a. Healthcare
   b. Business
   c. Education
   d. All of the above

5. Informed patients with the right to choose treatment options is the core value of:
   a. Justice
   b. Beneficence
   c. Autonomy
   d. Informed consent

6. The Hippocratic Oath emphasizes that caregivers should first do no harm. “Do no harm” is synonymous with which of the following terms?
   a. Non-maleficence
   b. Ideal beneficence
   c. Autonomy
   d. Veracity

7. Preventing a patient from taking a harmful medication is an example of:
   a. Informed consent
   b. Veracity
   c. Non-maleficence
   d. Justice

8. Health professionals are expected to be honest and provide full disclosure to patients on therapeutic procedures. This is an example of which core value?
   a. Veracity
   b. Trust
   c. Autonomy
   d. Beneficence

9. The second step in any ethical decision-making process is likely to be:
   a. Gathering the facts
   b. Listing alternatives
   c. Identifying the issue
   d. Acting on the decision

10. Healthcare professionals are not required to maintain confidentiality when it comes to:
   a. Abuse of any kind
   b. Financial status
   c. Educating a care provider
   d. None of the above

The following information is needed to process your CE certificate. Please allow 4 - 6 weeks to receive your certificate.

Please print clearly:
CDHA Membership ID#: ________________________    □ I am not a member
Name: ____________________________________________  License #: ________________________
Mailing Address: ____________________________________________________________
Phone: __________________________ Email: __________________________ Fax: __________________________
Signature: ______________________________________________________________________

Please mail the completed Post-test and completed information with your check payable to CDHA:
1900 Point West Way, Suite 222, Sacramento, CA 95815-4706
Keep a copy of your test for your records.
The California Dental Hygienists’ Association (CDHA) and the California Society of Periodontists (CSP) are collaborating on a legislative resolution to declare the month of March “Periodontal/Gum Disease Awareness Month.” The CSP started the ball rolling in May 2016 requesting support from the California Dental Board and the California Dental Association. CDHA, representing hygienists who are periodontal disease prevention specialists, hopped on the bandwagon and, with the aid of our advocacy firm, Aaron Read & Associates, drafted a resolution introduced to the Legislature this January 2017.

The changes made last year to Denti-Cal periodontal disease treatment policy and reimbursement rates once again remind us that awareness of the prevalence and significance of periodontal disease remains sorely lacking. Preventive periodontal disease care often takes a back seat to other dental and medical procedures by both state policy makers as well as in the minds of the public in general. This undermines the role and effectiveness of all dental hygienists as cost-effective healthcare providers, but especially the Registered Dental Hygienists in Alternative Practice (RDHAP) who provide oral health care to our most underserved Californians.

Consider the following facts:

- Periodontal disease is a chronic disease affecting the majority of the adult population. The Center for Disease Control (CDC) estimates that about half of U.S. adults over the age of 30 have some form of periodontal disease, and in California that number is estimated to range from 46 to 47%;
- The CDC also reports that periodontitis disproportionately affects ethnic minorities, those of lower socio-economic status, and those in areas with limited access to dental care;¹
- Untreated periodontal disease significantly correlates with an increased risk and/or worsening of many serious medical conditions including, but not limited to, cardiovascular disease, diabetes, pregnancy complications, metabolic syndrome, Alzheimer’s, dementia, and even certain cancers;
- Research published in the Journal of Preventive Medicine suggests that the treatment of periodontal disease for those with chronic illnesses resulted in better health outcomes and reduced overall healthcare spending and inpatient hospital admissions.²

Declaring March as “Periodontal Disease Awareness Month” is just one small step towards CDHA and CSP shared goals of reducing the incidence of this disease by educating policy makers as well as the public on the myriad health issues related to periodontal disease. Hopefully this will lead to improved health care policy, thereby improving health care program outcomes and the overall health of Californians, while reducing the long-term economic burden of the state.

California dental hygienists, both RDH and RDHAP, are an educated, eager and available healthcare workforce which should be utilized to the full extent of our education and scope of practice to address the oral healthcare needs of Californians.

References

About the Author
Lisa Okamoto, RDH, AS graduated with honors from the Foothill College Dental Hygiene Program in Los Altos Hills. Her 36 year career in dental hygiene includes general and periodontal private practice, as well as clinical teaching at Foothill College. A member since graduation, Lisa is a past president of the California Dental Hygienists’ Association. She became co-chair of the CDHA Government Relations Council in 2013, the same year she was honored for her leadership and service with the CDHA President’s Recognition Award.
California Dental Hygienists’ Association

Legislative Day
Tuesday – March 21, 2017

During Legislative Day we will have members of our CDHA family meeting with our California Legislators at our State Capitol.

We want our Legislators to recognize the role of dental hygienists, as well as, oral healthcare needs, and to support CDHA efforts! It’s a fact that legislators’ opinions are swayed by their constituents (YOU) who reach out to them as they put a face to our organization.

Help us show our legislators who we are: valued, educated health professionals; and what we can do to improve the health and lives of Californians. Be a part of the solution and join us in protecting the future of our profession!

In order to have our CDHA voice heard for our profession and oral healthcare needs we are asking for your support.

Send us your questions and comments you would like our attendees to ask our Legislators.

Send them to:
Alison@cdha.org or call (916) 993-9102

Transitioning to a New Future

www.cdha.org
Those Who Cared: Creating the RDHAP

The Registered Dental Hygienist in Alternative Practice (RDHAP) – a uniquely licensed dental hygienist in the United States – is encountering new challenges and stresses in delivering patient care. This article endeavors to explore those challenges. But to know where you’re going, you have to know where you’ve been and how the journey affected you. From that premise, let’s examine the status of the RDHAP in California today by reviewing where we started.

Almost forty years ago California hygienists seized the opportunity to make history. A handful of brave hygienists, members of the Southern California Dental Hygienists’ Association (SCDHA), began to work toward what was considered by many to be unthinkable - independent practice.

At the time, there was no evidence of the risks (claimed by organized dentistry) or benefits (asserted by the dental hygiene community) to the public of independent practice by hygienists. A report by the Institute of Medicine of the National Academy of Sciences cited the situation as “one of the clearest examples in which lack of research regarding supervision of allied health personnel [had] led to the substitution of rhetoric and political power for evidence and rational decision making.”1 The evidence of safety and benefits would have to be demonstrated by dental hygienists!

In 1972, California legislation (Assembly Bill 1503) created the Health Manpower Pilot Project (HMPP) under the Office of Statewide Planning and Development (OSHPD) as a way to bypass current regulations and test the feasibility of new and better ways to deliver health care. The HMPP became the vehicle for testing the theory that dental hygienists could deliver hygiene care directly to the public, safely, and reach people who had difficulty accessing traditional dental hygiene services.

By 1979, a special committee of SCDHA determined that obtaining “the ability for hygienists to practice independently of the dentist and obtain control of their economic destiny” was an important goal to achieve for all California dental hygiene. Several dental hygienists had become acquainted with a pioneering, dental hygienist, Linda Kroll. Linda had started an independent practice in late 1976, had weathered several investigations, been allowed to work next door to her referring dentists and to own her own dental hygiene business - as a Registered Dental Hygienist! She is said to have been the inspiration for much of what followed.2

For more than 5 years, members including Toby Segal, Myrna Kalman, Laurelyn Borst, Marilyn Blackmun, Melinda Hunter, Betty Blye and Charlotte Burruso toiled, laying the groundwork for what would eventually become California’s Registered Dental Hygienist in Alternative Practice (RDHAP) licensure category.3 That groundwork included gaining support, preparing the HMPP proposal for OSHPD, starting a non-profit corporation (DHAI) as the administrative body and raising the $500,000.00 projected project costs. All of that work was voluntary.

An institution to host the project and oversight investigators still had to be found. Several hygiene educators declined participation out of concern for retribution. However, Dorothy A. Perry, RDH, PhD, then at the University of California, San Francisco (UCSF) agreed to participate, as did Dr. James R. Freed, DDS, MPH of UCLA School of Dentistry, and John E. Kushman, PhD.

Although the project was submitted and accepted by OSHPD in 1981 with California State University, Northridge as the host institution, it took an additional five years to secure the required funding. In 1985, the Northern and Southern California DH Associations merged to form the California Dental Hygienists’ Association (CDHA) to present a unified voice. Contributions came from the CDHA components, the American Dental Hygienist Association, friends and families, and dental hygienists from all parts of the country. Finally, HMPP #139, The Dental Hygiene Independent Practice Training/Demonstration Project, launched in 1986. The goals were to safely provide greater access to care in non-traditional practice settings, utilizing the hygienist as the primary provider.

Any qualified hygienist could apply. Didactic training of 90 hours with 28 additional hours of infection control was required before a 300-hour practice management residency was begun. Then, the real work began as each participant set up varying types of practice settings from completely independent to office based practice, in institutions and with the homebound. They developed financial agreements, established relationships with dentists, and marketed their services.
New and Ongoing Challenges for the RDHAP

The implementation of the RDHAP licensure brought preventive dental hygiene services to populations that had been at risk, underserved and, in some cases, ignored. RDHAP practitioners moved into communities to treat patients in their own homes, in care facilities and even in “stand-alone” RDHAP offices.

But change has come to these practitioners and their patients as Denti-Cal reimbursement rates and policies have made it vastly more difficult for those RDHAPs serving primarily Denti-Cal patients. Many are re-evaluating whether or not they can afford to remain Denti-Cal providers at all. Those RDHAP who serve private pay patients find themselves more financially stable.

In order to explore the impact these changes have produced and to have a better understanding of how both practitioners and their patients will be affected in the future, over a dozen practicing RDHAPs were interviewed, all of whom wished to remain anonymous. Each had a personal story about their own practice and their patients. What was immediately clear, and repeated across the spectrum, was the passion these RDHAPs feel for their patients, the often desperate need for treatment these patients have, and the difficulties these RDHAPs face daily to meet those needs.

Some RDHAPs have built viable and successful practices treating private patients. Those who have chosen to work with Denti-Cal patients are finding their practices restricted, their livelihood threatened and the vulnerability of their patients increased. The most recent concerns stem from the new policy published in the July 2016 Denti-Cal Bulletin (Volume 32, Number 12). The pertinent points are excerpted here:

Previously, residents were allowed subgingival root planning (SRP) every 24 months with periodontal maintenance every three months without prior authorization but with supporting documentation.

The new regulations require prior authorization (submitting a TAR-Treatment Authorization Request) with x-rays or photographs. The RDHAP must wait for the TAR approval before rendering SRP treatment.

Additionally, the reimbursement for periodontal maintenance was drastically reduced - by 60% according to CDHA’s Policy Paper: “Oral health care for California’s elderly, homebound, and those with special needs is in jeopardy [as] California Department of Health Care Services implements new policies that effectively terminate care to vulnerable populations treated by Registered Dental Hygienists in Alternative Practice (RDHAP).”
These policies were developed without input from RDHAP providers and came as a surprise. All the practicing RDHAPs with whom we spoke stated the new regulations have created an onerous burden because:

- Residents in the named facilities are unlike traditional dental patients in that they are very often frail and some are developmentally disabled.
- Most of the patients treated by RDHAPs cannot tolerate being x-rayed and were originally exempted from that procedure.
- The new regulation states a photo can be submitted to explain why radiographs aren’t possible but clinicians state those submitted cases with photographs have, to date, not been approved resulting in denied treatment for the patient.
- The reduced reimbursement fees and increased paperwork, with a reduced probability of approval, has made the ‘economics’ of operating an RDHAP practice as a Denti-Cal provider unsustainable.

Designated Health Professional Shortage Areas

Establishing a new business is always challenging, and RDHAPs experience a number of specific challenges, about which most of us are ignorant. Among the primary challenges:

- RDHAPs who open their practice in a stationary (brick and mortar) location are required to prove they are in a Dental Health Professional Shortage Area (DHPSA), an area currently being underserved by the dental profession. Currently, the Office of Statewide Health Planning and Development (OSHPD) requires the RDHAP to gather the data proving the DHPSA designation is correct and to repeat that process every few years. The question has been asked why the burden of this information gathering is placed on the RDHAP and not the state — the organization with greater data and resource information collection capabilities.
- If or when additional dental providers move into that DHPSA area that designation can be lost and the RDHAP is forced to close the established practice. In 2014, CDHA sponsored AB 502 to address this obstacle and unfair business practice. Unfortunately, this aspect of the bill was deleted before final bill passage. CDA gained a stipulation that, in order to avoid forced closure, 60% of the RDHAP practice must serve Denti-Cal patients, a financially unsustainable model based on the low reimbursement rates.
- RDHAP practices incur many of the same expenses as a traditional dental office. For a fixed office in a DHPSA those expenses can include office rental, utilities, dental chair, sterilization equipment, disposable supplies and instruments, business software and more. Denti-Cal reimbursement rates are not adequate to cover these expenses and provide a sustainable living. A mobile DHPSA practice also incurs the expense of travel and exclusively portable equipment. This leads to an insufficient number of RDHAPs financially able and/or willing to operate in a DHPSA and vulnerable patients become even more vulnerable.

Skilled Nursing and Intermediate Care Facilities and Residential Care Homes

One of the greatest issues we hear is the difficulty in getting access to the Skilled Nursing and Intermediate Care facilities to offer care and, to establish a business relationship. Meeting with facility administrators and learning about the “system” in the area is critical and many RDHAPs have found the doors closed or hard to open. It’s the old story of “what is a dental hygienist”, what can you do for the patient and with which dentist are you working? Those RDHAP who have successfully established patient-provider relationships in institutions and residential care homes now find access to their former patients blocked as facilities increasingly enter into exclusive provider arrangements with dentists or dental corporations.

Where Do We Go From Here?

One RDHAP reports 99% of the elderly and developmentally disabled in her practice don’t or can’t care for their own teeth, are often uncooperative, and have periodontal disease — the underserved. But most of the RDHAPs interviewed also stated they’re moving away from the Denti-Cal process and marketing their practice only to private pay patients, or are sustaining their Denti-Cal practice by working part time in a traditional dental practice, limiting their ability to reach the underserved as intended. Almost a hundred of the RDHAPs who have successfully completed the program now hold delinquent or inactive licenses, financially unable to succeed in the current RDHAP environment.

School dental centers offer a potential option for children: there is...
generally a room available, multiple patients can be treated without moving all equipment/supplies after each appointment, and the family doesn’t have to transport the child to an off-site clinic. Some RDHAPs are finding homes within an existing public health setting, which has worked successfully under the administration of the San Francisco Public Health Department.

As reported by the Dental Hygiene Committee of California (DHCC) in December 2016, there were 17,390 RDHs and 539 RDHAPs with active licenses, making dental hygiene a sizable and readily available, but under-utilized, workforce, which could and should be put to work to help tackle some of California’s healthcare needs. This workforce might be substantially larger if current deterrents to RDH and RDHAP practice were mitigated.

A Legislative Solution?

As we meet with our legislators on CDHA’s Legislative Day, March 21st, what do we want those legislators to know about CDHA, the services both RDH and RDHAPs are educated, qualified and legally permitted to provide, notwithstanding unnecessary supervision and setting restrictions, and what changes we hope legislators can help us accomplish? When you visit your legislators in their districts, how do we help them understand the needs of their vulnerable constituents?

Points to Ponder? Questions to Ask!

We offer the following as points of discussion in your legislative districts and at the capitol in Sacramento.

Bill AB 502, signed by the Governor in 2015, successfully clarified that RDHAPs can incorporate and employ a dental team. Unfortunately, other key provisions included in AB 502 were amended out prior to passage due to opposition from organized dentistry and the insurance industry:

1. Removal of the prescription requirement to continue RDHAP services – the patients’ need for preventive services do not stop at 18 months.

   **Question:** Who benefits by denying patients healthcare services that the RDHAP is well educated to provide and has already been providing safely for 18 months?

2. The threat of closure for an RDHAP practice in a DHPSA if the “shortage” designation is lost – what other healthcare provider’s practice is forced to close because other providers have moved into the area? The patients of the RDHAP would also be denied their right to choose and remain with their established provider.

   **Questions:** How can the RDHAP, a licensure category created to reach the vulnerable and underserved, remain financially viable in this environment? What other small business owner is required to devote 60% of their healthcare practice to treating patients at or near below overhead expense rates?

3. The increased corporatization of dentistry – more corporate entities are taking over care in nursing/care facilities. They often enter into exclusive provider arrangements with these facilities, blocking the RDHAP from prior patients. Although under the law, a patient has the right to choose their provider, a patient or their guardian must provide a written letter requesting the RDHAP to continue as their provider, a task many are unable or reluctant to do for fear of repercussions. Some facilities with these exclusive dental provider contacts will allow RDHAPs access to their patients, but only if the patient is transported off site; for the frail and immobile, that is an unreasonable barrier to care. Change is needed to ensure that the rights of our most vulnerable are protected.

   **Question:** Are dental corporations and facilities willing to collaborate with and include RDHAPs in the best interest of the patients?

4. There is a movement toward “interprofessional patient centered care” and the coordination of medical and dental health care to facilitate improved health outcomes. Dental hygienists welcome collaborative partnerships with other healthcare professionals, both dental and medical, and embrace the patient-centered team approach. Oral health is an integral part of total health; it’s time to integrate dental and medical healthcare.

**Continued on Page 20**
Question: As providers of primary preventive healthcare, why aren’t dental hygienists positioned as among the providers at the front line of this team?

5. One development in the team approach is telehealth, of which the “virtual dental home” is a part. For communication between team members, telehealth utilizes sophisticated computer software and imaging equipment to communicate between team members — cost-prohibitive for most RDHAPs to purchase outright.

Questions: Would shared access to such equipment among team members, be they dental or medical, facilitate telehealth efforts? If team members are to participate effectively under telehealth, what can be done to increase their recognition as authorized providers within their scope of practice so that they can reimbursed for their services?

6. Integrating the services of the RDH and RDHAP into physician’s offices would further facilitate the creation of virtual dental homes.

Question: What restrictions in the current Dental Practice Act prevent full utilization of dental hygienists in the interprofessional patient-centered team?

7. Are there restraint or limitation of trade issues at work?

Question: How can the RDH and RDHAP be utilized to the fullest extent of their education, qualifications, and scope of practice, in the best interest of Californians?

8. It is vital that the dental hygienist is represented, respected and heard by the Department of Health Care Services (DHCS) so that new Denti-Cal regulations don’t put a greater burden on the patients themselves, up to and including loss of dental care and dental care providers in their area.

Questions: How do we insure our voices and, through us, the voices of these patients, are heard at DHCS? Will DHCS include CDHA, the experts on preventive dental hygiene care, at the table?

9. How can we affect Legislative change and have greater access to the state budget? How do we gather the data and get it in front of those who control this process to demonstrate that preventive care for adults and children saves the state money in total healthcare costs? Any disease left untreated puts the patient at greater overall health risk and adds costs to any future treatment for that patient. This is a proven principle and surely there is adequate data to confirm the principle.

Questions: with whom do we work in alliance and cooperation to educate our legislators? Where do we get the data they need and how do we become part of that decision making process?

10. How will the current political situation — the battle over the Affordable Care Act, which had added mandatory pediatric dental benefits for children, affect opportunities for the dental hygienists in the future?

Conclusion

The members attending CDHA Legislative Day in Sacramento and the Government Relations Council will be working on behalf of all RDHs and RDHAPs to promote our education, skills and commitment to improve the oral and overall health of everyone in local communities and throughout the state of California. We hope you will help in your local area as well — by educating patients, the local dental community, health coalitions, First 5 Commissions, public health agencies, Area Agency on Aging, other senior groups, and school districts of the health role an RDH or RDHAP can provide.

References
2. Newspaper articles and background materials from Laurelyn Borst
3. Interview with Toby Segal, 2008, by Susan McLearan
4. Redig, DF. Which side of the war are you on? JCDA 1986 Sept. and letter to CDA Membership February 13, 1987
ABSTRACT

Purpose: To assess the nature and availability of accommodations for limited-English proficient (LEP) patients in clinics associated with California (CA) dental hygiene (DH) programs.

Methods: A 26-item survey, sent electronically to the 28 (CA) DH program directors, was used to assess the following: clinic LEP resources, interpretation services and training, knowledge of Culturally and Linguistically Appropriate Services (CLAS) Standards, and respondents’ perceptions of the clinic’s preparedness to serve LEP patients. An online survey research program collected and tabulated the responses and calculated the response frequencies for each survey item.

Results: Ten respondents completed the survey for a 36% response rate. All respondents reported that their clinic served LEP patients at least 2-3 times weekly and expressed some level of difficulty in addressing LEP patients’ needs. All clinics offered forms translated in at least one language; the Spanish medical history form was common to all. All respondents reported the use of translators: patient’s family or friend, clinic staff member, or student clinician, but the availability of staff varied. Training in interpretation services was offered to students, staff and/or faculty in 3 programs. The 4 respondents who were familiar with CLAS Standards offered forms in languages additional to Spanish. Only 2 respondents perceived that their clinic was prepared to serve LEP patients; others were ambivalent.

Conclusion: Enhancements in accommodations for LEP patients in DH clinics, such as more language-appropriate forms and multimedia resources and greater use of interpretation services, would improve the DH care and the oral health of the LEP population.

Keywords: cultural competency, dental hygiene education, health literacy, health services.

National Dental Hygiene Research agenda: Health Services Research: Assess the impact of increasing access to dental hygiene services on the oral health outcomes of underserved populations.

INTRODUCTION

Effective communication is critical to the delivery of optimal patient-centered health care. Issues concerning the communication barriers experienced by limited-English proficient (LEP) patients have become significant as the U.S population continues to diversify.1-5,10-12,18 Patients with limited-English proficiency are often unable to communicate their thoughts, concerns, and questions to their English-speaking healthcare provider. Studies have shown that the quality of care received by LEP patients is not comparable to the care received by English proficient patients.3 In fact, LEP patients rated their health care experiences more negatively than patients that spoke fluent English.4 Communication barriers can place the patient’s health at risk,1-2,4,7 restrict treatment options, and provide grounds for potential litigation.2 In addition, cultural diversity may influence oral hygiene routines, diet, health beliefs, reaction to pain, and access to care: all of which influence an individual’s oral health.8-9 Some cultures do not recognize poor oral health as abnormal, therefore the individual may not prioritize optimal oral health as important or seek dental care.8 An individual’s experience of oral health in their early life may influence the way they value oral health.11 By contrast, language-concordant dental services can improve the understanding of and compliance with proposed treatment plans, patient satisfaction with treatment, and positive disease outcomes.1,4

Language-appropriate accommodations and resources are needed to overcome the challenges created by language barriers.17 The Office of Minority Health, a subdivision of the Department of Health and Human Services, created the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care6 (hereafter to be referred to as the CLAS Standards) to guide health-care organizations in developing protocols to eliminate ethnic and racial health disparities.5 To evaluate hospitals’ adherence to these standards, the Cultural Competency Assessment Tool in Hospitals (CCATH) was developed and tested for its reliability and validity. Subsequent analysis of the 12 CCATH composites for a sample of California hospitals indicated that the tool was useful for evaluating...
the hospitals’ performances regarding the policies and practices related to the CLAS standards. This tool may also be useful in evaluating other healthcare organizations’ compliance with these standards.

In California, there are 28 dental hygiene (DH) education programs with clinics that provide low-cost, comprehensive dental hygiene care. These clinics serve many LEP patients, but the nature and availability of language-appropriate accommodations for these patients are unknown.

The purpose of this study was to assess the nature and availability of accommodations for LEP patients in clinics associated with California DH educational programs, using an online survey. Our research questions include: What resources and services are offered by the DH clinic to accommodate LEP patients in the DH clinic? Are California DH administrators familiar with CLAS Standards? Is interpretive services training offered to the DH staff and students? What are the administrators’ perceptions regarding their clinic’s ability to accommodate LEP patients?

Methods and Materials

The Institutional Review Board of the University of California, San Francisco determined that this quantitative, cross-sectional study was research activity that did not involve human subjects and hence did not require further Institutional Review Board oversight.

The target population for our study was the program directors or administrators at the 28 DH programs with clinics located in California.

A 26-item survey instrument was used to assess the clinics’ methods for serving LEP patients, LEP resources available, policies and procedures utilized, availability of interpretation services training, knowledge regarding CLAS Standards, and perceptions concerning the preparedness of the clinic to serve LEP patients. The survey items used the Likert-like scale and multiple-choice format for responses.

The survey was pre-tested with a convenience sample of 11 Masters of Science DH graduate students and five DH faculty members for clarity, and modified based on their feedback.

Requests to participate in the survey were electronically sent to the potential respondents using email addresses acquired from websites for the individual institutions and the California Dental Association. The request provided the purpose of the study, notice that participation was voluntary, the promise of anonymity and instructions for giving informed consent and the link to the survey. Reminder messages were emailed to non-respondents at weeks 3, 7, and 9. The identity of the survey respondents and respective dental hygiene programs was blind to the researchers.

The survey was created in Qualtrics Survey Software, an online survey research program, which tabulated responses of the participants and calculated frequencies (percentages) of responses for each survey item.

RESULTS

Representatives from 10 out of the 28 DH programs in California completed the survey for a 36% response rate. Three of the DH programs were located in Northern California, two located in Central California, and five were located in Southern California.

The majority of respondents identified their role as the program director for their respective DH program (Table 1). Nine of the 10 respondents identified themselves as Non-Hispanic White or Euro-American. The years of experience working in DH education varied.

LEP Patients in Clinic

All respondents indicated that they served LEP patients at their respective program’s DH clinic. Thirty percent indicated that they serve LEP patients 2-3 times a week, while the remaining 70% indicated that they serve this population on a daily basis. Respondents reported the various languages spoken by the clinic’s LEP population (Figure 1). Regarding the frequency with which they perceived difficulty in addressing the needs of the LEP patients: five responded having difficulty “sometimes,” three responded having difficulty “half the time,” and two responded having difficulty “more than half the time.”

Clinic Accommodations for LEP Patients

According to our survey results, the accommodations available to LEP patients varied greatly. The types of forms available and translated

<table>
<thead>
<tr>
<th>Table I. Demographic characteristics of the respondents (N=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Title</td>
</tr>
<tr>
<td>Program Director</td>
</tr>
<tr>
<td>Clinic Coordinator</td>
</tr>
<tr>
<td>Academic Chair</td>
</tr>
<tr>
<td>Racial or Ethnic Group *</td>
</tr>
<tr>
<td>Non-Hispanic White or Euro-American</td>
</tr>
<tr>
<td>Latino or Hispanic American</td>
</tr>
<tr>
<td>Middle Eastern or Arab American</td>
</tr>
<tr>
<td>Years of Experience in Dental Hygiene Education</td>
</tr>
<tr>
<td>&lt; 5 years</td>
</tr>
<tr>
<td>11-15 years</td>
</tr>
<tr>
<td>16-20 years</td>
</tr>
<tr>
<td>21-30 years</td>
</tr>
<tr>
<td>&gt; 30 years</td>
</tr>
<tr>
<td>*Respondents were allowed to select “All that Apply” so percentages may not add up to 100%</td>
</tr>
</tbody>
</table>
Research

Figure 1. Languages spoken by LEP patients and the respective forms available in that language, as reported by respondents (N=10)

Table II. DH clinics that offer forms and patient education materials translated in any non-English language, as reported by respondents (N=10)

<table>
<thead>
<tr>
<th>Initial Patient Forms</th>
<th>Respondent % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical History Forms</td>
<td>100 (10)</td>
</tr>
<tr>
<td>HIPPA Policy</td>
<td>60 (6)</td>
</tr>
<tr>
<td>Receipt of HIPPA Policy</td>
<td>60 (6)</td>
</tr>
<tr>
<td>Clinic Policies for Patients</td>
<td>60 (6)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Related Forms</th>
<th>Respondent % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed Consent for Treatment</td>
<td>70 (7)</td>
</tr>
<tr>
<td>Post-Treatment Care Instructions</td>
<td>50 (5)</td>
</tr>
<tr>
<td>Medical Clearance Form</td>
<td>40 (4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
<th>Respondent % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Records Release Form</td>
<td>30 (3)</td>
</tr>
<tr>
<td>Dental Records Release Form</td>
<td>20 (2)</td>
</tr>
<tr>
<td>Release of Radiographs Form</td>
<td>30 (3)</td>
</tr>
<tr>
<td>Patient Education Materials</td>
<td>90 (9)</td>
</tr>
</tbody>
</table>

into non-English language were related to the languages of the LEP patients served (Table 2). All respondents reported the availability of a Spanish medical history form (Figure 1).

Alternative resources were frequently used to accommodate LEP patients (Table 3). All respondents reported the use of an interpreter, whether it was the patient’s family or friend, a clinic staff member, or student clinician. Only four respondents reported the use of professional interpretation services.

The availability of a bilingual staff or faculty member during clinic hours varied: one respondent reported that the service was available “all the time,” four respondents reported that the service was available “most of the time,” and five respondents reported that “no one is available.”

Interpretation Services Training

Respondents reported that formal training in interpretation services was offered in 3 programs. Of the three, two offered training to students and one offered training to students and faculty and/or staff (Table 4). The format of training varied with the program, with one program listing “Faculty input”. Although unspecified, we can assume it was informal advice provided to the students by staff or faculty when students inquired about how to manage language barriers during the appointment.

Knowledge of CLAS Standards

Six respondents indicated being unfamiliar with the CLAS Standards. Of the four respondents who were familiar with CLAS Standards, one reported that their clinic offered interpretation services training for students, one clinic used professional interpretation services, and one had a designated bilingual staff or faculty member available during clinic hours “most of the time.” Three of the 4 respondents familiar with CLAS Standards offered forms translated in non-English languages in addition to Spanish, which may have included Chinese, Farsi, Korean, Tagalog, and Vietnamese depending on the population served at the clinic; all other respondents only offered forms translated into Spanish.

Table III. The frequency of alternative resources between clinicians and LEP patients, as reported by respondents (N=10)

<table>
<thead>
<tr>
<th>Resource Description</th>
<th>Always % (n)</th>
<th>Sometimes % (n)</th>
<th>Never % (n)</th>
<th>N/A % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s family or friend is present and acts as a liaison to help translate or interpret</td>
<td>10 (1)</td>
<td>90 (9)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Clinic staff or another student clinician fluent in the native language will help translate or interpret</td>
<td>20 (2)</td>
<td>80 (8)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Materials written in the patient’s native language is used (ex. clinic policies, informed consent, patient education)</td>
<td>10 (1)</td>
<td>90 (9)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Use of language appropriate multi-media (ex. videos, pictures, etc.) to illustrate treatment or patient education</td>
<td>10 (1)</td>
<td>80 (8)</td>
<td>0 (0)</td>
<td>10 (1)</td>
</tr>
<tr>
<td>Use of professional interpretation services to bridge the language barrier</td>
<td>10 (1)</td>
<td>30 (3)</td>
<td>60 (6)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

Continued on Page 24
Perceived Preparedness to Serve LEP Patients

When asked to express their perceptions concerning the following statement: “My clinic is prepared to serve LEP patients,” eight respondents neither agreed nor disagreed and two agreed with the statement. Of the two participants that agreed, only one was familiar with CLAS Standards.

DISCUSSION

Populations with limited English-speaking abilities are frequently served in clinics associated with California dental hygiene programs. This study assessed the accommodations that are available to the patients in these clinics. Respondents from all participating clinics reported serving LEP patients in their DH clinic at a minimum of two times per week and experiencing some level of difficulty addressing the needs of their patients; however, the clinics attempted to meet the language challenges by various means of accommodations.

One method of meeting the challenge was making available non-English forms. All respondents reported having a Spanish language medical history form available, and various clinics also offered forms translated into languages including Chinese, Farsi, Korean, Tagalog, and Vietnamese. The alternative language forms available at these clinics accommodated the commonly spoken languages of the patients served in that particular clinic, which reflects the specific ethnic population in the region. Those respondents from clinics offering translated forms in addition to Spanish were familiar with CLAS Standards, while those who were unfamiliar with CLAS Standards worked in clinics which offered forms in Spanish only.

The types of translated forms available in the clinic varied. The respondents identified the following forms as available, in addition to the medical history: HIPAA policy, receipt of HIPAA policy, informed consent, clinic policies, post-treatment care instructions, and patient education materials. These forms are important to offer in alternative languages for various reasons: HIPAA forms are legally mandated; informed consent forms address the ethical principle for autonomy; clinic policies outline important clinic and patient expectations; and lastly, treatment-related materials are critical to combat oral health diseases and improve post-treatment outcomes.

Another form of accommodation in the clinics was the use of interpreters—both informal and professional. Respondents reported that LEP patients occasionally brought an English-fluent family member or friend to interpret the clinician’s words during the appointment and, at more than half the clinics, policies and procedures regarding the use of a patient’s family or friend as an interpreter had been developed. Use of informal interpreters presents many advantages and disadvantages. Informal interpreters can help alleviate a patient’s anxiety if the language barrier does not interfere with the treatment, they are convenient, and they can quickly interpret between the clinician and the patient at no cost to the patient or the clinic. Most importantly, these interpreters help bridge communication between the clinician and the patient. The most common disadvantage to employing help from informal interpreters is the questionable accuracy of the interpretation. Clinicians are generally unable to assess the interpreter’s understanding of dental terminology and proficiency in both English and the patient’s native language to insure adequate comprehension. This is critically important when explaining concepts regarding dental treatments and the oral disease process. The age of the interpreter can also be a disadvantage. LEP patients may use their children as interpreters, but the child may be unable to comprehend complicated concepts. Additionally, using children as interpreters can occasionally place the child and/or patient in uncomfortable situations if they are embarrassed by some questions.

In an effort to counter the disadvantages of interpretation through the patient’s family or friends, 5 DH clinic administrators have designated a staff or faculty member to interpret during clinic hours. Most respondents reported using this method “sometimes” while few respondents “always” relied on this method. Again, at more than half the clinics, policies and procedures regarding the use of a staff, faculty member, or student clinician as interpreters had been developed. Student clinicians are frequently asked to interpret for their peers. It is important to have policies related to the use of student clinicians as interpreters so that their patient care responsibilities are not interrupted and/or compromised. The benefits usually outweigh the inconvenience to these students. Studies reveal that
clinicians who received training on cultural competency reported increased awareness regarding the "specific needs of ethnic minorities, embracing diversity in their clientele and alertness to their own stereotypical views and generalizations." Students who receive training for interpretation services and have experiences caring for a diverse population during their entry-level DH program may develop the confidence to share their knowledge and skills to bridge language barriers after they graduate. This concept is supported by a recent study which reported that students' participation in community oral health experiences encouraged them to participate after graduation. The dental community could also benefit from these former students initiating service for LEP patients in public health clinics and private dental offices. In-house interpreters may be an effective solution when the staff, faculty, and student population is diverse and has fluency in the languages spoken by the patients. This waives the cost of professional interpreters while also retaining the confidence that the program interpreter has sufficient knowledge of language, as well as the disease concepts.

Professional interpretation can frequently be the preferred method to help alleviate the language barrier between the LEP patient and clinician. Despite less than half of the respondents employing this method, professional interpreters can often effectively bridge the language barrier gap between LEP patients and their DH clinician. The advantages of professional interpreters are similar to those for informal interpreters, including speed, accuracy, and clinician confidence in the patient's ability to understand their treatment plan and provide informed consent. In addition, professional interpreters are familiar with medical ethics and patient confidentiality issues. Also, by using professional interpreters, patients are more likely to have positive experiences, gain trust in their healthcare providers, and remain loyal to dental practices. Disadvantages of professional interpreters include the cost of service, increased length of appointment time, and whether the interpreter has a background on dental terminology.

The CLAS Standards are a set of recommendations developed to eliminate ethnic and racial health disparities. Less than half of respondents were familiar with the CLAS standards, and those familiar with the standards still reported experiencing difficulty in addressing the needs of LEP patients. The majority of respondents familiar with CLAS Standards had developed policies and procedures regarding the use of the patient’s family or friend, clinic staff member, faculty, or student clinician as an interpreter. As suggested by the CLAS Standards, organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. Written plans allow the DH clinic to provide consistent care and evaluate their methods to implement necessary changes to accommodate the LEP patients. Healthcare organizations interested in implementing the CLAS Standards can also utilize the freely available internet source, Think Cultural Health: Bridging the Healthcare Gap Through Cultural Competency Continuing Education Programs, which offers e-learning programs and communication tools.

Two respondents perceived that their clinic was prepared to serve the LEP population in their community. Both respondents' clinics served LEP patients daily, so this frequency may have encouraged the clinic to develop resources for their patients; however, only one was familiar with CLAS standards. Common accommodations found in the two DH clinics included: (1) language-appropriate health history, treatment-related forms, patient education materials, and multi-media; (2) interpretation services from the patient's family and/or friends, the DH student clinician, program faculty member, or program staff member; and (3) clinic policies and procedures regarding the use of these various people as interpreters. Language concordant resources are widely available to dental professionals. One of the simplest ways a DH clinic may serve valuable resources to serve LEP patients is to download the free health history forms developed by and available from Metlife Insurance Company and the University of the Pacific, School of Dentistry. The health history forms are available in the 40 most commonly spoken languages for both adults and children. Moreover, the questions on the

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**Table V. Resources for dental communication tools**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Resource Available</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Dental Association</td>
<td>Spanish Oral Hygiene Instruction Videos</td>
<td><a href="http://www.youtube.com/user/AmericanDentalAssoc">www.youtube.com/user/AmericanDentalAssoc</a></td>
</tr>
<tr>
<td>California SB 853</td>
<td>Information regarding the law that requires California dental insurance companies to provide interpretation services and health-related forms translated into key languages.</td>
<td><a href="http://cpehn.org/policy-center/cultural-and-linguistic-competency/sb853-health-care-language-assistance-act">http://cpehn.org/policy-center/cultural-and-linguistic-competency/sb853-health-care-language-assistance-act</a></td>
</tr>
<tr>
<td>Metlife and University of the Pacific</td>
<td>Medical history forms translated into top 40 common languages</td>
<td><a href="http://oralfitnesslibrary.com/Multi-Language-Health-History-Forms">http://oralfitnesslibrary.com/Multi-Language-Health-History-Forms</a></td>
</tr>
<tr>
<td>Think Cultural Health</td>
<td>Free e-learning programs and communication tools</td>
<td><a href="http://www.thinkculturalhealth.hhs.gov/education/oral-health-providers">www.thinkculturalhealth.hhs.gov/education/oral-health-providers</a></td>
</tr>
</tbody>
</table>
CONCLUSION

The need for California DH clinics to expand their resources and services in an effort to accommodate LEP patients is supported by our study. The United States Census indicates that 58 million people over the age of 5 speak a language other than English in their homes. Diverse cultures will continue to grow, and healthcare professionals will need to be prepared to treat the increased numbers of LEP patients. Dental hygienists are in an excellent position to develop and utilize resources for LEP patients because they provide direct care to the patient. Their use of language appropriate resources would increase their ability to communicate and care for these patients. Reducing the language barrier would lead to better treatment outcomes and optimal oral health.

References available online at www.CDHA.org

About the Authors

Connie Cheng, RDH, BS, MS, graduated with honors from the Foothill College Dental Hygiene Program. As a student, she received the Student Leadership Award. Her time at Foothill College helped her develop a true passion for dental hygiene, which led Connie to pursue her Master of Science in Dental Hygiene degree at the University of California, San Francisco. She currently works in a private practice in San Francisco and is a proud member of the CDHA and the ADEA.

Cheryl A. Davis, RDH, BS, MS, JD, is an assistant clinical professor in the Master of Science Program, Department of Preventive and Restorative Dental Science, University of California, San Francisco. She has worked as a clinical dental hygienist in private practice for 15 years. She holds a juris doctorate degree from the University of Tennessee, Knoxville, and worked for the Tennessee Court of Criminal Appeals as a judicial clerk after graduation. Cheryl is a licensed attorney in California, holds a Baccalaureate degree in Environmental Science from East Tennessee State University and a Master of Science in Dental Hygiene from the University of California, San Francisco. Her passions include teaching and education, research, and her volunteer work for numerous local organizations.

Dorothy J. Rowe, RDH, MS (dental hygiene education), PhD (oral biology) has had a 50-year career of doing what she enjoys most — teaching and conducting research. Her position in the Master of Science program in Dental Hygiene at UCSF has encompassed both these passions — teaching biological- and research-oriented courses and supervising the development and execution of research projects, culminating in a written scientific manuscript. Her dental hygiene career has focused on producing the future educators and researchers in dental hygiene.
Think out of the box. Be creative and flexible. Be open and prepared. In the search for employment opportunities, diversity and variety are not always apparent. Phyllis Martina RDH, MBA has found her niche in the corporate world.

Phyllis Martina was 7 years old when she met a dental hygienist, a meeting which set the path for Phyllis’ professional journey. Phyllis recalls “The hygienist was nice to me and urged me to consider a career in dental hygiene.”

Professional education for Phyllis began with a Bachelor of Science, Dental Hygiene at the University of Missouri, Kansas City in 1978 and later to a Master of Business Administration, with a concentration in Marketing, at the University of Southern California (USC) in 1994.

Phyllis began her career as a clinical dental hygienist. She went on to hold positions in education as Clinical Instructor & Supervisor, interim Doctoral Course Director, and Clinical Assistant Professor, Department of Periodontology, at the USC Dental School before accepting corporate positions.

How did you make the transition from clinical to corporate and why?

I have always been open to different and unique opportunities. At a Los Angeles DHS component meeting I met an RDH who worked as a part time pharmaceutical sales representative and thought that sounded different and fun so I contacted her company. I worked with Parke-Davis for a couple of years, talking about Listerine with the new ADA seal for gingivitis. During that time I worked in private practice, taught and did pharmaceutical sales – all part time, all at the same time. That sales experience gave me insight into working in marketing and sales for a major corporation.

My original intent was to teach full time. However, when my chairman said I needed a DDS and PhD to continue to teach, I applied for corporate positions and got a summer intern position with Coors Brewing Co. I was then hired full time with Hu-Friedy and moved to Chicago, IL. I moved back to Los Angeles and now work for Colgate as a Senior Academic Relations Manager.

While working at Hu-Friedy, Mfg. Co., Inc how did you apply previous dental hygiene experience?

I was employed at Hu-Friedy for 17 years initially, as a Product Specialist. I was able to utilize my perspective as a clinical hygienist and clinical educator. I was soon promoted to Marketing Manager and able to use my advanced education with a Marketing concentration. When I became School & Institution Manager; School & Institution Team Leader, North America; School and Institution Manager; and Senior Clinical Education Manager my MBA and past experiences were even more applicable. I was responsible for marketing, sales, and educational programs, sales, service and support in dental and dental hygiene schools, dental residency programs and government dental facilities in the United States.

How has your dental hygiene background been of benefit in your current position?

I am the Senior Academic Manager, North America at Colgate Oral Pharmaceuticals, Inc. I manage Colgate academic activities, supervise a team of nine dental hygienist who manage all the dental and dental hygiene schools in the US and Canada. I create programs for schools and students on the patient benefits of Colgate Therapies. My dental hygiene and teaching experience is essential to understanding the clinical aspects and patient benefits of the products, as well as in understanding the needs of the students and faculty.

In your many positions since clinical employment, what do you enjoy most?

Creativity. I get to create educational and marketing programs. The process involves talking to hygienists, dentists, students, and faculty to discover what is important to them, what they like and dislike, how they use different marketing tools and what they want to make their life easier. I incorporate that information to create a program that will work for them. That process is interesting to me. I also work with a great team. The Colgate Academic Managers are smart, dedicated, and very fun to work with. I am very fortunate to work with these wonderful hygienists.

Continued on Page 28
Any advice for fellow hygienists to expand their career options?

1. Find out what you want to do: find people who do it, find out what skills are needed, then get those skills.

2. Network: talk to many people who do what you want to do, ask their advice and maintain a dialogue with those people.

3. For a career in corporate: as a dental educator you will need a master’s degree, teaching experience, and some business experience is helpful. Most companies at least require a bachelor’s degree.

4. Keep in mind, that most corporate positions require more than 40 hours per week and include weekends. The compensation includes benefits (health insurance, retirement, sick and vacation time), as well as perks, I attended a dinner in the same room where Abraham Lincoln wrote the Emancipation Proclamation-- very cool!

I loved my time in clinical practice as I did my time teaching. There are wonderful benefits to all the positions I have had and the skills learned led me to the position I have now. I am glad I was active in my DH component (I am still friends with many of my old component friends) and was open to different opportunities. I would not have had those opportunities without my connection to my professional associations. So my advice is to be involved and open to what can happen.

About the Author:

Carol Lee received her Bachelor of Science in Dental Hygiene from the University of California, San Francisco and holds a Master’s degree in Health Science. Carol’s forty year career includes private practice, public health and dental hygiene education. She is particularly passionate about working with the underserved, has organized countless outreach programs and received ADHA’s first Community Outreach Award. A past President of the California Dental Hygienists’ Association, Carol currently serves on the CDHA Journal Advisory Board. Outside of dental hygiene, Carol practices Tai Chi, which she integrates into the ergonomic practice of dental hygiene.

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2017 Calendar of Events

March 21
CDHA Legislative Day
Sacramento, CA

March 25 & 26
Board of Trustees Meeting
Los Angeles, CA

May 5 & 6
Spring Scientific Session
Anaheim, CA

June 2 – 4
House of Delegates
San Diego, CA

2017 Spring Scientific Session
May 4 & 5, 2017
Sheraton Park Hotel at the Anaheim Resort

Thursday, May 4
7:00 p.m. – 9:00 p.m.
Oral Pathology for the Dental Professional (2 CEUs)
Speaker: Olga Ibsen, RDH, MS

Friday, May 5
2:00 p.m. – 4:00 p.m.
Providing Care in a Marijuana Legal World (2 CEUs)
Speaker: Heather Rogers, BSDH

Friday, May 5
9:00 a.m. – Noon
Common and Unusual Oral Pathologic Lesions (3 CEUs)
Speaker: Olga Ibsen, RDH, MS

Friday, May 5
5:00 p.m. – 6:30 p.m.
Coffee Chat with Anastasia

Registration information available at www.cdha.org

Registration Opens
February 2017