

**Testimony**  
**Health Services Committee**  
**Wednesday, July 30, 2014 – 9:20 a.m.**  
**North Dakota Department of Health**

Good morning, Madam Chair and members of the Health Services Committee. My name is Kimberlie Yineman and I am the Director of the Oral Health Program for the North Dakota Department of Health (NDDoH). I am here today to provide testimony regarding the potential for local public health units to support the provision of dental services, especially in rural areas of the state, and reintroduction of basic dental health prevention services in schools, including an estimated cost and resources available to provide the services. Mary Amundson, who represents the North Dakota Department of Health as the director of the primary care office, will testify on the dental loan repayment program limits and the potential for expansion, as well as options to improve access to dental services and the use of incentives for dental providers.

Currently, the majority of local public health unit nurses are applying fluoride varnish to children's teeth (as authorized by 2007 legislation). An opportunity to provide additional dental services in local public health units could be utilized through regional public health networks. North Dakota Century Code 23-35-1 authorizes local public health units to form public health regional networks through joint powers agreements (JPA). The 2013 Legislative Assembly appropriated funding for the purposes of planning and/or establishing a regional public health network. The North Dakota Century Code requires that a JPA, along with a work plan, describe shared or expanded services, including core public health activities. The core activities include: 1) prevent epidemics and spread of disease; 2) protect against environmental hazards; 3) prevent injuries; 4) promote health behaviors; 5) respond to disasters; and 6) assure the quality and accessibility of health services.

As a result of the state-appropriated funding and Bush Foundation funding, four regional networks will be established by June 30, 2015. The four networks encompass 24 of the 28 local public health units. The local public health units not included are Bismarck Burleigh Department of Health, First District Health Unit, Upper Missouri District Health Unit, and Southwestern District Health Unit.

Public health regional networks are an efficient and effective model for delivering public health services because they can increase capacity through collaboration and sharing of services and resources. Therefore, there is great potential for local public health networks to provide additional dental health services beyond the scope of what public health nurses currently provide (fluoride varnish applications). Public health regional networks could collaborate and/or contract with dental offices to have hygienists provide services within local public health units including screenings, dental sealants and teeth cleanings. Logistics regarding billing for services would need to be addressed.

In previous testimony, we reported that federal funding to support our school-based fluoride varnish and dental sealant prevention service programs had not been reinstated in 2013. When the program was fully funded, it provided services to almost 1,700 students in more than 50 schools statewide in the 2011 to 2013 school years. This was reduced to less than 100 students in two schools in the 2013-2014 school year. However, we have recently received notification that federal funding may become available to re-establish our school-based dental health prevention service programs for the next three years. We are confident that the documentation required to secure this funding will be approved, and we anticipate funding will be awarded by September 1, 2014.

Assuming the federal funding is received as anticipated, in the first year of the grant, four public health hygienist positions that were previously eliminated will need to be filled, and appropriate supplies will need to be ordered. Funding will be adequate to support these positions and purchase supplies to continue services to the previously participating schools. Current school participation criteria require that 50 percent or greater of the student population qualify for the free and reduced-fee school lunch program.

In years two and three of the grant, we have requested funding to expand the school-based dental health prevention service programs to schools with 45 percent or greater of their student population on the free and reduced-fee school lunch program. Funding would also be used to support services in rural schools in underserved areas of the state. Furthermore, additional funding would allow the

re-establishment of contracts with the Ronald McDonald Care Mobile and Bridging the Dental Gap to increase services in rural and tribal communities.

The federal grant, if awarded, is only guaranteed for three years. We estimate that funding to maintain staffing and operating expenses for school-based dental health prevention service programs that target high risk and underserved students/schools would cost approximately \$450,000 annually.

This concludes my presentation. I am happy to answer any questions you may have.