Kentucky Oral Health Coalition

For a lifetime of oral health

December Annual Meeting

Friday, December 2, 2022
10:00am EST
This meeting is hosted by:

Kentucky Oral Health Coalition
For a lifetime of oral health

To learn more about KOHC and become a member, please visit [www.kyoralhealthcoalition.org](http://www.kyoralhealthcoalition.org)

@KYOralHealth  Facebook: Kentucky Oral Health Coalition
Welcome and Introductions

Alicia Whatley, Policy and Advocacy Director
Kentucky Youth Advocates
Thank you to our Signature Sponsor

aetna®

with support from

CareQuest Institute for Oral Health™
Dental Workforce Shortage

JoAnn Gurenlian, RDH, MS, PhD, AFAAOM
Dental team shortage during COVID-19
Could there be more to the story?
Shortage of dentists
Solutions
Current status
Dental Team Shortage During COVID-19
Employment Patterns of Dental Hygienists

Journal of Dental Hygiene
February 2021

Critical Issues Facing the Dental Hygiene Profession

Employment Patterns of Dental Hygienists in the United States During the COVID-19 Pandemic

JoAnn R. Gurenlian, RDH, MS, PhD, AFAAOM; Rachel Morrissey, MA; Cameron G. Estrich, MPH, PhD; Ann Battrell, MSDH; Sue K. Bessner; Ann Lynch; Matthew Mikkelsen, MA; Marcelo W. B. Araujo, DDS, MS, PhD; Marko Vujicic, PhD

Abstract

**Purpose:** The COVID-19 pandemic has led to drops in patient volume and staffing in dental practices in the United States (US). This study aimed to provide insights on dental hygienists’ employment patterns as well as their attitudes toward working as dental hygienists during a pandemic.

**Methods:** Licensed dental hygienists were invited to participate in a web-based 30-question survey between September 29 and October 8, 2020. Employment questions included current and pre-pandemic work status, reasons for not currently working as a dental hygienist, and estimated levels of personal protective equipment (PPE) in the primary work location. All statistical analysis was conducted in Qualtrics Core XM; cross tabulation was used to examine dental hygienist working patterns and attitudes by age, practice PPE supply, and other factors.

**Results:** The COVID-19 pandemic has led to an estimated 8% reduction in dental hygienist employment. The majority (59.1%, n=205) of this reduction is voluntary, with the main reason being general concerns over COVID-19 (48.3%, n=100). Other reasons include issues surrounding childcare and concerns over safety measures in the workplace. Dental hygienists aged 65 and older were most likely to have left the workforce voluntarily. More than half of respondents reported that their work locations had more than a two-week supply of most PPE items, although about 10% did not know supply levels. Dental hygienists working in settings with lower supplies of PPE were more concerned with COVID-19 transmission risk to themselves or to patients.

**Conclusion:** COVID-19 has led to a reduction in the dental hygienist workforce that is likely to persist until the pandemic passes. The dental hygienist labor market has tightened and employers may continue to experience difficulties in filling vacant dental hygienist positions until the pandemic subsides. There is also likely to be a longer term, yet smaller, impact on dental hygiene employment levels.

**Keywords:** COVID-19, employment patterns, dental hygienists, pandemic, dental hygiene workforce

This manuscript supports the NDIHRA priority area Professional development: Occupational health (Determination and assessment of risks)

Submitted for publication: 12/17/20; accepted 1/8/21.
Key Study Results

- Of 4,776 completing the survey, almost one-third had at least one medical condition associated with a higher risk of developing severe illness from SARS-COV-2.

- 6.7% decrease in full-time employed dental hygienist from March 1 to the time of the survey; older aged dental hygienists affected more significantly compared to dental hygienists under age 35.

- Nearly one in twelve (7.9%, n=360) left the workforce:
  - 59.1% (n=205) left voluntarily
  - 24.1% (n=84) furloughed/laid off
  - 16.7% (n=58) permanently let go

- 3/5 working same number of hours, 1/5 working reduced hours, 1/5 working in DSOs more hours than before pandemic.
Reasons cited for voluntarily leaving a dental hygiene position (n=205).

- I do not want to work as a dental hygienist until after the COVID-19 pandemic is under control, 48.3% (n=100)
- Concerns about adherence to workplace/safety standards, 12.7% (n=26)
- I do not want to work as a dental hygienist any longer, 11.2% (n=2)
- Childcare concerns, 10.7% (n=22)
- Other (includes medical reasons, retired, accepted another non-hygienist position, unable to wear/tolerate PPE, moved to another state, and employer reduced salary to much), 17.1% (n=35)
Level of concern regarding risk of COVID-19 transmission in primary work location.
### Employment status among respondents pre-COVID-19 (n=4674) and currently (n=4543)

<table>
<thead>
<tr>
<th>Years of Age</th>
<th>Status on March 1, 2020</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Under 35</td>
<td>74.4</td>
<td>775</td>
<td>25.4</td>
<td>264</td>
<td>0.2</td>
<td>2</td>
<td>68.2</td>
<td>710</td>
<td>25.7</td>
</tr>
<tr>
<td>35-44</td>
<td>71.3</td>
<td>798</td>
<td>28.7</td>
<td>321</td>
<td>0.1</td>
<td>1</td>
<td>61.3</td>
<td>686</td>
<td>31.3</td>
</tr>
<tr>
<td>45-54</td>
<td>67.0</td>
<td>599</td>
<td>32.4</td>
<td>290</td>
<td>0.6</td>
<td>5</td>
<td>58.4</td>
<td>522</td>
<td>32.7</td>
</tr>
<tr>
<td>55-64</td>
<td>59.1</td>
<td>469</td>
<td>38.2</td>
<td>303</td>
<td>2.8</td>
<td>22</td>
<td>51.3</td>
<td>407</td>
<td>35.4</td>
</tr>
<tr>
<td>65+</td>
<td>39.6</td>
<td>67</td>
<td>51.5</td>
<td>87</td>
<td>8.9</td>
<td>15</td>
<td>28.4</td>
<td>48</td>
<td>39.6</td>
</tr>
<tr>
<td>All Ages</td>
<td>65.7</td>
<td>3,072</td>
<td>30.4</td>
<td>1,423</td>
<td>1.2</td>
<td>56</td>
<td>59.0</td>
<td>2,679</td>
<td>31.1</td>
</tr>
</tbody>
</table>

- **Employed Full-Time** represents individuals working at least 30 hours per week.
- **Employed Part-Time** represents individuals working less than 30 hours per week.
- **Semi-Retired** represents individuals working less than 20 hours per week.
- **Not Employed** includes individuals who are not working.
Key Takeaways

7.9% of dental hygienists left the workforce since the onset of the pandemic translating to ~18,000 from the workforce. Dentists reporting extremely challenging to fill vacant positions.

Most dental hygienists who left their jobs did so voluntarily and analysis suggests this departure is likely short-term. However, 0.5% may be permanently leaving.

Most common reason for not returning to work is waiting for pandemic to be under control. Other concerns were workplace safety, childcare, and no longer wanting to work as a dental hygienist.

PPE supplies and workplace safety remain a concern.

Age is a consideration. Dental hygienists 65 and older were unemployed or voluntarily left their positions possibly related to comorbidities placing them or family at greater risk.

Need to examine factors associated with those age 45-54 who were permanently let go and reason for termination.

Onset of vaccines and capacity to administer them may provide new avenues for dental hygienists to become involved or reinvest in the provision of healthcare.
Employment Patterns of Dental Hygienists – An Update

Journal of Dental Hygiene
February 2022

Research

Employment Patterns of Dental Hygienists in the United States During the COVID-19 Pandemic: An update

Rachel W. Morrissey, MA; JoAnn R. Gurelian, RDH, MS, PhD, AFADAOM; Cameron G. Estrich, MPH, PhD; Laura A. Eldridge, MS; Ann Battrel, MSDH; Ann Lynch; Matthew Mikkelsen, MA; Brittany Harrison, MA; Marcelo W. B. Araujo, DDS, MS, PhD; Marko Vujicic, PhD

Abstract

Purpose: Despite recovery in dental practices' patient volume, dentists in the United States (US) continue to report difficulties in hiring dental hygienists due to the COVID-19 pandemic. This study updates previous data on US dental hygienists' employment patterns and attitudes concerning returning to work.

Methods: Licensed dental hygienists were invited to participate in monthly web-based surveys between September 2020 and August 2021. Employment questions included current and pre-pandemic work status as well as reasons for not currently working as a clinical dental hygienist. Descriptive statistics were used to describe dental hygienists' employment status and reasons for not currently working. Cross tabulation analysis included employment status and reasons for not working by age group.

Results: As of August 2021, 4.9% (n=59) of the participants reported that they were not currently employed as a dental hygienist. Most reported that the reason for non-employment as a dental hygienist was voluntary (74.1%; n=43). Safety concerns for self and others were the primary reasons for not returning to work; participants also indicated retirement or that they no longer wished to practice due to the pandemic. However, the percentage of respondents citing insufficient childcare, wanting the COVID-19 vaccine but not obtaining it, and having an underlying health condition, decreased between the beginning and the conclusion of the study.

Conclusion: A measurable degree of hesitancy among US dental hygienists to return to work has persisted over a year and a half into the pandemic and may continue despite some improvements in workplace safety and vaccine uptake. Future research should examine workforce levels after the pandemic resolves.

Keywords: COVID-19, employment patterns, dental hygienists, pandemic, dental hygiene workforce

This manuscript supports the NDHRA priority area, Professional development: Occupational health (determination and assessment of risks).

Submitted for publication: 11/8/21; accepted: 1/14/22
Employment status of dental hygienists over time.
Employment status among respondents pre-COVID-19 (n=6,749) and as of August 2021 (n=1,216).

<table>
<thead>
<tr>
<th>Years of Age</th>
<th>Status on March 1, 2020</th>
<th></th>
<th>Status as of August 16, 2021</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employed Full-Time</td>
<td></td>
<td>Employed Full-Time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
<td></td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>18-34</td>
<td>1175 (76.1)</td>
<td></td>
<td>128 (71.9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>368 (23.8)</td>
<td></td>
<td>45 (25.3)</td>
<td></td>
</tr>
<tr>
<td>35-44</td>
<td>1220 (71.4)</td>
<td></td>
<td>156 (60.7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>486 (28.5)</td>
<td></td>
<td>88 (34.2)</td>
<td></td>
</tr>
<tr>
<td>45-54</td>
<td>966 (66.9)</td>
<td></td>
<td>207 (64.7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>474 (32.8)</td>
<td></td>
<td>100 (31.3)</td>
<td></td>
</tr>
<tr>
<td>55-64</td>
<td>765 (61.2)</td>
<td></td>
<td>186 (50.5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>455 (36.4)</td>
<td></td>
<td>136 (37.0)</td>
<td></td>
</tr>
<tr>
<td>Over 65</td>
<td>104 (40.0)</td>
<td></td>
<td>19 (22.9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>138 (53.1)</td>
<td></td>
<td>32 (38.6)</td>
<td></td>
</tr>
<tr>
<td>All Ages*</td>
<td>4600 (68.2)</td>
<td></td>
<td>701 (57.6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2081 (30.8)</td>
<td></td>
<td>403 (33.1)</td>
<td></td>
</tr>
</tbody>
</table>

|                     | Semi-Retired |   | Semi-Retired |   |
|                     | n (%)        |   | n (%)        |   |
| 18-34                | 2 (0.1)      |   | 0 (0.0)      |   |
| 35-44                | 2 (0.1)      |   | 2 (0.8)      |   |
| 45-54                | 5 (0.3)      |   | 3 (0.9)      |   |
| 55-64                | 29 (2.3)     |   | 26 (7.1)     |   |
| Over 65              | 18 (6.9)     |   | 20 (24.1)    |   |
| All Ages*            | 68 (1.0)     |   | 53 (4.2)     |   |

|                     | Not Employed |
|                     | n (%)        |
| 18-34                | 5 (2.8)      |
| 35-44                | 11 (4.3)     |
| 45-54                | 10 (3.1)     |
| 55-64                | 20 (5.4)     |
| Over 65              | 12 (14.5)    |
| All Ages*            | 59 (4.9)     |

*Includes respondents whose age was not reported.
Reasons for not working as a dental hygienist at three points in time.

<table>
<thead>
<tr>
<th>Voluntary reasons for not working:</th>
<th>Week of November 9, 2020 (n=41)</th>
<th>Week of March 1, 2021 (n=40)</th>
<th>Week of August 16, 2021 (n=43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not want to work as a dental hygienist until after the COVID-19 pandemic is under control</td>
<td>25 (61.0)</td>
<td>19 (47.5)</td>
<td>13 (30.2)</td>
</tr>
<tr>
<td>I have concerns about my employer's adherence to workplace/safety standards</td>
<td>13 (31.7)</td>
<td>11 (27.5)</td>
<td>9 (20.9)</td>
</tr>
<tr>
<td>I have insufficient childcare available while working</td>
<td>10 (24.4)</td>
<td>10 (25.0)</td>
<td>5 (11.6)</td>
</tr>
<tr>
<td>I have an underlying health condition</td>
<td>10 (24.4)</td>
<td>5 (12.5)</td>
<td>6 (14.0)</td>
</tr>
<tr>
<td>Someone in my household has an underlying health condition</td>
<td>7 (17.1)</td>
<td>8 (20.0)</td>
<td>7 (16.3)</td>
</tr>
<tr>
<td>I do not want to work as a dental hygienist any longer</td>
<td>4 (9.8)</td>
<td>5 (12.5)</td>
<td>6 (14.0)</td>
</tr>
<tr>
<td>I have retired from practicing dental hygiene</td>
<td>4 (9.8)</td>
<td>10 (25.0)</td>
<td>16 (37.2)</td>
</tr>
<tr>
<td>I am unable to tolerate wearing a mask or other PPE</td>
<td>4 (9.8)</td>
<td>2 (5.0)</td>
<td>6 (14.0)</td>
</tr>
<tr>
<td>I have accepted a non-dental hygienist position</td>
<td>3 (7.3)</td>
<td>5 (12.5)</td>
<td>6 (14.0)</td>
</tr>
<tr>
<td>My employer reduced my salary too much</td>
<td>3 (7.3)</td>
<td>1 (2.5)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>I have moved to another state and am not licensed as a dental hygienist yet</td>
<td>1 (2.4)</td>
<td>0 (0.0)</td>
<td>3 (7.0)</td>
</tr>
<tr>
<td>I do not want to work as a dental hygienist until I receive the COVID-19 vaccine</td>
<td>n/a</td>
<td>13 (32.5)</td>
<td>1 (2.3)</td>
</tr>
<tr>
<td>Other reason</td>
<td>1 (2.4)</td>
<td>3 (7.5)</td>
<td>(3) 7.0</td>
</tr>
<tr>
<td>I prefer not to say</td>
<td>1 (2.4)</td>
<td>0 (0.0)</td>
<td>1 (2.3)</td>
</tr>
</tbody>
</table>
Key Takeaways

The pandemic has resulted in a voluntary contraction of the dental hygiene workforce by ~3.75% or ~7,500. Dentists still reporting extremely challenging to fill vacant positions.

1.6% indicated they had either retired or no longer wanted to work clinically, which could represent a permanent reduction in the workforce of close to 3,300 dental hygienists.

Non-adherence to CDC infection control guidance and COVID-19 protocols is of concern to dental hygienists and contributes to the decision about continued employment.

Recommendations for recruiting and retaining dental hygienists have included addressing reasons for dissatisfaction including workplace safety and compensation.
Current Status
Dental Workforce
Shortages:
Data to Navigate
Today’s Labor Market

What keeps dental assistants and dental hygienists satisfied in their roles?

What workplace conditions are to blame for dental assistants and dental hygienists leaving their positions?

What levers are available to recruit and retain a high quality dental workforce?

ADA.org/HPI
Why This Matters

Have you recently or are you currently recruiting any of the following positions in your dental practice? (Percentages indicating “yes.”)

- **37.7%** Dental assistants
- **36.4%** Dental hygienists
- **26.8%** Administrative staff
- **14.0%** Dentists

In any given month, roughly 4 out of 10 dental practices are hiring dental assistants or dental hygienists.
What the New Report Tells Us

- Approximately one-third of the dental assistant (33.7%) and dental hygienist (31.4%) workforce indicate they expect to retire in five years or less.
- The majority of dental assistants and dental hygienists are satisfied in their current job.
- Roughly half of dental assistants and dental hygienists indicate they have received a raise within the past year. The majority of wage increases are in the 1-3% range.
- The majority of dental assistants and dental hygienists indicated that they receive dental benefits, paid holidays, paid vacation, and retirement savings from their employers. Health insurance, paid sick time, paid leave, and continuing education or professional development funds are rare overall. These benefits matter for recruitment and retention.
- Factors associated with retention include work-life balance, positive workplace culture, and ability to help patients.
- Factors associated with attrition include negative workplace culture, insufficient pay, lack of growth opportunity, inadequate benefits, and feeling overworked.
The majority of currently employed dental assistants and dental hygienists indicate they are satisfied in their role.

Fewer than 1 in 10 indicate a low level of satisfaction.
A lesser share of dental service organization (DSO) employees and part-time employees indicate high job satisfaction.
The majority of dental assistants and dental hygienists receive dental benefits, paid holidays, paid vacation, and retirement savings.

Health insurance, paid sick time, paid leave, and continuing education or professional development funds are much less common.
Group Settings Offer More Benefits

Share of dental hygienists receiving select workplace benefits by practice type

Health insurance, paid sick time, paid leave, and continuing education or professional development funds – while rare overall – are available to the majority of dental hygienists working in public health settings.

These benefits are also more common in DSOs and group practices than in private solo practices.
Why Health Insurance Isn’t More Common

Dentists' reasons for not offering health insurance

- Too costly: 83.1%
- Staff has other source of coverage: 15.5%
- Not the industry norm: 13.3%
- Don't know how/unfamiliar with vendors: 9.9%
- Don't feel it's my obligation: 6.3%
- Don't feel it's important: 0.7%

Dentists' reasons for not offering paid leave

- Too costly: 68.6%
- Not the industry norm: 30.9%
- Don't feel it's my obligation: 29.4%
- Don't know how/unfamiliar with vendors: 7.7%
- Decreases productivity / Cannot operate: 4.1%
- Don't feel it's important: 2.1%

Dentists who do not offer their employees health insurance were asked why, and the overwhelming majority indicated cost as a reason.

While cost was also the predominant reason among dentists not offering paid leave, nearly 1 in 3 also indicated that they do not offer the benefit because it is not the industry norm and/or not their obligation.
Leaving the Field Voluntarily

The most common reasons dental hygienists opt to leave the field include negative workplace culture, lack of growth opportunity, and inadequate benefits.

The most common reasons among dental assistants were insufficient pay, negative workplace culture, and feeling overworked.
Considerations for Dental Employers

- Dental practices need to remain competitive as employers when it comes to employee benefits.
- Responsive compensation is a must.
- Workplace culture cannot be overlooked.
- Consolidated dental practices have an edge when it comes to employee benefits.
- Shoring up the workforce pipeline will require long-term changes.
There’s More…
What We Knew in 2016

Dental hygienists reported workplace concerns including lack of employment benefits, inadequate appointment scheduling, low wages and dissatisfaction with office culture.

37% cited lack of respect for dental hygienists in the workplace.

32% reported concern over having to clock out when a patient canceled an appointment.
What We Knew in 2019 Pre-Pandemic

43% were considering seeking a new job within the next year due to not feeling respected or valued and not receiving compensation that was acceptable.
Dental practices are contending with less busy schedules and lower patient demand.

A recent ADA HPI poll of 1200 dentists indicated that 82% reported that no-shows and cancellations with less than 24 hours notice were the largest factors preventing appointing schedules from reaching 100%.

The second most common reason for unfilled schedules was patient volume. 46% of respondents stated that not enough patients are making appointments.
Shortage of Dentists
Dentist-reported staffing shortages have resulting in an estimated **11% decrease** in practice capacity. The exit of older dentists from the workforce may accelerate the “de-aging” trend of the dentist population. Younger dentists tend to have different practice patterns than older dentists, such as less practice ownership and more affiliation with DSOs.

Retirement among dentists is on the rise for the first time in years. In 2021, 6,641 dentists over age 55 exited the workforce compared to 4,785 in 2017. While dentists entering the workforce continue to outnumber those exiting the workforce and the supply of dentists is expected to increase through 2040, the increase in dentist retirements is contributing to job losses in the dental sector.

ADA HPI reported that dental offices lost **1,500 jobs** from February to March 2022 according to the Bureau of Labor Statistics’ Current Employment Statistics report. The job count includes full and part-time dentists and non-dentist staff. This decline was the first experienced by the dental sector since April 2020.
Despite concerns about health professional shortage areas, HPI states that perceived cost of dental care is the greatest deterrent for why people do not go to the dentist, and that dental care is not a priority.

Marko Vujicic, Chief Economist and VP of ADA HPI, offers comment that that workforce adequacy is not the issue. This is counterintuitive in health policy circles which argue that lack of providers is the key barrier. He offers two solutions: reduce the cost of care or change people’s perceived benefit of care.
Solutions
Solutions – Dental Assistants

Open more schools with early recruitment

Promote a positive workplace culture

Provide a balanced work schedule

Increase benefits
Solutions – Dental Hygienists

Increase in Communication

Creating a workplace culture that is supportive, open, and respectful

Provide opportunities for growth and innovation

Increase benefits
Solutions – Dentists

Revisit where dental students choose to practice

Educate on the difference between collaboration versus control

Immerse dental students in community and public health

Prepare for change
Thank You
Small Group Discussions

10 minutes

• Reflect on what you heard today - any surprises? Does this ring true to your experiences?
  • What solutions stood out to you?
• How can you, your practice, or the Coalition as a whole take steps to move the needle on this issue?
The Council of State Governments

Founded in 1933 at the University of Chicago.

Scope
The nation’s only organization serving all three branches of state government

Membership
CSG is a region-based membership organization that fosters the exchange of insights and ideas to help state officials shape public policy

Mission
Champion excellence in state governments in order to advance the common good

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National Center for Interstate Compacts (NCIC)

- Exists within The CSG Center of Innovation

- Seeks to help states work cooperatively to solve mutual issues and meet shared goals

- Serves as an:
  1. Information clearinghouse
  2. Provider of training and technical assistance
  3. Primary facilitator for assisting states in the review, revision and creation of new interstate compacts
What is an interstate compact?

A legal, legislatively enacted contract between two or more states that allows states to:

#1 Address shared problems

#2 Maintain state sovereignty

#3 Respond to national priorities
Occupational Licensing Interstate Compacts

Facilitate Multistate Practice
Maintain or Improve Public Health and Safety
Preserve State Authority Over Professional Licensing

45 states (+ DC, Guam, USVI) have adopted at least 1 compact.
35 states (+ DC) have adopted at least 3 compacts.
230 pieces of occupational licensure compact legislation have been enacted since January 2016.
9 professions have active interstate compacts for occupational licensing.
Active Occupational Licensing Interstate Compacts

- Nurse Licensure Compact – 39
- Medical Licensure Compact – 39
- Psychology Interjurisdictional Compact – 34
- Physical Therapy Compact – 34
- Audiology and Speech Language Pathology Compact – 23
- Occupational Therapy Compact – 22
- EMS Compact – 22
- Counseling Compact – 17
- Advanced Practice Nursing Compact – 3
Occupational Licensing Interstate Compacts Under Development

- Cosmetology
- PA
- Dentistry and Dental Hygiene
- Social Work
- Massage Therapy
- K-12 Teaching
- School Psychologists
- Dietitians
# Compact Development Process

<table>
<thead>
<tr>
<th>Phase I</th>
<th>Phase II</th>
<th>Phase III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development</td>
<td>Education and Enactment</td>
<td>Transition and Operation</td>
</tr>
</tbody>
</table>

## TECHNICAL ASSISTANCE GROUP
- Composed of approximately 20 state officials, stakeholders and issue experts
- Examines issues, current policy, best practices and alternative structures
- Establishes recommendations as to the content of an interstate compact

## COMPACT DOCUMENT TEAM
- Composed of 5 to 8 state officials, stakeholders, and issue experts
- Crafts compact based on Technical Assistance Group recommendations
- Circulates draft compact to states and stakeholder groups for comment

## FINAL PRODUCT
- Drafting team considers comments and incorporates into compact
- Final product sent to TA group
- Released to states for consideration

## EDUCATION
- Develop comprehensive legislative resource kit
- Develop informational website with state-by-state tracking and support documents
- Convene “National Briefing” to educate legislators and key state officials

## STATE SUPPORT
- Develop network of “champions”
- Provide on-site technical support and assistance
- Provide informational testimony to legislative committees

## STATE ENACTMENTS
- Track and support state enactments
- Prepare for transition and implementation of compact
- Provide requested support as needed

## TRANSITION
- Enactment threshold met
- State notification
- Interim Executive Board appointed
- Interim Committee’s established
- Convene first Compact meeting
- Information system development (standards, security, vendors)

## OPERATION
- Ongoing state control and governance
- Staff support
- Annual assessment, if necessary
- Annual business meeting
- Information system oversight (maintenance, security, training, etc.)
- Long-term enhancements / up-grades
Public Review

1. Draft compact circulated for public comment
2. Virtual meetings to review provisions of the compact
3. Provide comments and feedback through survey
4. Document Team considers feedback and edits the compact as needed
5. Released to states for consideration and enactment
OVERVIEW OF DENTIST AND DENTAL HYGIENIST COMPACT
# Commonly Used Terms

<table>
<thead>
<tr>
<th>DDH Licensing Compact Defined Term</th>
<th>What does it mean?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating State</td>
<td>A state that has enacted the compact</td>
</tr>
<tr>
<td>Qualifying License</td>
<td>An active and unencumbered license issued by a Participating State</td>
</tr>
<tr>
<td>Remote State</td>
<td>A Participating State where a Licensee is not licensed and is seeking to practice via a compact privilege</td>
</tr>
<tr>
<td>Compact Privilege</td>
<td>Authorization granted to practice in a single Remote State</td>
</tr>
<tr>
<td>Compact Commission or Commission</td>
<td>Joint government agency made up of all Participating States who is responsible for administering the compact</td>
</tr>
</tbody>
</table>
Interstate Licensure Compacts

0 compacts | 1-3 compacts | 4-5 compacts | 6+ compacts

*Information as of May 2022

CSG The Council of State Governments
A dentist or dental hygienist holds an active, unencumbered license in a compact state.

The practitioner applies for a compact privilege.

The practitioner undergoes an FBI background check.

The practitioner’s license and eligibility are verified.

The practitioner pays fees and completes jurisprudence requirements.

The commission issues the compact privilege on behalf of the remote state.

The practitioner now has legal authorization to practice in the remote state where they hold a compact privilege.
Holding a qualifying license in a participating state punches your ticket to obtain compact privileges in remote states.
Key State Requirements to Join the Compact

1. Utilize the National Board Examinations of the Joint Commission on National Dental Examinations as a requirement for licensure.

2. Require for licensure that applicants graduate from a predoctoral dental education program, leading to the D.D.S. or D.M.D. degree, or a dental hygiene education program accredited by the Commission on Dental Accreditation.

3. Require for licensure successful completion of a clinical assessment.
Key State Requirements to Join the Compact

- Implement procedures for conducting a Criminal Background Check
- Have Continuing Professional Development requirements as a condition for license renewal
- Pay participation fee
Key Practitioner Requirements to be Eligible for a Compact Privilege

- Hold a qualifying license issued by a participating state
- Have passed a National Board Examinations of the Joint Commission on National Dental Examinations
- Have graduated from a predoctoral dental education program, leading to the D.D.S. or D.M.D. degree, or a dental hygiene education program accredited by the Commission on Dental Accreditation
Key Practitioner Requirements to be Eligible for a Compact Privilege

- Successful completion of a clinical assessment
- Meet any jurisprudence requirements established by the remote state where the licensee is seeking a compact privilege
- Pay applicable fees to commission and remote state
BENEFITS OF DENTISTS AND DENTAL HYGIENISTS LICENSING COMPACT FOR LICENSEES:
- Facilitates multistate practice.
- Enhances license portability when changing state of residence.
- Expands employment opportunities into new markets.
- Improves continuity of care when patients or providers relocate.
- Supports relocating military spouses.
- Reduces burden of maintaining multiple licenses.

BENEFITS OF DENTISTS AND DENTAL HYGIENISTS LICENSING COMPACT FOR REGULATORS:
- Reduces administrative burden.
- Facilitates practitioner mobility during public health emergencies.
- Ensures retention of jurisdiction over practitioners working in their state.
- Expands state licensure board cooperation on investigations and disputes.
- Enhances public safety through shared data system.

BENEFITS OF DENTISTS AND DENTAL HYGIENISTS LICENSING COMPACT FOR STATES:
- Promotes workforce development and strengthens labor markets.
- Expands consumer access to highly qualified practitioners.
- Preserves state sovereignty.
- Increases collaboration among states.
Next Steps

Comacts.CSG.org/Compact-Updates/Dentistry-and-Dental-Hygiene

Video available on website

Review and edit compact as necessary by the Technical Assistance Group and Document Team

Compact model language out to states to be considered for enactment
QUESTIONS?

- General Inquiries: dentalcompact@csg.org
- Jessica Thomas: jthomas@csg.org
KOHC 2023 Projects and Initiatives

• Translation of materials for increased accessibility

• Monitoring implementation of expanded adult Medicaid dental benefits

• Oral health landscape assessment
Lunch
2023 Policy Priorities

Protect community water fluoridation programs

Kentucky Oral Health Coalition
KOHC
For a lifetime of oral health
2023 Policy Priorities

Establish a statewide tobacco retail license

Kentucky Oral Health Coalition

For a lifetime of oral health
2023 Policy Priorities

Support mental health needs of new mothers

Kentucky Oral Health Coalition
KOHC
For a lifetime of oral health
2023 Policy Priorities

Support efforts to positively impact the dental workforce
Questions?
Virtual and In-Person Advocacy Events, February 6-10, 2023
Day at the Capitol, February 8  9:00-2:00 PM

Throughout the week, Kentuckians will be stepping up for kids by participating in policy forums, conversations with decision-makers, and more.

Join us in making Kentucky the best place to be a kid!

Visit kyyouth.org/childrens-advocacy-week/ or scan here to learn more!
Where to connect with KOHC online

Website
• Kyoralhealthcoalition.org

Twitter
• @KYOralHealth

Facebook
• Kentucky Oral Health Coalition
Voting

Current KOHC members only

Please use the voting cards provided to indicate your vote
Vote #1

Protect community water fluoridation programs

Kentucky Oral Health Coalition

For a lifetime of oral health
Vote #2

Establish a statewide tobacco retail license
Vote #3

Support mental health needs of new mothers
Vote #4

Support efforts to positively impact the dental workforce
Questions?
Thank you!

Jennifer Hasch, Registered Dental Hygienist
KOHC steering committee member
Thank you for joining us!

This meeting was hosted by:

Kentucky Oral Health Coalition

For a lifetime of oral health

To learn more about KOHC and become a member, please visit www.kyoralhealthcoalition.org