



100 Years of Leadership in Dental Hygiene

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The American Dental Hygienists' Association is celebrating their 100-year anniversary, definitely a momentous occasion! I am celebrating my 49th year as a dental hygienist – nearly half the years of our professional organization! That first ADHA gathering was held in Cleveland, Ohio with 46 dental hygienists in attendance.¹ Officers were elected and the Committee on Constitution and Bylaws and Exhibit Chair were appointed.¹ This year we are anticipating over 1,750 attendees and speakers from around the world who will be expanding our knowledge base in areas such as education, research, public health, clinical practice, diversity and equity, infection control, and oral medicine, just to name a few. What a momentous change 100 years has brought! This is an important time for us to take a moment to reflect on our past, acknowledge our accomplishments, and envision our future.

When the dental hygiene profession was first created by Dr. Alfred C. Fones in Bridgeport Connecticut, he envisioned women who would “provide an added service to school children, offering them prophylactic care, instruction in brushing and flossing, and education in nutrition and general hygiene.”¹ Did you know that two of those early graduates moved west to Colorado to work for the Colorado Fuel and Iron Company and provided care to the employees and their families in the coal camps? The coal company owner had heard a presentation at a parent-teacher meeting on public health dentistry that included the work of Dr. Fones and the development of the dental

hygienist program and he wanted that benefit for his worker communities, building on that original public health focus.²

During the 1950-70's many state laws were changed limiting dental hygienist employment to private practice or dental clinic settings only, shifting away from our origins in public health. When I first moved to Colorado in 1974, there were 14 dental hygienists employed by the Denver Public School System. These dental hygienists were able to screen and refer students without a dental home to a dental clinic manned by volunteer dentists and dental hygienists. On a personal note, I was a volunteer along with my dentist employer the third Wednesday every other month and we were able to provide care to children referred to the clinic. Sadly, by the end of the 1970's due to changes in the state law, dental hygienists were no longer allowed to be employed by the school system and the clinic was closed.

As a result of these restrictive changes occurring across the country dating back to the 1950's, dental hygiene state organizations, with support from ADHA, were pursuing legislative activities to allow for representation on regulatory boards of dentistry and expand our scope of practice along with our practice settings. In 1984, the state of Washington passed legislation allowing for unsupervised practice and employment opportunities outside of private practice, followed by independent and unsupervised practice in Colorado in 1987.³ Today, due to the collaborative work

of organized dental hygiene across the country, 42 states now allow some form of direct access to dental hygiene services without the authorization of a dentist.³ However, efforts remain ongoing to remove restrictive supervision requirements, increase access to care and to acknowledge that a dental hygiene diagnosis is an integral part of the process of patient care.

Beginning in the 1990's, dental hygiene became part of the movement to recognize that "oral health is a part of total health."⁴ The links between oral health and chronic diseases and the related risk factors are now well established in the literature.⁵⁻⁹ Dental caries is the most common chronic disease in children and adults in the United States⁹ and nearly half of all adults over the age of 30 had periodontal disease in 2009-2014.^{10,11} The incidence of oral and oropharyngeal cancers continues to increase.¹² However, in 2009, the World Health Organization began to advocate for the integration of dental care into primary health care settings in recognition of the co-morbidities of oral and systemic disease and lack of access to dental health care.¹³

Medical dental integration (MDI) places the patient or person at the center of the care delivery model that requires health care providers to deliver comprehensive care. I am excited to see the establishment of medical integrations projects across the country. In this issue we are highlighting the work of MDI projects in Colorado, Wisconsin and Michigan and their impact on the overall health and well-being of populations with unmet oral health needs. Medical dental integration provides opportunities for dental hygienists to become fully integrated into medical care teams and the ability to offer comprehensive person-centered care.

As I learn about these projects and reflect on my own experiences in Colorado, I think about the characteristics that are needed for dental hygienists to be successful in these exciting new practice settings. Those that come to mind include being flexible, creative, innovative and solution minded, engaged, compassionate, life-long learner and committed to evidence-based practice. Which leads me to the

question, "What are we doing to instill and encourage these behaviors in our dental hygiene education and our continuing education programs?" Not everyone will want to leave the traditional dental practice setting to pursue MDI in the public health sector. However, we can also embrace these same concepts in private practice. This requires us to be open to opportunities to fully utilize the dental hygiene process of care deliver comprehensive oral health care in a mindful way, rather than the commonly accepted concept of "cleaning teeth" as the model of what contemporary dental hygiene care should be.

Implementing MDI requires us to recognize that we have not eradicated dental caries, oral and oropharyngeal cancers, or periodontal disease; we do not have the workforce to ensure that all people receive oral health care services, and that we, as dental hygienists, must promote our unique sphere of expertise as essential oral health care providers and disease prevention specialists. As oral health care professionals, I challenge you to engage in your practices, schools, and communities to utilize all the tools you have at your disposal to promote oral health. Incorporate behavior modification skills to assist your patients with dietary counseling and other preventive habits. Use fluoride varnish, silver diamine fluoride, interim therapeutic restorations, and atraumatic restorative treatments to the fullest extent possible. Modify your periodontal programs to focus on reversing gingivitis. Perform regular oral cancer and disease identification screenings. Last, but not least, continue to support our professional association to ensure that we are all able deliver care at our full scope of practice.

Let's make sure the next 100 years continue to be trailblazing, not stationery, for the dental hygiene profession. The choice is yours!

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