PAUL R. LEPAGE
GOVERNOR

STATE OF MAINE
BOARD OF DENTAL PRACTICE
143 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0143

April 28, 2017

Senator Amy Volk, Senate Chair
Representative Ryan Fecteau, House Chair
Joint Standing Committee on Labor, Commerce, Research and Economic Development
100 State House Station
Augusta, ME 04333-0100

Dear Senator Volk and Representative Fecteau, and Members of the Committee:

Enclosed is the "Report of the Maine Board of Dental Practice" submitted to you pursuant to Public Law 2016, c. 429. The law, in part, required the Board of Dental Practice ("Board") to conduct a study of the Maine Revised Statutes, Title 32, chapter 143 and any rules adopted by the Board and recommend changes to the scopes of practice of dental practitioners, practice settings and delivery models, and any other dental practice issues.

The Board enlisted the assistance of stakeholders and formed an ad hoc committee to help identify the various practice issues. To that end, this report provides a comprehensive record of data collected, resource information reviewed, and practice issues discussed by participants at the ad hoc committee meetings over the course of three meetings. This report also reflects specific actions voted on by the Board of Dental Practice in consideration of the issues brought forward by the ad hoc committee at its April 14, 2017 meeting.

The Board's recommendations are identified into three categories – statutory changes, rulemaking changes, and regulatory practice issues needing further consideration. It is important to note here that neither statutory changes, nor rulemaking proceedings alone will solve all of the complex issues in providing accessible dental services in Maine. However, the Board believes that this effort demonstrates a clear commitment of all involved to move beyond tensions and conflicts of the past. The Board is hopeful that this report will continue a dialogue of the challenges and best practices in the delivery of dental services to ensure the safety and protection of Maine's public.

Again, thank you for giving the Board the opportunity to report back to you and we look forward to next steps as deemed appropriate.

Respectfully submitted,

Geraldine A. Schneider, DMD
Board Chairperson

PHONE: (207) 287-3333
FAX: (207) 287-8140

WEBSITE ADDRESS: www.maine.gov/dental
E-MAIL ADDRESS: dental.board@maine.gov

STATE OF MAINE
BOARD OF DENTAL PRACTICE
143 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0143

Report of the Board of Dental Practice

Submitted to the

Joint Standing Committee on
Labor, Commerce, Research and Economic Development

Pursuant to Public Law 2016, c. 429

Directing the Board of Dental Practice to Study and Recommend Changes to Laws and Rules Governing Dental Practice

April 28, 2017

Board's Report Pursuant to Public Law 2016, c. 429

Public Law 2016, c. 429, enacted by the 127th Legislature, directs the Board of Dental Practice, "… in consultation with interested parties to conduct a study of the Maine Revised Statutes, Title 32, chapter 143 and any rules adopted by the board and recommend changes..". The legislative language appears below.

"An Act To Revise the Laws Regarding Dental Practices"

Sec. 25. Board of Dental Practice to study the dental practice laws and recommend changes. The Board of Dental Practice, in consultation with interested parties, shall conduct a study of the Maine Revised Statutes, Title 32, chapter 143 and any rules adopted by the board and recommend changes to the scopes of practice of dental practitioners, practice settings and delivery models and any other dental practice issues. The board shall report its recommendations to the joint standing committee of the Legislature having jurisdiction over labor, commerce, research and economic development matters on or before March 1, 2017. The joint standing committee may report out a bill to the Second Regular Session of the 128th Legislature related to the board's report.

.

Public Law Background

LD 1596 "*An Act to Revise the Laws Regarding Dental Practices"* was considered by the Joint Standing Committee on Labor, Commerce, Research and Economic Development ("Committee") during the Second Regular Session of the 127th Maine Legislature. The bill was submitted at the request of the Board of Dental Practice ("Board") in an effort to streamline the licensing provisions, scopes of practice provisions, and administrative provisions. More specifically, the Board requested that the Committee not move forward on various legislative initiatives to allow the Board time to conduct a comprehensive review of its existing statutes and rules.

Given the complexity of the initiatives involved, the Committee agreed to split the effort into two distinct review processes. The review processes, more commonly referred to as "Phase I" and "Phase II" were subsequently identified. The goal of Phase I was to streamline certain provisions of the Dental Practice Act. The goal of Phase II was to study and report back recommendations regarding certain dental practice issues not addressed in Phase I. LD 1596 successfully met the goal of Phase I, and it also required the Board to begin the work on Phase II.

An ad hoc committee was identified and convened by the Board. Participants of the ad hoc committee included licensed dentists practicing in private dental office settings, community health settings, federally qualified health centers, and a dentist representing a dental education program in Maine; licensed dental hygienists practicing independently, in a non-profit/hospital clinic, in public health supervision settings, in private dental office settings, and a dental hygienist representing a dental hygiene education programs, a licensed expanded function

dental assistant/certified dental assistant, and two licensed denturists. Two members of the Board served as co-chairs, and the Board's Executive Director provided staffing resources to the committee. **(Appendix 1)**

Board Objective - Role of the Ad Hoc Committee

The Board's objective of Phase II was to identify, discuss, and report recommendations to the Committee. The Board utilized the ad hoc committee as a resource to help identify regulatory barriers impacting the delivery of dental services such as scope of practice restrictions/expansions, evolving business models of dental services, coordination of care among dental providers in various practice settings, etc. Below are categories of practice areas that were distributed to committee participants for their consideration:

1) **Dental Practice Settings/Delivery Models**: Over the years, dental practice settings and various delivery models of dental care have evolved to respond to the dental needs of Maine's citizens. In addition to private practice dental offices, Maine's delivery systems of dental care includes settings such as corporate dental offices, non-profit clinics, clinics associated with hospitals, clinics associated with a dental school, volunteer/free dental clinic events, a dental hygiene clinic, school based programs, nursing home services, public health services, independent practice of hygienists, denturist practices, and business ventures involving dentists, dental hygienists, and denturists.

   The current Dental Practice Act does not contemplate such changes, and consequently it is either silent on the issues, or appears to restrict certain practices in certain settings. Below is a list identified by the Board and distributed to the ad hoc committee:

2) **Dental Hygienists**: There are five different scopes of practice when providing dental hygiene services. They include private dental practice setting with a supervising dentist, public health supervision, independent practice, and dental hygiene therapy. Depending upon the level of supervision, dental hygienists can also administer local anesthesia and nitrous oxide, as well as perform expanded procedures if they are also licensed as an expanded function dental assistant.

   The current statute does not contemplate utilizing the services of the various RDH scopes of practice in the different settings. For example, the Board is often asked whether an RDH working for a dentist could volunteer or work on a limited basis in a school setting to help administer a school nurse grant program to provide fluoride varnish. Additionally, the statute does not clarify whether or not independently practicing dental hygienists can work in a private dental office per diem, or as a separate provider.

3) **Dentists/Dental Faculty/Dental Externs**: The current statute does not regulate businesses, yet the growth of corporate dentistry and other business practice models raises practice questions regarding proper treatment planning and responsibility for

maintaining/retaining patient records. Also, the current statute does not clarify or define tele-dentistry, or clarify the use of dermal fillers for non-dentally related procedures.

The current statute identifies several different types of dentist licensure (charitable, limited, temporary, clinical educator, etc. and exploring the possibility of identifying a licensure category as an alternative is worth exploring.

The Board has seen an increase in dental faculty applications and the issue has been raised that the current statute limits the dental school's ability to recruit qualified dentists to the school setting. The qualifications for faculty licensure require that the individual be licensed in another state/province in order to qualify in Maine. There are prospective faculty employees who are foreign trained and may not necessarily qualify for full licensure in Maine, so they obtain the faculty license as a pathway to practice.

Dental extern students are required to apply to the Board to practice under the supervision of a Maine licensed dentist to perform dentistry under the auspices of the dental school. There is relative consensus to consider eliminating the externship category, as the supervising dentist is already regulated and the student falls under the governance of the educational institution.

4) **Teeth whitening**: The current statute identifies teeth whitening as an authorized procedure in the denturist scope of practice. However, it begs the question as to whether or not the legislature intends to regulate teeth whitening or not, as the procedure is not listed under the other scopes of practice identified in statute.

5) **List of practice procedures / delegation authority**: To list, or not to list - that is the question. The current statute enumerates authorized procedures for dental hygienists, expanded function dental assisting, and procedures authorized by a dentist to delegate to an "unlicensed person" (a/k/a dental assistants). The other consideration is whether or not creating a license category for dental assistants is needed to protect the public, or to continue to allow dentists to delegate. Dental hygienists and denturists have also expressed an interest in allowing the delegation of their scope to an "unlicensed person" to be authorized in statute.

   There are other sections of the statute that capture the essence or principles of a particular practice without listing specific procedures such as the dentist scope of practice, independent practice dental hygienist scope of practice, public health supervision, dental hygiene therapy, and denturism.

   The Board is aware that the list of authorized procedures is not helpful to the regulated community as the list is antiquated, and does not necessarily reflect actual practice in the various dental settings. The Board has shifted away from writing rules and managing "who-can-do-what procedure" toward creating a statutory framework that reflects an authorized scope of practice based on education, examination and training.

6) **<u>Minimum patient care standards for all licensees</u>**: Current statute and board rules are not consistent with identifying standards for any licensee of the Board such as informed consent, blood pressure readings, dismissal of a patient, selection of dental radiographs, infection control, recordkeeping, listings of medications, employee training and certification requirements, etc.

Ad Hoc Committee Process and Discussions

The ad hoc committee convened in public session on December 2, 2016, January 20, 2017, and March 3, 2017 from 9:00 a.m. to 12:00 p.m. Meeting materials were distributed to participants in advance to the extent practicable, and meeting notes were recorded for each meeting. **(Appendices 2, 3, and 4)**

Additional time was spent at the ad hoc committee meetings clarifying the Board's role and responsibilities in light of recent changes to its organizational structure, its role in substantive policy discussions, and the new dental practice act. The role of the Board is to implement legislation (policy) and adopt rules to further clarify intent of legislative policy. Further clarification was provided that substantive policy issues are to be decided by the Legislature and/or the Office of the Governor, not the Board. The purpose of the Board is to protect the public, not the interests of the various professions.

Ground rules were provided at the beginning of each meeting. Each participant was given an opportunity to express their interests and/or concerns regarding the work of the ad hoc committee. Complete comments and meetings notes are available in the "Draft Report of the Ad Hoc Committee" document dated March 6, 2017. (**Appendix 5)** Highlights of the ad hoc committee discussions are noted below:

1) **<u>RDH practice issues</u>**:

   a) Confusion among those who practice as IPDH and PHS.
   b) Transferability of scopes from one practice setting to another.
   c) Expand the scope of RDH to include all of the practice types such as independent practice, public health, etc. instead of requiring separate qualifications.
   d) Reporting requirements are overly restrictive in PHS practice.
   e) Believes in accountability but to streamline the requirements such that it does not restrict a licensee's ability to practice.
   f) Stressed importance of dentist agreements with PHS practice.
   g) Believes that IPDH who practice public health should practice with dentist agreements.
   h) Agrees that there is confusion between IPDH and PHS practice and issue of "patient of record."
   i) Recommends tweaking the language of dental externs.
   j) Identify settings to practice without a dentist.
   k) Apply fluoride in facility settings without a supervising dentist.

2) **Dentist /dentist extern practice issues**:

a) Interested in clarifying dental student externship requirements.
b) Revisit the notion of "if not on the list of things authorized, then you can't do it."
c) Identified licensure challenges for foreign trained dentists seeking employment at UNE/licensure with the Board

3) **Denturist practice issues**:

a) Institute "DD" designation instead of "LD" for licensed denturists.
b) Allow denturists to delegate to denturist assistants and lab technicians under their employment.

4) **Delegation of duties to dental assistants or "unlicensed person"**:

a) Suggests another term be used other than "unlicensed person" as it currently appears in statute.
b) Suggests licensing of dental assistants based on infection control issues, risks to employees, and patients.
c) FQHC has oversight protections in place, but not private practice settings.
d) Regulating dental assistants will mandate the education and CPR requirements.
e) Examine delegated duties such as fluoride varnish and teeth whitening.

Subsequent recommendations and conclusions were reached by the ad hoc committee and reported to the Board. The recommendations identified as a statutory change, a board rulemaking change, or other considerations:

1) **Recommended Statutory Changes**

a) Licensure:
   i. Dental student externs – eliminate licensure/registration requirements
   ii. Denturist student externs – eliminate licensure/registration of externs, but create a "trainee permit" to allow individuals to gain clinical experience after completing denturism program in lieu of externship.
   iii. Dentist - create locum tenens licensure category and eliminate the various dentist license categories
   iv. Faculty dentist – eliminate requirement to be licensed in another state/province
   v. IPDH authority – revise requirements to streamline requirements regardless of degree earned; streamline hours and timeframe

b) Dental Hygiene scope of practice

i. RDH scope - replace list of procedures with principles of the practice of dental hygiene
ii. RDH scope – expand to allow placing of sealants under general supervision
iii. RDH scope – expand to allow administration of local anesthesia and nitrous oxide; eliminate requirement to hold separate permits
iv. IPDH – expand to allow supervision of dental radiographers

c) Delegation authority
   i. Denturists/Dental Hygienists – allow delegated duties to unlicensed persons

d) Owner identification – removable dental prosthesis
   i. Revise to reflect current technologies (i.e. digital scanning)

2) Issues Identified for Rulemaking Changes

a) Public Health Supervision
   a. Remove notification and reporting requirements
   b. Eliminate the requirement to screen for qualified services

b) Dentist training responsibilities when delegating to unlicensed persons

c) Standards of practice chapter that addresses baseline practice issues for all licensees such as medical records documentation, blood pressure readings, use of dental radiographs, informed consent, dismissal of a patient, storing and providing records, etc.

3) Issues Identified for Further Legislative Consideration

a) Teeth whitening
   i. Determine whether or not it should be a regulated dental procedure

b) Regulation of dental assistants
   i. Further review to consider whether a sunrise review process is necessary to ensure protection of the public given recent cases in other states involving infection control

c) List of authorized procedures
   i. Consider further refinements or alternative ways instead of listing what is authorized; perhaps list what is not authorized

Regulatory Context in Consideration of Ad Hoc Committee Work

In addition to the Board's purpose of protecting the public, the Dental Practice Act authorizes the Board to issue licenses to qualified applicants to practice in the following areas: dentistry;

denturism; dental hygiene and its various practice authorities such as independent practice dental hygiene, public health dental hygiene, and dental hygiene therapy; dental radiography; expanded function dental assisting; student externs; and licensees seeking to provide sedation and/or general anesthesia.

Public Law 2016, c. 429 not only streamlined the licensing categories, but it also clarified the scope of the Board's regulatory authority. The new law clarified that the Board does not regulate businesses or entities; rather it regulates individuals. Similarly, the new law clarified that it does not regulate dental assistants; rather it regulates dentists who are authorized to delegate certain duties to unlicensed persons.

However, the most significant change resulted when various scopes of practice for dental auxiliaries were removed from board rule, and placed into statute. This exercise resulted in an awareness of just how complicated the regulatory framework had become when attempting to respond to the changing ways of providing dental services in Maine. Consequently, the commitment made to conduct a Phase II review was not fully realized until the layers of the practice onion had been peeled.

While the efforts undertaken in the Phase I review were considered substantial, it became clear to the Board that its effort to resolve the remaining practice issues as part of a Phase II review was not realistic. Three meetings of an ad hoc committee, despite their dedication to their profession and willingness to assist the Board, was not sufficient time to identify all of the practice issues. As reported by participants of the ad hoc committee, the issue also includes accessing and competing for limited dental dollars within the dental provider community. A regulatory board alone cannot and should not attempt to address public health policy issues, or attempt to make regulatory policy recommendations regarding dental practice in a vacuum.

In conclusion, the Board took a realistic and practical approach to its Phase II review task, and believes there is more work to be done. Moreover, there might also be value in allowing some of the most recent changes to take full effect and reassess with ongoing collaboration among all stakeholders, not just the Board of Dental Practice. Below are the recommendations in light of the noted limitations and considerations in this section.

Board's Recommendations

This report identifies the following recommendations and/or actions for further review:

1) Statutory changes **(Appendix 6)**
    a. Licensing provisions
        i. Eliminate externship registration
        ii. Eliminate charitable dentist license, clinical dentist educator license
        iii. Add a visiting dentist license category
        iv. Add denturist trainee permit (provisional permit)

v. Revise IPDH requirements such that dental hygienists must complete 2,000 regardless of dental hygiene education level

b. Scopes of practice provisions
    i. Amend dental hygiene scope to eliminate list of procedures already duplicated under delegated duties
    ii. Amend dental hygiene scope to show principles of practice, not list of authorized procedures **(Appendix 7)**
    iii. Amend dental hygiene scope to include application of sealants and remove dentist determination
    iv. Amend expanded function dental assisting scope to eliminate list of procedures already duplicated under delegated duties
    v. Amend scope of IPDH to supervise dental radiographers

2) Board rulemaking proposed changes
    a. Chapter 2 – remove public health notification; screening requirements
    b. Identify standards that apply to all dental providers such as coordination of care, infection control, ionizing radiation control, recordkeeping, informed consent, etc.
    c. Identify minimum certification/training requirements when delegating duties to unlicensed persons
    d. Chapter 1 – revisit teledentistry definition

3) Issues for further review/discussion
    a. Sunrise review
        i. regulation of dental assistants
        ii. expansion of dental hygiene scope of practice to include nitrous oxide and/or local anesthesia
        iii. expansion of dentist scope of practice to include use of Botox and dermal fillers (non-dentally related procedures)
        iv. delegation authority of dental hygienists and denturists
    b. Alternative pathways for foreign trained applicants
    c. Remove requirement to be licensed in another state/province to qualify for faculty license
    d. Clarify regulation of teeth whitening; present in denturist scope but not others
    e. Consider supervision exemption language for volunteering services for certain procedures

If the committee wishes to pursue legislative changes, the Board would be happy to provide technical assistance and/or clarification regarding the recommendations.

List of Appendices

Maine Board of Dental Practice
Ad Hoc Committee
Phase II Statutory Review pursuant to Public Law 2016, c. 429
December 1, 2016

Tab 1: Introductions:

Ad Hoc Committee Members:

Dr. Lisa Howard, Board Vice Chair	Maine Board of Dental Practice
Nancy Foster, RDH, EFDA, EdM	Maine Board of Dental Practice
Dr. Jon Ryder, Dean	UNE, Dental School
Marji Harmer-Beem, RDH	UNE, Dental Hygiene Program
Amanda Willette, CDA, EFDA	University of Maine at Augusta
Tracey Jowett, IPDH	Public Health Supervision setting
Austin Carbone, LD	Maine Licensed Denturist Association
Paul Levassuer, LD	Maine Society of Denturists
Lorraine Klug, IPDH	Maine Dental Hygienists Association
Dr. David Pier	Maine Dental Association
Dr. James Schmidt	Non-profit dental clinic
Michelle Gallant, RDH	Public Health Supervision; hospital clinic
Dr. Marion Hernon	FQHC

Staff:

Penny Vaillancourt, Executive Director	Maine Board of Dental Practice
Legal counsel	Attorney General's Office

Tab 2: Timeline, meeting schedule, ground rules, etc.

- Board to report back to legislature by March 1, 2017.
- Ad Hoc Committee schedule (9 a.m. – 12 p.m.):
    - Friday, December 2nd
    - Friday, January 20th
    - Friday, February 17th
    - Friday, March 3rd

Tab 3: Review statutory mandate; role of the ad hoc committee

Section 25 of PL 2016, c.429 reads: "**Board of Dental Practice to study the dental practice laws and recommend changes.** The Board of Dental Practice, in consultation with interested parties, shall conduct a study of the Maine Revised Statutes, Title 32, chapter 143 and any rules adopted by the board and recommend changes to the scopes of practice of dental practitioners, practice settings and delivery models and any other dental practice issues. The board shall report its recommendations to the joint standing committee of the Legislature having jurisdiction over labor, commerce, research and economic development matters on or before March 1, 2017. The joint standing committee may report out a bill to the Second Regular Session of the 128th Legislature related to the board's report.

Tab 4: Overview of the new Dental Practice Act

- PowerPoint presentation
- Informational Letters

Tab 5: Scope of review (statutes and rules)

- Scopes of practice
- Practice settings
- Delivery models
- Other issues

Tab 6: Reference materials provided

- Maine Dental Practice Act
- Board Rules
- 32 M.R.S. §60-J thru L –Sunrise Review Procedures
- 3 M.R.S. §951 et seq. - State Government Evaluation Act
- American Association of Dental Board's 2016 Composite Book (reference only, not for distribution at this time due to copyright)
- Practice issues identified by Board

Tab 7: Discussion/Next Steps

MAINE BOARD OF DENTAL PRACTICE
Phase II – Ad Hoc Committee – Reference Sheet
December 2, 2016

Participants:

Dr. Lisa Howard, Board Vice Chair	MBDP
Alternate: Dr. Geraldine Schneider, Board Chair	
Nancy Foster, RDH, EFDA, EdM	MBDP
Dr. Jon Ryder, Dean	UNE, Dental School
Alternate: Dr. Rachel King	
Marji Harmer-Beem, RDH	UNE, Dental Hygiene Program
Amanda Willette, CDA, EFDA	UMA
Tracey Jowett, IPDH	PHS
Austin Carbone, LD	Denturist Association
Paul Levassuer, LD	Denturist Society
Lorraine Klug, IPDH	MHDA
Dr. David Pier	MDA
Alternate: Dr. Kristina Lake Harriman	
Dr. James Schmidt	Non-profit dental clinic
Michelle Gallant, RDH	PHS; hospital clinic
Dr. Marion Hernon	FQHC

Staff:

Penny Vaillancourt, Executive Director	MBDP
Legal counsel	Attorney General's Office

Meeting Dates:

Friday, December 2nd
Friday, January 20th
Friday, February 17th
Friday, March 3rd

Background:

During the 127th Second Regular Session, the Board of Dental Practice provided testimony on a variety of legislative initiatives that were before the Joint Standing Committee on Labor, Commerce, Research and Economic Development with the recommendation to approach various practice issues in two phases. The first phase was to repeal and replace the Dental Practice Act and provide a statutory framework that makes clear the legislative intent and scope of the Board's work. Phase II was to further examine the Board's statutes and rules and identify recommendations regarding practice issues, practice settings, delivery models for legislative consideration.

Objective:

The objective of the ad hoc committee is to review the Board's statutes and rules and identify issues related to scopes of practice, various practice settings, delivery models, etc. The work of the committee will be considered by the Board when it reports back to the Legislature in March of 2017.

Ground Rules:

1. • Hands to speak.

2. Minimize distractions. Side conversations, cell phones - try to be fully present as a group for the whole meeting.

3. Name tensions. Surely there are tensions and areas of disagreement. There are bound to be differences of opinion. Agree to disagree, respectfully.

4. Emphasize that this is not a forum to air grievances with the Board/Board staff – this is a focused effort. However, board staff will capture other topics in a "parking lot" list for the Board's review.

5. Audience decorum - discussion is among the ad hoc participants. Members of the audience can reach out to board staff by email or during a break if they have an issue, comment, etc.

6. Goal is to identify the issues, the committee is not being asked to provide solutions. The solutions are likely to be public policy decisions that are determined by the Legislature, not the Board.

7. Board staff to disseminate and collect information. This is a public process, so please do not REPLY ALL on email exchanges. Please direct your email to board staff and it will be disseminated to participants either in advance or at the next meeting.

PAUL R. LEPAGE
GOVERNOR

STATE OF MAINE
BOARD OF DENTAL PRACTICE
143 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0143

VIA Email: mharmerbeem@une.edu

November 29, 2016

Marji Harmer-Beem, M.S., RDH
Interim Director for Dental Hygiene
University of New England

Re: Phase II – Statutory Review Consultation Pursuant to Public Law 2016, c. 429

Dear Ms. Harmer-Beem:

Please accept this letter as confirmation of your participation to assist the Maine Board of Dental Practice ("Board") in its efforts to report back to the Maine State Legislature pursuant to Public Law 2016, c. 429. As you may know, the Board's authorizing statute was completely repealed and replaced during the last legislative session, and its authorizing statute is now codified in Title 32, Chapter 143 entitled "Dental Professionals."

The new law also required the Board to: "...study the dental practice laws and recommend changes. The Board of Dental Practice, ***in consultation with interested parties***, shall conduct a study of the Maine Revised Statutes, Title 32, chapter 143 and any rules adopted by the board and recommend changes to the scopes of practice of dental practitioners, practice settings and delivery models and any other dental practice issues." (Emphasis added.)

To that end, the Board is convening an ad hoc committee to assist in identifying key issues for further review and analysis by the Board. The committee will be co-chaired by Dr. Lisa Howard (Board Vice-Chair) and Nancy Foster, RDH, EFDA, EdM (Board Member), and other committee participants will be soon identified to ensure appropriate stakeholder involvement. It is anticipated that there will be a total of four meetings scheduled as follows: December 2, 2016; January 20, 2017; February 17, 2017 and March 3, 2017.

As noted above, the first meeting of the committee will be **Friday, December 2nd at from 9:00 a.m. to 12:00 p.m.** located at the Board's office at 161 Capitol Street, Augusta, Maine. Meeting materials will be distributed in advance and additional meetings will be scheduled as necessary.

I look forward to hearing from you and should you have any questions in the meantime, please feel free to contact me directly.

Sincerely,

Penny Vaillancourt
Executive Director

PHONE: (207) 287-3333
FAX: (207) 287-8140

WEBSITE ADDRESS: www.maine.gov/dental
E-MAIL ADDRESS: dental.board@maine.gov

PAUL R. LEPAGE
GOVERNOR

STATE OF MAINE
BOARD OF DENTAL PRACTICE
143 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0143

VIA Email: mharmerbeem@une.edu

October 26, 2016

Marji Harmer-Beem, M.S., RDH
Interim Director for Dental Hygiene
University of New England

Re: Phase II – Statutory Review Consultation Pursuant to Public Law 2016, c. 429

Dear Ms. Harmer-Beem:

Please accept this letter as a request for your organization to identify a member to serve on an ad hoc committee developed by the Maine Board of Dental Practice ("Board") in its efforts to report back to the Maine State Legislature pursuant to Public Law 2016, c. 429. As you may know, the Board's authorizing statute was completely repealed and replaced during the last legislative session, and its authorizing statute is now codified in Title 32, Chapter 143 entitled "Dental Professionals."

The new law also required the Board to: "...study the dental practice laws and recommend changes. The Board of Dental Practice, ***in consultation with interested parties***, shall conduct a study of the Maine Revised Statutes, Title 32, chapter 143 and any rules adopted by the board and recommend changes to the scopes of practice of dental practitioners, practice settings and delivery models and any other dental practice issues." (Emphasis added.)

To that end, the Board is convening an ad hoc committee to assist in identifying key issues for further review and analysis by the Board. The committee will be co-chaired by Dr. Lisa Howard (Board Vice-Chair) and Nancy Foster, RDH, EFDA, EdM (Board Member), and other committee participants will be soon identified to ensure appropriate stakeholder involvement. It is anticipated that there will be a total of four meetings scheduled as follows: December 2, 2016; January 20, 2017; February 17, 2017 and March 3, 2017.

Your participation is purely voluntary; however, if you agree to participate, please contact me by phone at (207) 287-3333 or by email at penny.vaillancourt@maine.gov to confirm. As noted above, the first meeting of the committee will be **Friday, December 2nd at from 9:00 a.m. to 12:00 p.m.** located at the Board's office at 161 Capitol Street, Augusta, Maine. Meeting materials will be distributed in advance and additional meetings will be scheduled as necessary.

I look forward to hearing from you and should you have any questions in the meantime, please feel free to contact me directly.

Sincerely,

Penny Vaillancourt
Executive Director

Maine Board of Dental Practice
Review of the Maine Dental Practice Act – Phase II

Pursuant to Public Law 2016, c. 429
"An Act to Revise the Laws Governing Dental Practices"

Meeting Materials – December 2, 2016

1. Agenda and meeting outline
2. Board list of practice issues
3. Title 32, Chapter 143 "Dental Practice Act" – on file
4. Board Rules, Chapters 1-21 – on file
5. Title 32, Chapter 1-A – Sunrise Review Procedures
6. Title 3, Chapter 35 – Government Evaluation Act
7. Correspondence submitted for the committee's consideration
   a. Dr. David Pier
   b. Dr. Jon Ryder
   c. Paul Levasseur, LD
   d. Bonnie Vaughan, IPDH
   e. Recent communications to the Board
      i. Susan Feeney-Hopkins, Pines Health Services
      ii. Kristin Sanborn, IPDH
8. American Association of Dental Boards – 2016 Composite (to be collected at the end of each meeting) * copyright materials – cannot distribute.
9. July 19, 2016 Informational Letter to licensees from the Board of Dental Practice
10. PowerPoint presentation of statutory changes
11. Ad Hoc Committee – reference sheet
12. LD 1596 – Licensing/Permitting Data (March 2016)

MAINE BOARD OF DENTAL PRACTICE

Ad Hoc Committee – Phase II Meeting Notes
December 2, 2016

****

The Ad Hoc Committee convened at 9:00 a.m.

Participants Present:

Dr. Lisa Howard, Vice-Chair of the Board of Dental Practice; Nancy Foster, RDH, EFDA, EdM, Member of the Board of Dental Practice; Dr. Rachel King; Marji Harmer-Beem, RDH; Amanda Willette, CDA, EFDA; Tracey Jowett, IPDH; Austin Carbone, LD; Lorraine Klug, IPDH; Dr. David Pier; and Michelle Gallant, RDH; Penny Vaillancourt, Executive Director, Board of Dental Practice.

Also Present:

Dorothy Moroon; Frederick Jones; Lindsey Young; Beth Stevens; Kacey Sabounin; Terria Palmer; Cindy Leavitt; Dr. Stan Armstrong; Janet Stocco; Bonnie Vaughan; Sharon Smith-Bouchard; and Tricia Spearin.

Introduction/Background/Ground Rules/Role of the Committee:

Dr. Lisa Howard and Nancy Foster, RDH, EFDA, EdM, co-chairs of the Ad Hoc Committee opened the meeting and welcomed participants and members of the public attending the meeting. Dr. Howard and Ms. Foster provided an overview of the Board's task. More specifically, the chairs reported that during the 127th Second Regular Session, the Board of Dental Practice provided testimony on a variety of legislative initiatives that were before the Joint Standing Committee on Labor, Commerce, Research and Economic Development with the recommendation to approach various practice issues in two phases. The first phase was to repeal and replace the Dental Practice Act and provide a statutory framework that makes clear the legislative intent and scope of the Board's work. Phase II was to further examine the Board's statutes and rules and identify recommendations regarding practice issues, practice settings, delivery models for legislative consideration.

Additional context was provided to the committee which included an outline of the many changes to the Board since it last convened an ad hoc committee. Further clarification was provided that substantive policy issues are to be decided by the Legislature/Governor, not the Board. The role of the Board is to implement legislation (policy) and adopts rules to further clarify intent of legislative policy. The purpose of the Board is to protect the public, not the interests of the various professions. The final update was to make participants aware that the Board is in the midst of proposing rules to fully implement the new Dental Practice Act.

Dr. Howard and Ms. Foster identified the objective of the committee which is to review the Board's statutes and rules and identify issues related to scopes of practice, various practice settings, delivery models, etc. The work of the committee will be considered by the Board when it reports back to the Legislature in March of 2017.

Dr. Howard and Ms. Foster provided ground rules for participants which included:

1) Hands to speak.
2) Minimize distractions. Side conversations, cell phones - try to be fully present as a group for the whole meeting.
3) Name tensions. Surely there are tensions and areas of disagreement. There are bound to be differences of opinion. Agree to disagree, respectfully.
4) Emphasize that this is not a forum to air grievances with the Board/Board staff – this is a focused effort. However, board staff will capture other topics in a "parking lot" list for the Board's review.
5) Audience decorum - discussion is among the ad hoc participants. Members of the audience can reach out to board staff by email or during a break if they have an issue, comment, etc.
6) Goal is to identify the issues, the committee is not being asked to provide solutions. The solutions are likely to be public policy decisions that are determined by the Legislature, not the Board.
7) Board staff to disseminate and collect information. This is a public process, so please do not REPLY ALL on email exchanges. Please direct your email to board staff and it will be disseminated to participants either in advance or at the next meeting.

The Ad Hoc Committee is scheduled to meet again on Friday, January 20th / Friday, February 17th / Friday, March 3rd.

Participant's Comments:

Each participant was given an opportunity to express their interests and/or concerns regarding the work of the ad hoc committee. Below is a summary of the topics identified:

1) Lorraine Klug, IPDH, Maine Dental Hygienists' Association
    a) Confusion among those who practice as IPDH and PHS.
    b) Transferability of scopes from one practice setting to another.
    c) Expand the scope of RDH to include all of the practice types such as independent practice, public health, etc. instead of requiring separate qualifications.

2) Tracey Jowett, IPDH, PHS
    a) Reporting requirements are overly restrictive in PHS practice.
    b) Believes in accountability but to streamline the requirements such that it does not restrict a licensee's ability to practice.
    c) Stressed importance of dentist agreements with PHS practice.
    d) Believes that IPDH who practice public health should practice with dentist agreements.

3) Michelle Gallant, RDH
    a) Agrees that there is confusion between IPDH and PHS practice and issue of "patient of record."
    b) Recommends tweaking the language of dental externs.
    c) Identify settings to practice without a dentist.

d) Apply fluoride in facility settings without a supervising dentist.
e) Interested in hearing suggestions from denturists.

4) Dr. David Pier, Maine Dental Associations
   a) Interested in clarifying dental student externship requirements.
   b) Interested in sedation rule changes.
   c) Revisit the notion of "if not on the list of things authorized, then you can't do it."

5) Austin Carbone, LD, Maine Licensed Denturist Association
   a) Institute "DD" designation instead of "LD" for licensed denturists.
   b) Allow denturists to delegate to denturist assistants and lab technicians under their employment.

6) Dr. Rachel King, UNE Dental School
   a) Made general observations about the statute regarding the multiple dental licenses.
   b) Identified licensure challenges for foreign trained dentists seeking employment at UNE/licensure with the Board.
   c) Identify a pathway for otherwise qualified dentists.
   d) Suggested a clinical license category.

7) Marji Harmer-Beem, RDH, UNE Dental Hygiene Program
   a) Agrees with challenges shared by colleagues.
   b) Discussion of supervision requirements of dental hygienists (3-4 year programs)
   c) CODA competencies are structure of academic program.

8) Amanda Willette, CDA, EFDA
   a) Suggests another term be used other than "unlicensed person" as it currently appears in statute.
   b) Suggests licensing of dental assistants based on infection control issues, risks to employees, and patients.
   c) FQHC has oversight protections in place, but not private practice settings.
   d) Regulating dental assistants will mandate the education and CPR requirements.
   e) Examine delegated duties such as fluoride varnish and teeth whitening.

Overview of the Dental Practice Act:

An overview of the new Dental Practice Act was provided by Ms. Vaillancourt to provide additional foundation and context to some of the issues that have already been addressed in statute, and to highlight the areas of additional work.

Review of reference materials:

Meeting materials provided to participants included the following:
1) Agenda and meeting outline
2) Board list of practice issues dated November 2016

3) Title 32, Chapter 143 "Dental Practice Act"and Board Rules Chapters 1 -21
4) Title 32, Chapter 1-A – Sunrise Review Procedures
5) Title 3, Chapter 35 – Government Evaluation Act
6) Correspondence submitted for the committee's consideration:
    a. Dr. David Pier
    b. Dr. Jon Ryder
    c. Paul Levasseur, LD
    d. Bonnie Vaughan, IPDH
    e. Recent communications to the Board
        i. Susan Feeney-Hopkins, Pines Health Services
        ii. Kristin Sanborn, IPDH
7) American Association of Dental Boards – 2016 Composite (to be collected at the end of each meeting)
8) July 19, 2016 Informational Letter to licensees from the Board of Dental Practice
9) PowerPoint presentation of statutory changes
10) Ad Hoc Committee – reference sheet
11) LD 1596 – Licensing/Permitting Data (March 2016)

Discussion:

Participants engaged in a variety of practice issues as summarized below:

1) Require dentist by rule to require that unlicensed personnel obtain training, certification to ensure protection of the public. (OSHA, infection control, CPR, etc.).
2) Review neighboring state statutes.
3) Include delegation authority of IPDH's to unlicensed persons.
4) Concept of dental home – great concept but creates barriers. Patient choice at issue but regulations restrict such choice; dental hygienists must get permission from dentist; restriction of trade issue.
5) Concept of coordination of care – there is a tremendous need for care especially in public health settings; permission to treat versus competition among license types.
6) Practice ownership questions.
7) Allow denturist students to practice for the purpose of gaining additional supervised experience after the externship. Bridges a gap between graduating a denturist program and waiting to take the required examination.
8) Need to further examine the criteria for FQHC – example of integrated care for dental/medical.

Next Steps: Participants were tasked with reviewing the current list of RDH authorized procedures in statute for the purpose of identifying the components of dental hygiene practice, as opposed to listing specific procedures. Additional information regarding practice settings/regulations for FQHC facilities and other state statutes will be provided at the next meeting.

The meeting adjourned at 12:00 p.m.

BOARD OF DENTAL PRACTICE
Ad Hoc Committee - Phase II Review meeting of: December 2, 2016

PLEASE SIGN IN

Please PRINT Your Name and Your Agency Name **Clearly**

NAME	AGENCY
Dorothy Maroon	Tooth Fairies Inc.
Frederick Jones	Tooth Fairies Inc
Lindsey Young	MLDA
Beth Stevens	MLDA
Kacey Sabourin + Terria Palmer	Standish Denture Center
Cindy Leavitt	T.F.I.
Stan Hampton	M.D.E.
Janet Stacco	OPLA
Bonni Vaughn	IPDH, KVFD
Shawn Smith, Brenda	IPDH
Tricia Spears	RDH EFDA.

#1

Maine Board of Dental Practice

Ad Hoc Committee

Phase II Statutory Review pursuant to Public Law 2016, c. 429

December 2, 2016 - 9:00 a.m. - 12:00 p.m.

Meeting Agenda

1) Introduction of participants and board staff

2) Timeline, meeting schedule, ground rules, etc.

3) Review statutory mandate; role of the ad hoc committee

4) Overview of the new Dental Practice Act

5) Scope of review (statutes and rules)

6) Review of reference materials

7) Discussion/next steps

8) Adjourn

Location: Maine Board of Dental Practice, Conference room, 161 Capitol Street, Augusta, ME 04330
Directions: http://www.maine.gov/dental/board-information/contact.html

Contact staff: Penny Vaillancourt, Executive Director; tel: (207) 287-3333; TTY users call Maine relay 711; or email penny.vaillancourt@maine.gov

#2

Maine Board of Dental Practice
Ad Hoc Committee
Phase II Statutory Review pursuant to Public Law 2016, c. 429

November 2016 – List of Practice Issues

I. Practice Settings/Delivery Models

A. Dental Hygiene practice/practice settings
   1. RDH.
   2. IPDH.
   3. PHS.
   4. DHT.

B. Multi-disciplinary settings
   1. Hospitals.
   2. Clinics.
   3. Non-profit organizations.
   4. Schools.
   5. Nursing Homes.
   6. FQHCs.

C. Denturist practice/practice settings

D. Dentist practice/practice settings

E. Sunrise Review Issues
   1. Identify sunrise review considerations (new regulations).

F. Sunset Review Issues
   1. Identify sunset review considerations (de-regulation).

G. FAQs – Practice Questions
   1. Patient of record; dental home.
   2. Dental Hygiene clinics.
   3. Dental Hygienists volunteering in schools.
   4. Public Health supervision.
   5. Teledentistry.

II. Scopes of Practice Issues

A. Dentists
   1. Adopt ADA scope of practice of a dentist.
   2. Use of dermal fillers for non-dentally related procedures.
   3. Delegation provisions to unlicensed persons (dental assistants).
   4. Consider pathway for foreign trained dentists; currently faculty license used as alternative to full licensure.
   5. Consider "locum tenens" license and eliminate all the other various dental license types.
   6. Include "teeth whitening" to scope.

B. Dental Hygienists
   1. Scopes of Practice in current statute – consider alternative to long list of "authorized procedures" for each of the following:
      i. RDH.
      ii. EFDA.
      iii. Delegation duties to unlicensed persons.
   2. Public Health settings
      i. Increased interest of IPDHs to practice in school settings, nursing homes.
      ii. Increased interest of dentists to have hygienists working under their general supervision.
   3. Dental Hygiene clinics
      i. Hiring of IPDHs to practice per diem.

C. Denturists

D. Expanded Function Dental Assistants
   1. Revisit list of delegated duties in statute.

E. Dental Assistants
   1. Revisit list of delegated duties in statute.

III. Practice settings; standards of care, professional ethics

A. Provider responsibilities of all licensees in various practice settings such as private, corporate, non-profits, clinics, hospitals.

B. Informed Consent, HIPPA, infection control, recordkeeping, personnel, medications, etc.

C. "Patient of Record" removed from statute but concept is still present in rules and policies as it relates to a dentist; concepts need to be revisited.

D. Title 13, Chapter 22-A "Corporations" language.

#5

Title 32: PROFESSIONS AND OCCUPATIONS

Chapter 1-A: GENERAL PROVISIONS

Table of Contents

Subchapter 1: GENERAL PROVISIONS CONCERNING LICENSES

§59. TEMPORARY LICENSES

If a person holds a valid license issued by an occupational or professional licensing board established in Title 5, section 12004-A, at the time of initial enlistment in the United States Armed Forces and the license lapses during the licensee's initial enlistment, that person may obtain a temporary license if that person meets all requirements for issuance of that license except examination by payment of a $5 fee, provided that the application for the temporary license is made not later than 90 days after the date of discharge. This temporary license shall continue in force until the results of the next licensing examination are available. The terms of this section shall apply notwithstanding any contrary provision contained in the statutes governing these licensing boards. [1989, c. 503, Pt. B, §118 (AMD).]

SECTION HISTORY
1985, c. 297, (NEW). 1989, c. 503, §B118 (AMD).

§59-A. CONSUMER INFORMATION

(REPEALED)

SECTION HISTORY
1993, c. 600, §A26 (NEW). 1995, c. 370, §1 (RP).

§59-B. DEFERMENT FOR CONTINUING EDUCATION

(REPEALED)

SECTION HISTORY
2001, c. 285, §1 (NEW). 2007, c. 402, Pt. C, §7 (RP).

§60. STANDARDIZED TERMS

(REPEALED)

SECTION HISTORY
1993, c. 600, §A26 (NEW). 1999, c. 687, §§D1,2 (AMD). 2007, c. 402, Pt. C, §8 (RP).

§60-A. CONSUMER COMPLAINTS OF BOARD PROCEDURE

Complaints received by an occupational and professional regulatory board regarding that board's administrative procedure must be filed by the board with the Department of the Attorney General. [1993, c. 600, Pt. A, §26 (NEW).]

SECTION HISTORY
1993, c. 600, §A26 (NEW).

§60-B. COMPENSATION

(REPEALED)

SECTION HISTORY
1995, c. 397, §16 (NEW). 1995, c. 502, §H18 (AMD). 1999, c. 687, §D3 (RP).

§60-C. DISPOSITION OF FEES

(REPEALED)

SECTION HISTORY
1995, c. 397, §16 (NEW). 1995, c. 502, §H18 (AMD). 1999, c. 687, §D3 (RP).

§60-D. CONTRACTS

(REPEALED)

SECTION HISTORY
1995, c. 397, §16 (NEW). 1995, c. 502, §H18 (AMD). 1999, c. 386, §D1 (AMD). 1999, c. 687, §D4 (RP).

§60-E. BUDGET

(REPEALED)

SECTION HISTORY
1995, c. 397, §16 (NEW). 1995, c. 502, §H18 (AMD). 1999, c. 687, §D5 (RP).

§60-F. EMPLOYEES

(REPEALED)

SECTION HISTORY
1995, c. 397, §16 (NEW). 1995, c. 502, §H18 (AMD). 1999, c. 687, §D5 (RP).

§60-G. DISCIPLINARY ACTIONS; UNLICENSED PRACTICE

(REPEALED)

SECTION HISTORY
1995, c. 397, §16 (NEW). 1995, c. 502, §H18 (AMD). 1997, c. 727, §C7 (AMD). 1999, c. 687, §D6 (RP).

§60-H. INVESTIGATIONS; ENFORCEMENT DUTIES; ASSESSMENTS

(REPEALED)

SECTION HISTORY
1995, c. 397, §16 (NEW). 1995, c. 502, §H18 (AMD). 1999, c. 386, §D2 (AMD). 1999, c. 687, §D7 (RP).

§60-I. CITATIONS AND FINES

(REPEALED)

SECTION HISTORY

1995, c. 397, §16 (NEW). 1995, c. 502, §H18 (AMD). 1999, c. 386, §D3 (AMD). 1999, c. 687, §D8 (RP).

Subchapter 2: SUNRISE REVIEW PROCEDURES

§60-J. EVALUATION CRITERIA

Pursuant to Title 5, section 12015, subsection 3, any professional or occupational group or organization, any individual or any other interested party, referred to in this section as the "applicant group," that proposes regulation of any unregulated professional or occupational group or substantial expansion of regulation of a regulated professional or occupational group shall submit with the proposal written answers and information pertaining to the evaluation criteria enumerated in this section to the appropriate committee of the Legislature. The technical committee, the Commissioner of Professional and Financial Regulation, referred to in this subchapter as the "commissioner," and the joint standing committee, before it makes its final recommendations to the full Legislature, also shall accept answers and information pertaining to the evaluation criteria from any party that opposes such regulation or expansion and from any other interested party. All answers and information submitted must identify the applicant group, the opposing party or the interested party making the submission and the proposed regulation or expansion of regulation that is sought or opposed. The commissioner may develop standardized questions designed to solicit information concerning the evaluation criteria. The preauthorization evaluation criteria are: [1995, c. 686, §2 (NEW).]

1. Data on group. A description of the professional or occupational group proposed for regulation or expansion of regulation, including the number of individuals or business entities that would be subject to regulation, the names and addresses of associations, organizations and other groups representing the practitioners and an estimate of the number of practitioners in each group;

[1995, c. 686, §2 (NEW) .]

2. Specialized skill. Whether practice of the profession or occupation proposed for regulation or expansion of regulation requires such a specialized skill that the public is not qualified to select a competent practitioner without assurances that minimum qualifications have been met;

[1995, c. 686, §2 (NEW) .]

3. Public health; safety; welfare. The nature and extent of potential harm to the public if the profession or occupation is not regulated, the extent to which there is a threat to the public's health, safety or welfare and production of evidence of potential harm, including a description of any complaints filed with state law enforcement authorities, courts, departmental agencies, other professional or occupational boards and professional and occupational associations that have been lodged against practitioners of the profession or occupation in this State within the past 5 years;

[1995, c. 686, §2 (NEW) .]

4. Voluntary and past regulatory efforts. A description of the voluntary efforts made by practitioners of the profession or occupation to protect the public through self-regulation, private certifications, membership in professional or occupational associations or academic credentials and a statement of why these efforts are inadequate to protect the public;

[1995, c. 686, §2 (NEW) .]

5. Cost; benefit. The extent to which regulation or expansion of regulation of the profession or occupation will increase the cost of goods or services provided by practitioners and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers;

[1995, c. 686, §2 (NEW) .]

6. Service availability of regulation. The extent to which regulation or expansion of regulation of the profession or occupation would increase or decrease the availability of services to the public;

[1995, c. 686, §2 (NEW) .]

7. Existing laws and regulations. The extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from nonregulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated practitioners;

[1995, c. 686, §2 (NEW) .]

8. Method of regulation. Why registration, certification, license to use the title, license to practice or another type of regulation is being proposed, why that regulatory alternative was chosen and whether the proposed method of regulation is appropriate;

[1995, c. 686, §2 (NEW) .]

9. Other states. A list of other states that regulate the profession or occupation, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on the profession or occupation in terms of a before-and-after analysis;

[1995, c. 686, §2 (NEW) .]

10. Previous efforts. The details of any previous efforts in this State to implement regulation of the profession or occupation;

[1995, c. 686, §2 (NEW) .]

11. Mandated benefits. Whether the profession or occupation plans to apply for mandated benefits;

[1995, c. 686, §2 (NEW) .]

12. Minimal competence. Whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are; and

[1995, c. 686, §2 (NEW) .]

13. Financial analysis. The method proposed to finance the proposed regulation and financial data pertaining to whether the proposed regulation can be reasonably financed by current or proposed licensees through dedicated revenue mechanisms.

[1995, c. 686, §2 (NEW) .]

SECTION HISTORY
1995, c. 686, §2 (NEW).

§60-K. COMMISSIONER'S INDEPENDENT ASSESSMENT

1. Fees. Any applicant group whose regulatory proposal has been directed to the commissioner for independent assessment shall pay an administrative fee determined by the commissioner, which may not exceed $500. The commissioner may waive the fee if the commissioner finds it in the public's interest to do so. Such a finding by the commissioner may include, but is not limited to, circumstances in which the commissioner determines that:

A. The applicant group is an agency of the State; or [1995, c. 686, §2 (NEW).]

B. Payment of the application fee would impose unreasonable hardship on members of the applicant group. [1995, c. 686, §2 (NEW).]

[1995, c. 686, §2 (NEW) .]

2. Criteria. In conducting the independent assessment, the commissioner shall apply the evaluation criteria established in section 60-J to all of the answers and information submitted to the commissioner or otherwise collected by the commissioner pursuant to section 60-J.

[1995, c. 686, §2 (NEW) .]

3. Recommendations. The commissioner shall prepare a final report, for the joint standing committee of the Legislature that requested the evaluation, that includes any legislation required to implement the commissioner's recommendation. The commissioner may recommend that no legislative action be taken on a proposal. If the commissioner finds that final answers to the evaluation criteria are sufficient to support some form of regulation, the commissioner shall recommend an agency to be responsible for the regulation and the level of regulation to be assigned to the applicant group. The recommendations of the commissioner must reflect the least restrictive method of regulation consistent with the public interest.

[1995, c. 686, §2 (NEW) .]

SECTION HISTORY
1995, c. 686, §2 (NEW).

§60-L. TECHNICAL COMMITTEE; FEES; MEMBERSHIP; DUTIES; COMMISSIONER'S RECOMMENDATION

1. Fees. Any applicant group whose regulatory proposal has been directed to the commissioner for review by a technical committee shall pay a fee determined by the commissioner as required to administer the technical committee, which fee may not exceed $1,000. The administrative fee is not refundable, but the commissioner may waive all or part of the fee if the commissioner finds it in the public's interest to do so. Such a finding by the commissioner may include, but is not limited to, circumstances in which the commissioner determines that:

A. The applicant group is an agency of the State; or [1995, c. 686, §2 (NEW).]

B. Payment of the application fee would impose unreasonable hardship on members of the applicant group. [1995, c. 686, §2 (NEW).]

[1995, c. 686, §2 (NEW) .]

2. Technical committee membership. The commissioner shall appoint a technical committee consisting of 7 members to examine and investigate each proposal.

A. Two members must be from the profession or occupation being proposed for regulation or expansion of regulation. [1995, c. 686, §2 (NEW).]

B. Two members must be from professions or occupations with a scope of practice that overlaps that of the profession or occupation being proposed for regulation or expansion of regulation. If there is more than one overlapping profession or occupation, representatives of the 2 with the greatest number of practitioners must be appointed. [1995, c. 686, §2 (NEW).]

C. One member must be the commissioner or the commissioner's designee. [1995, c. 686, §2 (NEW).]

D. Two members must be public members. These persons and their spouses, parents or children may not be or ever have been members of, and may not have or ever have had a material financial interest in, the profession or occupation being proposed for regulation or expansion of regulation or another profession or occupation with a scope of practice that may overlap that of the profession or occupation being proposed for regulation. [1995, c. 686, §2 (NEW).]

The professional and public members serve without compensation. The chair of the committee must be the commissioner, the commissioner's designee or a public member. The commissioner shall ensure that the total composition of the committee is fair and equitable.

[1995, c. 686, §2 (NEW) .]

3. Meetings. As soon as possible after appointment, a technical committee shall meet and review the proposal assigned to it. Each committee shall investigate the proposed regulation and, on its own motion, may solicit public input. Notice of all meetings must be printed in the legislative calendar at an appropriate time preceding the meeting.

[1995, c. 686, §2 (NEW) .]

4. Procedure for review. Applicant groups are responsible for furnishing evidence upon which a technical committee makes its findings. The technical committee may also utilize information received through public input or through its own research or investigation. The committee shall make a report of its findings and file the report with the commissioner. The committee shall evaluate the application presented to it based on the information provided as required by section 60-J. If the committee finds that additional information is required to assist in developing its recommendations, it may require that the applicant group provide this information or may otherwise solicit information for this purpose. If the committee finds that final answers to the evaluation criteria are sufficient to support regulation of a profession or occupation not currently regulated, the committee must also recommend the least restrictive method of regulation to be implemented, consistent with the public interest. Whether it recommends approval or denial of an application, the committee may make additional recommendations regarding solutions to problems identified during the review.

[1995, c. 686, §2 (NEW) .]

5. Commissioner report. After receiving and considering reports from the technical committee, the commissioner shall prepare a final report, for the joint standing committee of the Legislature that requested the review, that includes any legislation required to implement the commissioner's recommendation. The final report must include copies of the committee report, but the commissioner is not bound by the findings and recommendations of the report. In compiling the report, the commissioner shall apply the criteria established in section 60-J and may consult with the technical committee. The recommendations of the commissioner must reflect the least restrictive method of regulation consistent with the public interest. The final report must be submitted to the joint standing committee of the Legislature having jurisdiction over occupational and professional regulation matters no later than 9 months after the proposal is submitted to the technical committee and must be made available to all other members of the Legislature upon request.

The commissioner may recommend that no legislative action be taken on a proposal. If the commissioner recommends that a proposal of an applicant group be approved, the commissioner shall recommend an agency to be responsible for the regulation and the level of regulation to be assigned to the applicant group.

[1995, c. 686, §2 (NEW) .]

SECTION HISTORY
1995, c. 686, §2 (NEW).

Subchapter 3: REPORT

§60-N. REPORT

(REPEALED)

SECTION HISTORY
2007, c. 240, Pt. LLL, §1 (NEW). 2007, c. 466, Pt. C, §8 (RP).

#6

Title 3: LEGISLATURE

Chapter 35: STATE GOVERNMENT EVALUATION

Table of Contents

Title 3: LEGISLATURE

Chapter 35: STATE GOVERNMENT EVALUATION

§951. SHORT TITLE

This chapter may be known and cited as the "State Government Evaluation Act." [1995, c. 488, §2 (NEW).]

SECTION HISTORY
1995, c. 488, §2 (NEW).

§952. SCOPE

This chapter provides for a system of periodic review of agencies and independent agencies of State Government in order to evaluate their efficacy and performance. Only those agencies, independent agencies or parts of those agencies and independent agencies that receive support from the General Fund or that are established, created or incorporated by reference in the Maine Revised Statutes are subject to the provisions of this chapter. The financial and programmatic review must include, but is not limited to, a review of agency management and organization, program delivery, agency goals and objectives, statutory mandate and fiscal accountability. [1995, c. 488, §2 (NEW).]

SECTION HISTORY
1995, c. 488, §2 (NEW).

§953. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1995, c. 488, §2 (NEW).]

1. Agency. "Agency" means a governmental entity subject to review pursuant to this chapter, but not subject to automatic termination.

[1995, c. 488, §2 (NEW) .]

2. Committee or committee of jurisdiction. "Committee or committee of jurisdiction" means the joint standing committee of the Legislature having jurisdiction over the same policy and substantive matters as an agency subject to review under this chapter.

[1995, c. 488, §2 (NEW) .]

3. Independent agency. "Independent agency" means a governmental entity subject to review and to termination pursuant to this chapter.

[1995, c. 488, §2 (NEW) .]

SECTION HISTORY
1995, c. 488, §2 (NEW).

§954. DESIGNATION BY LEGISLATIVE POLICY COMMITTEE

1. Authorization. On or before April 1st of any first regular session, the committee of jurisdiction shall review the list of agencies scheduled for review in section 959.

[1995, c. 488, §2 (NEW) .]

2. Waiver from review. The committee of jurisdiction may, with a 2/3 vote of all committee members, do one of the following with regard to an agency review:

A. Exempt an agency or independent agency from review and establish a new review date; [1995, c. 488, §2 (NEW).]

B. Establish a modified review process in which an agency or independent agency may be asked to provide less information than required by this section or additional information; or [1995, c. 488, §2 (NEW).]

C. Add an additional agency or independent agency for review, except that an agency that has been reviewed in accordance with this chapter in the legislative session immediately preceding the current legislative session may not be added for review. [1995, c. 488, §2 (NEW).]

[1995, c. 488, §2 (NEW) .]

SECTION HISTORY
1995, c. 488, §2 (NEW).

§955. COMMITTEE SCHEDULE

1. Review established. The committee of jurisdiction shall establish its agency review schedule in accordance with this chapter and upon approval of the necessary resources by the Legislative Council. The committee of jurisdiction shall request from each agency and independent agency scheduled for review under section 959 a single-page list of organizational units and programs within each organizational unit by March 1st of the first regular session of the Legislature. The agency or independent agency shall provide the list to the committee of jurisdiction by April 1st of the first regular session of the Legislature. The committee of jurisdiction shall provide an agency or independent agency with a written notice of its intent to review the agency or independent agency by May 1st of the first regular session of the Legislature.

[2013, c. 307, §1 (AMD) .]

2. Submission of program evaluation report. Each agency and independent agency shall prepare and submit no later than November 1st prior to the second regular session of the Legislature, a program evaluation report as required in section 956, to the Legislature through the committee of jurisdiction.

[1995, c. 488, §2 (NEW) .]

3. Conduct review. The committee of jurisdiction shall begin its agency review process no later than February 1st of the second regular session of the Legislature and in accordance with this chapter.

[1995, c. 488, §2 (NEW) .]

4. Report issued. For those agencies and independent agencies selected for review by the committee of jurisdiction, the committee shall submit to the Legislature no later than March 15th of the second regular session of the Legislature the findings, administrative recommendations or legislation required to implement recommendations made as a result of its review, analysis and evaluation.

[1995, c. 488, §2 (NEW) .]

5. Follow-up review. The committee of jurisdiction shall establish in its final report a specified time in which the committee may review the progress of an agency in meeting the recommendations of the committee report. A follow-up review may consist of written progress reports, public hearings with the agency and committee or any other method approved by the committee of jurisdiction in its final report.

[1995, c. 488, §2 (NEW) .]

SECTION HISTORY
1995, c. 488, §2 (NEW). 2013, c. 307, §1 (AMD).

§956. PROGRAM EVALUATION REPORT

1. Report required. Each agency and independent agency shall prepare and submit to the Legislature, through the committee of jurisdiction, a program evaluation report by a date specified by the committee.

[1995, c. 488, §2 (NEW) .]

2. Program evaluation report; contents. Each report must include the following information in a concise but complete manner:

A. Enabling or authorizing law or other relevant mandate, including any federal mandates; [1995, c. 488, §2 (NEW).]

B. A description of each program administered by the agency or independent agency, including the following for each program:

(1) Established priorities, including the goals and objectives in meeting each priority;

(2) Performance measures or other benchmarks used by the agency to measure its progress in achieving the goals and objectives; and

(3) An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance measures. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives; [2013, c. 307, §2 (AMD).]

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility; [1995, c. 488, §2 (NEW).]

D. [2013, c. 307, §3 (RP).]

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years; [1995, c. 488, §2 (NEW).]

F. [2013, c. 307, §4 (RP).]

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements; [1999, c. 661, §1 (AMD).]

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes; [1995, c. 488, §2 (NEW).]

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives; [1995, c. 488, §2 (NEW).]

J. Identification of emerging issues for the agency or program in the coming years; [1999, c. 661, §1 (AMD).]

K. Any other information specifically requested by the committee of jurisdiction; [2001, c. 321, Pt. A, §1 (AMD).]

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; [2001, c. 495, §1 (AMD).]

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement; [2013, c. 110, §2 (AMD); 2013, c. 307, §5 (AMD).]

N. A list of reports, applications and other similar paperwork required to be filed with the agency by the public. The list must include:

(1) The statutory authority for each filing requirement;

(2) The date each filing requirement was adopted or last amended by the agency;

(3) The frequency that filing is required;

(4) The number of filings received annually for the last 2 years and the number anticipated to be received annually for the next 2 years; and

(5) A description of the actions taken or contemplated by the agency to reduce filing requirements and paperwork duplication; [2013, c. 588, Pt. A, §1 (RPR).]

O. A list of reports required by the Legislature to be prepared or submitted by the agency or independent agency; [2013, c. 1, §4 (COR).]

(Paragraph O as enacted by PL 2013, c. 110, §4 is REALLOCATED TO TITLE 3, SECTION 956, SUBSECTION 2, PARAGRAPH Q)

P. A copy of the single-page list of organizational units and programs within each organizational unit required pursuant to section 955, subsection 1, placed at the front of the report; and [2013, c. 1, §4 (COR).]

Q. (REALLOCATED FROM T. 3, §956, sub-§2, ¶O) Identification of provisions contained in the agency's or independent agency's enabling or authorizing statutes that may require legislative review to determine the necessity of amendment to align the statutes with federal law, other state law or decisions of the United States Supreme Court or the Supreme Judicial Court. [2013, c. 1, §3 (RAL).]

[2013, c. 588, Pt. A, §1 (AMD) .]

SECTION HISTORY
1995, c. 488, §2 (NEW). 1999, c. 661, §§1,2 (AMD). 2001, c. 321, §§A1-3 (AMD). 2001, c. 495, §§1-3 (AMD). RR 2013, c. 1, §§3, 4 (COR). 2013, c. 110, §§2-4 (AMD). 2013, c. 307, §§2-7 (AMD). 2013, c. 588, Pt. A, §1 (AMD).

§957. COMMITTEE ANALYSIS AND RECOMMENDATIONS; AUTHORITY

For each agency or independent agency or a component part of each agency or independent agency subject to review pursuant to section 952, the committee of jurisdiction may conduct an analysis and evaluation that may include, but need not be limited to, an evaluation of the program evaluation report submitted pursuant to section 956, subsection 1, including: [2013, c. 307, §8 (NEW).]

1. Statutory authority. The extent to which the agency or independent agency operates in accordance with its statutory authority;

[2013, c. 307, §8 (RPR) .]

2. Goals and objectives. The degree of success in meeting the agency's or independent agency's goals and objectives for each program, including population served;

[2013, c. 307, §8 (NEW) .]

3. Statutory and administrative mandates. The degree of success achieved by the agency or independent agency in meeting its statutory and administrative mandates; and

[2013, c. 307, §8 (NEW) .]

4. Filing requirements. The extent to which the agency or independent agency has increased or reduced filing requirements and paperwork duplication burdens on the public.

[2013, c. 307, §8 (NEW) .]

In consultation with the Legislative Council, the committee of jurisdiction shall select agencies or independent agencies for review either in accordance with the scheduling guidelines provided in this chapter or at any time determined necessary by the committee. [2013, c. 307, §8 (NEW).]

SECTION HISTORY
1995, c. 488, §2 (NEW). 2001, c. 495, §4 (AMD). 2013, c. 307, §8 (RPR).

§958. TERMINATION OF INDEPENDENT AGENCIES

1. Termination process. The committee of jurisdiction may recommend to the Legislature that any independent agency be terminated if indicated or warranted by the committee's review, analysis and evaluation of the independent agency. An independent agency may be accorded a grace period of not more than one year from the effective date of the legislation approving termination in which to complete its business. During the grace period, the statutory powers and duties of the independent agency are not limited or reduced.

[1995, c. 488, §2 (NEW) .]

2. Disposition of property, funds and records. During the grace period, the Legislature shall determine the disposition of:

A. All property, including any land, buildings, equipment and supplies used by the independent agency; [1995, c. 488, §2 (NEW).]

B. All funds remaining in any account of the independent agency; and [1995, c. 488, §2 (NEW).]

C. All records resulting from the activities of the independent agency. [1995, c. 488, §2 (NEW).]

[1995, c. 488, §2 (NEW) .]

3. Expiration of grace period. Upon the expiration of the grace period, the independent agency shall cease its activities and terminate.

[1995, c. 488, §2 (NEW) .]

SECTION HISTORY
1995, c. 488, §2 (NEW).

§959. SCHEDULING GUIDELINE FOR REVIEW OF AGENCIES OR INDEPENDENT AGENCIES

1. Scheduling guidelines. Except as provided in subsection 2, reviews of agencies or independent agencies must be scheduled in accordance with the following. Subsequent reviews must be scheduled on an ongoing basis every 8 years after the dates specified in this subsection.

A. The joint standing committee of the Legislature having jurisdiction over agriculture, conservation and forestry matters shall use the following list as a guideline for scheduling reviews:

(1) Baxter State Park Authority in 2017;

(2) Board of Pesticides Control in 2019;

(3) Wild Blueberry Commission of Maine in 2019;

(4) Maine Dairy and Nutrition Council in 2015;

(5) Maine Dairy Promotion Board in 2015;

(6) Maine Milk Commission in 2015;

(7) State Harness Racing Commission in 2015;

(8) Maine Agricultural Bargaining Board in 2017;

(9) Department of Agriculture, Conservation and Forestry in 2017; and

(10) Land for Maine's Future Board in 2015. [2013, c. 405, Pt. D, §1 (RPR).]

B. The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters shall use the following list as a guideline for scheduling reviews:

(1) State Employee Health Commission in 2017; and

(2) Department of Professional and Financial Regulation, in conjunction with the joint standing committee of the Legislature having jurisdiction over business and economic development matters, in 2015. [2013, c. 505, §1 (AMD).]

C. The joint standing committee of the Legislature having jurisdiction over business, research and economic development matters shall use the following list as a guideline for scheduling reviews:

(1) Maine Development Foundation in 2021;

(5) Department of Professional and Financial Regulation, in conjunction with the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters, in 2015;

(19) Department of Economic and Community Development in 2021;

(23) Maine State Housing Authority in 2015;

(32) Finance Authority of Maine in 2017;

(36) Board of Dental Practice in 2019;

(37) Board of Osteopathic Licensure in 2019;

(38) Board of Licensure in Medicine in 2019;

(41) State Board of Nursing in 2019;

(42) State Board of Optometry in 2019; and

(45) State Board of Registration for Professional Engineers in 2019. [2013, c. 588, Pt. E, §1 (AMD); 2013, c. 588, Pt. E, §2 (AFF); 2015, c. 429, §23 (REV).]

D. The joint standing committee of the Legislature having jurisdiction over criminal justice and public safety matters shall use the following list as a guideline for scheduling reviews:

(1) Department of Public Safety, except for the Emergency Services Communication Bureau, in 2015;

(2) Department of Corrections in 2019; and

(3) The Maine Emergency Management Agency within the Department of Defense, Veterans and Emergency Management in 2015. [2013, c. 505, §1 (AMD).]

E. The joint standing committee of the Legislature having jurisdiction over education and cultural affairs shall use the following list as a guideline for scheduling reviews:

(2) Department of Education in 2021;

(2-A) State Board of Education in 2021;

(3) Maine Arts Commission in 2015;

(5) Maine Historic Preservation Commission in 2015;

(5-A) Notwithstanding section 952, Maine Historical Society in 2015;

(6) Maine Library Commission in 2015;

(6-A) Maine State Cultural Affairs Council in 2015;

(6-B) Maine State Library in 2015;

(6-C) Maine State Museum in 2015;

(7) Maine State Museum Commission in 2015;

(8) Office of State Historian in 2015;

(9) Board of Trustees of the Maine Maritime Academy in 2017;

(10) Board of Trustees of the University of Maine System in 2017;

(12) Maine Community College System in 2017; and

(13) Maine Health and Higher Educational Facilities Authority in 2019.

[2015, c. 170, §1 (AMD); 2015, c. 170, §30 (AFF).]

F. The joint standing committee of the Legislature having jurisdiction over health and human services matters shall use the following list as a guideline for scheduling reviews:

(6) Department of Health and Human Services in 2017;

(7) Board of the Maine Children's Trust Incorporated in 2019; and

(9) Maine Developmental Disabilities Council in 2019. [2013, c. 505, §1 (AMD).]

G. The joint standing committee of the Legislature having jurisdiction over inland fisheries and wildlife matters shall use the following list as a guideline for scheduling reviews:

(1) Department of Inland Fisheries and Wildlife in 2015; and

(2) Advisory Board for the Licensing of Taxidermists in 2015. [2013, c. 505, §1 (AMD).]

H. The joint standing committee of the Legislature having jurisdiction over judiciary matters shall use the following list as a guideline for scheduling reviews:

(2) Maine Human Rights Commission in 2017;

(3) Maine Indian Tribal-State Commission in 2019; and

(4) Department of the Attorney General in 2019. [2013, c. 505, §1 (AMD).]

I. The joint standing committee of the Legislature having jurisdiction over labor matters shall use the following list as a guideline for scheduling reviews:

(2) Department of Labor in 2015;

(3) Maine Labor Relations Board in 2017; and

(4) Workers' Compensation Board in 2017. [2013, c. 505, §1 (AMD).]

J. The joint standing committee of the Legislature having jurisdiction over legal and veterans affairs shall use the following schedule as a guideline for scheduling reviews:

(2) State Liquor and Lottery Commission in 2015;

(3) The Department of Administrative and Financial Services with regard to the enforcement of the law relating to the manufacture, importation, storage, transportation and sale of all liquor and the laws relating to licensing and the collection of taxes on malt liquor and wine in 2015; and

(4) Department of Defense, Veterans and Emergency Management in 2019, except for the Maine Emergency Management Agency within the department. [2013, c. 505, §1 (AMD).]

K. The joint standing committee of the Legislature having jurisdiction over marine resource matters shall use the following list as a guideline for scheduling reviews:

(1) Atlantic States Marine Fisheries Commission in 2021;

(2) Department of Marine Resources in 2021; and

(4) Lobster Advisory Council in 2015.

[2015, c. 494, Pt. A, §2 (AMD).]

L. The joint standing committee of the Legislature having jurisdiction over natural resource matters shall use the following list as a guideline for scheduling reviews:

(1) Department of Environmental Protection in 2017;

(2) Board of Environmental Protection in 2017;

(4) Saco River Corridor Commission in 2021; and

(5) Board of Underground Oil Tank Installers in 2019. [2013, c. 505, §1 (AMD).]

M. The joint standing committee of the Legislature having jurisdiction over state and local government matters shall use the following list as a guideline for scheduling reviews:

(1) Capitol Planning Commission in 2019;

(1-A) Maine Governmental Facilities Authority in 2021;

(2) State Civil Service Appeals Board in 2021;

(3) State Claims Commission in 2021;

(4) Maine Municipal Bond Bank in 2015;

(5) Office of Treasurer of State in 2015;

(6) Department of Administrative and Financial Services, except for the Bureau of Revenue Services, in 2019; and

(7) Department of the Secretary of State, except for the Bureau of Motor Vehicles, in 2019.
[2013, c. 505, §1 (AMD).]

N. The joint standing committee of the Legislature having jurisdiction over taxation matters shall use the following schedule as a guideline for scheduling reviews:

(1) State Board of Property Tax Review in 2019; and

(2) Department of Administrative and Financial Services, Bureau of Revenue Services in 2019.
[2013, c. 505, §1 (AMD).]

O. The joint standing committee of the Legislature having jurisdiction over transportation matters shall use the following schedule as a guideline for scheduling reviews:

(1) Maine Turnpike Authority in 2021;

(2) The Bureau of Motor Vehicles within the Department of the Secretary of State in 2015;

(3) The Department of Transportation in 2017; and

(4) Maine State Pilotage Commission in 2017. [2015, c. 473, §1 (AMD).]

P. The joint standing committee of the Legislature having jurisdiction over utilities and energy matters shall use the following list as a guideline for scheduling reviews:

(1) Public Advocate in 2015;

(2) Board of Directors, Maine Municipal and Rural Electrification Cooperative Agency in 2015;

(3) Public Utilities Commission, including the Emergency Services Communication Bureau, in 2015; and

(5) Telecommunications Relay Services Advisory Council in 2015. [2013, c. 505, §1 (AMD).]

Q. The joint standing committee of the Legislature having jurisdiction over retirement matters shall use the following list as a guideline for scheduling reviews:

(1) Maine Public Employees Retirement System in 2021. [2013, c. 505, §1 (AMD).]

[2015, c. 429, §23 (REV); 2015, c. 473, §1 (AMD); 2015, c. 494, Pt. A, §2 (AMD) .]

2. Waiver. Notwithstanding this list of agencies arranged by year, an agency or independent agency may be reviewed at any time by the committee pursuant to section 954.

[1995, c. 488, §2 (NEW) .]

SECTION HISTORY
1995, c. 488, §2 (NEW). 1995, c. 560, §K82 (AMD). 1995, c. 560, §K83 (AFF). 1995, c. 671, §§1-3 (AMD). 1997, c. 245, §19 (AMD). 1997, c. 455, §31 (AMD). 1997, c. 526, §14 (AMD). 1997, c. 683, §D1 (AMD). 1997, c. 727, §§A1,2 (AMD). 1999, c. 127, §§C1-15 (AMD). 1999, c. 415, §1 (AMD). 1999, c. 585, §1 (AMD). 1999, c. 603, §§1,2 (AMD). 1999, c. 687, §A1 (AMD). 1999, c. 706, §1 (AMD). 1999, c. 790, §§D2,3 (AMD). 1999, c. 790, §D14 (AFF). 2001, c. 354, §3 (AMD). 2001, c. 439, §§EEEE1,2 (AMD). 2001, c. 471, §§D4,5 (AMD). 2001, c. 519, §1 (AMD). 2001, c. 548, §1 (AMD). 2001, c. 597, §1 (AMD). 2001, c. 697, §A1 (AMD). 2003, c. 20, §OO2 (AMD). 2003, c. 20, §OO4 (AFF). 2003, c. 451, §§T1,2 (AMD). 2003, c. 578, §1 (AMD). 2003, c. 600, §1 (AMD). 2005, c. 155, §1 (AMD). 2005, c. 294, §1 (AMD). 2005, c. 397, §C3 (AMD). 2005, c. 477, §1 (AMD). 2005, c. 550, §1 (AMD). 2005, c. 605, §§1,2 (AMD). 2005, c. 634, §§1,2 (AMD). 2007, c. 356, §1 (AMD). 2007, c. 356, §31 (AFF). 2007, c. 395, §1 (AMD). 2007, c. 560, §1 (AMD). 2007, c. 695, Pt. A, §6 (AMD). 2007, c. 695, Pt. D, §3 (AFF). 2009, c. 122, §3 (AMD). 2009, c. 552, §1 (AMD). 2009, c. 561, §1 (AMD). 2011, c. 579, §1 (AMD). 2011, c. 655, Pt. CC, §2 (AMD). 2011, c. 655, Pt. CC, §4 (AFF). 2011, c. 657, Pt. AA, §1 (AMD). 2013, c. 1, Pt. DD, §§1, 2 (AMD). 2013, c. 368, Pt. V, §§1, 2 (AMD). 2013, c. 405, Pt. D, §1 (AMD). 2013, c. 505,

§1 (AMD). 2013, c. 588, Pt. E, §1 (AMD). 2013, c. 588, Pt. E, §2 (AFF). 2015, c. 170, §1 (AMD). 2015, c. 170, §30 (AFF). 2015, c. 429, §23 (REV). 2015, c. 473, §1 (AMD). 2015, c. 494, Pt. A, §2 (AMD).

§960. FUTURE OR REORGANIZED AGENCIES AND INDEPENDENT AGENCIES

The chief staff administrator of a newly created or substantially reorganized agency or independent agency shall contact the committee to ensure placement of that agency or independent agency in the scheduling guideline outlined in section 959. The committee and the Legislative Council shall determine the placement of that agency or independent agency in the scheduling guideline. [1995, c. 488, §2 (NEW).]

SECTION HISTORY
1995, c. 488, §2 (NEW).

§961. LEGISLATIVE COUNCIL

The Legislative Council shall issue rules necessary for the efficient administration of this chapter and shall provide the committees of jurisdiction with assistance as required to carry out the purposes of this chapter. [1995, c. 488, §2 (NEW).]

SECTION HISTORY
1995, c. 488, §2 (NEW).

§962. LEGAL CLAIMS

Termination, modification or establishment of agencies or independent agencies as a result of the review required by this chapter does not extinguish any legal claims against the State, any state employee or state agency or independent agency. The provisions of this chapter do not relieve the State or any agency or independent agency of responsibility for making timely payment of the principal and interest of any debt issued in the form of a bond or note. [1995, c. 488, §2 (NEW).]

SECTION HISTORY
1995, c. 488, §2 (NEW).

§963. REVIEW

The joint standing committee of the Legislature having jurisdiction over state and local government matters shall review the provisions and effects of this chapter no later than June 30, 2022 and at least once every 10 years after June 30, 2022. [2013, c. 505, §2 (AMD).]

SECTION HISTORY
1995, c. 488, §2 (NEW). 2013, c. 505, §2 (AMD).

#7

Maine Board of Dental Practice
Review of the Maine Dental Practice Act – Phase II

Pursuant to Public Law 2016, c. 429
"An Act to Revise the Laws Governing Dental Practices"

Correspondence Submitted for Committee's Consideration

1. Dr. David Pier; email dated November 25, 2016
2. Dr. Jon Ryder; email dated November 20, 2016
3. Paul Levasseur, LD; email dated November 30, 2016
4. Bonnie Vaughan, IPDH; email dated December 1, 2016
5. Recent Communication with Board regarding practice issues
   a. Susan Feeney-Hopkins, Pines Health Services
   b. Kristin Sanborn, IPDH

COMMENTS RECEIVED BY

DR. DAVID PIER

AND

DR. JON RYDER

Maine Board of Dental Practice
Ad Hoc Committee
Phase II Statutory Review pursuant to Public Law 2016, c. 429

November 2016 – List of Practice Issues

I. Practice Settings/Delivery Models

A. Dental Hygiene practice/practice settings
   1. RDH.
   2. IPDH.
   3. PHS.
   4. DHT.

B. Multi-disciplinary settings
   1. Hospitals.
   2. Clinics.
   3. Non-profit organizations.
   4. Schools.
   5. Nursing Homes.
   6. FQHCs.
   7. Dental Schools and associated outreach
   8. Hygiene Schools and associated outreach
   9. Denturist Schools and associated outreach
   10. Dental Student Externships

– Dr. Pier's comment

– Dr. Ryder's comment

C. Denturist practice/practice settings

D. Dentist practice/practice settings

E. Sunrise Review Issues
   1. Identify sunrise review considerations (new regulations).

F. Sunset Review Issues
   1. Identify sunset review considerations (de-regulation).

G. FAQs – Practice Questions
   1. Patient of record; dental home.
   2. Dental Hygiene clinics.
   3. Dental Hygienists volunteering in schools.
   4. Dental Students Volunteering in schools (or like) under supervision of faculty
   5. Public Health supervision.
   6. Teledentistry.

Dr. Pier's comment

II. Scopes of Practice Issues

A. Dentists
   1. Adopt ADA scope of practice of a dentist. → Dr. Pier's comment
   2. Use of dermal fillers and botox for non-dentally related procedures.
   3. Delegation provisions to unlicensed persons (dental assistants).
   4. Consider pathway for foreign trained dentists; currently faculty license used as alternative to full licensure.
   5. Consider "locum tenens" license and eliminate all the other various dental license types.
   6. Include "teeth whitening" to scope.
   7. Sedation – Dr. Pier's comment

B. Dental Hygienists
   1. Scopes of Practice in current statute – consider alternative to long list of "authorized procedures" for each of the following:
      i. RDH.
      ii. EFDA.
      iii. Delegation duties to unlicensed persons.
   2. Public Health settings
      i. Increased interest of IPDHs to practice in school settings, nursing homes.
      ii. Increased interest of dentists to have hygienists working under their general supervision.
   3. Dental Hygiene clinics
      i. Hiring of IPDHs to practice per diem.

C. Denturists

D. Expanded Function Dental Assistants
   1. Revisit list of delegated duties in statute.

E. Dental Assistants
   1. Revisit list of delegated duties in statute.

III. Practice settings; standards of care, professional ethics

A. Provider responsibilities of all licensees in various practice settings such as private, corporate, non-profits, clinics, hospitals.

B. Informed Consent, HIPPA, infection control, recordkeeping, personnel, medications, etc.

C. "Patient of Record" removed from statute but concept is still present in rules and policies as it relates to a dentist; concepts need to be revisited.

D. Title 13, Chapter 22-A "Corporations" language.

COMMENTS RECEIVED BY

PAUL LEVASSEUR, LD

Vaillancourt, Penny

om:	Paul Levasseur <plevasseur@fairpoint.net>
Sent:	Wednesday, November 30, 2016 2:16 PM
To:	Jon Ryder; Vaillancourt, Penny
Cc:	Amanda Willette; Austin Carbone; Dr. David Pier; Dr. David Pier 2; Dr. James Schmidt; Dr. Lisa Howard; lorraineklug@hotmail.com; michelle gallant; nancy.foster@maine.edu; Tracy Jowett; Johnson, Teneale E; Ingram, Kerrie H; LaRochelle, Lauren; Bowie, Jim; Rachel King
Subject:	Re: Meeting Materials

Good afternoon everyone,

Please add the following to the list of practice issues:

Increased scope to include X-rays and all removables with justified exceptions.
Replacing abutments on implants.
Denture ID's to include scanning technology.
Repopulating the dental board to reflect the Supreme Court's decision upholding the FTC's antitrust action re FTC v North Carolina Dental Board.
Allowing any licensees majority ownership of a dental practice.
Allowing approved schools, CERP providers and state, national and international denturist associations to accredit continuing education.
equiring internship to LD's before unsupervised practice.
Reflect legislative intent to provide up to 2 years of externship for denturist students.

Thank you all for your consideration.

I will not be able to attend the first meeting, however I am sending a surrogate, Kacey Sabourin, Bsc to attend.

Sincerely,

Paul M Levasseur, LD
On Wed, 30 Nov 2016 18:21:41 +0000
Jon Ryder <jryder2@une.edu> wrote:
> Hello everyone,
>
> I have added one item to the Board List of Practice Issues and
>attached here.
>
> I would also like you to be aware that I will not be able to attend
>the first meeting. Attending in my place will be Dr. Rachel King, UNE
>College of Dental Medicine faculty member. Dr. King is an Assistant
>Professor, a pediatric dentist and holds both an MPH and a certificate
>in Dental Public Health. I believe she will make a great addition to
>the committee.

> Thank you again for the opportunity to participate.
>

> Sincerely,
>
> Jon S. Ryder, D.D.S., M.S.
Dean
> College of Dental Medicine
> University of New England
> 716 Stevens Avenue
> Portland, Maine 04103
> jryder2@une.edu<mailto:jryder2@une.edu>
> (207) 221-4700
>
> [cid:4eb2540d-d483-4b62-907b-ee771781d631@namprd07.prod.outlook.com]
>
>
> This message may contain privileged and/or confidential information.
>This information is intended only for the use of the individual(s) or
>entity to who it is intended even if addressed incorrectly. If you have
>received this email in error or are not the intended recipient, you may
>not use copy, disseminate or distribute it; do not open any
>attachments, delete it immediately from your system and notify the
>sender promptly by email that you have done so. Thank you.
>
>
>
>
>

> On Nov 23, 2016, at 3:03 PM, Vaillancourt, Penny
><Penny.Vaillancourt@maine.gov<mailto:Penny.Vaillancourt@maine.gov>>
>wrote:
>
> Good afternoon,
>
> Attached is the agenda and related materials for the ad hoc
>committee's first meeting, which is scheduled for Friday, December
>2ndat 9:00 a.m. with the meeting location to be in the large conference
>room at the Board's office located at 161 Capitol Street, Augusta,
>Maine. For directions to the Board, please visit the Board's website:
> http://www.maine.gov/dental/board-information/contact.html
>
> The Board's Rules (Chapters 1 through 21) can be accessed by clicking
>on the following:
> http://www.maine.gov/sos/cec/rules/02/chaps02.htm#313
>
> I have also attached a list of issues identified by the Board to date.
>However, if you have additional issues that ought to be considered,
>then please forward them to me via email prior to the meeting. I will
>collect your responses and make them available to you at the first
meeting. Also, if you prefer to have paper copies of the meeting
>materials, then I will have them available at the meeting as well.
>

> Again, thank you for your willingness to assist the Board and I look
>forward to seeing you on December 2nd.
>
Sincerely,
> Penny
>
> Penny Vaillancourt, Executive Director Maine Board of Dental Practice
> 143 State House Station
> 161 Capitol Street
> Augusta, ME 04333-0143
> t: 207.287.3333
> c: 207.441.7153
> f: 207.287.8140
> website: www.maine.gov/dental<http://www.maine.gov/dental>
>
> Confidentiality Notice: This e-mail message, including any
>attachments, is for the sole use of the intended recipient(s) and may
>contain confidential and privileged information. If you are not the
>intended recipient, or an authorized agent of the intended recipient,
>please immediately contact sender by reply e-mail and destroy/delete
>all copies of the original message. Any unauthorized review, use,
>copying, forwarding, disclosure, or distribution by other than the
>intended recipient or authorized agent is prohibited.
>
> <December 2, 2016 Agenda and Outline.docx><Board List of Practice
>Issues.docx><Title 32, Chapter 143.pdf><title32ch1-A - Sunrise Review
Procedures.pdf><title3ch35 - Government Evaluation Act.pdf>
>

COMMENTS RECEIVED BY

BONNIE VAUGHAN, IPDH

Vaillancourt, Penny

om: Bonnie Vaughan <BSSvaughan@msn.com>
Sent: Thursday, December 01, 2016 10:28 AM
To: Vaillancourt, Penny
Subject: Fw: Dec 2 Ad Hoc committee meeting, material on the Maine State School Oral Health Program and IPDH/PHS:/RDH , thank you giving this with the Committee
Attachments: 7-safety-net-dental-clinics-maine (1).pdf; 8-schools-with-state-funded-fluoride-mouth-rinse-program-maine.pdfFLV (1).pdf; 9-schools-with-state-funded-sealant-program-maine.pdfsealant.pdf; Pew_Dental_Sealants_Maine.pdf2015.pdf

Maine Board of Dental Practice
SHS #143
Augusta, ME 04333

Re: Ad Hoc Committee, Review of the Maine Dental Practice Act Phase II

I would like to share the attached information with the Ad Hoc Committee that is reviewing dental hygiene practice
settings for IPDH and RDH/PHS.

The **State of Maine School Oral Health Program** has provided schools support to implement school oral ealth programs since the inception in 1970. These programs have included dental screenings, sealants, fluoride mouth rinses ,
fluoride varnish and education. The School Oral Health Programs are implemented by the school nurses.

Yearly the school nurses attend the State of Maine School Oral Health Program workshops to review the program guidelines.
Over the years many nurses have reached out to local hygienists to assist them in providing these services to the school children.
All school oral health services are provided with active parental permission.

The attached State of Maine maps show the extent of the involvement of schools in the program across the State.
The schools chosen for the program usually have a 40% or higher participation rate in the school free and reduced
lunch program.

Oral Health in Maine
http://www.maine.gov/dhhs/mecdc/population-health/odh/

The ability for IPDHs and PHS hygienists to assist school nurses in these programs is extremely valuable.

In the past the State of Maine has received an **A from the PEW foundation for the high number of children receiving sealants.**

Other data collected is reported to national data bases such as the Burton Report, National surveillance systems and the CDC Maternal Block Grants.

ental Sealants are a critical preventive service
www.pewtrusts.org
http://www.pewtrusts.org/en/research-and-analysis/reports/2015/04/states-stalled-on-dental-sealant-programs

Allowing both IPDHs and PHS hygienists to provide their scope of practice services for children in the public schools is a great health benefit to the
State of Maine and to the children.

I would be glad to answer any questions that you or the committee might have regarding the State of Maine SOHP.

The other public health service that IPDHs and PHS have been invaluable is in the public dental clinics in the state.

There are 26 public dental clinics in the State, that serve the undeserved populations both adults and children.
These are either Federally Qualified Health Centers which include a dental center or
Community Based or Hospital non profit dental clinics. Over the years it has been a challenge for these centers to recruit and retain dentists.
In the past the Board of Dental Examiners has allowed PHS hygienists to continue to work in these centers
ntil a new dental provider
is recruited. Recently there may have been a shift in that policy to encourage centers to hire only IPDHs to assist the centers
to maintain services until a new dental provider is found.

I would encourage the Committee to allow this practice for both PHS and IPDHs to assist the public dental centers to continue to
operate until new dental providers are recruited.

If you or the committee have any questions regarding using IPDH and PHS in the public clinics or public schools, I would be glad to assist in answering their
questions.

Thank you for sharing this information with the Ad Hoc Committee.

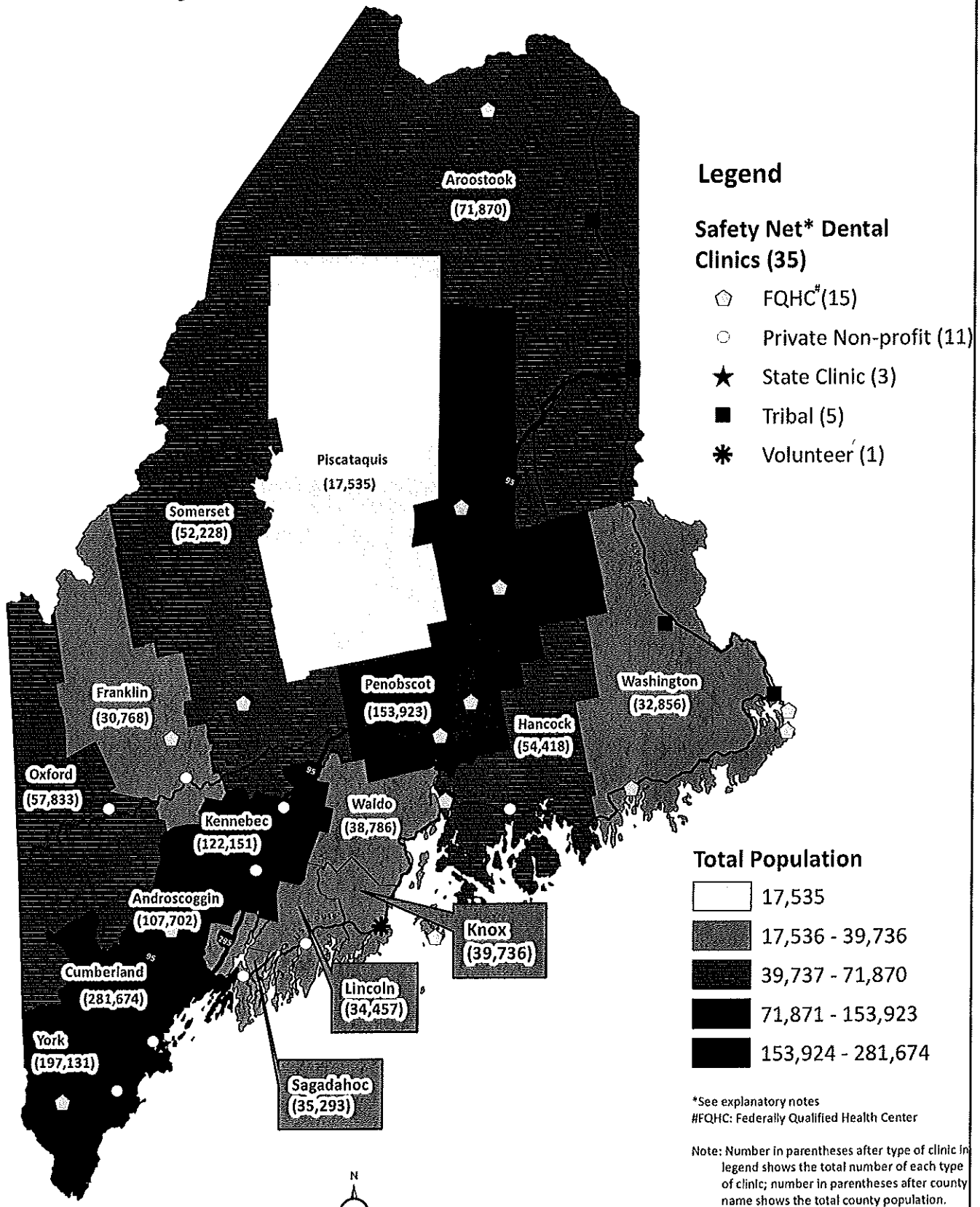
Sincerely,

Bonnie

Bonnie Vaughan RDH, IPDH, MEd, MBA
tate of Maine School Oral Health Program
Interim Coordinator

Executive Director
Kennebec Valley Family Dentistry
269 Water St.
ugusta, ME 04110
bssvaughan@msn.com
207-232-4836

7. Safety Net* Dental Clinics, Maine 2011



Legend

Safety Net* Dental Clinics (35)

- FQHC#(15)
- Private Non-profit (11)
- State Clinic (3)
- Tribal (5)
- Volunteer (1)

Total Population

- 17,535
- 17,536 - 39,736
- 39,737 - 71,870
- 71,871 - 153,923
- 153,924 - 281,674

*See explanatory notes
#FQHC: Federally Qualified Health Center

Note: Number in parentheses after type of clinic in legend shows the total number of each type of clinic; number in parentheses after county name shows the total county population.

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Data Sources:
Oral Health Division, Maine CDC 2011
Summary File 1, U. S. Census Bureau 2010

Maps constructed by: Santosh Nazare, Research Associate I/Epidemiologist, University of Southern Maine for Maine CDC Oral Health Program, December 2011

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
Maine Center for Disease Control and Prevention
286 Water Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-8016; Fax: (207) 287-9058
TTY Users: Dial 711 (Maine Relay)

Oral Health in Maine, 2011 – 2012
A Series of Maps Describing Professional and Prevention Resources: Explanatory Notes

These maps were constructed by Santosh Nazare, MBBS, MPH, CPH, Epidemiologist/Research Associate I, University of Southern Maine Department of Applied Medical Sciences, for the Oral Health Program in the Maine Center for Disease Control and Prevention's Division of Population Health, and by David Pied, Policy, Systems and Environmental Change Program Manager in the Division, using data available in 2011 and 2012. It is expected that they will be updated after new data becomes available by the end of 2013. Specific data sources and dates are noted on each map. Certain terms and other details are defined and discussed below.

1. Dentists and dental hygienists (maps # 1 – 6):
   a. The term "active" is used to describe dentists and registered dental hygienists who have up-to-date, active licenses from the State Board of Dental Examiners.
   b. Because a dental professional holds an active license does not necessarily mean that the individual is actively practicing.
   c. There is no practical way to indicate the number of hours an individual dentist or dental hygienist practices and whether that is full-time, part-time, or some other basis.
   d. Dental hygienist location is based upon county of residence, which may or may not be the county of practice.

2. Total population maps (maps # 1, 5, 6) indicate the numbers of active license holders per county and the total county population.

3. Population density maps (maps #2, 3, 4) denote the approximate location of each licensed dental professional.
   a. Dentists are located by practice address. If several practice addresses are located in close proximity to each other, the map may not show more than one "dot," or "dots" may be overlaid on top of each other, due to the scale of the map. Dentists practicing at "safety net" dental clinics may not be shown, due to how they reported information. See map #7 for clinic locations.
   b. Dental hygienists provide home addresses and so were not mapped by population density due to privacy concerns.

4. "Safety net dental clinics" (#7) include any dental clinic or dental center that operates as, or is operated by, a private non-profit organization, including Federally Qualified Health Centers (FQHC) and FQHC-lookalikes; other private non-profit organizations; state-operated clinics; tribal clinics; and one volunteer program. The Institute of Medicine's report, *America's Health Care Safety Net* (2000), defines safety net providers as those who "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients." Although private practitioners may provide such services, only non-profit safety net sites are included on this map. A map of federally designated dental health professional shortage areas may be found at: http://www.maine.gov/dhhs/mecdc/local-public-health/orhpc/index.shtml/.

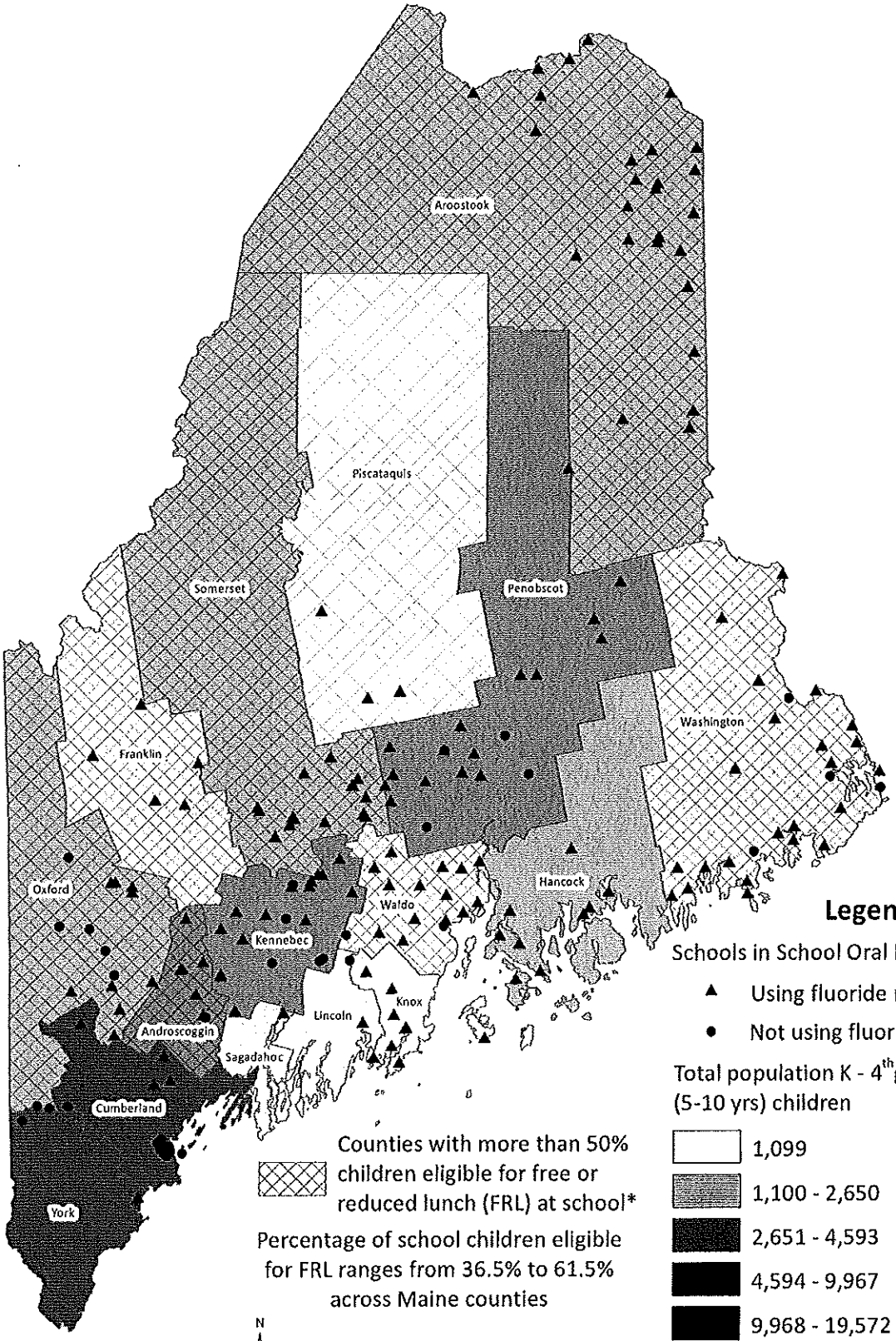
5. The maps showing the locations of schools funded by the Maine CDC to provide fluoride mouthrinse and dental sealants (#8, 9) also indicate counties in which more than 50% of children are eligible for the federal Free and Reduced Lunch (FRL) Program at school. The School Oral Health Program, an initiative of the Maine CDC's Oral Health Program, provides these resources to schools that meet a combination of community-based risk factors, within the limits of available funds. Generally speaking, a threshold level of 40% FRL eligibility will qualify a school for the state-funded program. In 2013, fewer schools use the fluoride mouthrinse.

6. In 2011, 66 public water systems provided optimally fluoridated water to 133 communities in Maine, comprising 80 percent of people who are served by public water systems. (Since then, two systems combined corporately, and small one system discontinued fluoridating [on Mt. Desert Island, adjacent to the Bar Harbor on the map] resulting in 64 systems serving 132 communities.) Because just over half of the state's population uses wells or small private systems, this translates to 40 percent of the total population of the state. Not all people in a community where public water is provided have access to that water.

7. Map #11 represents Independent Practice Dental Hygienist (IPDH) practice locations in Maine as reported in September 2012. An IPDH is licensed by the Maine Board of Dental Examiners to practice without supervision by a dentist in Maine within a scope of practice that includes many but not all of all the duties described under general supervision of Registered Dental Hygienists.

8. Map #12, Public Health Dental Hygienists Providing School Linked Services in Maine schools, 2012, represents the school districts, grouped by zip codes, where hygienists practicing in Public Health Supervision status are providing preventive oral health services in schools. A Public Health Supervision Dental Hygienist is a registered dental hygienist who practices in settings other than a traditional dental practice, providing preventive services, under the general supervision of a dentist.

8. Schools with State-Funded Fluoride Mouth Rinse Program, Maine 2011
Maine CDC Oral Health Program



Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

*See explanatory notes
Data source:
School fluoride mouth rinse data: Maine Oral Health Program, Maine CDC, 2011-12 school year
Child population: U.S. Census Bureau, 2010
Free and reduced lunch report, Maine Department of Education, 2010

Maps constructed by: Santosh Nazare, Research Associate I/Epidemiologist, University of Southern Maine for Maine CDC Oral Health Program, December 2011

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
Maine Center for Disease Control and Prevention
286 Water Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-8016; Fax: (207) 287-9058
TTY Users: Dial 711 (Maine Relay)

Oral Health in Maine, 2011 – 2012
A Series of Maps Describing Professional and Prevention Resources: Explanatory Notes

These maps were constructed by Santosh Nazare, MBBS, MPH, CPH, Epidemiologist/Research Associate I, University of Southern Maine Department of Applied Medical Sciences, for the Oral Health Program in the Maine Center for Disease Control and Prevention's Division of Population Health, and by David Pied, Policy, Systems and Environmental Change Program Manager in the Division, using data available in 2011 and 2012. It is expected that they will be updated after new data becomes available by the end of 2013. Specific data sources and dates are noted on each map. Certain terms and other details are defined and discussed below.

1. Dentists and dental hygienists (maps # 1 – 6):
   a. The term "active" is used to describe dentists and registered dental hygienists who have up-to-date, active licenses from the State Board of Dental Examiners.
   b. Because a dental professional holds an active license does not necessarily mean that the individual is actively practicing.
   c. There is no practical way to indicate the number of hours an individual dentist or dental hygienist practices and whether that is full-time, part-time, or some other basis.
   d. Dental hygienist location is based upon county of residence, which may or may not be the county of practice.

2. Total population maps (maps # 1, 5, 6) indicate the numbers of active license holders per county and the total county population.

3. Population density maps (maps #2, 3, 4) denote the approximate location of each licensed dental professional.
   a. Dentists are located by practice address. If several practice addresses are located in close proximity to each other, the map may not show more than one "dot," or "dots" may be overlaid on top of each other, due to the scale of the map. Dentists practicing at "safety net" dental clinics may not be shown, due to how they reported information. See map #7 for clinic locations.
   b. Dental hygienists provide home addresses and so were not mapped by population density due to privacy concerns.

4. "Safety net dental clinics" (#7) include any dental clinic or dental center that operates as, or is operated by, a private non-profit organization, including Federally Qualified Health Centers (FQHC) and FQHC-lookalikes; other private non-profit organizations; state-operated clinics; tribal clinics; and one volunteer program. The Institute of Medicine's report, *America's Health Care Safety Net* (2000), defines safety net providers as those who "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients." Although private practitioners may provide such services, only non-profit safety net sites are included on this map. A map of federally designated dental health professional shortage areas may be found at: http://www.maine.gov/dhhs/mecdc/local-public-health/orhpc/index.shtml/.

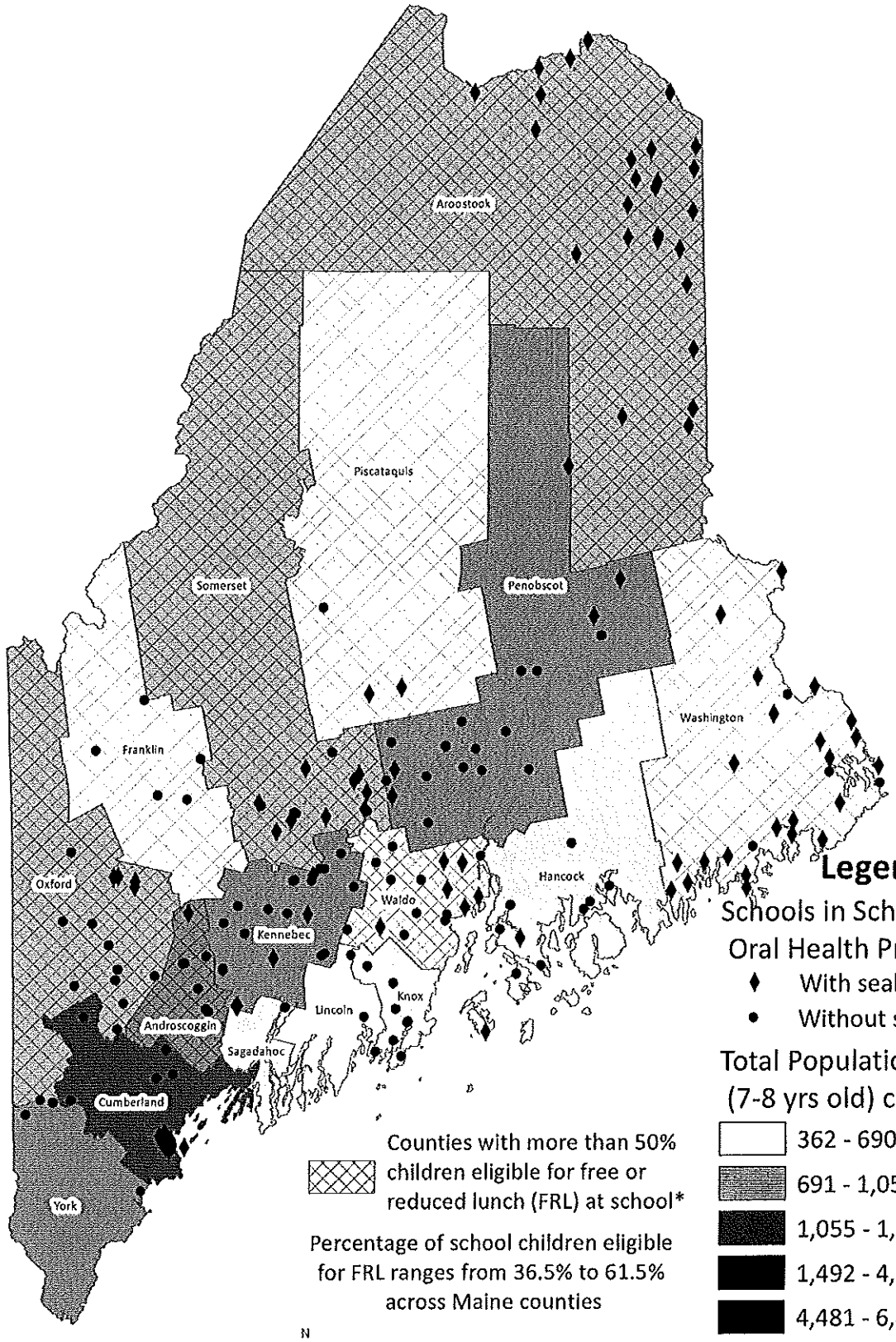
5. The maps showing the locations of schools funded by the Maine CDC to provide fluoride mouthrinse and dental sealants (#8, 9) also indicate counties in which more than 50% of children are eligible for the federal Free and Reduced Lunch (FRL) Program at school. The School Oral Health Program, an initiative of the Maine CDC's Oral Health Program, provides these resources to schools that meet a combination of community-based risk factors, within the limits of available funds. Generally speaking, a threshold level of 40% FRL eligibility will qualify a school for the state-funded program. In 2013, fewer schools use the fluoride mouthrinse.

6. In 2011, 66 public water systems provided optimally fluoridated water to 133 communities in Maine, comprising 80 percent of people who are served by public water systems. (Since then, two systems combined corporately, and small one system discontinued fluoridating [on Mt. Desert Island, adjacent to the Bar Harbor on the map] resulting in 64 systems serving 132 communities.) Because just over half of the state's population uses wells or small private systems, this translates to 40 percent of the total population of the state. Not all people in a community where public water is provided have access to that water.

7. Map #11 represents Independent Practice Dental Hygienist (IPDH) practice locations in Maine as reported in September 2012. An IPDH is licensed by the Maine Board of Dental Examiners to practice without supervision by a dentist in Maine within a scope of practice that includes many but not all of all the duties described under general supervision of Registered Dental Hygienists.

8. Map #12, Public Health Dental Hygienists Providing School Linked Services in Maine schools, 2012, represents the school districts, grouped by zip codes, where hygienists practicing in Public Health Supervision status are providing preventive oral health services in schools. A Public Health Supervision Dental Hygienist is a registered dental hygienist who practices in settings other than a traditional dental practice, providing preventive services, under the general supervision of a dentist.

9. Schools with State-Funded Sealant Program, Maine 2011
Maine CDC Oral Health Program



Legend

Schools in School Oral Health Program
- With sealant program
- Without sealant program

Total Population of 2nd grade (7-8 yrs old) children
- 362 - 690
- 691 - 1,054
- 1,055 - 1,491
- 1,492 - 4,480
- 4,481 - 6,494

N W E S

0 15 30 60 Miles

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

*See explanatory notes

Data source:
School sealant program data: Maine Oral Health Program, Maine CDC, 2011-12 school year
Child population: U.S. Census Bureau, 2010
Free and reduced lunch report, Maine Department of Education, 2010

Maps constructed by: Santosh Nazare, Research Associate I/Epidemiologist, University of Southern Maine for Maine CDC Oral Health Program, December 2011

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
Maine Center for Disease Control and Prevention
286 Water Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-8016; Fax: (207) 287-9058
TTY Users: Dial 711 (Maine Relay)

Oral Health in Maine, 2011 – 2012
A Series of Maps Describing Professional and Prevention Resources: Explanatory Notes

These maps were constructed by Santosh Nazare, MBBS, MPH, CPH, Epidemiologist/Research Associate I, University of Southern Maine Department of Applied Medical Sciences, for the Oral Health Program in the Maine Center for Disease Control and Prevention's Division of Population Health, and by David Pied, Policy, Systems and Environmental Change Program Manager in the Division, using data available in 2011 and 2012. It is expected that they will be updated after new data becomes available by the end of 2013. Specific data sources and dates are noted on each map. Certain terms and other details are defined and discussed below.

1. Dentists and dental hygienists (maps # 1 – 6):
   a. The term "active" is used to describe dentists and registered dental hygienists who have up-to-date, active licenses from the State Board of Dental Examiners.
   b. Because a dental professional holds an active license does not necessarily mean that the individual is actively practicing.
   c. There is no practical way to indicate the number of hours an individual dentist or dental hygienist practices and whether that is full-time, part-time, or some other basis.
   d. Dental hygienist location is based upon county of residence, which may or may not be the county of practice.

2. Total population maps (maps # 1, 5, 6) indicate the numbers of active license holders per county and the total county population.

3. Population density maps (maps #2, 3, 4) denote the approximate location of each licensed dental professional.
   a. Dentists are located by practice address. If several practice addresses are located in close proximity to each other, the map may not show more than one "dot," or "dots" may be overlaid on top of each other, due to the scale of the map. Dentists practicing at "safety net" dental clinics may not be shown, due to how they reported information. See map #7 for clinic locations.
   b. Dental hygienists provide home addresses and so were not mapped by population density due to privacy concerns.

4. "Safety net dental clinics" (#7) include any dental clinic or dental center that operates as, or is operated by, a private non-profit organization, including Federally Qualified Health Centers (FQHC) and FQHC-lookalikes; other private non-profit organizations; state-operated clinics; tribal clinics; and one volunteer program. The Institute of Medicine's report, *America's Health Care Safety Net* (2000), defines safety net providers as those who "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients." Although private practitioners may provide such services, only non-profit safety net sites are included on this map. A map of federally designated dental health professional shortage areas may be found at: http://www.maine.gov/dhhs/mecdc/local-public-health/orhpc/index.shtml/.

5. The maps showing the locations of schools funded by the Maine CDC to provide fluoride mouthrinse and dental sealants (#8, 9) also indicate counties in which more than 50% of children are eligible for the federal Free and Reduced Lunch (FRL) Program at school. The School Oral Health Program, an initiative of the Maine CDC's Oral Health Program, provides these resources to schools that meet a combination of community-based risk factors, within the limits of available funds. Generally speaking, a threshold level of 40% FRL eligibility will qualify a school for the state-funded program. In 2013, fewer schools use the fluoride mouthrinse.

6. In 2011, 66 public water systems provided optimally fluoridated water to 133 communities in Maine, comprising 80 percent of people who are served by public water systems. (Since then, two systems combined corporately, and small one system discontinued fluoridating [on Mt. Desert Island, adjacent to the Bar Harbor on the map] resulting in 64 systems serving 132 communities.) Because just over half of the state's population uses wells or small private systems, this translates to 40 percent of the total population of the state. Not all people in a community where public water is provided have access to that water.

7. Map #11 represents Independent Practice Dental Hygienist (IPDH) practice locations in Maine as reported in September 2012. An IPDH is licensed by the Maine Board of Dental Examiners to practice without supervision by a dentist in Maine within a scope of practice that includes many but not all of all the duties described under general supervision of Registered Dental Hygienists.

8. Map #12, Public Health Dental Hygienists Providing School Linked Services in Maine schools, 2012, represents the school districts, grouped by zip codes, where hygienists practicing in Public Health Supervision status are providing preventive oral health services in schools. A Public Health Supervision Dental Hygienist is a registered dental hygienist who practices in settings other than a traditional dental practice, providing preventive services, under the general supervision of a dentist.

RECENT CORRESPONDENCE RECEIVED BY THE BOARD REGARDING SPECIFIC PRACTICE ISSUES AND/OR DELIVERY MODELS

✓Susan Feeney-Hopkins, Pines Health Services

✓Kristin Sanborn, IPDH

PINES HEALTH SERVICES
"Pines Health Services - collaborating with Cary Medical Center and others to provide quality health care"
Administration
Post Office Box 40, Caribou, Maine 04736
(207) 498-2359 • (800) 371-6240 • Fax: (207) 498-3947

PINES

CARIBOU
☐ *Primary Care*
(207) 498-2356 • Fax: (207) 492-6260

☐ *OB/GYN • Pediatrics*
OB: (207) 498-6921 • Peds: (207) 492-3451
Fax: (207) 498-1697

☐ *Orthopedics & Sports Medicine*
(207) 493-5791 • Fax (207) 498-1326

CARIBOU
☐ *Pines Urological Services*
(207) 498-8678 • Fax: (207) 493-7725

☐ *Surgery*
(207) 498-2595 • Fax: (207) 498-2483

☐ *Ophthalmology*
647 Main Street • (207) 496-6851

FORT FAIRFIELD
☐ *Primary Care*
(207) 472-0590 • Fax: (207) 472-0597

PRESQUE ISLE
☐ *Primary Care • Pediatrics • OB/GYN*
Occupational Medicine
(207) 769-2025 • Fax: (207) 764-0629

☐ VAN BUREN
Primary Care • Pediatrics • OB/GYN
(207) 868-2796 • Fax: (207) 868-2799

☐ WASHBURN
Primary Care
(207) 455-4750 • (207) 455-4729

October 28, 2016

Maine Board of Dental Examiners
143 State House Station
161 Capital Street
Augusta, ME 04330

Dear Maine Dental Board Members:

I am writing on behalf of Pines Health Services in Caribou, ME. We are a non-profit, Federally Qualified Health Center (FQHC) providing accessible, patient-centered primary, behavioral and specialty health care services throughout rural Aroostook County since 1981.

As you are aware, Aroostook County experiences a chronic shortage dental providers and an even larger shortage of dental providers willing to accept MaineCare. Pines recognized this on the basis of direct input from our patients and from extensive community health needs assessment surveys. With approval from the Health Resources and Services Administration (HRSA), we received funding in late June to plan and implement an oral health services program. Our goal over the next few years is to establish a dental home for those who are currently going without dental care and/or lacking in dental care, particularly as a result of being uninsured or under-insured.

The Pines oral health program is designed to provide onsite preventative/hygiene services. Our business model does not include a dentist at start-up, since recruitment will take at least 12 – 18 months. Our Independent Practice Dental Hygienist (IPDH) will contract via formal written agreements with at least two local private dentists who will agree to see referred Pines dental patients. These dentists provided written support for the grant application submitted to HRSA earlier in the year. These dentists will receive payment for their professional services through Oral Health Services Expansion (OHSE) grant funds and overall program income generated by Pines. In addition, our IPDH will be credentialed with MaineCare and private insurers for billing purposes.

Our practice model utilizes an IPDH to serve as the primary care provider, until we can recruit a full-time permanent dentist, to deliver preventative care services per the IPDH statutes as outlined in:

1) Title 32: Professions and Occupations
   Chapter 16: Dentists and Dental Hygienists
   Sub-Chapter 3-B: Independent Practice Dental Hygienists
   1094-I thru T: Independent practice

2) Department of Professional and Financial Regulation
   Board of Dental Examiners
   Chapter 16: Rules for IPDH to process Dental Radiographs

We understand the IPDH will be responsible for our patients and serve as their primary dental hygiene care provider. Each patient/guardian will be made aware of this and will be given an Informed Consent which outlines this information.

Further considerations of our practice model include:

1. **Anesthesia:** The IPDH will <u>not</u> deliver anesthesia and does not have certification to do so otherwise
2. **Referral Network:** we are in the process of building our list of providers to include general dentist(s), a pediatric dentist and an oral surgeon. This list will be in place prior to our first day of service
3. **X-Rays:** a written agreement will be in place between the IPDH and a Maine-licensed dentist to review all radiographs taken within 21 days of the date of service
4. **Radiation Shielding:** a Plan will be in place that includes rules and responsibilities to assure radiation safety for patients and staff.

Thank you for your review of our practice model. We would welcome your guidance and any other recommendations you may have for our plan.

Sincerely,

Susan Feeney-Hopkins

Susan Feeney-Hopkins, CDA
Pines Health Services
Dental Practice Manager

Email - Sfeeney-hopkins@pineshealth.org

Kristin Sanborn IPDH
81 Maple Street, Monmouth, ME 04259
krissanbornipdh@gmail.com
207-370-9080

Tab 9.F.

October 31, 2016

Maine Board of Dental Examiners
SHS #143
Augusta, ME 04333-0143

Dear Board,

I am writing to bring attention to concerns with the practice act regarding barriers to care.

- The Maine School Dental Health Program – Application of Fluoride Varnish
  As a RDH or IPDH we have to apply for PHS to be able to take part in this valuable program. The fact that we have to get standing orders signed and submit them for notification is another step that many RDHs and IPDHs decide not to go through to help out with this program. The varnish program requires a screening at the same time the varnish is applied. The school nurses and personnel are not trained to identify decay or existing restorations. The screening asks for identification of areas of decay and whether there is evidence of existing restorations. As we know, composites are very difficult to identify. The nurses really enjoy having a trained person to apply the varnish and complete the screening. The duties of the school nurse are wide and far reaching, being able to rely on a trained hygienist to complete the varnish program takes one thing off their list of things to accomplish.
  - I believe we need to remove the need for notification of PHS status for any RDH or IPDH to work with the school fluoride varnish program. We apply fluoride on a daily basis in our roles in general practice. School volunteerism should not be difficult to accomplish.

- The practice act does not allow a PHS hygienist to apply varnish to a child that sends in a permission slip and states that they have been to the dentist in the past 6 months. The "dental home" issue is a real barrier.

  As a PHS hygienist, I would have to get the school nurse to apply the varnish on any child that has a "dental home". Many children take part in the varnish program because it is at no cost to the parent. They may refuse a fluoride treatment at their general dentist due to the cost or lack of

insurance coverage (since insurance pays only 1 time in a year). They choose to have the fluoride applied at school during the varnish program since it is free and they can have it done every 6 months. Follow up notes are sent home informing the parents of findings and recommendations, including need for homecare help and need to see their dentist of record. If the child has no dentist of record the school nurse helps get them to care.

  - The dental home issue should be removed from the practice act to enable every child to participate in the varnish program.

- As IPDHs we should not be prevented from being mobile. We should be able to care for patients where ever it is needed. ie. Schools, nursing homes, group homes, hospices, hospitals or their homes. Some patients are not able to get to a dental office comfortably and/or they are no longer mobile. IPDHs should not be restricted to being stationary. The whole idea of providing care is going to the patient. Being stationary is a real barrier to care. We are willing and able to provide care in many settings and aide the patient in receiving the care they need. There are many professions that provide mobile care: Veterinarians, doctors, nurses, denturists, dentists or even hair stylists.
  - We need to remove the limitations on practice settings.

- The requirement of sponsorship for Category 1 CE credits needs to be examined. Receiving sponsorship is very costly and the sponsor has requirements that are not always reasonable. The sponsorship fees are annual and they require you to charge for your continuing education courses.
  - We need to remove the requirement of sponsorship for Category 1 CE credits.

Sincerely,

Kristin Sanborn IPDH

#9

PAUL R. LEPAGE
GOVERNOR

STATE OF MAINE
BOARD OF DENTAL EXAMINERS
143 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0143

July 19, 2016

Informational Letter Regarding Enacted Laws
By the Maine State Legislature During the 127th Second Regular Session

There were a number of laws enacted during the last legislative session that directly impact the Maine Board of Dental Examiners. Below is a list of those laws, including their effective dates and implementation status. I've also included Public Law 2016, c. 407 as the Board recently adopted a policy regarding the mandatory training and how the completed training might be used in meeting the continuing education requirements outlined in Chapter 13 of the Board's Rules.

New laws directly impacting Board's statute:

- Public Law 2016, c. 429 "An Act to Revise the Laws Regarding Dental Practices"
- Public Law 2016, c. 488 "An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program"

New laws not directly impacting the Board's statute, but directly impacts licensees:

- Public Law 2016, c. 407 "An Act To Require Training of Mandated Reporters under the Child Abuse Laws"

Summaries:

- Public Law 2016, c. 429 - repealed Chapter 16 of the Board's authorizing statutue and replaced it with the new provisions outlined in Chapter 143. This new law also requires that the Board report back to the Legislature by March 1, 2017, regarding its efforts to identify recommendations for further legislative review. Highlights of the statutory changes are outlined in the attached document entitiled "Highlights of Statutory Changes – Public Law 2016, c. 429."
- Public Law 2016, c. 488 - amends the Board's new statute by identifying new requirements when prescribing opioid medication. There are certain provisions of the new law that take effect on July 29, 2016, and there are provisions of the new law that will become effective on or after January 1, 2017. The new law also provides exceptions to the limitations on prescribing opioids, sets new electronic prescribing requirements, and requires 3 hours of continuing education every two years as a condition for dentists who prescribe opioid medication.
- Public Law 2016, c. 407 - requires those who are mandated reporters of child abuse to obtain training approved by the Maine Department of Health and Human Services at least once every 4 years.

Implementation status:

- Public Law Public Law 2016, c. 429: there are a number of new statutory provisions that will take effect immediately and a number of provisions that will require further rulemaking provisions. The attached document outlines those provisions that need further rulemaking.
- Public Law 2016, c. 488: the Board will undergo rulemaking to further implement the continuing education requirements. Additional efforts to implement the limitations on prescribing opioid medication is not anticipated at this time. However, a review of Board Rule, Chapter 21 "Use of Controlled Substnatces For Treatment of Pain" which is a joint rule with other regulatory boards will be examined to ensure that prescribing standards are consistent with this new law.
- Public Law 2016, c. 407: the Board does not have any enforcement authority on this new law. However, the Board will make efforts to educate applicants and licensees regarding the new law via email, website, applications, etc. Additionally, at its June 24, 2016 meeting, the Board voted to adopt a policy stating that it will recognize 1 hour of Category II home-study credit for dentists or dental hygienists who complete the mandated training provided by the Maine Department of Health and Human Services ("DHHS") in meeting the biennial registration renewal requirements. However, the following criteria must be met: licensees must complete the DHHS training within the licensure biennium, licensees are responsible for maintaining and producing a record of the training in the event they are audited by the Board, and licensees must be aware of the limit on home-study courses as outlined in Chapter 13.

FMI:
Maine State Legislature: http://legislature.maine.gov/
State Agency Rulemaking: http://www.maine.gov/sos/cec/rules/index.html
Board's Website: http://www.maine.gov/dental/

Should you have any questions regarding this notice, please feel free to contact Penny Vaillancourt, Executive Director, by email at penny.vaillancourt@maine.gov or by using the contact information provided below:

Attach.

JULY 2016

HIGHLIGHTS OF STATUTORY CHANGES IDENTIFIED IN PUBLIC LAW 2016, C. 429 (EFF. 7/29/2016)

New/Revised Changes from former Title 32, Chapter 16

Section	Subject	Notes
1) 18302	Definitions	• This is a new section
2) 18304 (2)	Unlawful Practice	• This section is not to be confused with the disciplinary action provisions
3) 18305	Licensure Exemptions	• Clarifies exemptions to licensure under the Act
4) 18302 (1)	Board Name Change	• Board of Dental Practice
5) 18322 (3)	Board Quorum	• Quorum is majority of members serving instead of the number "5" • Chair; Vice-Chair
6) 18325 (1)	Disciplinary Action	• Aligned provisions of Title 10, Chapter 901 into Board statute
7) 18345	Dental Hygiene Licensure and Authorities	• Establishes a baseline license with the ability to add authorities as outlined below: o LAN and NOX Permits o Independent Practice o Public Health Dental Hygienist o Dental Hygiene Therapist o Provisional DHT
8) 18347	Endorsement	• Two pathways o Licensed at least 3 years (substantially equivalent – examine license laws) o Licensed less than 3 years (substantially similar – examine individual's qualifications for licensure)
9) 18348	Registrations	• Dentist Externships • Denturists Externships • Dentists - Sedation/general anesthesia training • Dental Hygienists – LAN/NOX training
10) 18349	Renewals and Reinstatements	• Late renewals - licensees can renew up to 90 days with payment of late fee • Reinstatements – licensees can reinstate between 91 days and 2 years; board may waive examination requirements • Beyond 2 years – meet all new requirements

*Highlights in yellow denote agency rulemaking required

New/Revised Changes from former Title 32, Chapter 16 (cont.)

11) 18351	Inactive Status	• Clarifying language
12) 18352	10 Day Reporting Requirements	• Change in name • Criminal conviction • Disciplinary action • Material change in conditions or qualifications (i.e. sedation permits, supervision changes)
13) Subchapter 4 §18371 – §18379	Scope of Practice Provisions	• No changes in scope; rather scope in board rules now placed into statute
14) §18371	Scope of Practice – Dentists	• Clarifies by including delegation authority to unlicensed individuals
15) §18376	Scope of Practice – Public Health Dental Hygienists	• Puts back into statute a practice category that will be added as an authority under an RDH license
16) §18345	IPDH - new pathway to licensure	• The new law provides a pathway for RDH w/public health supervision experience to qualify for IPDH licensure

Provisions Removed from former Title 32, Chapter 16

Former Statute Section	Subject	Notes
17) 1084 (4), 1094 (1)	Posting of Licenses	• Removed from statute – nullifies Chapter 9 requirement?
18) Various provisions of Chapter 16	Term "dental assistant" or "dental auxiliaries"	• Replaces with the delegation authority to unlicensed persons; however, new statute does maintain "dental assistant" in §18377 (4) – reimbursement provisions
19) 1077	Informal Conferences	• §1077 (1) provisions removed in their entirety as the authority is contained in Title 10, Chapter 901 provisions
20) Various provisions of Chapter 16	Interviews	• Removed personal interviews as a requirement for licensure
21) Various provisions of Chapter 16	Fee Caps	• Individual fee caps removed and one fee cap set at $550.00

Maine Board Of Dental Practice

An Overview of Title 32, Chapter 143

"Dental Professionals"

Presented by
Penny Vaillancourt, Executive Director
December 2, 2016

www.maine.gov/dental

Design / Layout of the New Practice Act

- Title 32, Chapter 143 – "Dental Professionals"
  - Title 32, Chapter 16 "Dentists and Dental Hygienists" was repealed
- Chapter 143 has five (5) subchapters:
  - Subchapter 1 – General Provisions
  - Subchapter 2 – Board of Dental Practice
  - Subchapter 3 – Licensing Qualifications
  - Subchapter 4 – Scope of Practice; Supervision; Practice Requirements
  - Subchapter 5 – Practice Standards

Subchapter 1 – General Provisions

- Highlights
  - Dental Practice Act is the short title for reference purposes
    - Not be confused with Board Rules or Board Policies
    - Will be applied to filings with the Board on or after 07/29/2016
    - Title 32, Chapter 16 (old statute) – keep as reference document as there are pending matters that fall under the former statute
  - Definitions
    - This section is new and identifies terms used in statute – some of the definitions were pulled from existing rules – rule will be rewritten to avoid duplication
  - Individual license; license required
    - These sections identify the Board's statutory authority over individuals; and requires those providing services described in law to be duly licensed by the Board
    - §18304(2) Unlawful practice – not to be confused with disciplinary action provisions in §18325

Subchapter 1 – General Provisions

- Highlights (cont.)
  - Exemptions to licensure under the Dental Practice Act
    - Resident physician, student in medical school, CRNAs, anesthetists, etc.
    - Student enrolled in an educational program practicing under supervision of instructors
    - Students participating in a board-approved externship program who are registered with the Board pursuant to §18348
    - Individuals licensed who is registered pursuant to §18348 for the purpose of obtaining clinical experience needed to meet the requirements to administer sedation, local anesthesia, general anesthesia
  - Fraudulent sale / alteration of diplomas or licenses
    - Violations of this section are considered Class E crimes – considered a strict liability crime (ignorance of the law is not a defense)
  - Review committee immunity
    - Offers immunity from civil liability to dentist performing duties re: peer review

Subchapter 2 – Board of Dental Practice

- Highlights
  - Establishes the Board and provides a declaration of policy:

    "...its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions."

Subchapter 2 – Board of Dental Practice

- Highlights (cont.)
  - Sets statutory compensation for members of the Board, Subcommittee on Denturists, and Subcommittee on Dental Hygienists
  - Board membership; terms; quorum
    - §18322 – Quorum; removes a specific number and replaces with "majority of members serving"
  - Powers and duties of the board
    - Hearings and procedures (subpoena authority)
    - Complaint investigations; set fees; submit budget for approval; appoint an executive director, delegate review/approval of applications to board staff; authority to order a mental/physical examination of a licensee; adopt rules

Subchapter 2 – Board of Dental Practice

- Highlights (cont.)
  - Disciplinary action; judicial review
    - The board's statutory authority to suspend, revoke, refuse to issue or renew a license without proceedings pursuant to Title 5, section 10004 when:

"3. Health or safety hazard. The health or physical safety of a person or the continued well-being of a significant natural resource is in immediate jeopardy at the time of the agency's action, and acting in accordance with subchapter IV or VI would fail to adequately respond to a known risk, provided that the revocation, suspension or refusal to renew shall not continue for more than 30 days;"

Subchapter 2 – Board of Dental Practice

- Highlights (cont.)
  - Disciplinary action; judicial review (cont.)
    - The following are grounds to refuse to issue, modify, suspend, revoke or refuse to renew:
      - Title 32 chapter 143 (section 18325) p.13
      - Title 5 chapter 341 - criminal convictions
      - Title 10 chapter 90 (section 8003, subsection 5)
  - Subcommittee on Denturists
    - Membership, duties, quorum, election of chair/secretary
  - Subcommittee on Dental Hygienists
    - Membership, duties, quorum, election of chair/secretary

Subchapter 3 – Licensing Qualifications

- §18341 – Application; fees; general qualifications
  - Requirements apply to all licensing categories
    - Applicants must:
      - Submit an application, pay the required fee(s), and other materials required
      - Be 18 years of age or older
      - Time limit – 90 days to provide requested materials or may be denied

- §18342 (1) – Dentist license
  - Two pathways to licensure: 1. Standard licensure under §18342; or 2. Reciprocity as outlined in §18347
    - Standard licensure eligibility:
      - Education
      - Examination
      - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.

Subchapter 3 – Licensing Qualifications

- §18342 (2) – Faculty dentist license
  - Eligibility:
    - Active dental license in another state/Canadian province (in good standing)
    - Letter from employing school that indicates candidate meets their credentialing requirements and that they will teach as outlined in statute
    - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.

- §18342 (3) – Limited dentist license
  - Eligibility:
    - Education
    - Examinations
    - Active or expired dental license in good standing from another state/Canadian province
    - Verification that applicant will be practicing in a non-profit dental clinic without compensation
    - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.

Subchapter 3 – Licensing Qualifications

- §18342 (4) – Clinical dentist educator license
  - Eligibility:
    - Active dental license in another state/Canadian province (in good standing)
    - An outline of the clinical education program to be offered in this state
    - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.
- §18342 (5) – Charitable dentist license
  - Eligibility:
    - Education
    - Examinations
    - Active or expired dental license in good standing from another state/Canadian province
    - Verification that the purpose of the license is to offer free dental care in conjunction with a charitable or social organization
    - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.

Subchapter 3 – Licensing Qualifications

- §18342 (6) – Resident dentist license
  - Eligibility:
    - Education
    - Examinations
    - Practice setting approved by the Board
    - Statement from supervising dentist outlining the level of supervision and control of the services to be provided; and that the services to be performed are adequate given the applicant's knowledge and skill
    - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.
- §18343 (1) – Dental radiographer license
  - Eligibility:
    - High school diploma or equivalent as determined by the Board
    - Passing examination in radiologic technique and safety
    - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.

Subchapter 3 – Licensing Qualifications

- §18344 (1) – Expanded function dental assistant license
  - Eligibility:
    - High school diploma or equivalent as determined by the Board
    - Have one of the following: 1. current certification as a certified dental assistant from a board approved certificate program; 2. active hygiene license in Maine in good standing; or 3. active hygiene license in another state or Canadian province in good standing
    - Successful completion of a board approved training program
    - Examinations
    - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.
- §18345 (1) – Dental hygienist license
  - Two pathways to licensure: 1. Standard licensure under §18345; or 2. Reciprocity as outlined in §18347
    - Standard licensure eligibility:
      - Associates degree or higher in dental hygiene from a CODA approved dental hygiene program*; or completion of at least ½ of the prescribed courses in an accredited dental school as a dental student
      - Examinations
      - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.

Subchapter 3 – Licensing Qualifications

- §18345 (2) – Additional authority – see subsections below
- §18345 (2)(A) – Independent Practice Dental Hygiene authority
  - Eligibility:
    - Hygienist licensed under this subchapter either by standard licensure or reciprocity
    - 2,000 work hours of clinical practice (including public health supervision) with an earned bachelor's degree or higher in dental hygiene within 4 year period preceding application
    - 5,000 work hours of clinical practice (including public health supervision) with an earned associates degree in dental hygiene within a 6 year period preceding application
- §18345 (2)(B) – Public Health Dental Hygiene authority
  - Eligibility:
    - Hygienist licensed under this subchapter either by standard licensure or reciprocity
    - Written practice agreement with a licensed dentist and verification that services to be offerd in a public health setting

Subchapter 3 – Licensing Qualifications

- §18345 (2)(C) – Dental hygiene therapy authority
  - Eligibility:
    - Hygienist licensed under this subchapter either by standard licensure or reciprocity
    - Meets the educational qualifications of a dental hygiene therapy program and has an earned bachelors degree or higher in dental hygiene
    - 2,000 work hours of supervised clinical practice as a provisional licensee
    - Successful passage of clinical examination
    - Written practice agreement with a supervising dentists
- §18345 (2)(D) – Local anesthesia authority
  - Eligibility:
    - Hygienist licensed under this subchapter either by standard licensure or reciprocity
    - Successful completion of course require by board rule
    - Successful completions of examination

Subchapter 3 – Licensing Qualifications

- §18345 (2)(E) – Nitrous oxide analgesia authority
  - Eligibility:
    - hygienist licensed under this subchapter either by standard licensure or reciprocity
    - successful completion of course require by board rule
    - successful completions of examination
- §18345 (2)(F) – Provisional dental hygiene therapy authority
  - Eligibility:
    - hygienist licensed under this subchapter either by standard licensure or reciprocity
    - meets the educational qualifications of a dental hygiene therapy program and has an earned bachelors degree or higher in dental hygiene
    - successful passage of clinical examination
    - written practice agreement with a supervising dentists
- §18345 (3) – Faculty dental hygiene license
  - Eligibility:
    - Active dental hygiene license in another state/Canadian province (in good standing)
    - Letter from employing school that indicates candidate meets their credentialing requirements and that they will teach as outlined in statute
    - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.

Subchapter 3 – Licensing Qualifications

- §18346 (1) – Denturist
  - Eligibility:
    - hygienist licensed under this subchapter either by standard licensure or reciprocity
    - successful completion of course require by board rule
    - successful completions of examination
- §18346 (2) – Faculty denturist license
  - Eligibility:
    - Active denturist license in another state/Canadian province (in good standing)
    - Letter from employing school that indicates candidate meets their credentialing requirements and that they will teach as outlined in statute
    - Other materials required – i.e. NPDB report, licensure verifications, criminal background checks, etc.

Subchapter 3 – Licensing Qualifications

- §18347 – Endorsement; Applicants authorized to practice in another jurisdiction
  - Pathway One:
    - Substantially equivalent license at least 3 consecutive years
  - Pathway Two:
    - Substantially similar qualifications less than 3 years
- §18348 – Registration Requirements
  - Eligibility:
    - Dentist/denturist externs
    - Sedation; general anesthesia
    - Local anesthesia; nitrous oxide
- §18349 – License renewal; reinstatement
  - Renewal = pay fees; meet ce requirements
  - Late renewal = within 90 days – pay license fee/late fee; meet ce requirements
  - Reinstatement = 91 days to 2 years – new application; board may waive examination
  - Applications received 2 years plus – new application

Subchapter 3 – Licensing Qualifications

- §18350 – Continuing Education
  - Board rule; condition to renew a license
- §18351 – Inactive Status
  - Board rule
- §18352 – Duty to Require Certain Information from Applicants and Licensees (a/k/a 10 day reporting requirement)
  - A. Change of name or address;
  - B. Criminal conviction;
  - C. Revocation, suspension or other disciplinary action taken in this State or any other jurisdiction against any occupational or professional license held by the licensee or applicant; or
  - D. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the board.

Subchapter 4 – Scope of Practice, Supervision, Practice Requirements

- §18371 – Dentist
  - Delegation authorized, supervision requirements
- §18372 – Dental Radiographer
  - General supervision of a dentist
- §18373 – Expanded Function Dental Assistant
  - Direct supervision / General supervision
  - Procedures not authorized
- §18374 – Dental Hygienist
  - Direct supervision / General supervision
- §18375 – Independent Practice Dental Hygienist
  - Practice standards
- §18376 – Public Health Dental Hygienist
  - Supervision agreement

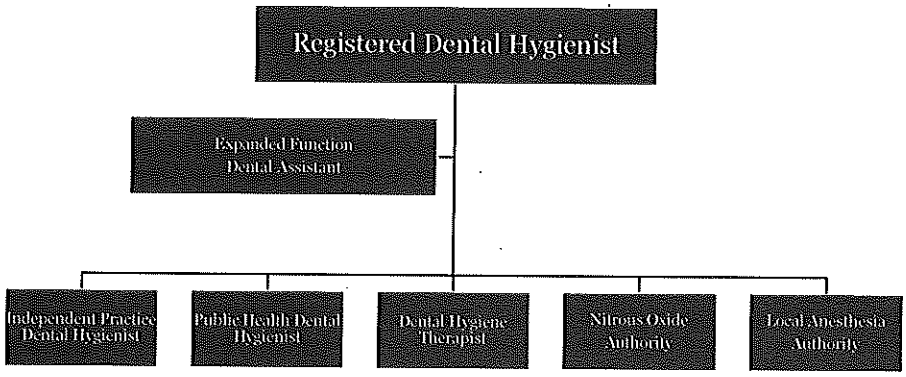
Subchapter 4 – Scope of Practice, Supervision, Practice Requirements

- §18377 – Dental Hygiene Therapist
  - Direct and general supervision
  - Supervision responsibilities, practice requirements, written practice agreement
- §18378 – Denturist
  - Scope; limitations
- §18379 – Sedation and General Anesthesia
  - Board rulemaking

Subchapter 5 – Practice Standards

- §18391 – Amalgam Brochures; Posters
- §18392 – Removable Dental Prosthesis; Owner Identification
- §18393 – Confidentiality

Dental Hygiene Practice



Questions???

#11

MAINE BOARD OF DENTAL PRACTICE
Phase II – Ad Hoc Committee – Reference Sheet
December 2, 2016

Participants:

Dr. Lisa Howard, Board Vice Chair	MBDP
Nancy Foster, RDH, EFDA, EdM	MBDP
Dr. Jon Ryder, Dean	UNE, Dental School
Marji Harmer-Beem, RDH	UNE, Dental Hygiene Program
Amanda Willette, CDA, EFDA	UMA
Tracey Jowett, IPDH	PHS
Austin Carbone, LD	Denturist Association
Paul Levassuer, LD	Denturist Society
Lorraine Klug, IPDH	MHDA
Dr. David Pier	MDA
Dr. James Schmidt	Non-profit dental clinic
Michelle Gallant, RDH	PHS; hospital clinic
Dr. Marion Hernon	FQHC

Staff:

Penny Vaillancourt, Executive Director	MBDP
Legal counsel	Attorney General's Office

Meeting Dates:

Friday, December 2nd
Friday, January 20th
Friday, February 17th
Friday, March 3rd

Background:

During the 127th Second Regular Session, the Board of Dental Practice provided testimony on a variety of legislative initiatives that were before the Joint Standing Committee on Labor, Commerce, Research and Economic Development with the recommendation to approach various practice issues in two phases. The first phase was to repeal and replace the Dental Practice Act and provide a statutory framework that makes clear the legislative intent and scope of the Board's work. Phase II was to further examine the Board's statutes and rules and identify recommendations regarding practice issues, practice settings, delivery models for legislative consideration.

Objective:

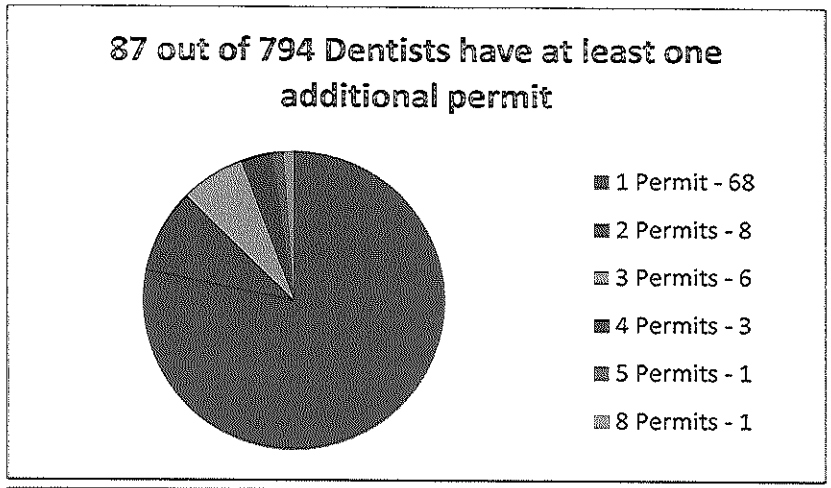
The objective of the ad hoc committee is to review the Board's statutes and rules and identify issues related to scopes of practice, various practice settings, delivery models, etc. The work of the committee will be considered by the Board when it reports back to the Legislature in March of 2017.

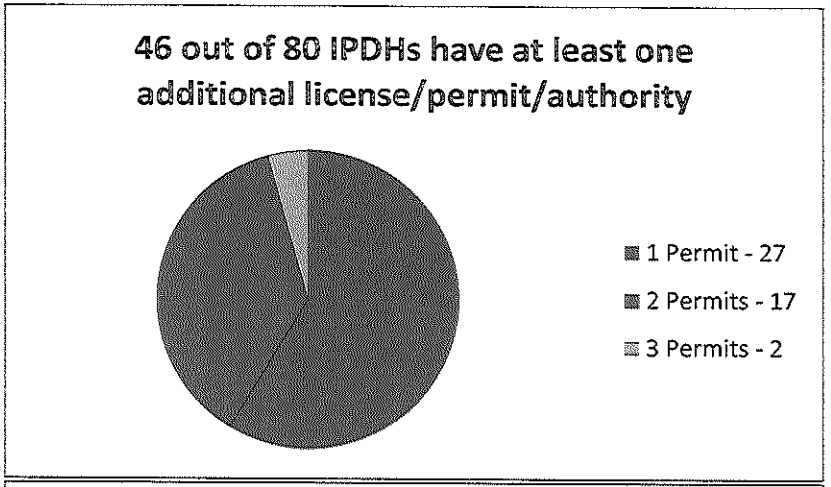
Ground Rules:

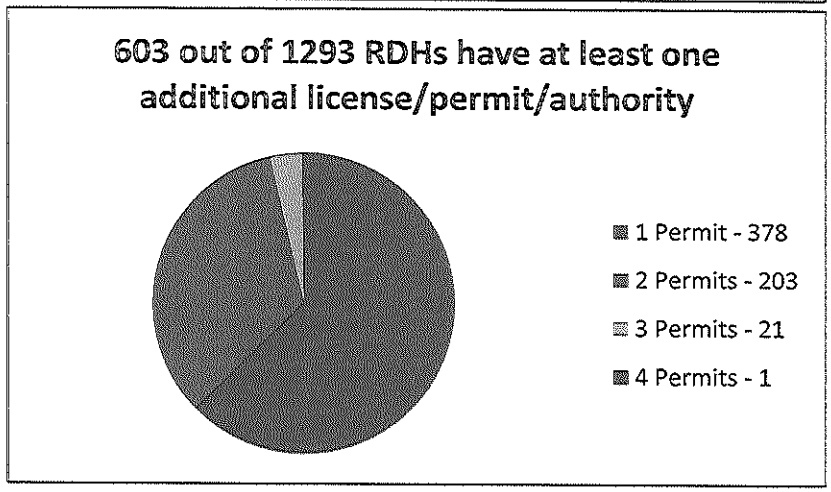
1. • Hands to speak.
2. Minimize distractions. Side conversations, cell phones - try to be fully present as a group for the whole meeting.
3. Name tensions. Surely there are tensions and areas of disagreement. There are bound to be differences of opinion. Agree to disagree, respectfully.
4. Emphasize that this is not a forum to air grievances with the Board/Board staff – this is a focused effort. However, board staff will capture other topics in a "parking lot" list for the Board's review.
5. Audience decorum - discussion is among the ad hoc participants. Members of the audience can reach out to board staff by email or during a break if they have an issue, comment, etc.
6. Goal is to identify the issues, the committee is not being asked to provide solutions. The solutions are likely to be public policy decisions that are determined by the Legislature, not the Board.
7. Board staff to disseminate and collect information. This is a public process, so please do not REPLY ALL on email exchanges. Please direct your email to board staff and it will be disseminated to participants either in advance or at the next meeting.

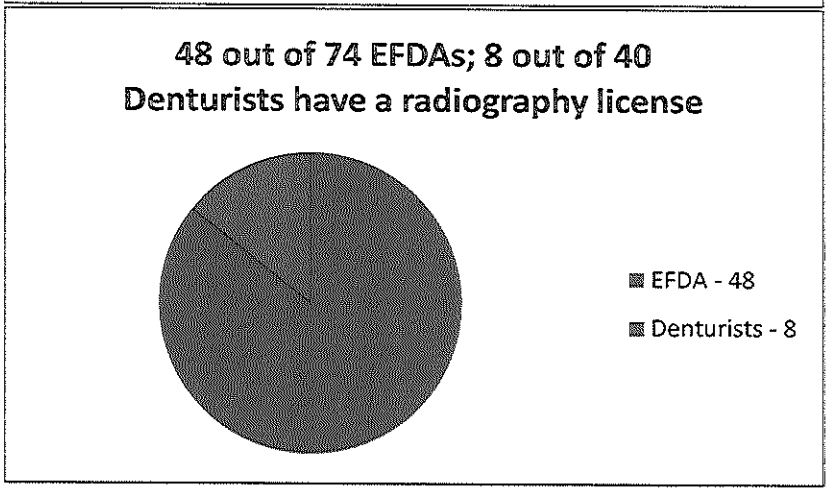
MAINE BOARD OF DENTAL EXAMINERS
LD 1596 – "An Act to Revise the Laws Regarding Dental Practice"
Licensing/Permitting Data – March 2016

#12









MAINE BOARD OF DENTAL EXAMINERS
LD 1596 – "An Act to Revise the Laws Regarding Dental Practice"
Licensing/Permitting Data – March 2016

RDH with one additional license/permit

- RDH w/ LAN 301
- RDH w/NOX 36
- RDH w/EFDA 4
- RDH w/RAD 2
- RDH s/ PHS 35

RDH with two additional licenses/permits

- RDH w/LAN and NOX 187
- RDH w/RAD and LAN 2
- RDH w/EFDA and LAN 2
- RDH w/EFDA and NOX 1
- RDH w/LAN and PHS 9
- RDH w/NOX and PHS 2

RDH with three additional licenses/permits

- RDH w/LAN, NOX, EFDA 12
- RDH w/LAN, NOX, RAD 2
- RDH w/LAN, NOX, PHS 6
- RDH w/EFDA, LAN, PHS 1

RDH with four additional licenses/permits

- RDH w/LAN, NOX, RAD, PHS 1

IPDH with one additional license/permit

- IPDH w/LAN 21
- IPDH w/NOX 6

IPDH with two additional licenses/permits

- IPDH w/LAN, NOX 11
- IPDH w/LAN, EFDA 1
- IPDH w/LAN, PHS 5

IPDH with three additional licenses/permits

- IPDH w/LAN, NOX, PHS 2

Expanded Function Dental Assistants with one additional license/permit

- EFDA w/RAD 48

Denturists with one additional license/permit

- DTR w/RAD 8

Dentists with additional sedation permit

- DEN w/ one permit 68
- DEN w/two permits 8
- DEN w/three permits 6
- DEN w/four permits 3
- DEN w/five permits 1
- DEN w/eight permits 1

Maine Board of Dental Practice
Review of the Maine Dental Practice Act - Phase II

Pursuant to Public Law 2016, c. 429
"An Act to Revise the Laws Governing Dental Practices"

Meeting Materials - January 20, 2017

1. Agenda
2. Draft meeting notes from December 2, 2016 meeting
3. List of issues identified at December 2, 2016 meeting
4. Chart of issues - categorized as statute review, rules review, etc.
5. RDH Scope as listed in 32 MRS §18374
6. Correspondence submitted for the committee's consideration
    a. Nancy Foster, RDH, EFDA, EdM - email dated January 12, 2017
    b. Lorraine Klug, IPDH - email dated January 17, 2017
    c. Tracey Jowett, IPDH - email dated January 18, 2017
    d. Marji Harmer-Beem RDH, MS - email dated January 18, 2017

MAINE BOARD OF DENTAL PRACTICE

Ad Hoc Committee – Phase II Meeting Notes
January 20, 2017

****

The Ad Hoc Committee convened at 9:00 a.m.

Participants Present:

Dr. Geraldine Schneider, Chair of the Board of Dental Practice; Nancy Foster, RDH, EFDA, EdM, Member of the Board of Dental Practice; Dr. Marion Hernon; Dr. Rachel King; Marji Harmer-Beem, RDH; Amanda Willette, CDA, EFDA; Austin Carbone, LD; Paul Levasseur, LD; Lorraine Klug, IPDH; Dr. David Pier; Dr. James Schmidt; Michelle Gallant, RDH; and Penny Vaillancourt, Executive Director, Board of Dental Practice.

Also Present:

Janet Stocco, Bonnie Vaughan, John Merrill, Ann Mitchell, Tricia Spearin, and Lauren LaRochelle, Assistant Attorney General.

Introduction/Background/Ground Rules/Role of the Committee:

Dr. Schneider and Nancy Foster, RDH, EFDA, EdM opened the meeting and welcomed participants and members of the public attending the meeting. Introductions were made, an overview of the ground rules was conducted, and objectives of the committee were shared.

Highlights of the discussion included:

- Issues raised in a letter submitted by Lorraine Klug
- Disagreement in using the term "dental hygiene diagnosis"
- Concepts were shared of writing an RDH scope of practice
- Support for the existing composition of the Board was expressed, as well as encouraging interdisciplinary discussions
- The FTC v. North Carolina Dental Board decision was mentioned in the context of not having one profession dominate membership of a dental regulatory board
- Consider regulating dental assistants and perhaps roll into the existing dental radiography licensure category
- Consider dentist scope to include non-dentally related use of Botox
- Distinctions were made between credentialing and licensing (medicine/dentistry)
- Desire to prioritize the issues identified and discuss each one for the purpose of providing recommendations to the Board

Action included:

- Review, discussion and vote on the list of issues identified

Meeting adjourned at 12:05 p.m.

BOARD OF DENTAL PRACTICE
Ad Hoc Committee - Phase II Review meeting of: January 20, 2017

PLEASE SIGN IN

Please PRINT Your Name and Your Agency Name **Clearly**

NAME	AGENCY
B. Vaughan IPDH	MDHA - KVFD
P. LEVASSEUR	MSD
Marion Hernon DMD	HHC
Ann Mitchell	MDA
John Merrill	
Janet Stocco	OPLA (legislature)
Trucia Spear	RDH, EFDA, faculty member UMA

Maine Board of Dental Practice

Ad Hoc Committee

Phase II Statutory Review pursuant to Public Law 2016, c. 429

January 20, 2017 - 9:00 a.m. - 12:00 p.m.

MEETING AGENDA

1) Opening remarks from co-chair(s)

2) Review timeline, meeting schedule, ground rules, etc.

3) Review/discuss draft notes of December 2, 2016 meeting

4) Review/discuss chart depicting issues identified to date
   a. Penny Vaillancourt to provide brief explanation to differences between statutes, rules, policies, sunrise review process, and sunset review.

5) Review/discuss RDH scope of practice list

6) Federally Qualified Health Centers
   a. A review of the regulations

7) State licensing laws
   a. A review of how some dental practice acts address practice issues such as patient of record; dental home; regulations and supervision in certain practice settings; scopes of practice definitions

8) Discussion/next steps

9) Adjourn

Location: Maine Board of Dental Practice, Conference room, 161 Capitol Street, Augusta, ME 04330
Directions: http://www.maine.gov/dental/board-information/contact.html

Contact staff: Penny Vaillancourt, Executive Director; tel: (207) 287-3333; TTY users call Maine relay 711; or email penny.vaillancourt@maine.gov

Key code:

Red = Statute change
Blue = Board rule change
Black = Statute and Board rule change
Strikethrough = already addressed

MAINE BOARD OF DENTAL PRACTICE

Ad Hoc Committee Meeting – List of Issues
December 2, 2016

Dental Hygienist

Red
1) Scope restrictions/supervision requirements/setting requirements
   a. IPDH
   b. Public Health
   c. Dental Hygiene Therapy.
2) Review list of authorized procedures and categorize the procedures instead of listing each particular procedure.
3) Review mobility of dental hygiene services.

Dentist

Red
1) Adopt ADA scope of practice of a dentist.
2) Use of dermal fillers and Botox for non-dentally related procedures.
3) Consider pathway for foreign trained dentists.
4) Consider "locum tenens" license and eliminate all the other various dental license types.
5) Tele-dentistry / tele-health definition.

Denturist

Red
1) Increased scope to include dental radiographs and all removable prosthetics with justified exceptions.
2) Replacing abutments on implants.
3) Denture ID's to include scanning technology.
4) Repopulating the dental board to reflect the Supreme Court's decision upholding the FTC's antitrust action re FTC v North Carolina Dental Board.
~~5) Allowing any licensees majority ownership of a dental practice.~~

Blue — 6) Allowing approved schools, CERP providers and state, national and international denturist associations to accredit continuing education.

Red — 7) Requiring internship to LD's before unsupervised practice.

~~8) Reflect legislative intent to provide up to 2 years of externship for denturist students.~~

Red
9) Use of International designation / identification of (DD) by Maine denturists.
10) Allow denturists to delegate authority for denturist assistance and lab technicians in their employ.

Dental Assistants / Unlicensed Person

Red — 1) Revisit list of delegated duties in statute.

Expanded Function Dental Assistants

Red — 1) Revisit list of delegated duties in statute.

Students

~~1) Dental, dental hygiene, denturist schools and associated outreach.~~
~~2) Dental student externships.~~

Issues that generally apply to dentists, dental hygienists, and denturists

Blue
1) Practice setting responsibilities: hospital; clinics; non-profit organizations; schools; nursing homes; FQHCs – what is the responsibility of the licensee versus the employer in terms of informed consent, treatment planning, HIPPA, recordkeeping, patient records, infection control, medications, pain management, etc.
2) Patient of Record; Provider of Record; Dental Home practice issues.

Red
3) Volunteer exemptions – students, licensees in either particular settings or limited to particular procedures.

Blue
4) Dental hygiene clinics without a supervising dentist.
5) Recruitment/retention of dentists; what level of dental hygiene services can be provided in the absence of a dentist of record – applicable only to non-profits and FQHCs?

Red
6) Teeth whitening; currently included in denturist scope, but not found in dental hygiene or dentists scope of practice.
7) Review Title 13, Chapter 22-A – corporate ownership language specific to dentists, IPDHs, and denturists.

Blue
8) Itinerant dental, dental hygiene, denturist services.

Other

Black
1) Increased coordination with the Maine School Oral Health Program
   a. Combination of regulatory issues such as setting, supervision requirements, scope of practice, dental home, etc.

Maine Board of Dental Practice
Ad Hoc Committee – Phase II Review Issues
Recommendation Chart

License Type	Practice Issue	Consensus
Dental Hygienists	1) Scope restrictions/supervision requirements/setting requirements a. IPDH i. Requirements too restrictive in terms of hours/timeframe of experience ii. Allow general supervision of dental radiographers b. Public Health i. Remove the notification requirements in board rule ii. Eliminate the PHS reporting in board rule iii. Remove patient qualifications for PHS services c. Dental Hygiene Therapy. 2) Review list of RDH authorized procedures and categorize the procedures instead of listing each particular procedure. 3) Add dental hygiene diagnosis to the definitions. 4) Allow RDHs to provide sealants under the general supervision of a dentist 5) Review mobility of dental hygiene services. a. IPDH practice in public health settings b. IPDH per diem 6)	1.a.i. – Remove distinction of years between degree type; vote unanimous. 1.a.i. – Add four years of clinical experience; vote: 6 in favor / 6 opposed. 1.a.i. – Streamline to 2,000 hours within preceding four years; vote: 9 in favor, 1 – opposed, 2 – not voting 1.a.ii. – Support; vote: unanimous 1.b.i. – Support; vote: unanimous 1.b.ii. – Support; vote unanimous 1.b.iii. – Support; vote unanimous 2 – Support; vote unanimous
Dentists	1) Adopt ADA scope of practice of a dentist. 2) Use of dermal fillers and Botox for non-dentally related procedures. 3) Consider pathway for foreign trained dentists. 4) Consider "locum tenens" license and eliminate all the other various dental license types. 5) Tele-dentistry definition.	
Denturists	1) Increased scope to include X-rays and all removables with justified exceptions. 2) Replacing abutments on implants. 3) Denture ID's to include scanning technology. 4) Repopulating the dental board to reflect the FTC v North Carolina Dental Board. 5) Requiring internship to LD's before unsupervised practice.	8) Allowing approved schools, CERP providers and state, national and international denturist associations to accredit continuing education.

	6) Use of International designation / identification of (DD) by Maine denturists. 7) Allow denturists to delegate authority for denturist assistance and lab technicians in their employ.	
License Type	**Statute Review**	**Combined/Other**
Dental Radiographers	1) Revisit list of delegated duties	
Expanded Function Dental Assistant	1) Revisit the list of delegated duties	
General Practice Issues	1) Volunteer exemptions – students, licensees in either particular settings or limited to particular procedures. 2) Teeth whitening; currently included in denturist scope, but not found in dental hygiene or dentists scope of practice. 3) Review Title 13, Chapter 22-A – corporate ownership language specific to dentists, IPDHs, and denturists.	
Other	1) Subcommittee authority – eliminate need for board ratification of subcommittee action; include subcommittee members as full members when voting on proposed rules	1) Increased coordination with the Maine School Oral Health Program - Combination of regulatory issues such as setting, supervision requirements, scope of practice, dental home, etc.

January 2017

MAINE BOARD OF DENTAL PRACTICE – AD HOC COMMITTEE
RDH Scope of Practice pursuant to 32 MRS §18374

Direct supervision:

A. Administer local anesthesia or nitrous oxide analgesia, as long as the dental hygienist or faculty dental hygienist has authority to administer the relevant medication pursuant to section 18345, subsection 2, paragraph D or E;

B. Irrigate and dry root canals;

C. Record readings with a digital caries detector and report them to the dentist for interpretation and evaluation;

D. Remove socket dressings;

E. Take cytological smears as requested by the dentist;

F. Take impressions for nightguards and occlusal splints as long as the dentist takes all measurements and bite registrations.

General supervision:

A. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse;

B. Apply cavity varnish;

C. Apply desensitizing agents to teeth;

D. Apply fluoride to control caries;

E. Apply liquids, pastes or gel topical anesthetics;

F. Apply sealants, as long as a licensed dentist first makes the determination and diagnosis as to the surfaces on which the sealants are applied;

G. Cement pontics and facings outside the mouth;

H. Change or replace dry socket packets after diagnosis and treatment planned by a dentist;

I. Deliver, but not condense or pack, amalgam or composite restoration material;

J. Expose and process radiographs;

K. Fabricate temporary crowns and bridges, limiting handpiece rotary instrumentation used in the fabrication to extraoral use only, as long as the dentist checks the occlusion and fit prior to releasing the patient;

L. For instruction purposes, demonstrate to a patient how the patient should place and remove removable prostheses, appliances or retainers;

M. For the purpose of eliminating pain or discomfort, remove loose, broken or irritating orthodontic appliances; [

N. Give oral health instruction;

O. Interview patients and record complete medical and dental histories;

P. Irrigate and aspirate the oral cavity;

Q. Isolate operative fields;

R. Obtain bacterial sampling when treatment is planned by the dentist;

S. Perform all procedures necessary for a complete prophylaxis, including root planing;

T. Perform cold vitality testing with confirmation by the dentist;

U. Perform complete periodontal and dental restorative charting;

V. Perform dietary analyses for dental disease control;

W. Perform electronic vitality scanning with confirmation by the dentist;

X. Perform oral inspections, recording all conditions that should be called to the attention of the dentist;

Y. Perform postoperative irrigation of surgical sites;

Z. Perform preliminary selection and fitting of orthodontic bands, as long as final placement and cementing in the patient's mouth are done by the dentist;

AA. Place and recement temporary crowns with temporary cement;

BB. Place and recement with temporary cement an existing crown that has fallen out;

CC. Place and remove gingival retraction cord without vasoconstrictor;

DD. Place and remove matrix bands, periodontal dressing, rubber dams and wedges;

EE. Place elastics or instruct in their use;

FF. Place, hold or remove celluloid and other plastic strips prior to or subsequent to the placement of a filling by the dentist;

GG. Place localized delivery of chemotherapeutic agents when treatment is planned by the dentist;

HH. Place or remove temporary separating devices;

II. Place wires, pins and elastic ligatures to tie in orthodontic arch wires that have been fitted and approved by the dentist at the time of insertion;

JJ. Place temporary restorations as an emergency procedure, as long as the patient is informed of the temporary nature of the restoration;

KK. Pour and trim dental models;

LL. Prepare tooth sites and surfaces with a rubber cup and pumice for banding or bonding of orthodontic brackets. This procedure may not be interpreted as a preparation for restorative material;

MM. Reapply, on an emergency basis only, orthodontic brackets;

NN. Remove composite material using slow-speed instrumentation for debonding brackets, as long as the dentist conducts a final check prior to release of the patient;

OO. Remove excess cement from the supragingival surfaces of teeth;

PP. Remove orthodontic arch wires and tension devices and any loose bands or bonds, but only as directed by the dentist;

QQ. Remove sutures;

RR. Retract lips, cheek, tongue and other tissue parts;

SS. Select and try in stainless steel or other preformed crowns for insertion by the dentist;

TT. Smooth and polish amalgam restorations;

UU. Take and record the vital signs of blood pressure, pulse and temperature;

VV. Take and pour impressions for study casts, athletic mouth guards, custom trays, bleaching trays, fluoride trays, opposing models, retainers and stents;

WW. Take dental plaque smears for microscopic inspection and patient education;

XX. Take intraoral measurements and make preliminary selection of arch wires and intraoral and extraoral appliances, including head gear; and

YY. Take intraoral photographs.

Practice categories of dental hygiene practice: (Ref: MN statutes)

1) Provides dental hygiene process of care:
    a. Educational, preventative, and therapeutic through , assessment, dental hygiene diagnosis, planning, evaluation, documentation, counseling, and therapeutic services to establish and maintain oral health (ref: MN statutes)

2) Evaluates patient health status:
    a. Reviews medical and dental histories, assesses and plans dental hygiene care needs, performs a prophylaxis including complete removal of hard, soft deposits, , cement, and stains by scaling, polishing, and perform root planing and periodontal debridement procedures

3) Administers nitrous oxide inhalation analgesia or local anesthesia by permit

4) Provides other services as follows:
    a. Application of agents:
        i. cavity varnish, desensitizing agents, topical anesthetics, topical antimicrobials, irrigation, fluorides, etc.)
    b. Sealants?
    c. Dental procedures:
        i. Cement crowns, temporary crowns, bridges
        ii. Amalgam/composite restorations
        iii. Teeth whitening?
        iv. Limited orthodontic functions
        v. Remove sutures
        vi. Administer locally delivered chemotherapeutic agents
    d. Dental and periodontal Charting; recordkeeping
    e. Administer, dispense, prescribe certain medications
    f. Expose and process dental radiographs

#6a

Vaillancourt, Penny

From: Nancy Mickles-Foster <nancy.foster@maine.edu>
Sent: Thursday, January 12, 2017 2:10 PM
To: Vaillancourt, Penny
Subject: Reference/info
Attachments: 2016-Revised-Standards-for-Clinical-Dental-Hygiene-Practice.pdf

Hi Penny,

For reference.. I have attached what we utilize (and CODA refers to) as what is deemed "standards for DH". This is where the hallmark- assessments, dental hygiene diagnosis, evaluation etc. came from.

Also, here is the CA board info (I especially like 1912-1915 - their list is much shorter than ours):

http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=BPC&division=2.&title=&part=&chapter=4.&article=9.

Please let me know if I can help clarify or if you have questions.

Thanks, -Nancy

--

Nancy L. Foster, CDA, EFDA, RDH, EdM
Assistant Professor- Dental Health
University of Maine at Augusta
201 Texas Ave
Bangor, ME 04401
P: 207-262-7883

SUPPLEMENT

adha

American Dental Hygienists' Association

STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE

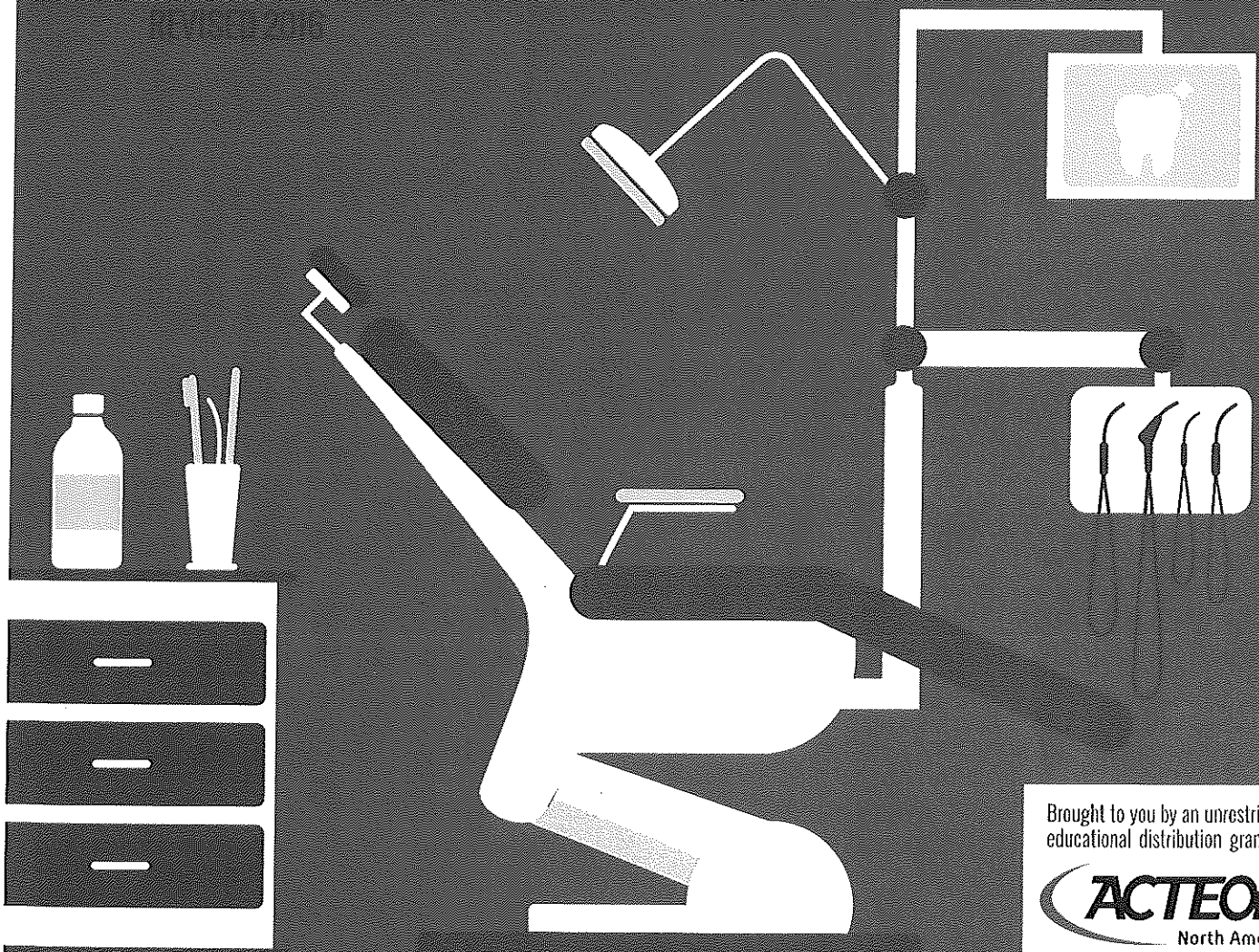


TABLE OF CONTENTS

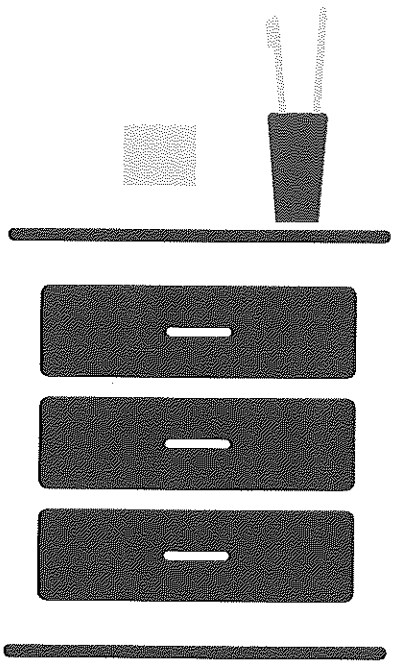
REVISED
JUNE 2016

REPRINTED
SEPTEMBER 2014 WITH UPDATED POLICIES AND REFERENCES

ADOPTED
MARCH 10, 2008

ITEM
STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE

ACTION
ADOPTED BY ADHA BOARD OF TRUSTEES



adha American Dental Hygienists' Association

STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE

REVISED 2016

History

One hallmark of a true profession is its willingness to assume responsibility for the quality of care that its members provide. In 1985, the American Dental Hygienists' Association (ADHA) took a major step toward fulfillment of that responsibility with the development of Applied Standards of Clinical Dental Hygiene Practice.[1] This document is the third revision[2] to build on those Standards and promote dental hygiene practice based on current and relevant scientific evidence.

Introduction

The Standards for Clinical Dental Hygiene Practice outlined in this document guide the individual dental hygienist's practice. Dental hygienists remain individually accountable to the standards set by the discipline and by applicable federal, state, and local statutes and regulations that define and guide professional practice.[3] These Standards should not be considered as a substitute for professional clinical judgment. In addition, they should not be confused with the Accreditation Standards for Dental Hygiene Education Programs, which are chiefly concerned with the structure and operation of dental hygiene education programs.[4]

Dental hygienists are valued members of the health care workforce. They have the knowledge, skills, and professional responsibility to provide oral health promotion and health protection strategies for all individuals as well as groups. As licensed professionals, they are accountable for the care and services they provide.

These Standards promote the knowledge, values, practices, and behaviors that support and enhance oral health with the ultimate goal of improving overall health. The primary purpose of the Standards for Clinical Dental Hygiene Practice is to assist dental hygiene clinicians in the provider-patient relationship. In addition, dental hygienists in other professional roles such as educator, researcher, entrepreneur, public health professional, and administrator — as well as those employed in corporate settings — can use these Standards to facilitate the implementation of collaborative, patient-centered care in interprofessional teams of health professionals. This collaboration can occur in a variety of practice settings including community and public health centers, hospitals, school-based programs, long-term care facilities, outreach, and home care programs. The secondary purpose of these Standards is to educate other health care providers, policymakers, and the public about the clinical practice of dental hygiene. The purpose of medical and dental science is to enhance the health of individuals as well as populations. Dental hygienists use scientific evidence in the decision-making process impacting their patient care. The dental hygienist is expected to respect the diverse values, beliefs, and cultures present in individuals and communities. When providing dental hygiene care, dental hygienists must support the right of the individual to have access to the necessary information and provide opportunities for dialogue to allow the individual patient to make informed care decisions without coercion. Facilitating effective communication might require an interpreter and/or translator based on the patient and practitioner's need to communicate. Dental hygienists must realize and establish their professional responsibility in accordance with the rights of individuals and groups. In addition, when participating in activities where decisions are made that have an im-

pact on health, dental hygienists are obligated to assure that ethical and legal issues are addressed as part of the decision-making process. Dental hygienists are bound by the Code of Ethics of the American Dental Hygienists' Association.[3]

The Standards for Clinical Dental Hygiene Practice provide a framework for clinical practice that focuses on the provision of patient-centered comprehensive care. The Standards describe a competent level of dental hygiene care[1,2,4-7] as demonstrated by the critical thinking model known as the dental hygiene process of care.[7] As evidenced by ADHA policy[6] and various dental hygiene textbooks,[8-10] the six components of the dental hygiene process of care include assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation (Appendix A). The dental hygiene process encompasses all significant actions taken by dental hygienists and forms the foundation of clinical decision-making.

Definition Of Dental Hygiene Practice

Dental hygiene is the science and practice of recognition, prevention and treatment of oral diseases and conditions as an integral component of total health.[11] The dental hygienist is a primary care oral health professional who has graduated from an accredited dental hygiene program in an institution of higher education, licensed in dental hygiene to provide education, assessment, research, administrative, diagnostic, preventive and therapeutic services that support overall health through the promotion of optimal oral health.[12] In practice, dental hygienists integrate multiple roles to prevent oral diseases and promote health (Appendix B).

Dental hygienists work in partnership with all members of the dental team. Dentists and dental hygienists practice together as colleagues, each offering professional expertise for the goal of providing optimum oral health care to the public. The distinct roles of the dental hygienist and dentist complement and augment the effectiveness of each professional and contribute to a collaborative environment. Dental hygienists are viewed as experts in their field; are consulted about appropriate dental hygiene interventions; are expected to make clinical dental hygiene decisions; and are expected to plan, implement, and evaluate the dental hygiene component of the overall care plan.[7-10] All states define their specific dental hygiene practice scope and licensure requirements.

Educational Preparation

The registered dental hygienist (RDH) or licensed dental hygienist (LDH) is educationally prepared for practice upon graduation from an accredited dental hygiene program (associate, post-degree certificate, or baccalaureate) within an institution of higher education and qualified by successful completion of a national written board examination and state or regional clinical examination for licensure. In 1986, the ADHA declared its intent to establish the baccalaureate degree as the minimum entry level for dental hygiene practice (Appendix C).[7,13-14]

Practice Settings

Dental hygienists can apply their professional knowledge and skills in a variety of work settings as clinicians, educators, researchers, administrators, entrepreneurs, and public health professionals, and as employees in corporate settings. Working in a private dental office c ontinues t o be the primary place of employment for dental hygienists. However, never before has there been more opportunity for professional growth. Clinical dental hygienists may be employed in a variety of health care settings including, but not limited to, private dental offices, schools, public health clinics, hospitals, managed care organizations, correctional institutions, or nursing homes.[6]

One example of an innovative, interprofessional practice model was tested by Patricia Braun, MD, MPH, Associate Professor, Pediatrics and Family Medicine at the University of Colorado Anschultz School of Medicine. This project co-located a dental hygienist in the pediatrician's office. Co-locating dental hygienists into medical practices is a feasible and innovative way to provide oral health care, especially for those who have limited access to preventive oral health services. [14]

Another innovative model exists in Oregon, where expanded practice dental hygienists (EPDHs) do not need a collaborative agreement with a dentist to initiate dental hygiene care for populations that qualify as having limited access to care; however, some aspects do require a collaborative agreement.15

EPDHs in Oregon are able to work in a variety of settings,16 such as nursing homes and schools, and many are employed as private business owners.14

Professional Responsibilities and Considerations

Dental hygienists are responsible and accountable for their dental hygiene practice, conduct, and decision-making. Throughout their professional career in any practice setting, a dental hygienist is expected to:

- Understand and adhere to the ADHA Code of Ethics.
- Maintain a current license to practice, including certifications as appropriate.
- Demonstrate respect for the knowledge, expertise, and contributions of dentists, dental hygienists, dental assistants, dental office staff, and other health care professionals.
- Articulate the roles and responsibilities of the dental hygienist to the patient, interprofessional team members, referring providers, and others.
- Apply problem-solving processes in decision-making and evaluate these processes.
- Demonstrate professional behavior.
- Maintain compliance with established infection control standards following the most current guidelines to reduce the risks of health-care-associated infections in patients, and illnesses and injuries in health care personnel.
- Incorporate cultural competence[17] in all professional interactions.
- Access and utilize current, valid, and reliable evidence in clinical decision-making through analyzing and interpreting the literature and other resources.
- Maintain awareness of changing trends in dental hygiene, health, and society that impact dental hygiene care.
- Support the dental hygiene profession through ADHA membership.
- Interact with peers and colleagues to create an environment that supports collegiality and teamwork.
- Prevent situations where patient safety and well-being could potentially be compromised.
- Contribute to a safe, supportive, and professional work environment.
- Participate in activities to enhance and maintain continued competence and address professional issues as determined by appropriate self-assessment.
- Commit to lifelong learning to maintain competence in an evolving health care system.

Dental Hygiene Process of Care

The purpose of the dental hygiene process of care is to provide a framework where the individualized needs of the patient can be met; and to identify the causative or influencing factors of a condition that can be reduced, eliminated, or prevented by the dental hygienist.[8-10] There are six components to the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation and evaluation, and documentation; see Appendix A).[7-10, 18]

The dental hygiene diagnosis is a key component of the process and involves assessment of the data collected, consultation with the dentist and other health care providers, and informed decision-making. The dental hygiene diagnosis and care plan are incorporated into the comprehensive plan that includes restorative, cosmetic, and oral health needs that the patient values. All components of the process of care are interrelated and depend upon ongoing assessments and evaluation of treatment outcomes to determine the need for change in the care plan. These Standards follow the dental hygiene process of care to provide a structure for clinical practice that focuses on the provision of patient-centered comprehensive care.

STANDARDS OF PRACTICE

Standard 1: Assessment

The ADHA definition of assessment: The collection and analysis of systematic and oral health data in order to identify client needs.[19]

I. HEALTH HISTORY

A health history assessment includes multiple data points that are collected through a written document and an oral interview. The process helps build a rapport with the patient and verifies key elements of the health status. Information is collected and discussed in a location that ensures patient privacy and complies with the Health Insurance Portability and Accountability Act (HIPAA).

Demographic information is any information that is necessary for conducting the business of dentistry. It includes but is not limited to address, date of birth, emergency contact information, phone numbers, and names and addresses of the referring/previous dentist and physician of record.

Vital Signs including temperature, pulse, respiration, and blood pressure provide a baseline or help identify potential or undiagnosed medical conditions.

Physical characteristics of height and weight provide information for drug dosing and anesthesia and indicate risk for medical complications. Disproportionate height and weight also combine as a risk factor for diabetes and other systemic diseases that impact oral health and should prompt the practitioner to request glucose levels for health history documentation.

Social history information such as marital status, children, occupation, cultural practices, and other beliefs might affect health or influence treatment acceptance.

Medical history is the documentation of overall medical health. This information can identify the need for physician consultation or any contraindications for treatment. This would include any mental health diagnosis, cognitive impairments (e.g., stages of dementia), behavioral challenges (e.g., autism spectrum), and functional capacity assessment. It would also include the patient's level of ability to perform a specific activity such as withstanding a long dental appointment as well as whether the patient requires modified positioning for treatment. Laboratory tests such as A1C and current glucose levels may need to be requested if they are not checked regularly.

Pharmacologic history includes the list of medications, including dose and frequency, which the patient is currently taking. This includes but is not limited to any over-the-counter (OTC) drugs or products such as herbs, vitamins, nutritional supplements, and probiotics. The practitioner should confirm any past history of an allergic or adverse reaction to any products.

II. CLINICAL ASSESSMENT

Planning and providing optimal care require a thorough and systematic overall observation and clinical assessment. Components of the clinical assessment include an examination of the head and neck and oral cavity including an oral cancer screening, documentation of normal or abnormal findings, and assessment of the temporomandibular function. A current, complete, and diagnostic

set of radiographs provides needed data for a comprehensive dental and periodontal assessment.

A comprehensive periodontal examination is part of clinical assessment. It includes

A. Full-mouth periodontal charting including the following data points reported by location, severity, quality, written description, or numerically:
   1. Probing depths
   2. Bleeding points
   3. Suppuration
   4. Mucogingival relationships/defects
   5. Recession
   6. Attachment level/attachment loss
B. Presence, degree, and distribution of plaque and calculus
C. Gingival health/disease
D. Bone height/bone loss
E. Mobility and fremitus
F. Presence, location, and extent of furcation involvement

A comprehensive hard-tissue evaluation that includes the charting of existing conditions and oral habits, with intraoral photographs and radiographs that supplement the data.

A. Demineralization
B. Caries
C. Defects
D. Sealants
E. Existing restorations and potential needs
F. Implants
G. Anomalies
H. Occlusion
I. Fixed and removable prostheses retained by natural teeth or implant abutments
J. Missing teeth

III. RISK ASSESSMENT[20-21]

Risk assessment is a qualitative and quantitative evaluation based on the health history and clinical assessment to identify any risks to general and oral health. The data provide the clinician with the information to develop and design strategies for preventing or limiting disease and promoting health. Examples of factors that should be evaluated to determine the level of risk (high, moderate, low) include but are not limited to:

A. Fluoride exposure
B. Tobacco exposure including smoking, smokeless/spit tobacco and second-hand smoke
C. Nutrition history and dietary practices including consumption of sugar-sweetened beverages
D. Systemic diseases/conditions (e.g., diabetes, cardiovascular disease, autoimmune, etc.)
E. Prescriptions and over-the-counter medications, and complementary therapies and practices (e.g., fluoride, herbal, vitamin and other supplements, daily aspirin, probiotics)
F. Salivary function and xerostomia
G. Age and gender
H. Genetics and family history
I. Habit and lifestyle behaviors
   1. Cultural issues
   2. Substance abuse (recreational drugs, prescription medication, alcohol)
   3. Eating disorders/weight loss surgery
   4. Piercing and body modification
   5. Oral habits
   6. Sports and recreation (swimming, extreme sports [marathon, triathlon], energy drinks/gels
J. Physical disability (morbid obesity, vision and/or hearing loss, osteoarthritis, joint replacement)
K. Psychological, cognitive, and social considerations
   1. Domestic violence
   2. Physical, emotional, or sexual abuse
   3. Behavioral
   4. Psychiatric
   5. Special needs
   6. Literacy
   7. Economic
   8. Stress
   9. Neglect

Standard 2: Dental Hygiene Diagnosis

The ADHA defines dental hygiene diagnosis as the identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. The dental hygiene diagnosis requires evidence-based critical analysis and interpretation of assessments in order to reach conclusions about the patient's dental hygiene treatment needs. The dental hygiene diagnosis provides the basis for the dental hygiene care plan.[22]

Multiple dental hygiene diagnoses may be made for each patient or client. Only after recognizing the dental hygiene diagnosis can the dental hygienist formulate a care plan that focuses on dental hygiene education, patient self-care practices, prevention strategies, and treatment and evaluation protocols to focus on patient or community oral health needs.[23]

I. Analyze and interpret all assessment data.
II. Formulate the dental hygiene diagnosis or diagnoses.
III. Communicate the dental hygiene diagnosis with patients or clients.
IV. Determine patient needs that can be improved through the delivery of dental hygiene care.
V. Identify referrals needed within dentistry and other health care disciplines based on dental hygiene diagnoses.

Standard 3: Planning

Planning is the establishment of realistic goals and the selection of dental hygiene interventions that can move the client closer to optimal oral health.[24] The interventions should support overall patient goals and oral health outcomes. Depending upon the work setting and state law, the dental hygiene care plan may be stand-alone or part of collaborative agreement. The plan lays the foundation for documentation and may serve as a guide for Medicaid reimbursement. Dental hygienists make clinical decisions within the context of legal and ethical principles.

The dental hygiene care plan should be a vehicle for care that is safe, evidence-based, clinically sound, high-quality, and equitable. The plan should be personalized according to the individual's unique oral health needs, general health status, values, expectations, and abilities. When formulating the plan, dental hygienists should be sensitive and responsive to the patient's culture, age, gender, language, and learning style. They should demonstrate respect and compassion for individual patient choices and priorities.

I. Identify all needed dental hygiene interventions including change management, preventive services, treatment, and referrals.
II. In collaboration with the patient and/or caregiver, prioritize and sequence the interventions allowing for flexibility if necessary and possible.
III. Identify and coordinate resources needed to facilitate comprehensive quality care (e.g., current technologies, pain management, adequate personnel, appropriate appointment sequencing, and time management).
IV. Collaborate and work effectively with the dentist and other health care providers and community-based oral health programs to provide high-level, patient-centered care.
V. Present and document dental hygiene care plan to the patient/caregiver.
VI. Counsel and educate the patient and/or caregiver about the treatment rationale, risks, benefits, anticipated outcomes, evidence-based treatment alternatives, and prognosis.
VII. Obtain and document informed consent and/or informed refusal.

Standard 4: Implementation

Implementation is the act of carrying out the dental hygiene plan of care.[24] Care should be delivered in a manner that minimizes risk; optimizes oral health; and recognizes issues related to patient comfort including pain, fear, and/or anxiety. Through the presentation of the dental hygiene

care plan, the dental hygienist has the opportunity to create and sustain a therapeutic and ethically sound relationship with the patient.

Depending upon the number of interventions, the dental hygiene care plan may implemented in one preventive/wellness visit or several therapeutic visits before a continuing or maintenance plan is established. Health promotion and self-care are integral aspects of the care plan that should be customized and implemented according to patient interest and ability.

I. Review and confirm the dental hygiene care plan with the patient/caregiver.
II. Modify the plan as necessary and obtain any additional consent.
III. Implement the plan beginning with the mutually agreed upon first prioritized intervention.
IV. Monitor patient comfort.
V. Provide any necessary post-treatment instruction.
VI. Implement the appropriate self-care intervention; adapt as necessary throughout future interventions.
VII. Confirm the plan for continuing care or maintenance.
VIII. Maintain patient privacy and confidentiality.
IX. Follow-up as necessary with the patient (post-treatment instruction, pain management, self-care).

Standard 5: Evaluation

Evaluation is the measurement of the extent to which the client has achieved the goals specified in the dental hygiene care plan. The dental hygienist uses evidence-based decisions to continue, discontinue, or modify the care plan based on the ongoing reassessments and subsequent diagnoses.[25] The evaluation process includes reviewing and interpreting the results of the dental hygiene care provided and may include outcome measures that are physiologic (improved health), functional, and psychosocial (quality of life, improved patient perception of care). Evaluation occurs throughout the process as well as at the completion of care.

I. Use measurable assessment criteria to evaluate the tangible outcomes of dental hygiene care (e.g., probing, plaque control, bleeding points, retention of sealants, etc.).
II. Communicate to the patient, dentist, and other health/dental care providers the outcomes of dental hygiene care.
III. Evaluate patient satisfaction of the care provided through oral and written questionnaires.
IV. Collaborate to determine the need for additional diagnostics, treatment, referral, education, and continuing care based on treatment outcomes and self-care behaviors.
V. Self-assess the effectiveness of the process of providing care, identifying strengths and areas for improvement. Develop a plan to improve areas of weakness.[26]

Standard 6: Documentation

The primary goals of good documentation are to maintain continuity of care, provide a means of communication between/among treating providers, and to minimize the risk of exposure to malpractice claims. Dental hygiene records are considered legal documents and as such should include the complete and accurate recording of all collected data, treatment planned and provided, recommendations (both oral and written), referrals, prescriptions, patient/client comments and related communication, treatment outcomes and patient satisfaction, and other information relevant to patient care and treatment.

I. Document all components of the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation, and evaluation) including the purpose of the patient's visit in the patient's own words. Documentation should be detailed and comprehensive; e.g., thoroughness of assessment (soft-tissue examination, oral cancer screening, periodontal probing, tooth mobility) and

reasons for referrals (and to whom and follow-up). Treatment plans should be consistent with the dental hygiene diagnosis and include no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.[26]

II. Objectively record all information and interactions between the patient and the practice (e.g., telephone calls, emergencies, prescriptions) including patient failure to return for treatment or follow through with recommendations.

III. Record legible, concise, and accurate information. For example, include dates and signatures, record clinical information so that subsequent providers can understand it, and ensure that all components of the patient record are current and accurately labeled and that common terminology and abbreviations are standard or universal.

IV. Recognize ethical and legal responsibilities of recordkeeping including guidelines outlined in state regulations and statutes.

V. Ensure compliance with the federal Health Information Portability and Accountability Act (HIPAA). Electronic communications must meet HIPAA standards in order to protect confidentiality and prevent changing entries at a later date.

VI. Respect and protect the confidentiality of patient information.

Summary

The Standards for Clinical Dental Hygiene Practice are a resource for dental hygiene practitioners seeking to provide patient-centered and evidence-based care. In addition, dental hygienists are encouraged to enhance their knowledge and skill base to maintain continued competence.27-28 These Standards will be modified based on emerging scientific evidence, ADHA policy development, federal and state regulations, and changing disease patterns as well as other factors to assure quality care and safety as needed.

KEY TERMS

Client: The concept of client refers to the potential or actual recipients of *dental hygiene* care, and includes persons, families, groups and communities of all ages, genders, socio-cultural and economic states.[24]

Cultural Competence: the awareness of cultural difference among all populations, respect of those differences and application of that knowledge to professional practice.[17]

Dental Hygiene Care Plan: an organized presentation or list of interventions to promote the health or prevent disease of the patient's oral condition. The plan is designed by the dental hygienist and consists of services that the dental hygienist is educated and licensed to provide.[5,7]

Evidence-Based Practice: the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual clients. The practice of evidence-based dental hygiene requires the integration of individual clinical expertise and client preferences with the best available external clinical evidence from systematic research.[25]

Intervention: dental hygiene services rendered to clients as identified in the dental hygiene care plan. These services may be clinical, educational, or health promotion related.[23]

Interprofessional Team: a group of health care professionals and their patients who work together to achieve shared goals. The team can consist of the dental hygienist, dentist, physician, nutritionist, smoking cessation counselor, nurse practitioner, etc.[31]

Outcome: result derived from a specific intervention or treatment.

Patient: the potential or actual recipient of dental hygiene care, including persons, families, groups, and communities of all ages, genders, and socio-cultural and economic states.[24]

Patient-Centered: approaching services from the perspective that the client is the main focus of attention, interest, and activity. The client's values, beliefs, and needs are of utmost importance in providing evidence-based care.[32]

Risk Assessment: an assessment based on characteristics, behaviors, or exposures that are associated with a particular disease, e.g., smoking, diabetes, or poor oral hygiene.[21]

REFERENCES

1. Standard of Applied Dental Hygiene Practice. Chicago: American Dental Hygienists' Association. 1985.

2. Standards for Clinical Dental Hygiene Practice. American Dental Hygienists' Association [Internet]. September 2014 [cited 2016 March 3]. Available from: http://www.adha.org/resources-docs/7261_Standards_Clinical_Practice.pdf

3. Code of Ethics. American Dental Hygienists' Association [Internet]. 2-14 [cited 2016 March 24]. Available from: https://www.adha.org/resources-docs/7611_Bylaws_and_Code_of_Ethics.pdf

4. Accreditation Standards for Dental Hygiene Education Programs. Chicago: American Dental Association. Commission on Dental Accreditation. Revised January 2016.

5. ADEA Competencies for Entry into the Allied Dental Professions. *J Dent Educ.* 2011; 75(7): 941-948.

6. *ADHA Policy Manual*. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 March 3]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

7. *ADHA Policy Manual* [4-10/SCDHP/18-96]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

8. Darby ML, Walsh MM. Dental Hygiene Theory and Practice. 4th ed. St. Louis, MO: Saunders. 2015. pp. 2, 9, 314-217.

9. Wilkins EM. Clinical Practice of the Dental Hygienist. 12th ed. Philadelphia: Wolters Kluwer. 2017. pp. 12-14.

10. Henry R, Goldie MP. Dental Hygiene: Applications to Clinical Practice. Philadelphia: FA Davis. 2016. pp. 549-553.

11. *ADHA Policy Manual* [3-14/14-83]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

12. *ADHA Policy Manual* [4-14/19-84]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

13. Focus on Advancing the Profession. Chicago: American Dental Hygienists' Association. 2005

14. Transforming Dental Hygiene Education and the Profession for the 21st Century. Chicago: American Dental Hygienists' Association. 2015.

15. State of Oregon Board of Dentistry. Dental Practice Act – ORS Chapter 679. Oregon.gov [Internet]. 2016 [cited 2016 May 17]. Available from: https://www.oregon.gov/dentistry/docs/Rules/DPA2016Statutes01012016Color.pdf

16. Oregon State Statute §679.010(2). Oregon State Legislature [Internet]. 2013 [cited 2015 July 20]. Available from: https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013orLaw0310.pdf

17. *ADHA Policy Manual* [7-07]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

18. *ADHA Policy Manual* [16-93]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

19. *ADHA Policy Manual* [SCDHP/18-96]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

20. *ADHA Policy Manual* [12-10]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

21. *ADHA Policy Manual* [11-10/21-82]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

22. *ADHA Policy Manual* [1-14/SCDHP/18-96]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

23. Swigart DJ, Gurenlian JR. Implementing Dental Hygiene Diagnosis into Practice. Dimensions Dent Hyg. 2015; 13(9): 56-59.

24. *ADHA Policy Manual* [SCDHP/18-96]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

25. *ADHA Policy Manual* [5-14/SCDHP/18-96]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

26. Guidelines for Medical Record Documentation. National Committee for Quality Assurance [Internet]. [cited 2016 January 31]. Available from: http://www.ncqa.org/portals/0/policyupdates/supplemental/guidelines_medical_record_review.pdf

27. *ADHA Policy Manual* [18-15]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

28. *ADHA Policy Manual* [17-15]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

29. *ADHA Policy Manual* [17-93]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

30. *ADHA Policy Manual* [1-07]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

31. *ADHA Policy Manual* [18-14/16-85]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

32. *ADHA Policy Manual* [6-97]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

33. *ADHA Policy Manual* [12-05]. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 April 15]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

RESOURCES

The following websites can provide evidence upon which to base clinical decisions in compliance with the Commission on Dental Accreditation (CODA) Accreditation Standards for Dental Hygiene Education Programs.

ADHA Policy Manual. Glossary, 18-96. American Dental Hygienists' Association [Internet]. 2016 [cited 2016 March 28]. Available from: https://www.adha.org/resources-docs/7614_Policy_Manual.pdf

American Academy of Public Health Dentistry: http://www.aaphd.org/.

American Academy of Pediatric Dentistry: http://www.aapd.org/.

American Academy of Periodontology: http://perio.org/.

American Dental Association: http://www.ada.org/.

Commission on Dental Accreditation. Accreditation Standards for Dental Hygiene Education Programs. American Dental Association [Internet]. 2016 January [cited 2016 March 3]. Available http://www.ada.org/~/media/CODA/Files/2016_dh.ashx

American Diabetes Association: http://www.diabetes.org/.

American Heart Association: http://www.americanheart.org/.

Association of State and Territorial Dental Directors: http://www.astdd.org/.

Canadian Dental Hygienists' Association: www.cdha.org.

Centers for Disease Control and Prevention (caries, mineralization strategies, and health protection goals): http://www.cdc.gov/ http://www.cdc.gov/osi/goals/goals.html http://www.cdc.gov/niosh/homepage.html

CDC Guidelines for Infection Control in Dental healthcare Settings. Centers for Disease Control and Prevention [Internet]. 2003. [cited 2016 March 28]. Available from; http://www.cdc.gov/OralHealth/infectioncontrol/guidelines/index.htm

Center for Evidence-Based Dentistry: http://www.cebd.org/.

Clinical Trials: http://www.clinicaltrials.gov/.

The Cochrane Collaboration: http://www.cochrane.org/.

Forrest JL, Miller SA. An Evidence-Based Decision-Making Model for Dental Hygiene Education, Research and Practice. *J Dent Hyg*. 2001; 75(1): 50-63.

Health Insurance Portability and Accountability Act (HIPAA): http://www.hipaa.org/.

National Guideline Clearing House: http://www.guidelines.gov/.

Nunn ME. Understanding the Etiology of Periodontitis: An Overview of Periodontal Risk Factors. Periodontol 2000. 2003; 32:11-23.

Occupational Safety and Health Administration: http://www.osha.gov/SLTC/dentistry/index.html.

The Organization for Safety and Asepsis Procedures (OSAP):http://www.osap.org/.

Special Care Dentistry: http://www.scdonline.org/.

The Selection of Patients for Dental Radiograph Examinations. American Dental Association and the US Department of Health and Human Services [Internet] Revised 2012 [cited 2016 March 28]. Available from: http://www.fda.gov/downloads/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/MedicalX-Rays/UCM329746.pdf

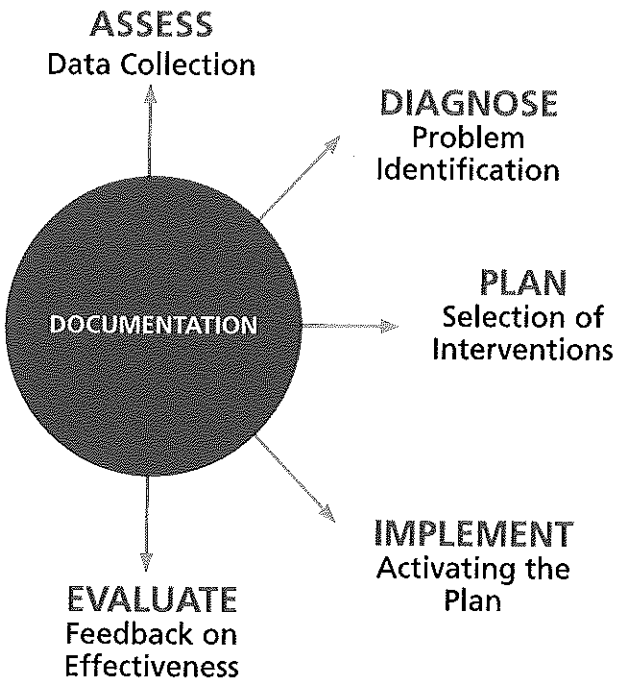
Comprehensive Periodontal Therapy: A Statement by the American Academy of Periodontology. *J Periodontol*. 2011; 82(7): 943-949.

Appendix A

DENTAL HYGIENE PROCESS OF CARE [7]

There are six components to the dental hygiene process of care. These include assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation. The six components provide a framework for patient care activities.

Adapted from: Wilkins EM. Clinical Practice of the Dental Hygienist. 12th ed. Philadelphia, PA: Wolters Kluwer. 2017. pp. 12-14.



Appendix B

PROFESSIONAL ROLE OF THE DENTAL HYGIENIST [33]

Overview

The dental hygienist plays an integral role in assisting individuals and groups in achieving and maintaining optimal oral health. Dental hygienists provide educational, clinical and consultative services to individuals and populations of all ages in a variety of settings and capacities. The professional roles of the dental hygienist are outlined below .

Clinician

Dental hygienists in a clinical role assess, diagnose, plan, implement, evaluate and document treatment for prevention, intervention and control of oral diseases, while practicing in collaboration with other health professionals. Examples of clinical employment settings include:

- Private dental practices
- Community clinics
- Hospitals
- University dental clinics
- Prison facilities
- Nursing homes
- Schools

Corporate

Corporate dental hygienists are employed by companies that support the oral health industry through the sale of products and services. Leaders throughout the dental industry often employ dental hygienists due to their clinical experience and understanding of dental practice. Examples of corporate positions include:

- Sales representatives
- Product researchers
- Corporate educators
- Corporate administrators

Public Health

Community health programs are typically funded by government or non-profit organizations. These positions often offer an opportunity to provide care to those who otherwise would not have access to dental care. Examples of positions for dental hygienists in public health settings include:

Clinician

- Rural or inner city community clinics
- Indian Health Service • Head Start programs
- School sealant programs

Administrator

- State public health officer
- Community clinic administrator

Researcher

Research conducted by dental hygienists can be either qualitative or quantitative. Quantitative research involves conducting surveys and analyzing the results, while qualitative research may involve testing a new procedure, product or theory for accuracy, effectiveness, etc. Examples of employment settings for dental hygienist researchers include:

- Colleges and universities
- Corporations
- Governmental agencies
- Nonprofit organizations

Educator

Dental hygiene educators are in great demand. Colleges and universities throughout the U.S. require dental hygiene instructors who use educational theory and methodology to educate competent oral health professionals. Corporations also employ educators who provide continuing education to licensed dental hygienists. Examples of dental hygiene educators include:

- Clinical instructors
- Classroom instructors
- Program directors
- Corporate educators

Administrator

Dental hygienists in administrative positions apply organizational skills, communicate objectives, identify and manage resources, and evaluate and modify programs of health, education and health care. Examples of administrative positions held by dental hygienists include:

- Clinical director, statewide school sealant program
- Program director, dental hygiene educational program
- Executive director, state association staff
- Research administrator, university
- Director, corporate sales

Entrepreneur

By using imagination and creativity to initiate or finance new commercial enterprises, dental hygienists have become successful entrepreneurs in a variety of businesses. Some examples of business opportunities developed by dental hygienists include:

- Practice management company
- Product development and sales
- Employment service
- CE provider or meeting planner
- Consulting business
- Founder of a nonprofit
- Independent clinical practice
- Professional speaker / writer

Appendix C

EDUCATIONAL PATH FOR ENTRY INTO THE PROFESSION

Dental hygienists must complete an accredited educational program to qualify for licensure in a particular state or region. Dental hygienists are licensed with the credential of Registered Dental Hygienist (RDH) or Licensed Dental Hygienist (LDH) following completion of an academic program that includes didactic and clinical requirements.

PROFESSIONAL SPECIALIZATION

Dental hygienists can further their academic credentials after earning a certificate, associate, and/or baccalaureate degree. A dental hygienist can continue their educational advancement by enrolling in a variety of Master's level programs which provides eligibility for a Doctoral level degree.

Four year academic program in an undergraduate educational environment

Two+ years of college (usually one year of pre-requisite course work followed by two years of professsional courses)

National Board Dental Hygiene Examination successfully passed

Clinical/written examination as required by region of state successfully passed

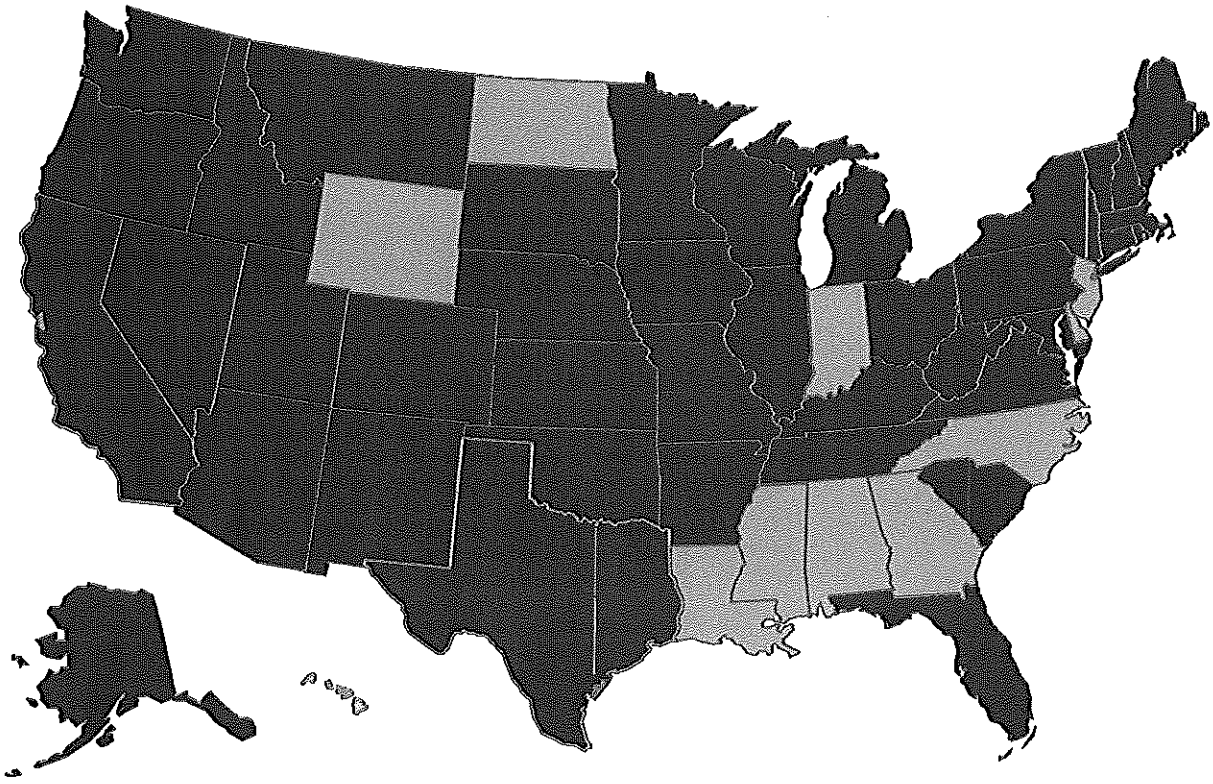
Licensure granted by state board of dentistry

Appendix D

DIRECT ACCESS 2016

The American Dental Hygienists' Association (ADHA) defines direct access as the ability of a dental hygienist to initiate treatment based on their assessment of a patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and maintain a provider-patient relationship (ADHA Policy Manual, 13-15).

States that permit direct access to dental hygienists
Revised April 2016 www.adha.org



Development and Validation Process for the Standards for Clinical Dental Hygiene Practice

In 2003, the ADHA Board of Trustees approved the establishment of a task force to define and develop standards of clinical dental hygiene practice. The previous standards of practice document created by ADHA was published in 1985 and was no longer being distributed due to the significant changes in dental hygiene practice; therefore the association did not have document accurately reflecting the nature of clinical dental hygiene practice. A series of task force meetings occurred by phone, electronically and in-person from 2004-2008 in order to create and revise the draft standards document.

As part of the validation process, in November 2005, a survey was distributed to all ADHA council members, 50 participants in the ADHA Constituent Officers Workshop, and a 50-member random selection of the ADHA membership to provide feedback regarding the draft Standards of Practice that had been created by the task force. The data collected from these audiences was collated, analyzed and reviewed by the task force in making subsequent modifications.

During the 2006 ADHA Annual Session, the chair of the task force presented the draft Standards document to the membership, responded to questions, and requested written and verbal feedback regarding the direction of the document. The Standards were also posted on the ADHA website prior to the annual meeting and for a period following in order to solicit feedback from the membership and other communities of interest. In the fall of 2006, the task force met and considered the comments from all respondents and made additional revisions to the document. The task force also reviewed clinical standards of practice documents from other professions as a point of comparison.

In 2007, the revised Standards were shared during the ADHA Annual Session with the draft document posted online and open for comments from the communities of interest. Following the annual meeting, the draft document was also broadly distributed to the broad communities of interest, which included a pool of approximately 200 organizations.

Following the collection of feedback from all interested parties, the task force considered all feedback and met by conference call in order to finalize the document. The final document was submitted to the ADHA Board of Trustees in March 2008 for their consideration and adoption.

In September 2014, the Standards for Clinical Dental Hygiene Practice policies and references were updated and the document was reprinted. It was determined at the 2015 Annual Session that the Standards would need to be revised since at least three years had passed since the last full revision of the document. A new task force was appointed by ADHA President Jill Rethman, RDH, BA, for the revision of the Standards.

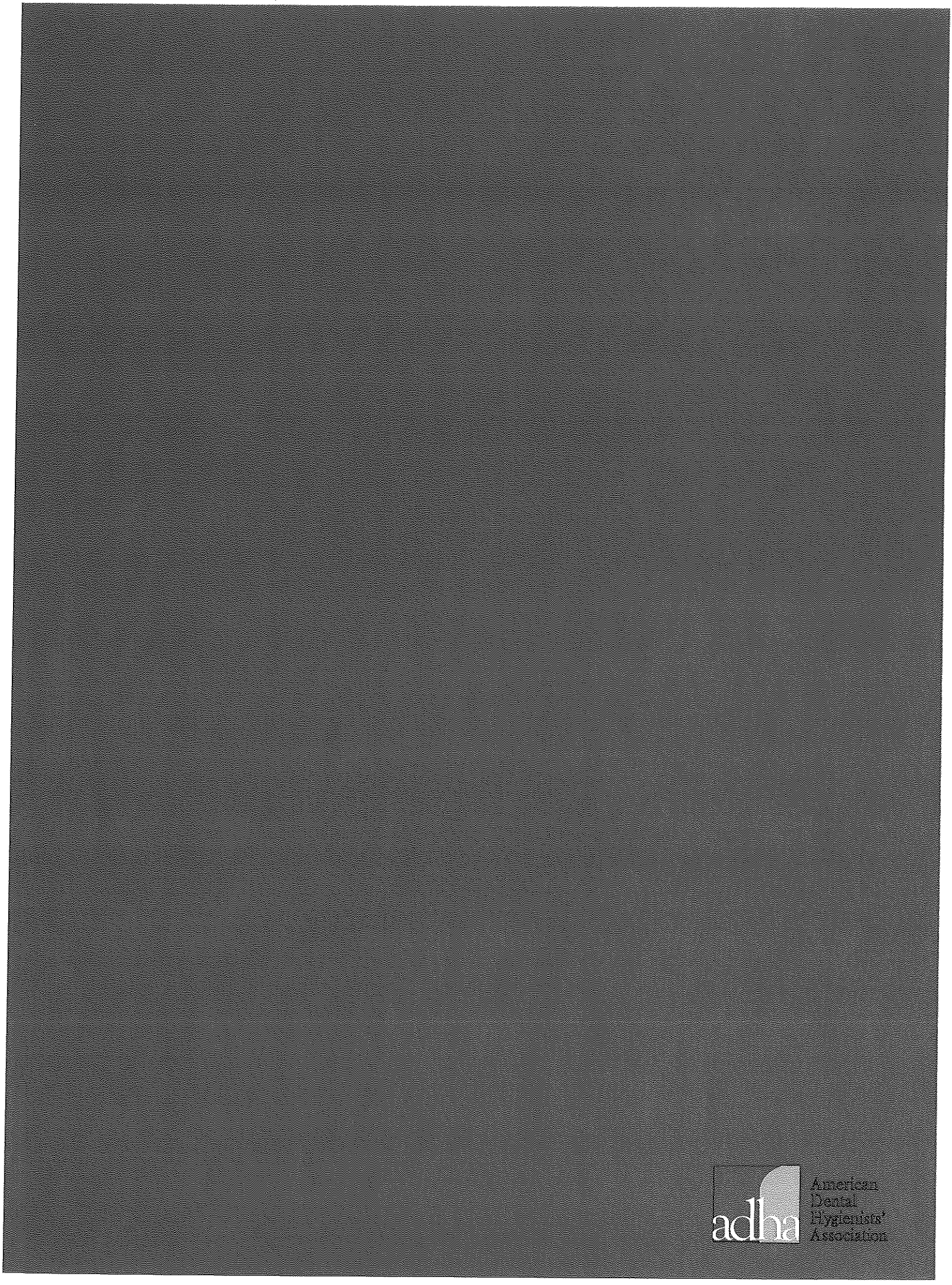
2016 TASK FORCE MEMBERSHIP:

Christine Nathe, RDH, MS, New Mexico, Chair
Carol Jahn, RDH, MS, Illinois
Deborah Lyle, RDH, BS, MS, New Jersey
JoAnn Gurenlian, RDH, MS, PhD, New Jersey
Jane Forrest, RDH, EdD, California

ADHA STAFF:

Pam Steinbach, RN, MS
Michelle Smith, RDH, MS
ADHA Board of Trustee Advisor:
Sharlee Burch, RDH, MPH, EdD, Kentucky

American Dental Hygienists' Association


adha
American
Dental
Hygienists'
Association

#66

Vaillancourt, Penny

From: Lorraine Klug <lorraineklug@hotmail.com>
Sent: Sunday, January 15, 2017 11:55 PM
To: Vaillancourt, Penny
Subject: ADHOC comm
Attachments: Adhoc committee #2.docx

Hello Penny,

I have attached a list for the committee and I would really like to address the subcommittees. I didn't even think about it at the 1st meeting as I wasn't expecting to be able to make suggestions so soon. I thought we would be going through the statutes section by section and I think the subcommitees are very important to address where there have been so many pieces of legislation about self regulation over the years.

Lorraine P. Klug, IPDH
Immediate Past President
Maine Dental Hygienists' Association
207-667-0828 207-460-9928

American Dental Hygienists' Association
Maine

15 Jan 2017

Maine Board of Dental Examiners
143 State House Station
Augusta, ME 04666-0143

Executive Director Ms. Penny Vaillancourt and ADHOC Committee:

I sent this letter to the MBDP over a year ago after our Annual Meeting. I asked at our meeting what hygienists would like to see for suggested rule changes and how to clarify our statutes to make them more user friendly. With the newly established rules committee and the proposal to clean up the statutes, I wanted to provide the board with what members and non-members alike had for ideas. The following is a list of ideas from that meeting and concerns we have received from talking with other hygienists. I have deleted some of the items in my original letter because they were no longer relevant but some of the rules suggestions may come up in conversation. **The one main point that I failed to mention at our 1st ADHOC meeting was that of the subcommittees duties which I would also like to see our committee address.**

1. **Allow the dental hygiene and denturist subcommittees to perform their existing duties with no need to report to the full board as well allowing the subcommittee members to be included as full voting members of the board for voting on rule changes.**

   A past board President had stated that they agree with the subcommittee 99% of the time so this would free up the boards' valuable time to take care of more pressing board business. The hope of the LCRED committee was that the 1210 legislation would take care of some of the legislation they voted "ought not to pass" last session and this could be a nice compromise to full self-regulation.

2. **Add dental hygiene diagnosis to the definitions.** A dental hygiene diagnosis is defined as *"the identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. The dental hygiene diagnosis requires evidence-based critical analysis and interpretation of assessments in order to reach conclusions about the patient's dental hygiene treatment needs. The dental hygiene diagnosis provides the basis for the dental hygiene treatment plan."*

   The definition of diagnosis is "the act of identifying a disease from its signs and symptoms," "a concise technical description," "investigation or analysis of the cause or nature of a condition, situation, or problem," and "a statement or conclusion from such an analysis." Dental hygiene program curricula are designed to provide students with the basic and dental science background to recognize the signs and symptoms of disease and to recognize the cause or nature of the problem. This results in determining a dental hygiene diagnosis within the comprehensive dental diagnosis.

3. **Allow RDH's working under general supervision to provide sealants without prior dentist exam.**

   PHS and IPDH's are allowed to provide sealants without an exam. The private practice dental office has standard operating procedures and much like the guidelines for taking radiographs under general supervision, the employing dentist could have guidelines for sealants under general supervision.

4. **Under dental hygiene duties list "all duties that a dental assistant or CDA can perform" and then list other duties that only the hygienist can perform. Under IPDH duties list "all duties that an RDH can perform."**

   This would clean up the statute and prevent the laundry list from being repeated when it's not necessary.

5. **Eliminate PSH reports.**
   PHS hygienists are taking the time to do these reports but the data is not being reviewed, tracked, or compiled to our knowledge and therefore creating unnecessary work for the PHS.

6. **Clarify sections on PHS rules and responsibilities.**
   One section states that you have to contact an IPDH or dentist if the patient has been seen in the previous 12 months but that does not preclude the PHS from providing preventative treatment to a patient within that 12 month period. It then goes on to state that all proprietary forms include that if a child is being seen every 6 months by a dentist that they do not qualify for treatment with the PHS. These statements seem to contradict each other and parents should be able to decide where they want their child to have preventative treatment. Finances can be an issue and some children are more cooperative in a setting outside the private practice.

7. **Clarify the board rule that states the board will assist the dental hygienist in finding a dentist to provide public health supervision.**
   PHS hygienists are encountering difficulty finding supervising dentists.

8. **Consider a rule much like the above to assist PHS and IPDH hygienists in finding a dentist to interpret radiographs.**
   PHS and IPDH hygienists are having difficulty finding dentists to interpret their radiographs.

9. **Allow an IPDH to supervise a dental radiographer.**
   A dental radiographer in an IPDH practice would be no less qualified than they would in a private practice dental office. They could possibly be considered to be more qualified working with an IPDH that has had formal education in radiography rather than another OJT dental assistant with no formal training.

10. **Eliminate or redefine the "traditional and nontraditional" setting.**
    This simple statement has caused a lot of confusion as to where a PHS and IPDH can practice. We would suggest that a private practice dental office is a traditional setting and all other settings are nontraditional. For example, an IPDH and a PHS should be able to work in a not-for-profit clinic, school system, or nursing home which would all be considered nontraditional settings.

11. **Allow local anesthesia and nitrous to be administered without supervision.**
    There have been no complaints against hygienists to our knowledge. RDH's with these permits have successfully completed board approved education, training, and examination.

12. **Allow hygienists who have taken local anesthesia and nitrous courses and passed appropriate exams to have those applications be part of their license much like a dentist license without having to renew and pay every biennium for separate permits.**
    This would be much more efficient for licensees and makes it consistent with the dentist license. Both DH programs in Maine require local and nitrous oxide as part of their currilicum.

13. **Allow all hygienists to provide in office whitening and add impressions for bleaching trays under IPDH duties.**
    This procedure is currently being provided by non-dental personnel and the public would be better served and protected to allow dental hygienists to provide these services. Denturists can also provide this service.

Lorraine Klug, RDH

6c

Vaillancourt, Penny

From: Jeff and Tracey Jowett <jowett_jt@live.com>
Sent: Wednesday, January 18, 2017 8:19 PM
To: Vaillancourt, Penny
Subject: Friday Ad Hoc Meeting
Attachments: RDH Scope of practice.pdf

Hi Penny,

Unfortunately, I will be unable to attend the Ad Hoc Committee meeting this Friday. In an attempt to be of some help I did review the RDH Scope of Practice and tried to categorize the authorized procedures. I did not try to change the language but did group closely related procedures. I did add in parentheses under RDH process of care line h. wording regarding Standing Order agreements for placement of sealants for PHS hygienists. More review, refining, and reformatting will be need but I hope this is of some help to start.

Please let me know if additional information from me would be helpful. I regret that I cannot be there this Friday. This is important work that has been needed for some time. I appreciate your efforts.

Tracey L. Jowett, IPDH

jowett_jt@live.com

Direct supervision:

A. Administer local anesthesia or nitrous oxide analgesia, as long as the dental hygienist or faculty dental hygienist has authority to administer the relevant medication pursuant to section 18345, subsection 2, paragraph D or E;
B. Irrigate and dry root canals;
C. Record readings with a digital caries detector and report them to the dentist for interpretation and evaluation;
D. Remove socket dressings;
E. Take cytological smears as requested by the dentist;
F. Take impressions for nightguards and occlusal splints as long as the dentist takes all measurements and bite registrations.

General Supervision:

Evaluate Health Status:

a. Take and record the vital signs of blood pressure, pulse and temperature; take intraoral photographs, expose and process radiographs; interview patients and record complete medical and dental histories; perform oral inspections, complete periodontal and dental restorative charting, and perform dietary analyses for dental disease control recording all conditions that should be called to the attention of the dentist;

RDH Process of Care:

a. Perform all procedures necessary for a complete prophylaxis, including root planing; give oral health instruction;
b. Retract lips, cheek, tongue and other tissue parts;
c. Demonstrate to a patient how the patient should place and remove removable prostheses, appliances or retainers;
d. Take and pour impressions for study casts, athletic mouth guards, custom trays, bleaching trays, fluoride trays, opposing models, retainers and stents;
e. Take dental plaque smears for microscopic inspection and patient education;
f. Obtain bacterial sampling when treatment is planned by the dentist;
g. Application of agents: cavity varnish; desensitizing agents; fluoride; topical anesthetics liquids, pastes or gel; Place localized delivery of chemotherapeutic agents when treatment is planned by the dentist;
h. Apply sealants, as long as a licensed dentist first makes the determination and diagnosis as to the surfaces on which the sealants are applied or through standing order agreement as under Public Health Supervision Status.
i. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse;

Dental Crown Procedures within RDH Scope:

a. Cement pontics and facings outside the mouth;
b. Fabricate temporary crowns and bridges, limiting handpiece rotary instrumentation used in the fabrication to extraoral use only, as long as the dentist checks the occlusion and fit prior to releasing the patient;
c. Place and re-cement temporary crowns with temporary cement;
d. Place and re-cement with temporary cement an existing crown that has fallen out;
e. Select and try in stainless steel or other preformed crowns for insertion by the dentist;

Dental Orthodontic Procedures within RDH Scope:

a. For the purpose of eliminating pain or discomfort, remove loose, broken or irritating orthodontic appliances.
b. Perform preliminary selection and fitting of orthodontic bands, as long as final placement and cementing in the patient's mouth are done by the;
c. Place or remove temporary separating devices;
d. Place elastics or instruct in their use;
e. Place wires, pins and elastic ligatures to tie in orthodontic arch wires that have been fitted and approved by the dentist at the time of insertion;
f. Prepare tooth sites and surfaces with a rubber cup and pumice for banding or bonding of orthodontic brackets. This procedure may not be interpreted as a preparation for restorative material;
g. Reapply, on an emergency basis only, orthodontic brackets;
h. Remove composite material using slow-speed instrumentation for debonding brackets, as long as the dentist conducts a final check prior to release of the patient;
i. Remove excess cement from the supragingival surfaces of teeth;
j. Remove orthodontic arch wires and tension devices and any loose bands or bonds, but only as directed by the dentist;
k. Take intraoral measurements and make preliminary selection of arch wires and intraoral and extraoral appliances, including head gear;

Dental Restorative Procedures within RDH Scope:

A. Change or replace dry socket packets after diagnosis and treatment planned by a dentist;
B. Deliver, but not condense or pack, amalgam or composite restoration material;
C. Perform cold and electronic vitality scanning with confirmation by the dentist;
D. Place and remove gingival retraction cord without vasoconstrictor;
E. Place and remove matrix bands, periodontal dressing, rubber dams and wedges;
F. Irrigate and aspirate the oral cavity and perform postoperative irrigation of surgical sites;
G. Isolate operative fields;
H. Place, hold or remove celluloid and other plastic strips prior to or subsequent to the placement of a filling by the dentist;
I. Place temporary restorations as an emergency procedure, as long as the patient is informed of the temporary nature of the restoration;
J. Pour and trim dental models;
K. Remove sutures; Smooth and polish amalgam restorations;

#6d

Vaillancourt, Penny

From: Marji Harmer-Beem <mharmerbeem@une.edu>
Sent: Wednesday, January 18, 2017 2:55 PM
To: Vaillancourt, Penny
Subject: Re: ADHOC comm

Dear Penny,
You asked the Ad Hoc Committee to capture the "essence" of the dental hygiene profession. Here is one definition of dental hygiene:

Dental hygiene is the study of oral hygiene practices and the management of adaptive behaviors required to perform these practices in order to assist clients/ patients in fulfilling their human need for wellness.
Dental hygiene involves a process of care: assessment, dental hygiene diagnosis, planning of interventions (dental hygiene treatment plan), and evaluation, it is accomplished through education of oral disease prevention, therapeutic treatment services, oral health promotion and collaboration with the patient /client and other health providers. (Darby and Walsh 2010)

As you can see there is not a laundry list of services that define dental hygiene, as physicians do not define themselves by medical procedures but by abilities that lead to healing and wellness.

Thank you for your leadership in this process.
Most sincerely,
Marji
Marji Harmer-Beem RDH, MS
Program Director
Associate Professor
Dental Hygiene Program
Westbrook College of Health Professions
University of New England
Portland, Maine 04103
1-207-221-4315

From: "Vaillancourt, Penny" <Penny.Vaillancourt@maine.gov>
Date: Wednesday, January 18, 2017 at 12:05 PM
To: Amanda Willette <amanda.e.willette@maine.edu>, Austin Carbone <austiebone@yahoo.com>, "Dr. David Pier" <davidpierdmd@gmail.com>, "Dr. David Pier 2" <davidpier@roadrunner.com>, "Dr. James Schmidt" <thumper5@aol.com>, "Dr. Lisa Howard" <lisa@howardortho.com>, Jon Ryder <jryder2@une.edu>, "lorraineklug@hotmail.com" <lorraineklug@hotmail.com>, "Marion Hernon DMD (mjhernon@gmail.com)" <mjhernon@gmail.com>, Marji Harmer-Beem <mharmerbeem@une.edu>, michelle gallant <mgallant500@icloud.com>, "nancy.foster@maine.edu" <nancy.foster@maine.edu>, Paul Levasseur <plevasseur@fairpoint.net>, Tracy Jowett <jowett_jt@live.com>, Rachel King <rking7@une.edu>, "gerry@roadrunner.com" <gerry@roadrunner.com>
Cc: "LaRochelle, Lauren" <Lauren.LaRochelle@maine.gov>, "Bowie, Jim" <Jim.Bowie@maine.gov>
Subject: FW: ADHOC comm

Good afternoon,

Maine Board of Dental Practice
Review of the Maine Dental Practice Act – Phase II

Pursuant to Public Law 2016, c. 429
"An Act to Revise the Laws Governing Dental Practices"

Meeting Materials – March 3, 2017

1. Agenda

2. Draft meeting notes from January 20, 2017 meeting

3. Faculty license materials from Dr. Rachel King

4. RDH scope documents
   a. Nancy Foster document
   b. Tracey Jowett document
   c. Lorraine Klug document

5. IPDH qualifications for licensure
   a. Susan Kuehl email/document

6. Dental Assistant – scope of delegated duties
   a. Dr. Marion Hernon's email

7. Ad Hoc Recommendations document – January 20, 2017

8. Unlicensed individuals / dental radiographers
   a. Amanda Willette document

MAINE BOARD OF DENTAL PRACTICE

DRAFT Ad Hoc Committee - Phase II Meeting Notes **DRAFT**
March 3, 2017

****

The Ad Hoc Committee convened at 9:00 a.m.

Participants Present:

Dr. Lisa Howard, Vice Chair of the Board of Dental Practice; Nancy Foster, RDH, EFDA, EdM, Member of the Board of Dental Practice; Dr. Rachel King; Bernice Mills, RDH; Tracey Jowett, IPDH; Amanda Willette, CDA, EFDA; Austin Carbone, LD; Paul Levasseur, LD; Lorraine Klug, IPDH; Dr. Kristina Lake Harriman; Dr. James Schmidt; and Penny Vaillancourt, Executive Director, Board of Dental Practice.

Also Present:

Bonnie Vaughan, John Merrill, Ann Mitchell, Tricia Spearin, and Lauren LaRochelle, Assistant Attorney General.

Introduction/Background/Ground Rules/Role of the Committee:

Dr. Howard and Nancy Foster, RDH, EFDA, EdM opened the meeting and welcomed participants and members of the public attending the meeting. Introductions were made, an overview of the ground rules was conducted, and objectives of the committee were shared.

Highlights of the discussion included:

- Maine requirements for faculty licensure
  - Maine law requires applicants to hold an active dentist license in another state/province - identified as a barrier to recruit faculty dentists by UNE
  - Review of other state faculty licensure laws; alternative pathways to licensure
  - Policy issue of how to qualify foreign trained dentists and/or non-CODA approved educational institutions

- RDH scope of practice
  - Maine law lists procedures authorized and there were sample proposals submitted to capture the principles of dental hygiene practice in a way that does not contain a laundry list
  - Concerns were noted about moving away from a list of authorized procedures, but there was also recognition that the list was outdated and not necessarily reflective of practice

- Public Health Supervision status
  - Question was posed whether or not PHS designation was still needed as a delivery model of care. Participants shared that public health dental hygiene services works well, and that value is added by requiring a practice agreement with a supervising dentist.

- Concerns were raised regarding the reporting requirements and eligibility requirements listed under current board rule. Participants shared that the eligibility requirements and reporting requirements seemed antiquated and no longer necessary. The Board does not use the data to report out the effectiveness of public health dental hygiene services.

- RDH scope – expand to include sealants regardless of setting
  - Dental Hygiene diagnosis was discussed and all agree that the term "diagnosis" is trigger word that causes concern, but should be explored in more detail it is part of the CODA curriculum, as well as the American Dental Hygienists' Association's Standards for Clinical Dental Hygiene Practice
  - Participants discussed the evolution of certain dental hygiene procedures and providing sealants is appropriate procedure to add under RDH scope of practice. Private practice settings may decide on their own practice/supervision requirements but expanding this scope will streamline dental hygiene services

- Review of Lorraine Klug's January 15, 2017 letter
  - Increase authority of subcommittees. Participants generally agreed that the current system works well, no need to expand authority.
  - Teeth whitening – policy discussion with Board and/or LCRED. Current statute appears to regulate it for denturists, but not listed in other scopes.
  - Expand RDH scope to include use of local anesthesia and nitrous oxide. Participants discussed the pros and cons of implementing that type of change. Similar to the discussion regarding sealants, there is an evolution of certain dental hygiene practices occurring. RDH programs are now including local/nitrous as required courses.

- Review of Amanda Willette's materials submitted March 3, 2017, regarding unlicensed individuals, dental assistants and dental radiographers
  - Regulation of dental assistants is necessary to protect the public, especially given other state experiences regarding infection control issues
  - Revise the statute to regulate dental assistants and eliminate dental radiography as those serving in that capacity are primarily dental assistants. However there are some denturists that also hold a dental radiography license

- Denturist practice issues
  - Bring back the use of "DD" which is a trademark used to recognize individuals who have successfully passed a certificate program in denturism (Diploma in Denturism). This will require some discussion of a practice act versus a title act, and concerns raised years ago by the Board of misrepresentation to the public.
  - Review Section 18392 of the statute as it relates to owner identification of removable dental prosthesis

- Denturist participants believes that the Board can expand the duties by rule, as opposed to requiring a legislative process to expand to allow the taking of all dental radiographs, all removable prosthetics with exceptions, and replace abutments on implants

- Expand delegated duties to include supragingival polishing. There was discussion about keeping the existing delegated duties as is as there will likely be a more robust discussion of whether to regulate the delegate duties that are in statute now. This raised an issue with regarding to the scope of the committee's work to examine all enumerated procedures listed in statute, or just the RDH scope. It is preferred to keep the RDH scope review separate from the delegated duties to an unlicensed person to avoid any confusion. Arriving at an agreed upon RDH scope may help guide the delegated duties discussion in the future.

Concluding comments:

- Dr. Howard and Nancy Foster thanked participants for their work to the effort. There was positive feedback regarding the process. All agree that additional work lies ahead, but this was a good second step effort.

Meeting adjourned at 11:55 a.m.

BOARD OF DENTAL PRACTICE
Ad Hoc Committee - Phase II Review meeting of: March 3, 2017

PLEASE SIGN IN

Please PRINT Your Name and Your Agency Name **Clearly**

NAME	AGENCY
Dr. Kristne Lake Harriman	MDA
Ann Mitchell	MDA
Bonni Vaughn	KVFD MDHA
John Merrill	
Aric Alper	RDA

#1

Maine Board of Dental Practice

Ad Hoc Committee
Phase II Review pursuant to Public Law 2016, c. 429
March 3, 2017 - 9:00 a.m. - 12:00 p.m.

MEETING AGENDA

1) **Opening remarks from co-chair(s)**

2) **Review timeline, meeting schedule, ground rules, etc.**

3) **Review/discuss draft notes of January 20, 2017 meeting**

4) **Review/discuss RDH scope of practice**

5) **Review remaining list of issues identified by the committee**

6) **Propose outline of draft report to the Board of Dental Practice**

7) **Discussion/next steps**

8) **Adjourn**

Location: Maine Board of Dental Practice, Conference room, 161 Capitol Street, Augusta, ME 04330
Directions: http://www.maine.gov/dental/board-information/contact.html

Contact staff: Penny Vaillancourt, Executive Director; tel: (207) 287-3333; TTY users call Maine relay 711; or email penny.vaillancourt@maine.gov

#2

MAINE BOARD OF DENTAL PRACTICE

Ad Hoc Committee – Phase II Meeting Notes
January 20, 2017

****

The Ad Hoc Committee convened at 9:00 a.m.

Participants Present:

Dr. Geraldine Schneider, Chair of the Board of Dental Practice; Nancy Foster, RDH, EFDA, EdM, Member of the Board of Dental Practice; Dr. Marion Hernon; Dr. Rachel King; Marji Harmer-Beem, RDH; Amanda Willette, CDA, EFDA; Austin Carbone, LD; Paul Levasseur, LD; Lorraine Klug, IPDH; Dr. David Pier; Dr. James Schmidt; Michelle Gallant, RDH; and Penny Vaillancourt, Executive Director, Board of Dental Practice.

Also Present:

Janet Stocco, Bonnie Vaughan, John Merrill, Ann Mitchell, and Tricia Spearin.

Introduction/Background/Ground Rules/Role of the Committee:

Dr. Schneider and Nancy Foster, RDH, EFDA, EdM opened the meeting and welcomed participants and members of the public attending the meeting. Introductions were made, an overview of the ground rules was conducted, and objectives of the committee were shared.

Highlights of the discussion included:

- Issues raised in a letter submitted by Lorraine Klug
- Disagreement in using the term "dental hygiene diagnosis"
- Concepts were shared of writing an RDH scope of practice
- Support for the existing composition of the Board was expressed, as well as encouraging interdisciplinary discussions
- The FTC v. North Carolina Dental Board decision was mentioned in the context of not having one profession dominate membership of a dental regulatory board
- Consider regulating dental assistants and perhaps roll into the existing dental radiography licensure category
- Consider dentist scope to include non-dentally related use of Botox
- Distinctions were made between credentialing and licensing (medicine/dentistry)
- Desire to prioritize the issues identified and discuss each one for the purpose of providing recommendations to the Board

Action included:

- Review, discussion and vote on the list of issues identified

Meeting adjourned at 12:05 p.m.

#3

Vaillancourt, Penny

From: Rachel King <rking7@une.edu>
Sent: Wednesday, January 25, 2017 1:29 PM
To: Vaillancourt, Penny
Subject: Supporting Docs for Adhoc Committee - Statutory Review
Attachments: Faculty License Statues - NY, CT, MA.docx; Massachusetts.pdf

Good Afternoon Penny,

Attached are two documents that provide the language of the statutory regulations and the application directions for a Faculty License for the states of New York, Massachusetts, and Connecticut. If these could be provided to committee members for reference during discussion of the "Faculty Licensure" statute.

Thank you,
Dr. King

Rachel L. King, DDS, MPH
Assistant Clinical Professor
University of New England
College of Dental Medicine
210 Goddard Hall
716 Stevens Avenue Portland, ME 04103
Office: (207) 221-4848
rking7@une.edu

New York

Article 133, Dentistry and Dental Hygiene

§ 6604-b. Restricted dental faculty license.

1. The department may issue a restricted dental faculty license to a full-time faculty member employed at an approved New York state school of dentistry. The holder of such restricted dental faculty license shall have the authority to practice dentistry, as defined in this article, but such practice of dentistry shall be limited to the school's facilities or the school's clinics, or facilities or clinics with relationships to the school confirmed by formal affiliation agreements. Nothing in this section shall be construed to authorize such holder of a restricted dental faculty license to engage in the private practice of dentistry at any other site.
2. To qualify for a restricted dental faculty license the applicant shall present satisfactory evidence of the following:
    a. The completion of a total of no less than six academic years of pre-professional and professional education, including:
        i. courses in general chemistry, organic chemistry, biology or zoology and physics; and
        ii. not less than four academic years of professional dental education satisfactory to the department culminating in a degree, diploma or certificate in dentistry recognized by the appropriate civil authorities of the jurisdiction in which the school is located as acceptable for entry into practice in the jurisdiction in which the school is located.
    b. Within the last five years, have two years of satisfactory practice as a dentist or have satisfactorily completed an advanced education program in general dentistry or in a dental specialty, provided such program is accredited by an organization accepted by the department as a reliable authority for the purpose of accrediting such programs (such as the commission on dental accreditation); and
    c. Possesses good moral character as determined by the department.
3. The dean of the dental school shall notify the department in writing upon the submission of an initial license application and yearly thereafter that the holder of the dental faculty license is employed full-time at the dental school. Full-time employment means the holder of such dental faculty license devotes at least four full working days per week in teaching or patient care, research or administrative duties at the dental school where employed. The dean of the dental school and the holder of such dental faculty license shall each notify the department in writing within thirty days of the termination of full-time employment.
4. In order to continue to practice dentistry, the holder of a restricted dental faculty license shall apply for and hold a current triennial registration which shall be subject to

the same registration requirements as apply to holders of unrestricted dental licenses, except that such registration shall be issued only upon the submission of documentation satisfactory to the department of the holder's continued status as a full-time dental faculty member, provided that such registration shall immediately terminate and the holder shall no longer be authorized to practice if the holder ceases to be a full-time dental faculty member at an approved New York state school of dentistry.

5. The holder of this restricted dental faculty license shall be subject to the professional misconduct provisions set forth in article one hundred thirty of this chapter and in the rules of the board of regents and the regulations of the commissioner.
6. The fee for each restricted dental faculty license shall be three hundred dollars, and the fee for initial registration and each subsequent re-registration shall be three hundred dollars.
7. In order to be eligible for a restricted dental faculty license an applicant must be a United States citizen or an alien lawfully admitted for permanent residence in the United States; provided, however, that the department may grant a three year waiver for an alien who otherwise meets all other requirements for a restricted dental faculty license except that the department may grant an additional extension not to exceed six years to an alien to enable him or her to secure citizenship or permanent resident status, provided such status is being actively pursued. No current faculty member shall be displaced by the holder of a restricted dental faculty license.

Application Instructions

The Department may issue a restricted dental faculty license to a full-time faculty member employed at an approved New York State school of dentistry. A restricted dental faculty license authorizes the holder to practice dentistry, as defined in Article 133 of New York's Education Law, **but** such practice of dentistry must be limited to the school's facilities or the school's clinics, or facilities or clinics with relationships to the school confirmed by formal affiliation agreements. A restricted dental faculty license **does not** authorize the holder to engage in the private practice of dentistry at any other site.

To receive a restricted dental faculty license in New York State you must:

- be of good moral character;
- be at least 18 years of age;
- meet educational requirements; and
- meet experience requirements.

You must file an Application for Licensure (Form 1) and the other forms indicated, along with the appropriate fee, to the Office of the Professions at the address specified on each form. **It is your responsibility to follow up with anyone you have asked to send us material.**

The specific requirements for licensure are contained in Title 8, Article 133, section 6604-b of New York's Education Law.

You should also read the general licensing information applicable for all professions.

Connecticut

General Statutes Chapter 379 Dentistry

Sec. 20-120.

Practice of dentistry in clinics, schools of dentistry and state institutions.

(a) Any graduate of a recognized dental college may practice dentistry in a clinic for a period not exceeding six months, provided he shall obtain the written consent and approval of the Dental Commission.

(b) A full-time faculty member of a school of dentistry in this state who is licensed in another state or who has exceptional qualifications as approved by the Dental Commission may be granted a provisional license upon consent and approval of the Dental Commission which provisional license shall be in effect during such time as the licensee is in the full-time employment of a school of dentistry within the state. Such provisional license shall limit the licensee to the practice of dentistry in the school of dentistry of which he is a member of the faculty or in any hospital affiliated with such school.

(c) Any graduate of a foreign dental school, who has exceptional qualifications, as approved by the Dental Commission, may practice dentistry in any state institution.

Application Instructions

In order to qualify for provisional licensure, an applicant must be a full-time faculty member of a Connecticut dental school. Once issued, the licensee is authorized to practice solely within the school of dentistry or a hospital affiliated with the dental school. The applicant must:

Be a graduate of a dental school located outside the United States and possess exceptional qualifications as determined by the Connecticut State Dental Commission; or

hold a current, unrestricted dental license in another state of the United States and possess exceptional qualifications as determined by the Connecticut State Dental Commission; or

> The Commission considers many factors when determining exceptional qualifications including, but not limited to, academic achievement, postgraduate training, examination history and board certification. Each applicant is reviewed individually prior to the Commission's determination.
>
> Please note that the Commission meets quarterly and all applications must be complete 14 business days prior to the meeting in order to place the application on the meeting agenda. Incomplete applications will not be placed on the agenda until the next regularly scheduled meeting.

Massachusetts

234 CMR: BOARD OF REGISTRATION IN DENTISTRY

234 CMR 4.00: LICENSURE AND LICENSE RENEWAL REQUIREMENTS

4.05: Initial Licensure as Limited License Full-time Faculty or Limited License Dental Intern

Pursuant to M.G.L. c. 112, § 45A, the Board may grant a limited license for a dentist to serve as a full-time member of a dental college faculty or as a limited license dental intern in a hospital or other institution maintained by the state, a county or municipality, or hospital or dental infirmary incorporated under the laws of the Commonwealth, provided that the applicant is of good moral character, has met all of the eligibility requirements, and has submitted the following information and documentation to the Board:

. (1) An accurate, complete, and signed application as specified by the Board for that purpose;

. (2) Payment of a non-refundable licensing and application fee as determined by the Executive

Office of Administration and Finance;

(3) Proof satisfactory to the Board that the applicant has received a diploma in dentistry from the faculty of a reputable dental college as defined in M.G.L. c. 112, § 46:

(a) Graduates of a dental program accredited by CODA or any successor accrediting agency approved by the Board shall submit an original transcript with the college seal indicating the degree granted and the date of issue from a CODA-accredited dental school or any successor accrediting agency approved by the Board, or a letter including the college's seal which is signed by the appropriate authority and attests to the applicant's degree and date of graduation.

(b) Graduatesofnon-CODAorforeigndentalprogramsshallsubmitanoriginaltranscript, with college seal that indicates the date of issuance of a dental diploma from a reputable dental college. If the transcript is not in English, the applicant shall provide a certified translated copy of the original dental college transcript demonstrating the applicant received a dental degree from a reputable dental college.

(4) Proof satisfactory to the Board of employment as full-time faculty in a dental school accredited by CODA or as a dental intern in a hospital or other institution maintained by the state, a county or municipality, or hospital or dental infirmary incorporated under the laws of the Commonwealth.

(a) A full-time member of faculty shall submit an original letter with the college seal that confirms the applicant's status and dates of appointment as a full-time faculty member. The application for licensure shall also include the printed name, signature and license number of the applicant's supervising dentist, who shall hold a valid license issued by the Board pursuant to M.G.L. c. 112, § 45 and be in good standing with the Board.

(b) A dental intern employed by a hospital or other institution maintained by the state, county or municipality, or hospital or dental infirmary incorporated under the laws of the Commonwealth shall submit an application for licensure that indicates the applicant's place(s) of employment and date of appointment. The application shall also include the printed name, signature and license number of the applicant's supervising dentist, who shall hold a valid license issued by the Board pursuant to M.G.L. c. 112, § 45 and be in good standing with the Board.

---

(5) study or a signed attestation from the applicant which confirms that he or she will, within one year of initial licensure, successfully complete the following in accordance with 234 CMR 8.00: Continuing Education:

(a) A minimum of three CEU's in CDC Guidelines (234 CMR 2.00: Purpose, Authority, Definitions);

Documentation of successful completion of continuing education in the following areas of

(b) (c) (d) (e) (f) or

A minimum of three CEU's in OSHA Standards at 29 CFR; A minimum of six CEU's in treatment planning and diagnosis; A minimum of three CEU's in record-keeping; A minimum of two CEU's in risk management; and

A minimum of three CEU's in pharmacology, with emphasis on prescription writing;

(g) Evidence of enrollment in a CODA-accredited dental school that includes the areas of study included in 234 CMR 4.05(5)(a) through (f).

(6) Documentation demonstrating current certification in American Red Cross Cardiopulmonary Resuscitation/Automated External Defibrillation for the Professional Rescuer (CPR/AED) or current certification in the American Heart Association Basic Life Support for Healthcare Providers (BLS);

(7) If the applicant has graduated from a dental school where the language of written or oral instruction (including textbooks) or both, is in a language other than English, the applicant shall submit documentation satisfactory to the Board that the applicant has achieved a minimum score, as specified by the Board, on a Board-designated test of English proficiency;

(8) A physician's statement that is the result of an examination, conducted within six months of the date of application, attesting to the health of the applicant and reporting impairments which may affect the applicant's ability to practice dentistry;

(9) Certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dentistry attesting to the standing of his or her license, including report of any past or pending disciplinary action, or any pending complaints against the applicant;

. (10) A practice history;

. (11) An original report from the National Practitioner Data Bank (NPDB) Self-query;

. (12) A statement disclosing any disciplinary action, civil and/or criminal action taken against

the applicant at any time prior to the date of application, with supporting documentation as may be required by the Board;

(13) Proof satisfactory to the Board of good moral character;

(14) Documentation of successful completion of the Massachusetts Dental Ethics and Jurisprudence Examination or any successor examination;

(15) A passport-size photograph in color; and

(16) An attestation, signed under pains and penalties of perjury, that the applicant has complied with all state tax laws pursuant to M.G.L. c. 62C, § 49A and child support laws pursuant to M.G.L. c. 119A, § 16(a).

4.06: Renewal of Limited License Full-time Faculty License and Limited License Dental Intern License

(1) Full-time Faculty. A licensee who has been initially issued a limited full-time faculty license by the Board pursuant to M.G.L. c. 112, § 45A may apply to the Board annually to renew his or her limited license by submitting the applications, fees, documents and information required by the Board including the applicant's compliance with 234 CMR 8.02(2).

(2) Limited License Dental Intern. A licensee who has been initially issued a limited dental intern license by the Board pursuant to M.G.L. c. 112, § 45A may apply to the Board annually to renew his or her limited license(s) for a maximum of five one-year periods, except that said licensee may, upon permission of the Board, take the NERB Clinical Exam in Dentistry (CED) or successor examination required by the Board. A limited license dental intern who successfully completes and passes the NERB/CED may thereafter apply to the Board annually to renew his or her license to practice dentistry in the Commonwealth in settings specified in M.G.L. c. 112, § 45A and in compliance with 234 CMR 8.02(2).

(3) An individual who holds a license to practice dentistry pursuant to M. G. L. c. 112, § 45A on or before August 20, 2010 shall be exempt from demonstrating proficiency in English (See 234 CMR 4.05(7)).

Application Instructions

See Attachment

The Commonwealth of Massachusetts
Division of Health Professions Licensure
Board of Registration in Dentistry
239 Causeway Street, 5th floor, Suite 500
Boston, MA 02114
(617) 973-0971
www.mass.gov/dph/boards/dn

INITIAL (FIRST-TIME) FULL-TIME FACULTY LIMITED LICENSE APPLICATION INSTRUCTIONS

(See 234 CMR 4.05 Effective August 20, 2010)

A full- time Faculty Limited License allows a full-time faculty member to perform all the duties of a dentist but only in a specifically-named hospital school, public clinic, or prison Private practice is not permitted at any time Full-Time Faculty Limited Licenses are valid for exactly one year from date of issue and may be re-applied for annually The Board may issue a Full- Time Faculty Limited License provided it receives the following documentation:

- An accurate, complete, and signed application including CORI report,
- Payment of a nonrefundable, nontransferable licensing fee.
- Proof satisfactory to the Board that the applicant has received a diploma in dentistry Graduates of non-CODA or foreign dental schools shall submit an original transcript, with college seal that indicates the date of issuance of a dental diploma from a reputable dental college. If the transcript is not in English, the applicant shall provide a certified translated copy of the original dental college transcript demonstrating the applicant received a dental degree from a reputable dental college.
- A full-time member of faculty shall submit an original letter with the college seal that confirms the applicant's status and dates of appointment as a full-time faculty member. The application for licensure shall also include the printed name, signature and license number of the applicant's supervising dentist, who shall hold a valid license issued by the Board pursuant to M. G. L. c. 112, § 45 and be in good standing with the Board.
- Documentation demonstrating current certification in American Red Cross Cardiopulmonary Resuscitation Automated External Defibrillation for the Professional Rescuer (CPR/AED) or current certification in the American Heart Association Basic Life Support for Healthcare Providers (BLS).
- If the applicant has graduated from a dental school where the language of written or oral instruction (including textbooks) or both, is in a language other than English, the applicant shall submit documentation satisfactory to the Board that the applicant has achieved a minimum score, as specified by the Board, on a Board-designated test of English proficiency.
- A physician's statement that is the result of an examination, conducted within six months of the date of application, attesting to the health of the applicant and reporting impairments which may affect the applicant's ability to practice dentistry.
- If applicable, certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dentistry attesting to the standing of his her license, including report of any past or pending disciplinary action, or any pending complaints against the applicant.
- A practice history, if applicable.

- An original report from the National Practitioner Data Bank (NPDB) Self-query.
- A statement disclosing any disciplinary action, civil and/or criminal action taken against the applicant at any time prior to the date of application, with supporting documentation as may be required by the Board.
- Successful completion of the Massachusetts Dental Ethics and Jurisprudence Examination. Email the Board at dentistry.admin@state.ma.us to request a copy of the exam.
- Attach a passport-size photograph in color (2x2) to application where indicated. See http://travel.state.gov/passport/guide/composition/composition_87.html
- An affidavit, signed under pains and penalties of perjury, and witnessed by a Notary Public.

PLEASE NOTE:

- Incomplete applications will delay license processing.
- Please retain a copy of all application materials for your records.
- Upon board approval, a certificate and a license number will be issued in your name and sent to your supervising dentist. Confirmation of your license number will be available under "Online Services/Check a License" on our website **www.mass.gov/dph/boards/dn** as soon as the Board approves the license.
- To contact potential employers or dental educational programs or educational opportunities

Hospitals	**www.mahospitalcareers.com**
Community Health Centers	www.massleague.org
Massachusetts Department of Corrections	www.mass.gov/doc
Harvard University School of Dental Medicine	www.hsdm.harvard.edu
Boston University Goldman School of Dental Medicine	www.bu.edu/dental
Tufts University School of Dental Medicine	www.tufts.edu/dental

#4.a.

Practice categories for the dental hygienist: (Ref: MN and CA statutes and textbook: *Dental Hygiene Theory and Practice* (4th ed), Darby and Walsh, 2015)

1) Provides dental hygiene process of care:
    a. Educational, preventative, and therapeutic through the following , assessment, dental hygiene diagnosis, planning, evaluation, documentation, counseling, and therapeutic treatment services to establish, promote and maintain oral health
    b. Evaluates patient health status:
        i. Reviews medical and dental histories, assesses and plans dental hygiene care needs, performs prophylaxis including complete removal of hard deposits, cement, composite material, stains, and other tooth accumulated materials by scaling, polishing, root planing and periodontal debridement procedures

2) Administers nitrous oxide inhalation analgesia or local anesthesia by permit

3) Provides other services as follows with appropriate supervision and or authority:
    a. Application of topical, therapeutic, and subgingival agents:
        i. Cavity varnish, desensitizing agents, topical anesthetics, topical chemotherapeutic/antibiotic agents, fluorides, etc.)
    b. Dental sealants
    c. Dental procedures with appropriate supervision:
        i. Fabrication and placement of temporary; crowns, bridges, and restorations
        ii. Smooth, polish and deliver (but not condense/pack): restorations
        iii. Teeth whitening/bleaching
        iv. Limited orthodontic functions (not for final placement)
        v. Remove sutures and change dry socket packets
        vi. Tooth vitality testing
        vii. Obtain oral samples: salivary/bacterial/cytological smears
        viii. Impressions (not for final restorative)
    d. Dental, periodontal charting, and caries detection recording; recordkeeping
    e. Administer, dispense, prescribe certain medications
    f. Expose and process dental radiographs

4) (ref: CA 1914)A dental hygienist may use any material or device approved for use in the performance of a procedure within the scope of practice under the appropriate level of supervision, if they have obtained the appropriate education and training to use the material or device.
5) Supervision: (ref: CA- 1912, 1913,1914) Unless otherwise specified in this chapter, a dental hygienist may perform any procedure or provide any service within the scope of practice in any setting, so long as the procedure is performed or the service is provided under the appropriate level of supervision required. So long as it does not give rise to a situation in the practice setting requiring

immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable dental conditions that, if not immediately diagnosed and treated, would lead to serious injury or death.

#4.b.

Direct supervision:

A. Administer local anesthesia or nitrous oxide analgesia, as long as the dental hygienist or faculty dental hygienist has authority to administer the relevant medication pursuant to section 18345, subsection 2, paragraph D or E;
B. Irrigate and dry root canals;
C. Record readings with a digital caries detector and report them to the dentist for interpretation and evaluation;
D. Remove socket dressings;
E. Take cytological smears as requested by the dentist;
F. Take impressions for nightguards and occlusal splints as long as the dentist takes all measurements and bite registrations.

General Supervision:

Evaluate Health Status:

a. Take and record the vital signs of blood pressure, pulse and temperature; take intraoral photographs, expose and process radiographs; interview patients and record complete medical and dental histories; perform oral inspections, complete periodontal and dental restorative charting, and perform dietary analyses for dental disease control recording all conditions that should be called to the attention of the dentist;

RDH Process of Care:

a. Perform all procedures necessary for a complete prophylaxis, including root planing; give oral health instruction;
b. Retract lips, cheek, tongue and other tissue parts;
c. Demonstrate to a patient how the patient should place and remove removable prostheses, appliances or retainers;
d. Take and pour impressions for study casts, athletic mouth guards, custom trays, bleaching trays, fluoride trays, opposing models, retainers and stents;
e. Take dental plaque smears for microscopic inspection and patient education;
f. Obtain bacterial sampling when treatment is planned by the dentist;
g. Application of agents: cavity varnish; desensitizing agents; fluoride; topical anesthetics liquids, pastes or gel; Place localized delivery of chemotherapeutic agents when treatment is planned by the dentist;
h. Apply sealants, as long as a licensed dentist first makes the determination and diagnosis as to the surfaces on which the sealants are applied or through standing order agreement as under Public Health Supervision Status.
i. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse;

Dental Crown Procedures within RDH Scope:

a. Cement pontics and facings outside the mouth;
b. Fabricate temporary crowns and bridges, limiting handpiece rotary instrumentation used in the fabrication to extraoral use only, as long as the dentist checks the occlusion and fit prior to releasing the patient;
c. Place and re-cement temporary crowns with temporary cement;
d. Place and re-cement with temporary cement an existing crown that has fallen out;
e. Select and try in stainless steel or other preformed crowns for insertion by the dentist;

Dental Orthodontic Procedures within RDH Scope:

a. For the purpose of eliminating pain or discomfort, remove loose, broken or irritating orthodontic appliances.
b. Perform preliminary selection and fitting of orthodontic bands, as long as final placement and cementing in the patient's mouth are done by the;
c. Place or remove temporary separating devices;
d. Place elastics or instruct in their use;
e. Place wires, pins and elastic ligatures to tie in orthodontic arch wires that have been fitted and approved by the dentist at the time of insertion;
f. Prepare tooth sites and surfaces with a rubber cup and pumice for banding or bonding of orthodontic brackets. This procedure may not be interpreted as a preparation for restorative material;
g. Reapply, on an emergency basis only, orthodontic brackets;
h. Remove composite material using slow-speed instrumentation for debonding brackets, as long as the dentist conducts a final check prior to release of the patient;
i. Remove excess cement from the supragingival surfaces of teeth;
j. Remove orthodontic arch wires and tension devices and any loose bands or bonds, but only as directed by the dentist;
k. Take intraoral measurements and make preliminary selection of arch wires and intraoral and extraoral appliances, including head gear;

Dental Restorative Procedures within RDH Scope:

A. Change or replace dry socket packets after diagnosis and treatment planned by a dentist;
B. Deliver, but not condense or pack, amalgam or composite restoration material;
C. Perform cold and electronic vitality scanning with confirmation by the dentist;
D. Place and remove gingival retraction cord without vasoconstrictor;
E. Place and remove matrix bands, periodontal dressing, rubber dams and wedges;
F. Irrigate and aspirate the oral cavity and perform postoperative irrigation of surgical sites;
G. Isolate operative fields;
H. Place, hold or remove celluloid and other plastic strips prior to or subsequent to the placement of a filling by the dentist;
I. Place temporary restorations as an emergency procedure, as long as the patient is informed of the temporary nature of the restoration;
J. Pour and trim dental models;
K. Remove sutures; Smooth and polish amalgam restorations;

#4.c.

American Dental Hygienists' Association
Maine

15 Jan 2017

Maine Board of Dental Examiners
143 State House Station
Augusta, ME 04666-0143

Executive Director Ms. Penny Vaillancourt and ADHOC Committee:

I sent this letter to the MBDP over a year ago after our Annual Meeting. I asked at our meeting what hygienists would like to see for suggested rule changes and how to clarify our statutes to make them more user friendly. With the newly established rules committee and the proposal to clean up the statutes, I wanted to provide the board with what members and non-members alike had for ideas. The following is a list of ideas from that meeting and concerns we have received from talking with other hygienists. I have deleted some of the items in my original letter because they were no longer relevant but some of the rules suggestions may come up in conversation. **The one main point that I failed to mention at our 1st ADHOC meeting was that of the subcommittees duties which I would also like to see our committee address.**

1. **Allow the dental hygiene and denturist subcommittees to perform their existing duties with no need to report to the full board as well allowing the subcommittee members to be included as full voting members of the board for voting on rule changes.**
   A past board President had stated that they agree with the subcommittee 99% of the time so this would free up the boards' valuable time to take care of more pressing board business. The hope of the LCRED committee was that the 1210 legislation would take care of some of the legislation they voted "ought not to pass" last session and this could be a nice compromise to full self-regulation.

2. **Add dental hygiene diagnosis to the definitions.** A dental hygiene diagnosis is defined as *"the identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. The dental hygiene diagnosis requires evidence-based critical analysis and interpretation of assessments in order to reach conclusions about the patient's dental hygiene treatment needs. The dental hygiene diagnosis provides the basis for the dental hygiene treatment plan."*
   The definition of diagnosis is "the act of identifying a disease from its signs and symptoms," "a concise technical description," "investigation or analysis of the cause or nature of a condition, situation, or problem," and "a statement or conclusion from such an analysis." Dental hygiene program curricula are designed to provide students with the basic and dental science background to recognize the signs and symptoms of disease and to recognize the cause or nature of the problem. This results in determining a dental hygiene diagnosis within the comprehensive dental diagnosis.

3. **Allow RDH's working under general supervision to provide sealants without prior dentist exam.**
   PHS and IPDH's are allowed to provide sealants without an exam. The private practice dental office has standard operating procedures and much like the guidelines for taking radiographs under general supervision, the employing dentist could have guidelines for sealants under general supervision.

4. **Under dental hygiene duties list "all duties that a dental assistant or CDA can perform" and then list other duties that only the hygienist can perform. Under IPDH duties list "all duties that an RDH can perform."**
   This would clean up the statute and prevent the laundry list from being repeated when it's not necessary.

5. **Eliminate PSH reports.**
   PHS hygienists are taking the time to do these reports but the data is not being reviewed, tracked, or compiled to our knowledge and therefore creating unnecessary work for the PHS.

6. **Clarify sections on PHS rules and responsibilities.**
   One section states that you have to contact an IPDH or dentist if the patient has been seen in the previous 12 months but that does not preclude the PHS from providing preventative treatment to a patient within that 12 month period. It then goes on to state that all proprietary forms include that if a child is being seen every 6 months by a dentist that they do not qualify for treatment with the PHS. These statements seem to contradict each other and parents should be able to decide where they want their child to have preventative treatment. Finances can be an issue and some children are more cooperative in a setting outside the private practice.

7. **Clarify the board rule that states the board will assist the dental hygienist in finding a dentist to provide public health supervision.**
   PHS hygienists are encountering difficulty finding supervising dentists.

8. **Consider a rule much like the above to assist PHS and IPDH hygienists in finding a dentist to interpret radiographs.**
   PHS and IPDH hygienists are having difficulty finding dentists to interpret their radiographs.

9. **Allow an IPDH to supervise a dental radiographer.**
   A dental radiographer in an IPDH practice would be no less qualified than they would in a private practice dental office. They could possibly be considered to be more qualified working with an IPDH that has had formal education in radiography rather than another OJT dental assistant with no formal training.

10. **Eliminate or redefine the "traditional and nontraditional" setting.**
    This simple statement has caused a lot of confusion as to where a PHS and IPDH can practice. We would suggest that a private practice dental office is a traditional setting and all other settings are nontraditional. For example, an IPDH and a PHS should be able to work in a not-for-profit clinic, school system, or nursing home which would all be considered nontraditional settings.

11. **Allow local anesthesia and nitrous to be administered without supervision.**
    There have been no complaints against hygienists to our knowledge. RDH's with these permits have successfully completed board approved education, training, and examination.

12. **Allow hygienists who have taken local anesthesia and nitrous courses and passed appropriate exams to have those applications be part of their license much like a dentist license without having to renew and pay every biennium for separate permits.**
    This would be much more efficient for licensees and makes it consistent with the dentist license. Both DH programs in Maine require local and nitrous oxide as part of their currilicum.

13. **Allow all hygienists to provide in office whitening and add impressions for bleaching trays under IPDH duties.**
    This procedure is currently being provided by non-dental personnel and the public would be better served and protected to allow dental hygienists to provide these services. Denturists can also provide this service.

Lorraine Klug, RDH

#5

Vaillancourt, Penny

From:	Susanne Kuehl <suzyql@comcast.net>
Sent:	Thursday, February 16, 2017 4:26 PM
To:	Lorraine Klug; Vaillancourt, Penny
Cc:	Tara Isa Koslov; Deane Rykerson; Bonnie Vaughan
Subject:	IPDH Ad Hoc Committee Written Testimony for LR986
Attachments:	IPDH Pathways Letter 02.16.17.docx

Thank you in advance for forwarding this email to the appropriate members.

Dear Ad Hoc Committee,

Please accept my written testimony to add to your deliberations for Friday February 17th.

A written reply (via email) would be much appreciated.

Respectfully Submitted,

Susanne Kuehl RDH, BS, CPHDH
Oral Health Consultant
Registered Dental Hygienist
207-752-2968
www.hygienehealth.net
info@hygienehealth.net

Susanne Kuehl RDH, BS, CPHDH www.linkedin.com/in/susannekuehl/

To: IPDH Ad Hoc Committee
Re: LR 986
Objective: Remove the restriction of trade language: "6 years preceding"
Date: February 16, 2017

Thank you for all of the work that has been done regarding Independent Practice Dental Hygienists including streamlining licensing categories. I am asking that you consider my written testimony to guide your deliberations and hope that you will see the logic in allowing part-time experienced hygienists achieve IPDH status.

Testimony Overview: Last year, I applied for my IPDH license only to learn that even though I have over 35 years in my profession I would not qualify due to legislative barriers that have nothing to do with patient safety. I have logged well over 25,000 hours of clinical experience over my career, have completed my BS Degree in Marketing in 2008 and have attended well over the 30 hours of continuing education courses to renew my license each biennium for 40 years.

However, as the law stands today, there is no alternative pathway for me to qualify based on the rules requiring 5,000 hours during the six years preceding the application. This section of the law seems like an arbitrary restriction of trade clause that is not evidenced based. Certainly after 35 years as a clinician, I have the "experience" necessary to deliver dental hygiene services safely to the public and was disappointed when I realized that I would never achieve the 5,000-hour requirement working
part-time doing clinical work in NH. There are simply no full-time jobs in southern Maine. My frustration led me to speaking with my state legislator, Representative Deane Rykerson about how to amend the current law.

Further, I received my ***Certified Public Health Dental Hygiene*** status in NH last year completing over 30 continuing education credits at NHTI including courses in medical records, infection control in alternative settings and caries stabilization.(https://www.nhti.edu) If granted IPDH status, I would relish working with local nursing homes to help prevent elders, like my own father, from aspiration pneumonia and/or root caries.

Currently, I am the ***Director of Hygiene*** for ***Virtudent***, https://www.myvirtudent.com, a start up company based in Boston leveraging wireless telehealth technology where we are able to transport the dental chair to the patient delivering preventive services using high standards of safety and quality. Our referring dentists are some of the best in the US and work closely with us to ensure we find our patients a dental home for their restorative needs. For the next three months, I will be conducting a part-time pilot program at the Boys and Girls Club located in Manchester NH in partnership with the North East Delta Dental Foundation. The students are only there from 3:00-7:00 which means once again the clinical services I provide will not result in the IPDH. This is just wrong and simply unfair.

My passion for prevention is unwavering and I believe that oral health is integral to overall health across all lifespans. I yearn to make a difference in patients' lives by achieving IPDH status in Maine.

I appreciate you taking my written comments and would have preferred to come talk to you in person, but missing work is very difficult financially and you never know what kind of traveling weather Mother Nature is going to throw our way. I am happy to provide my resume, a list of dental offices where I have temped and my CE course list 2014-2016 upon request.

Thank you in advance for your consideration.

Respectfully Submitted,
Susanne Kuehl RDH, BS, CPHDH
Oral Health Consultant
90 Haley Road
Kittery, Maine 03904
(207) 752-2968 cell
www.hygienehealth.net
info@hygienehealth.net

Hygiene HEALTH

#6

Vaillancourt, Penny

From:	MARION <mjhernon@gmail.com>
Sent:	Tuesday, February 28, 2017 9:03 PM
To:	Vaillancourt, Penny
Subject:	Re: Ad Hoc Committee Meeting - March 3rd at 9:00 a.m.

Unfortunately I will not be available this Friday, I will be traveling out of the country. One thing I had hope to clarify or address at the last meeting was dental assistant scope- whether they are able to do anything with dentures as far as adjustments or soft relines, etc. My impression was no- but I have heard conflicting ideas on whether they are allowed to do "temporary" or "emergency" soft reline/adjustments. If the conversation leads into this area and can be clarified that would be great.

Thank you!

Marion

On Feb 24, 2017, at 4:38 PM, Vaillancourt, Penny <Penny.Vaillancourt@maine.gov> wrote:

<image001.gif>
Good afternoon,

Attached are the following documents in anticipation of the next ad hoc committee meeting, which is scheduled for **Friday, March 3rd at 9:00 a.m.:**

1. Agenda
2. Documents submitted by Dr. Rachel King

I anticipate sending additional materials early next week, so please stay tuned for more information – please feel free to contact me should you have any questions.

Thank you,
Penny

Penny Vaillancourt, Executive Director
Maine Board of Dental Practice
143 State House Station
161 Capitol Street
Augusta, ME 04333-0143
t: 207.287.3333
c: 207.441.7153
f: 207.287.8140
website: www.maine.gov/dental

#7

Key code:

Red = Statute change
Blue = Board rule change
Black = Statute and Board rule change
Strikethrough = already addressed

MAINE BOARD OF DENTAL PRACTICE

Ad Hoc Committee Meeting – List of Issues
January 20, 2017

Dental Hygienist

1) Scope restrictions/supervision requirements/setting requirements
   a. IPDH
      i. Requirements too restrictive in terms of hours/timeframe of experience
      ii. Allow general supervision of dental radiographers
   b. Public Health
      i. Remove the notification requirements in board rule
      ii. Eliminate the PHS reporting in board rule
      iii. Remove patient qualifications for PHS services
   c. Dental Hygiene Therapy.
2) Review list of authorized procedures and categorize the procedures instead of listing each particular procedure.
3) Review mobility of dental hygiene services.
   a. IPDH practice in public health settings
   b. IPDH per diem and

Comment [VP1]: Remove the distinction of AS/BS; vote: unanimous
4 years of licensed clinical experience; vote: 6 in favor; 6 opposed
2,000 hours within preceding 4 years; vote: 9 in favor; 1 opposed; 2 not voting

Comment [VP2]: Vote: unanimous

Comment [VP3]: Vote: unanimous

Comment [VP4]: Vote: unanimous

Comment [VP5]: Vote: 10 in favor; 1 – no vote

Dentist

1) Adopt ADA scope of practice of a dentist.
2) Use of dermal fillers and Botox for non-dentally related procedures.
3) Consider pathway for foreign trained dentists.
4) Re-consider qualifications for faculty licensure for foreign trained applicants
5) Consider "locum tenens" license and eliminate all the other various dental license types.
6) Tele-dentistry / tele-health definition.

Denturist

1) Increased scope to include dental radiographs and all removable prosthetics with justified exceptions.
2) Replacing abutments on implants.
3) Denture ID's to include scanning technology.
4) Repopulating the dental board to reflect the Supreme Court's decision upholding the FTC's antitrust action re FTC v North Carolina Dental Board.
~~5) Allowing any licensees majority ownership of a dental practice.~~
6) Allowing approved schools, CERP providers and state, national and international denturist associations to accredit continuing education.
7) Requiring internship to LD's before unsupervised practice.
~~8) Reflect legislative intent to provide up to 2 years of externship for denturist students.~~
9) Use of International designation / identification of (DD) by Maine denturists.
10) Allow denturists to delegate authority for denturist assistance and lab technicians in their employ.

Dental Assistants / Unlicensed Person/ Dental Radiography

1) Revisit list of delegated duties in statute.
2) Place retraction cord
3) Perform supragingival polishing
4) Educational requirements for employment

Expanded Function Dental Assistants

1) Revisit list of delegated duties in statute.

Students

~~1) Dental, dental hygiene, denturist schools and associated outreach.~~
~~2) Dental student externships.~~
3) Sunset externship licensure category
4) Add provision for denturist students to obtain conditional/trainee licensee to gain paid work experience once graduated.

Issues that generally apply to dentists, dental hygienists, and denturists

1) Practice setting responsibilities: hospital; clinics; non-profit organizations; schools; nursing homes; FQHCs – what is the responsibility of the licensee versus the employer in terms of informed consent, treatment planning, HIPPA, recordkeeping, patient records, infection control, medications, pain management, etc.
2) Patient of Record; Provider of Record; Dental Home practice issues.
3) Volunteer exemptions – students, licensees in either particular settings or limited to particular procedures.
4) Dental hygiene clinics without a supervising dentist.
5) Recruitment/retention of dentists; what level of dental hygiene services can be provided in the absence of a dentist of record – applicable only to non-profits and FQHCs?
6) Teeth whitening; currently included in denturist scope, but not found in dental hygiene or dentists scope of practice.
7) Review Title 13, Chapter 22-A – corporate ownership language specific to dentists, IPDHs, and denturists.
8) Itinerant dental, dental hygiene, denturist services.

Other

1) Increased coordination with the Maine School Oral Health Program

a. Combination of regulatory issues such as setting, supervision requirements, scope of practice, dental home, etc.

#8

March 1, 2017

Maine Board of Dental Practice
143 State House Station
Augusta, ME 04666-0143

Dear Ms. Vaillancourt,

At the initial Ad Hoc Committee Meeting on December 2nd, I presented what I consider a major dental practice issue to the committee, the continued support of unlicensed dental assistants, reclassified as "unlicensed persons". As a Certified Dental Assistant and graduate of an accredited dental assisting program, I feel that many of these individuals recognized as unlicensed persons pose a risk to themselves, their colleagues, as well as the general public. Many of these individuals enter the profession with no experience, knowledge, or understanding of dentistry, emergency medical procedures, or the management of infectious disease with the use of safe infection control practices. Though it is a fair argument of a few committee members that many of the on-the-job-trained dental assistants are fantastic chairside assistants, several committee members have observed first-hand the dangers these individuals pose to the safety of the public as it relates to following the Centers for Disease Control Guidelines for Infection Control in Dental Health-Care Settings. Dental Assistants are integral members of the dental team with a variety of responsibilities related to direct patient care. In addition to assisting the dental provider chairside, the dental assistant is routinely responsible for the duties associated with radiation health and safety and the management of infection control and instrument processing, yet often have minimal training or oversight for these procedures. To protect the safety of the public, it is critical that this concern be addressed by the Board.

Suggestions:

1. Consider the elimination of the Licensed Dental Radiographer and re-categorize these individuals as Licensed Dental Assistants. The *majority* of Dental Radiographer's are dental assistants. A licensure requirement of these individuals allows the opportunity to ensure minimal educational requirements for initial licensure as well as continuing education requirements. If such changes were to be made, denturists may be impacted and consideration of dental radiography practice would need to be considered under their denturist license rather than a separate license.

2. Look to neighboring states for rules relating to dental assistants: Massachusetts recently adopted rules requiring all dental assistants to be registered with the Board of Dentistry. In addition to registering, individuals must be at least 18 years of age, complete a course in infection control/CDC guidelines, and hold current CPR certification. Additional information relating to the registration of dental assistants can be found here: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section511~2

Like Maine and Massachusetts, Vermont recognizes various levels of dental assistants (OJT, CDA, EFDA), has a registration requirement and requires emergency office procedures training.

3. Consider requirement for completion of a CODA approved dental assisting school or completion of the Dental Assisting National Board's National Entry Level Dental Assistant (NELDA) exam with six months of hire. This would be consistent with the current requirements for the licensed dental radiographer. Education is the key component of protecting the safety of the public. A committee member expressed concern with the requirement of a CODA approved school creating an access to care problem as there is only one CODA approved school and it is extremely challenging for dentist to find formally trained assistants. The alternative suggestion of completion of the NELDA exam, which includes examination on tooth anatomy, infection control and radiation health and safety would at the very least require self-study.

In addition to the concerns noted above, other issues relating to dental assistants were recognized. The list of delegable duties is outdated and challenging to stay abreast of given the continuous advances in dentistry. The list is limiting and fails to allow dental assistants to perform skills other unlicensed persons can perform, such as teeth whitening. Also, the delegable duties are authorized for dentists, however, fails to consider an IPDH or PHS hygienist's needs for a dental assistant.

Suggestions:

1. Consider eliminating the list of specific duties that can be delegated to dental assistants and create a list of duties that may not be delegated such as irreversible procedures or procedures delegated specifically to Expanded Functions Dental Assistants and/or Registered Dental Hygienists.
2. Consider changing the language to allow an IPDH and/or PHS Dental Hygienists to delegate duties and employ dental assistants.

Subchapter 2, Section 18321, states "The Board of Dental Practice, as established in Title 5, section 12004-A, subsection 10, is created within this subchapter, its sole purpose being to **protect the public health and welfare.** The board carries out this purpose by ensuring that the public is served by **competent and honest practitioners** and by **establishing minimum standards of proficiency in the professions regulated by the board by testing, licensing, regulating, and disciplining practitioners** of those regulated professions." It is imperative that Board members and those invited to advise the Board, remain cognizant of the Board's primary purpose rather than to allow personal business and professional interests to drive recommendations.

Respectfully Submitted,

Amanda Willette

Amanda Willette, CDA, EFDA. M.S. Ed

Draft Report of the Ad Hoc Committee

To the Maine Board of Dental Practice

On Section 25 of

Public Law 2016, Chapter 429

"An Act to Revise the Laws Regarding Dental Practices"

March 6, 2017

*Addendum to include email communications after draft report was released.

I. Introduction

In October 2016, the Maine Board of Dental Practice contacted various interested parties for the purpose of forming an ad hoc committee pursuant to Public Law 2016, c. 429 "An Act to Revise the Laws Regarding Dental Practice." This effort is more commonly known as the "Phase II Review" to examine the more complex regulatory and practice issues that were not addressed in repealing and replacing the Dental Practice Act during the 127th legislative session.

Participants of the ad hoc committee included licensed dentists practicing in private dental office settings, community health settings, federally qualified health centers, and a dentist representing a dental education program in Maine; licensed dental hygienists practicing independently, in a non-profit/hospital clinic, in public health supervision settings, in private dental office settings, and a dental hygienist representing a dental hygiene education programs, a licensed expanded function dental assistant/certified dental assistant, and two licensed denturists. Two members of the Board served as co-chairs, and the Board's Executive Director provided staffing resources to the committee. **(Appendix 1)**

The ad hoc committee convened in public session on December 2, 2016, January 20, 2017, and March 3, 2017 from 9:00 a.m. to 12:00 p.m. Meeting materials were distributed to participants in advance to the extent practicable, and meeting notes were recorded for each meeting. **(Appendices 2, 3, and 4)**

II. Legislative Charge to the Board of Dental Practice

Public Law 2016, c. 429 required the Board, in consultation with interested parties, to conduct a study of the Maine Revised Statutes, Title 32, chapter 143 and any rules adopted by the Board and recommend changes to the scopes of practice of dental practitioners, practice settings and delivery models, and any other dental practice issues. A March 1, 2017 deadline was established to allow the Committee time to report out a bill to the Second Regular Session of the 128th Legislature related to the Board's report.

At its October 10, 2016 meeting, the Board discussed the ad hoc committee's role and scope of the Board's work. The Board developed a list of issues which was provided to the ad hoc committee for their consideration as summarized below.

Dental Practice Settings/Delivery Models: Over the years, dental practice settings and various delivery models of dental care have evolved to respond to the dental needs of Maine's citizens. In addition to private practice dental offices, Maine's delivery systems of dental care includes settings such as corporate dental offices, non-profit clinics, clinics associated with hospitals, clinics associated with a dental school, volunteer/free dental clinic events, a dental hygiene clinic, school based programs, nursing home services, public health services, independent practice of hygienists, denturist practices, and business ventures involving dentists, dental hygienists, and denturists.

The current Dental Practice Act does not contemplate such changes, and consequently it is either silent on the issues, or appears to restrict certain practices in certain settings. Below is a list identified by the Board and distributed to the ad hoc committee:

Dental Hygienists: There are five different scopes of practice when providing dental hygiene services. They include private dental practice setting with a supervising dentist, public health supervision, independent practice, and dental hygiene therapy. Depending upon the level of supervision, dental hygienists can also administer local anesthesia and nitrous oxide, as well as perform expanded procedures if they are also licensed as an expanded function dental assistant.

The current statute does not contemplate utilizing the services of the various RDH scopes of practice in the different settings. For example, the Board is often asked whether an RDH working for a dentist could volunteer or work on a limited basis in a school setting to help administer a school nurse grant program to provide fluoride varnish. Additionally, the statute does not clarify whether or not independently practicing dental hygienists can work in a private dental office per diem, or as a separate provider.

Dentists/Dental Faculty/Dental Externs: The current statute does not regulate businesses, yet the growth of corporate dentistry and other business practice models raises practice questions regarding proper treatment planning and responsibility for maintaining/retaining patient records. Also, the current statute does not clarify or define tele-dentistry, or clarify the use of dermal fillers for non-dentally related procedures.

The current statute identifies several different types of dentist licensure (charitable, limited, temporary, clinical educator, et. and exploring the possibility of identifying a locum tenens licensure category as an alternative is worth exploring.

The Board has seen an increase in dental faculty applications and the issue has been raised that the current statute limits the dental school's ability to recruit qualified dentists to the school setting. The qualifications for faculty licensure require that the individual be licensed in another state/province in order to qualify in Maine. There are applicants who are foreign trained and may not necessarily qualify for full licensure in Maine.

Dental extern students are required to apply to the Board to practice under the supervision of a Maine licensed dentist to perform dentistry under the auspices of the dental school. There is relative consensus to consider eliminating the externship category, as the supervising dentist is already regulated and the student falls under the governance of the educational institution.

Teeth whitening: The current statute identifies teeth whitening as an authorized procedure in the denturist scope of practice. However, it begs the question as to whether or not the legislature intends to regulate teeth whitening or not, as the procedure is not listed under the other scopes of practice identified in statute.

List of practice procedures / delegation authority: To list, or not to list - that is the question. The current statute enumerates authorized procedures for dental hygienists, expanded function dental assisting, and procedures authorized by a dentist to delegate to an "unlicensed person" (a/k/a dental assistants). The other consideration is whether or not creating a license category for dental assistants is needed to protect the public, or to continue to allow dentists to delegate. Dental hygienists and denturists have also expressed an interest in allowing the delegation of their scope to an "unlicensed person" to be authorized in statute.

There are other sections of the statute that capture the essence or principles of a particular practice without enumerating principles of a particular practice without enumerating lists such as dentist scope of practice, independent practice dental hygienist, public health supervision, dental hygiene therapy, and denturism.

The Board is aware that the list is not helpful to the regulated community as the list is antiquated, and does not necessarily reflect actual practice in the various dental settings. The Board has shifted away from managing who can do what procedure, as the intent is to provide a solid statutory framework by which licensees can rely upon.

Minimum patient care standards for all licensees: Current statute and board rules are not consistent with identifying standards for any licensee of the Board such as informed consent, blood pressure readings, dismissal of a patient, selection of dental radiographs, infection control, recordkeeping, listings of medications, employee training and certification requirements, etc.

III. Review Process of the Ad Hoc Committee

There were a total of three meetings, and the first meeting was held on December 2, 2016. At the first meeting, the co-chairs provided additional context to the committee's work, which included an outline of the many changes experienced by the Board since it last convened an ad hoc committee. Further clarification was provided such that substantive policy issues are to be decided by the Legislature/Governor, not the Board.

It was explained that the role of the Board is to implement legislation (policy) and adopts rules to further clarify intent of legislative policy. The purpose of the Board is to protect the public, not the interests of the various professions. The final update was to make participants aware that the Board is in the midst of proposing rules to fully implement the new Dental Practice Act.

The objective of the committee was reiterated to the group, which is to review the Board's statutes and rules and identify issues related to scopes of practice, various practice settings, delivery models, etc. The work of the committee will be considered by the Board when it reports back to the Legislature in March of 2017.

Ground rules were provided at the beginning of each meeting to include the following:

1) Hands to speak.
2) Minimize distractions. Side conversations, cell phones - try to be fully present as a group for the whole meeting.
3) Name tensions. Surely there are tensions and areas of disagreement. There are bound to be differences of opinion. Agree to disagree, respectfully.
4) Emphasize that this is not a forum to air grievances with the Board/Board staff – this is a focused effort. However, board staff will capture other topics in a "parking lot" list for the Board's review.
5) Audience decorum - discussion is among the ad hoc participants. Members of the audience can reach out to board staff by email or during a break if they have an issue, comment, etc.

6) Goal is to identify the issues, the committee is not being asked to provide solutions. The solutions are likely to be public policy decisions that are determined by the Legislature, not the Board.
7) Board staff to disseminate and collect information. This is a public process, so please do not REPLY ALL on email exchanges. Please direct your email to board staff and it will be disseminated to participants either in advance or at the next meeting.

Each participant was given an opportunity to express their interests and/or concerns regarding the work of the ad hoc committee. Below is a summary of the topics identified:

RDH practice issues:

a) Confusion among those who practice as IPDH and PHS.
b) Transferability of scopes from one practice setting to another.
c) Expand the scope of RDH to include all of the practice types such as independent practice, public health, etc. instead of requiring separate qualifications.
d) Reporting requirements are overly restrictive in PHS practice.
e) Believes in accountability but to streamline the requirements such that it does not restrict a licensee's ability to practice.
f) Stressed importance of dentist agreements with PHS practice.
g) Believes that IPDH who practice public health should practice with dentist agreements.
h) Agrees that there is confusion between IPDH and PHS practice and issue of "patient of record."
i) Recommends tweaking the language of dental externs.
j) Identify settings to practice without a dentist.
k) Apply fluoride in facility settings without a supervising dentist.

Dentist/dentist extern practice issues:

a) Interested in clarifying dental student externship requirements.
b) Revisit the notion of "if not on the list of things authorized, then you can't do it."
c) Identified licensure challenges for foreign trained dentists seeking employment at UNE/licensure with the Board

Denturist practice issues:

a) Institute "DD" designation instead of "LD" for licensed denturists.
b) Allow denturists to delegate to denturist assistants and lab technicians under their employment.

Delegation of duties to dental assistants or "unlicensed person":

a) Suggests another term be used other than "unlicensed person" as it currently appears in statute.
b) Suggests licensing of dental assistants based on infection control issues, risks to employees, and patients.
c) FQHC has oversight protections in place, but not private practice settings.
d) Regulating dental assistants will mandate the education and CPR requirements.
e) Examine delegated duties such as fluoride varnish and teeth whitening.

Discussion of Practice Issues/Recommendations:

The following is a summary of additional issues identified at the December 2nd meeting:

a) Require dentist by rule to require that unlicensed personnel obtain training, certification to ensure protection of the public. (OSHA, infection control, CPR, etc.).
b) Review neighboring state statutes.
c) Include delegation authority of IPDH's to unlicensed persons.
d) Concept of dental home – great concept but creates barriers. Patient choice at issue but regulations restrict such choice; dental hygienists must get permission from dentist; restriction of trade issue.
e) Concept of coordination of care – there is a tremendous need for care especially in public health settings; permission to treat versus competition among license types.
f) Practice ownership questions.
g) Allow denturist students to practice for the purpose of gaining additional supervised experience after the externship. Bridges a gap between graduating a denturist program and waiting to take the required examination.
h) Need to further examine the criteria for FQHC – example of integrated care for dental/medical.

At the January 20, 2017 meeting, the ad hoc committee focused on prioritizing and recommending specific changes to the Board. The group made specific recommendations on the following:

Independent Practice Dental Hygiene:

a) Consensus: remove the experience requirements based on obtaining either an associate's degree or bachelor's degree program; requiring 2,000 hours within preceding 4 years; allow general supervision of dental radiographers
b) Lack of consensus: requiring 4 years of clinical experience;

Public Health Supervision

a) Consensus: remove the notification requirements in board rule; eliminate the reporting requirements in board rule; remove patient qualifications in board rule.

There were additional discussions of various practice issues as summarized below:

a) Issues raised in a letter submitted by Lorraine Klug
b) Disagreement in using the term "dental hygiene diagnosis"
c) Concepts were shared of writing an RDH scope of practice
d) Support for the existing composition of the Board was expressed, as well as encouraging interdisciplinary discussions
e) The FTC v. North Carolina Dental Board decision was mentioned in the context of not having one profession dominate membership of a dental regulatory board
f) Consider regulating dental assistants and perhaps roll into the existing dental radiography licensure category
g) Consider dentist scope to include non-dentally related use of Botox
h) Distinctions were made between credentialing and licensing (medicine/dentistry)
i) Desire to prioritize the issues identified and discuss each one for the purpose of providing recommendations to the Board

At the March 3, 2017 meeting, the ad hoc committee focused on continuing the discussion on practice issues and suggesting further recommendations for the Board's consideration as summarized below.

Maine requirements for faculty licensure

a) Maine law requires applicants to hold an active dentist license in another state/province - identified as a barrier to recruit faculty dentists by UNE
b) Review of other state faculty licensure laws; alternative pathways to licensure
c) Policy issue of how to qualify foreign trained dentists and/or non-CODA approved educational institutions

RDH scope of practice

a) Maine law lists procedures authorized and there were sample proposals submitted to capture the principles of dental hygiene practice in a way that does not contain a laundry list
b) Concerns were noted about moving away from a list of authorized procedures, but there was also recognition that the list was outdated and not necessarily reflective of practice

Public Health Supervision status

a) Question was posed whether or not PHS designation was still needed as a delivery model of care. Participants shared that public health dental hygiene services works well, and that value is added by requiring a practice agreement with a supervising dentist.
b) Concerns were raised regarding the reporting requirements and eligibility requirements listed under current board rule. Participants shared that the eligibility requirements and reporting requirements seemed antiquated and no longer necessary. The Board does not use the data to report out the effectiveness of public health dental hygiene services.

RDH scope - expand to include sealants regardless of setting

a) Dental Hygiene diagnosis was discussed and all agree that the term "diagnosis" is trigger word that causes concern, but should be explored in more detail it is part of the CODA curriculum, as well as the American Dental Hygienists' Association's Standards for Clinical Dental Hygiene Practice
b) Participants discussed the evolution of certain dental hygiene procedures and providing sealants is appropriate procedure to add under RDH scope of practice. Private practice settings may decide on their own practice/supervision requirements but expanding this scope will streamline dental hygiene services

Review of Lorraine Klug's January 15, 2017 letter

a) Increase authority of subcommittees. Participants generally agreed that the current system works well, no need to expand authority.
b) Teeth whitening – policy discussion with Board and/or LCRED. Current statute appears to regulate it for denturists, but not listed in other scopes.
c) Expand RDH scope to include use of local anesthesia and nitrous oxide. Participants discussed the pros and cons of implementing that type of change. Similar to the discussion regarding sealants, there is an evolution of certain dental hygiene practices occurring. RDH programs are now including local/nitrous as required courses.

Review of Amanda Willette's materials submitted March 3, 2017 materials

a) Regulation of dental assistants is necessary to protect the public, especially given other state experiences regarding infection control issues
b) Revise the statute to regulate dental assistants and eliminate dental radiography as those serving in that capacity are primarily dental assistants. However there are some denturists that also hold a dental radiography license

Denturist practice issues

a) Bring back the use of "DD" which is a trademark used to recognize individuals who have successfully passed a certificate program in denturism (Diploma in Denturism). This will require some discussion of a practice act versus a title act, and concerns raised years ago by the Board of misrepresentation to the public.
b) Review Section 18392 of the statute as it relates to owner identification of removable dental prosthesis
c) Denturist participants believes that the Board can expand the duties by rule, as opposed to requiring a legislative process to expand to allow the taking of all dental radiographs, all removable prosthetics with exceptions, and replace abutments on implants

Expand delegated duties to include supragingival polishing. There was discussion about keeping the existing delegated duties as is as there will likely be a more robust discussion of whether to regulate the delegate duties that are in statute now. This raised an issue with regarding to the scope of the committee's work to examine all enumerated procedures listed in statute, or just the RDH scope. It is preferred to keep the RDH scope review separate from the delegated duties to an unlicensed person to avoid any

confusion. Arriving at an agreed upon RDH scope may help guide the delegated duties discussion in the future.

IV. Ad Hoc Committee Recommendations/Conclusions

Recommended Statutory Changes

a) Licensure:
   i. Dental student externs – eliminate licensure/registration requirements
   ii. Denturist student externs – eliminate licensure/registration of externs, but create a "trainee permit" to allow individuals to gain clinical experience after completing denturism program in lieu of externship.
   iii. Dentist - create locum tenens licensure category and eliminate the various dentist license categories
   iv. Faculty dentist – eliminate requirement to be licensed in another state/province
   v. IPDH authority – revise requirements to streamline requirements regardless of degree earned; streamline hours and timeframe

b) Dental Hygiene scope of practice
   i. RDH scope - replace list of procedures with principles of the practice of dental hygiene
   ii. RDH scope – expand to allow placing of sealants under general supervision
   iii. RDH scope – expand to allow administration of local anesthesia and nitrous oxide; eliminate requirement to hold separate permits
   iv. IPDH – expand to allow supervision of dental radiographers

c) Delegation authority
   i. Denturists/Dental Hygienists – allow delegated duties to unlicensed persons

d) Owner identification – removable dental prosthesis
   i. Revise to reflect current technologies (i.e. digital scanning)

Issues Identified for Rulemaking Changes

a) Public Health Supervision
    a. Remove notification and reporting requirements
    b. Eliminate the requirement to screen for qualified services

b) Dentist training responsibilities when delegating to unlicensed persons

c) Standards of practice chapter that addresses baseline practice issues for all licensees such as medical records documentation, blood pressure readings, use of dental radiographs, informed consent, dismissal of a patient, storing and providing records, etc.

Issues Identified for Further Legislative Consideration

a) Teeth whitening
    i. Determine whether or not it should be a regulated dental procedure

b) Regulation of dental assistants
    i. Further review to consider whether a sunrise review process is necessary to ensure protection of the public given recent cases in other states involving infection control

c) List of authorized procedures
    i. Consider further refinements or alternative ways instead of listing what is authorized; perhaps list what is not authorized

List of Appendices

Appendix 1: Ad Hoc Committee Overview, dated December 1, 206
Ad Hoc Committee Reference sheet, dated December 2, 2016
Participation confirmation letter, dated November 29, 2016
Participation invitation letter, dated October 26, 2016

Appendix 2: Meeting materials – December 2, 2016
Agenda
Meeting notes
Sign in sheet for members of the public
Meeting materials

Appendix 3: Meeting materials – January 20, 2017
Agenda
Meeting notes
Sign in sheet for members of the public
Meeting materials

Appendix 4: Meeting materials – March 3, 2017
Agenda
Meeting notes
Sign in sheet for members of the public
Meeting materials

Vaillancourt, Penny

From: Kristie Lake Harriman <kristie.lake@gmail.com>
Sent: Wednesday, March 08, 2017 9:37 PM
To: Vaillancourt, Penny
Subject: Re: Ad Hoc Committee - Draft Report/Draft Meeting Minutes
Attachments: DPA_CO.pdf; DPA_CT.pdf; DPA_Rhode Island.pdf; DPAOctober2015_Oregon.pdf

Importance: High

Hi Penny,

Thank you again for the amazing job you do for the Board! This rewriting of the practice act, while definitely necessary to clear up the muddy water, is a HUGE endeavor and I truly appreciate the hard work you put into this. I thought the attachments you sent out did a great job of capturing the essence of the meetings (from what I read of the previous meeting and my attendance at the last). I did have one question/comment, and I apologize if I don't know the answer simply because I was only present at the last meeting.
I understand that we want to move away from the "laundry list" of procedures and adopt scope definitions which reflect that. I see in the Draft Report recommended statutory changes that we're looking to replace the RDH scope with principles of the practice of dental hygiene and I think that makes total sense. But I don't see a change to replace the dentist scope laundry list with a definition of dentistry, or as noted in the list of issues under Dentist: Adopt ADA Scope of Practice. Would adopting a change to dentists' scope by defining dentistry rather than trying to delineate an exhaustive list of allowed procedures require a similar statute change? If so, would it be appropriate to include this in the ad hoc draft report? If the Ad Hoc Committee is recommending a statute change for hygiene licensees – RDH, IPDH, PHS, and dental therapist – would it not make sense to revise the dentist scope of practice with a definition, such as the ADA's, that captures ". . . the scope of his/her education, training and experience . . ." Individuals around the table on Friday addressed some of the advances in research, education, and training that make dentistry an evolving profession. I truly believe Maine's Dental Practice Act should reflect that fact. I've also attached some practice acts from other states with a definition of dentistry modeled after the ADA Scope of Practice in case that's helpful.

Anyway...my two cents. Again, thank you for all you do for our profession, Penny! (And its 20,000 license types.) Have a great evening!

~Kristie

On Mar 6, 2017, at 1:35 PM, Vaillancourt, Penny <Penny.Vaillancourt@maine.gov> wrote:

<image001.gif>
Good afternoon,

Attached is a draft Ad Hoc Committee Report for your review/comment. I have also attached draft meeting notes from March 3, 2017 for your review/comment. If you would like to make a comment/edit to either document, please send me an email. Please DO NOT REPLY ALL when you send your edits to me by email. I will be collecting and forwarding you all email comments once completed.

The intent is to share the draft with the Board at their March 10, 2017 meeting, if time permits. If not, then it will be placed on their April 10, 2017 agenda for review/consideration. I apologize for the short turnaround, but again appreciate your time with this effort. You are welcome to attend the meeting on March 10th – however it is difficult to say at this time when it will appear on the agenda.

Please feel free to contact me should you have any questions.

Thank you,
Penny

Penny Vaillancourt, Executive Director
Maine Board of Dental Practice
143 State House Station
161 Capitol Street
Augusta, ME 04333-0143
t: 207.287.3333
c: 207.441.7153
f: 207.287.8140
website: www.maine.gov/dental

<Draft Ad Hoc Committee - Phase II Review Report.doc><Draft Ad Hoc meeting notes - 03-03-2017.docx>

Vaillancourt, Penny

From: Amanda Willette <amanda.e.willette@maine.edu>
Sent: Thursday, March 09, 2017 4:26 PM
To: Vaillancourt, Penny
Subject: Re: Ad Hoc Committee - Draft Report/Draft Meeting Minutes

Hi Penny,

First and foremost, thank you for inviting me to serve as a member of the Ad Hoc Committee, for facilitating the meetings, drafting this proposal as well as for the time you have invested in the revisions to the laws relating to dentistry. I have reviewed the minutes as well as the final report summarizing the majority of our conversations and do have a few final comments I would like to share with you, committee members and the board:

1. At the end of our meeting on 3/3, we briefly discussed the inclusion of an EFDA on the Board of Dental Practice; I did not see note of this in either report. Upon further consideration, though not discussed amongst committee members, it seems it would be appropriate to discuss representation of all licensees to also include the dental radiographer.

2. I am not sure if it should be in this report or if this is being addressed in a separate document , however, I did not notice mention of the need for a revision to the language of student exemptions, in particular as it relates to dental radiographer students enrolled in a CODA approved dental assisting program completing dental assisting externships. This is extremely cloudy given that dental assistants are not currently regulated yet dental assisting students are required to complete radiography requirements, are not yet licensed radiographers nor are they dental radiography students in the spring semester when they are completing the radiography requirements as dental assisting students.

3. I noticed that the recommendation for licensing of dental radiographers as dental assistants with educational requirements in infection control has been listed as consideration for future legislation through the sunrise review process. I know I sound like a broken record but want to be clear that I remain extremely concerned for the safety of the public and that this issue is continuously brushed aside. I want to be sure committee members and board members are aware that the issue of many dental assistants not being properly trained in infection control procedures is pervasive and prevalent in our very own dental community. I fear that it is only a matter of time before Maine is in the national news much like Oklahoma was in 2013 for the major infection control infarctions that took place at an oral surgeon's practice. This is an opportunity to learn from another state's mishaps as well as an opportunity to be proactive rather than reactive.

4. Lastly, I just want to add a note to ensure that all committee members and board members understand my recommendation for educational requirements for dental assistants is for initial training in a board approved infection control course within six months of licensure as a dental assistant and the requirement for annual continuing education like all other licensees. I heard several concerns that my recommendation was for a requirement of attendance in a CODA approved dental assisting program. Given my background and experience, I obviously believe this is best, however,

this is absolutely not what I am recommending as I do realize this could create major staffing issues, which could ultimately lead to different safety concerns.

Thank you again and I look forward to continued discussions about revisions to the laws relating to dentistry.

Sincerest regards,

Amanda

On Mar 9, 2017, at 8:20 AM, Vaillancourt, Penny <Penny.Vaillancourt@maine.gov> wrote:

> <image002.gif>
> Good morning,
>
> Please note that the Board's scheduled hearing for Friday, March 10, 2017 has been continued. Consequently, the Board will be reviewing the ad hoc committee's draft report at the meeting. If your schedule permits, please feel free to attend the meeting. The Board understands that you may not be able to attend given the last minute change in agenda, however it wanted you to be aware in the event you are able to attend.
>
> Please contact me should you have any questions - thank you.
>
> Penny

Penny Vaillancourt, Executive Director
Maine Board of Dental Practice
143 State House Station
161 Capitol Street
Augusta, ME 04333-0143
t: 207.287.3333
c: 207.441.7153
f: 207.287.8140
website: www.maine.gov/dental

From: Vaillancourt, Penny
Sent: Monday, March 06, 2017 1:36 PM
To: Amanda Willette; Austin Carbone; Dr. David Pier; Dr. David Pier 2; Dr. James Schmidt; Dr. Lisa Howard ; jryder2@une.edu; lorraineklug@hotmail.com; Marion Hernon DMD (mjhernon@gmail.com); mharmerbeem@une.edu; michelle gallant; 'nancy.foster@maine.edu'; Paul Levasseur; Tracy Jowett; rking7@une.edu; bmills@une.edu; gerry@roadrunner.com; 'kristielake@gmail.com'
Cc: LaRochelle, Lauren (Lauren.LaRochelle@maine.gov); Bowie, Jim (Jim.Bowie@maine.gov); Johnson, Teneale E

Subject: Ad Hoc Committee - Draft Report/Draft Meeting Minutes
Importance: High

Good afternoon,

Attached is a draft Ad Hoc Committee Report for your review/comment. I have also attached draft meeting notes from March 3, 2017 for your review/comment. If you would like to make a comment/edit to either document, please send me an email. Please DO NOT REPLY ALL when you send your edits to me by email. I will be collecting and forwarding you all email comments once completed.

The intent is to share the draft with the Board at their March 10, 2017 meeting, if time permits. If not, then it will be placed on their April 10, 2017 agenda for review/consideration. I apologize for the short turnaround, but again appreciate your time with this effort. You are welcome to attend the meeting on March 10th – however it is difficult to say at this time when it will appear on the agenda.

Please feel free to contact me should you have any questions.

Thank you,
Penny

Penny Vaillancourt, Executive Director
Maine Board of Dental Practice
143 State House Station
161 Capitol Street
Augusta, ME 04333-0143
t: 207.287.3333
c: 207.441.7153
f: 207.287.8140
website: www.maine.gov/dental

PROPOSED CHANGES TO DENTAL PRACTICE ACT
APRIL 28, 2017

Title 32: PROFESSIONS AND OCCUPATIONS

Chapter 143: DENTAL PROFESSIONS

Table of Contents

Subchapter 1: GENERAL PROVISIONS

§18301. SHORT TITLE

This chapter may be known and cited as "the Dental Practice Act." [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18302. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2015, c. 429, §21 (NEW).]

1. **Board.** "Board" means the Board of Dental Practice established in Title 5, section 12004-A, subsection 10.

[2015, c. 429, §21 (NEW) .]

2. **Charitable dentist license.** "Charitable dentist license" means the authority granted to an individual to provide free dental care as requested by a charitable or social organization within the State when resident dental services are not available.

[2015, c. 429, §21 (NEW) .]

3. **Clinical dentist educator license.** "Clinical dentist educator license" means the authority granted to an individual who is licensed as a dentist in another state or jurisdiction to participate in clinical education for individuals licensed under this chapter.

[2015, c. 429, §21 (NEW) .]

4. **Commissioner.** "Commissioner" means the Commissioner of Professional and Financial Regulation.

[2015, c. 429, §21 (NEW) .]

5. **Dental auxiliary.** "Dental auxiliary" means a dental radiographer, expanded function dental assistant, dental hygienist, independent practice dental hygienist, public health dental hygienist, dental hygiene therapist or denturist.

[2015, c. 429, §21 (NEW) .]

6. **Dental hygiene.** "Dental hygiene" means the delivery of preventative, educational and clinical services supporting total health for the control of oral disease and the promotion of oral health provided by a dental hygienist in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

7. **Dental hygiene therapist.** "Dental hygiene therapist" means a person who holds a valid license as a dental hygienist issued by the board and is authorized to practice dental hygiene therapy under this chapter.

[2015, c. 429, §21 (NEW) .]

8. **Dental hygiene therapy.** "Dental hygiene therapy" means the delivery of dental hygiene services, including performance of certain dental procedures in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

9. **Dental hygienist.** "Dental hygienist" means a person who holds a valid license as a dental hygienist issued by the board.

[2015, c. 429, §21 (NEW) .]

10. **Dental radiographer.** "Dental radiographer" means a person who holds a valid license as a dental radiographer issued by the board.

[2015, c. 429, §21 (NEW) .]

11. **Dental radiography.** "Dental radiography" means the use of ionizing radiation on the maxilla, mandible and adjacent structures of human beings for diagnostic purposes while under the general supervision of a dentist in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

12. **Dentist.** "Dentist" means a person who holds a valid dentist license issued by the board.

[2015, c. 429, §21 (NEW) .]

13. **Dentistry.** "Dentistry" means the scope of practice for a dentist as described in section 18371.

[2015, c. 429, §21 (NEW) .]

14. **Denture.** "Denture" means any removable full or partial upper or lower prosthetic dental appliance to be worn in the human mouth to replace any missing natural teeth.

[2015, c. 429, §21 (NEW) .]

15. **Denturism.** "Denturism" means the process of ~~taking~~ obtaining denture impressions and bite registrations for the purpose of making, producing, reproducing, constructing, finishing, supplying, altering or repairing of a denture to be fitted to an edentulous or partially edentulous arch or arches and the fitting of a denture to an edentulous or partially edentulous arch or arches, including the making, producing, reproducing, constructing, finishing, supplying, altering and repairing of dentures, without performing alteration to natural or reconstructed tooth structure, in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

16. **Denturist.** "Denturist" means a person who holds a valid denturist license issued by the board.

[2015, c. 429, §21 (NEW) .]

17. **Department.** "Department" means the Department of Professional and Financial Regulation.

[2015, c. 429, §21 (NEW) .]

18. **Direct supervision.** "Direct supervision" means the supervision required by the board by rule of those tasks and procedures requiring the physical presence of the supervisor in the practice setting at the time such tasks or procedures are being performed. In order to provide direct supervision of patient treatment, the supervisor must at least diagnose the condition to be treated, authorize the treatment procedure prior to implementation and examine the condition after treatment and prior to the patient's discharge.

[2015, c. 429, §21 (NEW) .]

19. **Expanded function dental assistant.** "Expanded function dental assistant" means a person who holds a valid expanded function dental assistant license issued by the board.

[2015, c. 429, §21 (NEW) .]

20. **Expanded function dental assisting.** "Expanded function dental assisting" means performing certain dental procedures under the supervision of a dentist in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

21. **Faculty.** "Faculty" means, when used in conjunction with a license issued under this chapter, the authority granted to an individual who is authorized to practice only within the school setting, including any satellite locations approved by the board, and who teaches dentistry, dental hygiene or denturism as part of a clinical and didactic program.

[2015, c. 429, §21 (NEW) .]

22. **General supervision.** "General supervision" means the supervision required by the board by rule of those tasks and procedures when the physical presence of the supervisor is not required in the practice setting while procedures are being performed.

[2015, c. 429, §21 (NEW) .]

23. **Independent practice dental hygienist.** "Independent practice dental hygienist" means a person who holds a valid license as a dental hygienist issued by the board and who is authorized to practice independent dental hygiene.

[2015, c. 429, §21 (NEW) .]

24. **License.** "License" means a license or permit issued by the board granting authority to an individual authorized under this chapter to perform certain services.

[2015, c. 429, §21 (NEW) .]

25. **Limited dentist.** "Limited dentist" means a dentist who has retired from the regular practice of dentistry and who holds a valid license issued by the board to practice only in a nonprofit clinic without compensation for work performed at the clinic. Services provided by a limited dentist must be in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

26. **Local anesthesia.** "Local anesthesia" means a drug, element or other material that results in a state of insensibility of a circumscribed area or the loss of sensation in some definite, localized area without inhibition of conscious processes.

[2015, c. 429, §21 (NEW) .]

27. **Nitrous oxide analgesia.** "Nitrous oxide analgesia" means a gas containing nitrous oxide used to induce a controlled state of relative analgesia with the goal of controlling anxiety.

[2015, c. 429, §21 (NEW) .]

28. **Practice setting.** "Practice setting" means the physical location where services authorized under this chapter are provided to the public.

[2015, c. 429, §21 (NEW) .]

29. **Provisional dental hygiene therapist.** "Provisional dental hygiene therapist" means a person who holds a valid license as a dental hygienist issued by the board and who is authorized to practice dental hygiene therapy under the supervision of a dentist in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

30. **Public health dental hygiene.** "Public health dental hygiene" means the delivery of certain dental hygiene services under a written supervision agreement with a dentist for the purpose of providing services in a public health setting in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

31. **Public health dental hygienist.** "Public health dental hygienist" means a person who holds a valid license as a dental hygienist issued by the board and who is authorized to practice public health dental hygiene in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

32. **Public health setting.** "Public health setting" means a place where the practice of public health dental hygiene occurs, and includes, but is not limited to, public and private schools, medical facilities, nursing homes, residential care facilities, mobile units, nonprofit organizations and community health centers.

[2015, c. 429, §21 (NEW) .]

33. **Resident dentist license.** "Resident dentist license" means the authority granted to an individual who is a graduate of an approved dental school or college, who is not licensed to practice dentistry in this State and is authorized to practice under the direct or general supervision and direction of a dentist in a board-approved setting in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

34. **Reversible intraoral procedures.** "Reversible intraoral procedures" means placing and removing rubber dams and matrices; placing and contouring amalgam, composite and other restorative materials; applying sealants; supragingival polishing; and other reversible procedures.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18303. INDIVIDUAL LICENSE

Only an individual may be licensed under this chapter and only a licensed individual may provide services for which a license is required under this chapter. [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18304. LICENSE REQUIRED

1. **Unlicensed practice.** Except as provided in section 18305 and section 18371, subsections 3 and 6, a person may not practice or profess to be authorized to practice the activities described in this chapter without a license or during any period when that person's license has expired or has been suspended or revoked.

[2015, c. 429, §21 (NEW) .]

2. **Unlawful practice.** A person may not:

A. Practice dentistry under a false or assumed name; [2015, c. 429, §21 (NEW).]

B. Practice dentistry under the name of a corporation, company, association, parlor or trade name; [2015, c. 429, §21 (NEW).]

C. While manager, proprietor, operator or conductor of a place for performing dental operations, employ a person who is not a lawful practitioner of dentistry in this State to perform dental practices as described in section 18371; [2015, c. 429, §21 (NEW).]

D. While manager, proprietor, operator or conductor of a place for performing dental operations, permit a person to practice dentistry under a false name; [2015, c. 429, §21 (NEW).]

E. Assume a title or append a prefix or letters following that person's name that falsely represent the person as having a degree from a dental college; [2015, c. 429, §21 (NEW).]

F. Impersonate another at an examination held by the board; [2015, c. 429, §21 (NEW).]

G. Knowingly make a false application or false representation in connection with an examination held by the board; or [2015, c. 429, §21 (NEW).]

H. Employ a person as a dental hygienist, independent practice dental hygienist, denturist or dental radiographer who is not licensed to practice. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

3. **Penalties.** A person who violates this section commits a Class E crime. Violation of this section is a strict liability crime as defined in Title 17-A, section 34, subsection 4-A.

[2015, c. 429, §21 (NEW) .]

4. **Injunction.** The Attorney General may bring an action in Superior Court pursuant to Title 10, section 8003-C, subsection 5 to enjoin a person from violating this chapter.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18305. PERSONS AND PRACTICES NOT AFFECTED; EXEMPTIONS

1. **Persons and practices not affected.** Nothing in this chapter may be construed to limit, enlarge or affect the practice of persons licensed to practice medicine, osteopathy or dentistry in this State. Nothing in this chapter may be construed to prohibit a duly qualified dental surgeon or dental hygienist from performing work or services performed by a denturist licensed under this chapter to the extent those persons are authorized to perform the same services under other state law.

[2015, c. 429, §21 (NEW) .]

2. **Exemptions.** The requirement of a license under this chapter does not apply to:

A. A resident physician or a student enrolled in and attending a school or college of medicine or osteopathy; [2015, c. 429, §21 (NEW).]

B. A licensed physician or surgeon who practices under the laws of this State, unless that person practices dentistry as a specialty; [2015, c. 429, §21 (NEW).]

C. A qualified anesthetist or nurse anesthetist who provides an anesthetic for a dental operation; a certified registered nurse under the direct supervision of either a licensed dentist who holds a valid sedation or general anesthesia permit or a licensed physician who provides an anesthetic for a dental operation; a certified registered nurse under the direct supervision of a licensed dentist or physician who removes sutures, dresses wounds or applies dressings and bandages; and a certified registered nurse under the direct supervision of a licensed dentist or physician who injects drugs subcutaneously or intravenously; [2015, c. 429, §21 (NEW).]

D. A person serving in the United States Armed Forces or the United States Department of Health and Human Services, Public Health Service or employed by the United States Department of Veterans Affairs or other federal agency while performing official duties, if the duties are limited to that service or employment; [2015, c. 429, §21 (NEW).]

E. A graduate dentist or dental surgeon in the United States Army, Navy or Air Force; the United States Department of Health and Human Services, Public Health Service; the United States Coast Guard; or United States Department of Veterans Affairs who practices dentistry in the discharge of official duties; [2015, c. 429, §21 (NEW).]

F. A person having a current license to perform radiologic technology pursuant to section 9854 and who is practicing dental radiography under the general supervision of a dentist or physician; [2015, c. 429, §21 (NEW).]

G. A dentist licensed in another state or country at meetings of the Maine Dental Association or its affiliates or other like dental organizations approved by the board, while appearing as a clinician; [2015, c. 429, §21 (NEW).]

H. Any person, association, corporation or other entity who fills a prescription from a dentist for the construction, reproduction or repair of prosthetic dentures, bridges, plates or appliances to be used or worn as substitutes for natural teeth; [2015, c. 429, §21 (NEW).]

I. A dental laboratory technician constructing, altering, repairing or duplicating a denture, plate, partial plate, bridge, splint, orthodontic or prosthetic appliance with a prescription as set forth in section 18371, subsection 6; [2015, c. 429, §21 (NEW).]

J. A student enrolled in a board-approved dental program, dental hygiene program, dental therapy program, expanded function dental assisting program, dental radiography program or a denturism program practicing under the direct or general supervision of that student's instructors; [2015, c. 429, §21 (NEW).]

~~K. A student participating in a board-approved externship program who is registered and practicing under direct or general supervision as set forth in section 18348, subsection 1; and [2015, c. 429, §21 (NEW).]~~

L. An individual licensed under this chapter who is registered and practicing under the direct supervision of a dentist as set forth in section 18348, subsection 2 or 3 for the purpose of obtaining clinical experience needed for meeting the requirements to administer sedation, local anesthesia or general anesthesia. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18306. FRAUDULENT SALE OR ALTERATION OF DIPLOMAS OR LICENSES

1. **Fraudulent or altered diploma or license; bribery.** A person may not:

A. Sell or offer to sell a diploma conferring a dental degree or license granted pursuant to the laws of this State; [2015, c. 429, §21 (NEW).]

B. Procure a license or diploma with intent that it be used as evidence of the right to practice dentistry by a person other than the one upon whom the diploma or license was conferred; [2015, c. 429, §21 (NEW).]

C. With fraudulent intent alter a diploma or license to practice dentistry; [2015, c. 429, §21 (NEW).]

D. Use or attempt to use an altered diploma or license; or [2015, c. 429, §21 (NEW).]

E. Attempt to bribe a member of the board by the offer or use of money or other pecuniary reward or by other undue influence. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **Penalty.** A person who violates this section commits a Class E crime. Except as otherwise specifically provided, violation of this section is a strict liability crime as defined in Title 17-A, section 34, subsection 4-A.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18307. REVIEW COMMITTEE IMMUNITY

A dentist who is a member of a peer review committee of a state or local association or society composed of doctors of dentistry, a staff member of such an association or society assisting a peer review committee and a witness or consultant appearing before or presenting information to the peer review committee are immune from civil liability for, without malice, undertaking or failing to undertake any act within the scope of the function of the committee. [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18308. REQUIREMENTS REGARDING PRESCRIPTION OF OPIOID MEDICATION

1. **Limits on opioid medication prescribing.** Except as provided in subsection 2, an individual licensed under this chapter whose scope of practice includes prescribing opioid medication may not prescribe:

A. To a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day; [2015, c. 488, §32 (NEW).]

B. To a patient who, on the effective date of this section, has an active prescription for opioid medication in excess of 100 morphine milligram equivalents of an opioid medication per day, an opioid medication in an amount that would cause that patient's total amount of opioid medication to exceed 300 morphine milligram equivalents of opioid medication per day; except that, on or after July 1, 2017, the aggregate amount of opioid medication prescribed may not be in excess of 100 morphine milligram equivalents of opioid medication per day; [2015, c. 488, §32 (NEW).]

C. On or after January 1, 2017, within a 30-day period, more than a 30-day supply of an opioid medication to a patient under treatment for chronic pain. For purposes of this paragraph, "chronic pain" has the same meaning as in Title 22, section 7246, subsection 1-C; or [2015, c. 488, §32 (NEW).]

D. On or after January 1, 2017, within a 7-day period, more than a 7-day supply of an opioid medication to a patient under treatment for acute pain. For purposes of this paragraph, "acute pain" has the same meaning as in Title 22, section 7246, subsection 1-A. [2015, c. 488, §32 (NEW).]

[2015, c. 488, §32 (NEW) .]

2. **Exceptions.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication is exempt from the limits on opioid medication prescribing established in subsection 1 only:

A. When prescribing opioid medication to a patient for:

(1) Pain associated with active and aftercare cancer treatment;

(2) Palliative care, as defined in Title 22, section 1726, subsection 1, paragraph A, in conjunction with a serious illness, as defined in Title 22, section 1726, subsection 1, paragraph B;

(3) End-of-life and hospice care;

(4) Medication-assisted treatment for substance use disorder; or

(5) Other circumstances determined in rule by the Department of Health and Human Services pursuant to Title 22, section 7254, subsection 2; and [2015, c. 488, §32 (NEW).]

B. When directly ordering or administering a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility.

As used in this paragraph, "administer" has the same meaning as in Title 22, section 7246, subsection 1-B. [2015, c. 488, §32 (NEW).]

[2015, c. 488, §32 (NEW) .]

3. **Electronic prescribing.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication and who has the capability to electronically prescribe shall prescribe all opioid medication electronically by July 1, 2017. An individual who does not have the capability to electronically prescribe must request a waiver from this requirement from the Commissioner of Health and Human Services stating the reasons for the lack of capability, the availability of broadband infrastructure and a plan for developing the ability to electronically prescribe opioid medication. The commissioner may grant a waiver for circumstances in which exceptions are appropriate, including prescribing outside of the individual's usual place of business and technological failures.

[2015, c. 488, §32 (NEW) .]

4. **Continuing education.** By December 31, 2017, an individual licensed under this chapter must successfully complete 3 hours of continuing education every 2 years on the prescription of opioid medication as a condition of prescribing opioid medication. The board shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2015, c. 488, §32 (NEW) .]

5. **Penalties.** An individual who violates this section commits a civil violation for which a fine of $250 per violation, not to exceed $5,000 per calendar year, may be adjudged. The Department of Health and Human Services is responsible for the enforcement of this section.

[2015, c. 488, §32 (NEW) .]

SECTION HISTORY
2015, c. 488, §32 (NEW).

Subchapter 2: BOARD OF DENTAL PRACTICE

§18321. BOARD CREATION; DECLARATION OF POLICY; COMPENSATION

1. **Board creation; declaration of policy.** The Board of Dental Practice, as established in Title 5, section 12004-A, subsection 10, is created within this subchapter, its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions.

[2015, c. 429, §21 (NEW) .]

2. **Compensation.** Members of the board, the Subcommittee on Denturists under section 18326 and the Subcommittee on Dental Hygienists under section 18327 are entitled to compensation according to the provisions of Title 5, chapter 379.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18322. BOARD MEMBERSHIP

1. **Membership; terms; removal.** The board consists of 9 members appointed by the Governor as follows:

A. Five dentists. Each dentist member must hold a valid dental license under this chapter and must have been in the actual practice of dentistry in this State for at least 10 years immediately preceding appointment. A dentist is not eligible to serve as a member of the board while employing a dental hygienist or a denturist who is a member of the board; [2015, c. 429, §21 (NEW).]

B. Two dental hygienists. Each dental hygienist member must hold a valid dental hygiene license under this chapter and must have practiced in the State for at least 6 years immediately preceding appointment. A dental hygienist is not eligible to serve as a member of the board while employed by a dentist who is a member of the board; [2015, c. 429, §21 (NEW).]

C. One denturist. The denturist member must hold a valid denturist license under this chapter and must have practiced in the State for at least 6 years immediately preceding appointment. A denturist is not eligible to serve as a member of the board while employed by a dentist who is a member of the board; and [2015, c. 429, §21 (NEW).]

D. One public member. The public member must be a person who has no financial interest in the dental profession and has never been licensed, certified or given a permit in this or any other state for the dental profession. [2015, c. 429, §21 (NEW).]

The Governor may accept nominations from professional associations and from other organizations and individuals. A member of the board must be a legal resident of the State. A person who has been convicted of a violation of the provisions of this Act or any prior dental practice act, or who has been convicted of a crime punishable by more than one year's imprisonment, is not eligible for appointment to the board. Appointments of members must comply with Title 10, section 8009.

[2015, c. 429, §21 (NEW) .]

2. **Terms.** Terms of the members of the board are for 5 years. A person who has served 10 years or more on a dental examining board in this State is not eligible for appointment to the board. A member may be removed by the Governor for cause.

[2015, c. 429, §21 (NEW) .]

3. **Quorum; chair; vice-chair.** Notwithstanding any provision of law to the contrary, a majority of the members serving on the board constitutes a quorum. The board shall elect its chair and vice-chair annually.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18323. POWERS AND DUTIES OF THE BOARD

The board has the following powers and duties in addition to all other powers and duties imposed by this chapter: [2015, c. 429, §21 (NEW).]

1. **Hearings and procedures.** The power to hold hearings and take evidence in all matters relating to the exercise and performance of the powers and duties vested in the board and the authority to subpoena witnesses, books, records and documents in hearings before the board;

[2015, c. 429, §21 (NEW) .]

2. **Complaints.** The duty to investigate complaints in a timely fashion on its own motion and those lodged with the board or its representatives regarding the violation of a provision of this chapter or of rules adopted by the board;

[2015, c. 429, §21 (NEW) .]

3. **Fees.** The authority to adopt by rule fees for purposes authorized under this chapter in amounts that are reasonable and necessary for their respective purposes, except that the fee for any one purpose may not exceed $550;

[2015, c. 429, §21 (NEW) .]

4. **Budget.** The duty to submit to the commissioner its budgetary requirements in the same manner as is provided in Title 5, section 1665. The commissioner shall in turn transmit these requirements to the Department of Administrative and Financial Services, Bureau of the Budget without revision, alteration or change, unless alterations are mutually agreed upon by the department and the board or the board's designee. The budget submitted by the board to the commissioner must be sufficient to enable the board to comply with this chapter;

[2015, c. 429, §21 (NEW) .]

5. **Adequacy of budget, fees and staffing.** The duty to ensure that the budget submitted by the board to the commissioner pursuant to subsection 4 is sufficient, if approved, to provide for adequate legal and investigative personnel on the board's staff and that of the Attorney General to ensure that complaints pursuant to this chapter can be resolved in a timely fashion;

[2015, c. 429, §21 (NEW) .]

6. **Executive director; duties.** The power to appoint an executive director who serves at the pleasure of the board and who shall assist the board in carrying out its duties and responsibilities under this chapter. The executive director is responsible for the management of the board's affairs, including the authority to employ and prescribe the duties of personnel within the guidelines, policies and rules established by the board;

[2015, c. 429, §21 (NEW) .]

7. **Authority to delegate.** The power to delegate to staff the authority to review and approve applications for licensure pursuant to procedures and criteria established by rule;

[2015, c. 429, §21 (NEW) .]

8. **Protocols for professional review committee.** The authority to establish protocols for the operation of a professional review committee as defined in Title 24, section 2502, subsection 4-A. The protocols must include the committee reporting information the board considers appropriate regarding reports received, contracts or investigations made and the disposition of each report, as long as the committee is not required to disclose any personally identifiable information. The protocols may not prohibit an impaired licensee under this chapter from seeking alternative forms of treatment; and

[2015, c. 429, §21 (NEW) .]

9. **Authority to order a mental or physical examination.** The authority to direct a licensee, who by virtue of an application for and acceptance of a license to practice under this chapter is considered to have given consent, to submit to an examination whenever the board determines the licensee may be suffering from a mental illness or physical illness that may be interfering with competent practice under this chapter or from the use of intoxicants or drugs to an extent that prevents the licensee from practicing competently and with safety to patients. A licensee examined pursuant to an order of the board may not prevent the testimony of the examining individual or prevent the acceptance into evidence of the report of an examining individual. The board may petition the District Court for immediate suspension of a license if the licensee fails to comply with an order of the board to submit to a mental or physical examination pursuant to this subsection.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18324. RULES

The board shall adopt rules that are necessary for the implementation of this chapter. The rules may include, but need not be limited to, requirements for licensure, license renewal and license reinstatement as well as practice setting standards that apply to individuals licensed under this chapter relating to recordkeeping, infection control, supervision and administering sedation and anesthesia. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18325. DISCIPLINARY ACTION; JUDICIAL REVIEW

1. **Disciplinary action.** The board may suspend, revoke, refuse to issue or renew a license pursuant to Title 5, section 10004. The following are grounds for an action to refuse to issue, modify, suspend, revoke or refuse to renew the license of a person licensed under this chapter:

A. The practice of fraud, deceit or misrepresentation in obtaining a license or authority from the board or in connection with services within the scope of the license or authority; [2015, c. 429, §21 (NEW).]

B. Misuse of alcohol, drugs or other substances that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients; [2015, c. 429, §21 (NEW).]

C. A professional diagnosis of a mental or physical condition that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients; [2015, c. 429, §21 (NEW).]

D. Incompetence in the practice for which the licensee is licensed or authorized by the board. A licensee is considered incompetent in the practice if the licensee has:

(1) Engaged in conduct that evidences a lack of ability or fitness to perform the duties owed by the licensee to a client or patient or the general public; or

(2) Engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed; [2015, c. 429, §21 (NEW).]

E. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed or authorized by the board; [2015, c. 429, §21 (NEW).]

F. Subject to the limitations of Title 5, chapter 341, conviction of a crime that involves dishonesty or false statement or that relates directly to the practice for which the licensee is licensed or authorized by the board, or conviction of a crime for which incarceration for one year or more may be imposed; [2015, c. 429, §21 (NEW).]

G. Engaging in false, misleading or deceptive advertising; [2015, c. 429, §21 (NEW).]

H. Aiding or abetting unlicensed practice by a person who is not licensed or authorized as required under this chapter; [2015, c. 429, §21 (NEW).]

I. Failure to provide supervision as required under this chapter or a rule adopted by the board; [2015, c. 429, §21 (NEW).]

J. Engaging in any activity requiring a license or authority under this chapter or rule adopted by the board that is beyond the scope of acts authorized by the license or authority held; [2015, c. 429, §21 (NEW).]

K. Continuing to act in a capacity requiring a license or authority under this chapter or a rule adopted by the board after expiration, suspension or revocation of that license or authority; [2015, c. 429, §21 (NEW).]

L. Noncompliance with an order of or consent agreement executed by the board; [2015, c. 429, §21 (NEW).]

M. Failure to produce any requested documents in the licensee's possession or under the licensee's control relevant to a pending complaint, proceeding or matter under investigation by the board; [2015, c. 429, §21 (NEW).]

N. Any violation of a requirement imposed pursuant to section 18352; [2015, c. 488, §33 (AMD).]

O. A violation of this chapter or a rule adopted by the board; and [2015, c. 488, §33 (AMD).]

P. Failure to comply with the requirements of Title 22, section 7253. [2015, c. 488, §34 (NEW).]

[2015, c. 488, §§33, 34 (AMD) .]

2. **Judicial review.** Notwithstanding Title 10, section 8003, subsection 5, any nonconsensual revocation pursuant to Title 10, section 8003, subsection 5 of a license or authority issued by the board may be imposed

only after a hearing conforming to the requirements of Title 5, chapter 375, subchapter 4 and is subject to judicial review exclusively in the Superior Court in accordance with Title 5, chapter 375, subchapter 7.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW). 2015, c. 488, §§33, 34 (AMD).

§18326. SUBCOMMITTEE ON DENTURISTS

The Subcommittee on Denturists, referred to in this section as "the subcommittee," is established as follows. [2015, c. 429, §21 (NEW).]

1. **Membership.** The subcommittee consists of 5 members as follows:

A. The denturist who is a member of the board; [2015, c. 429, §21 (NEW).]

B. Two denturists, appointed by the Governor, who are legal residents of the State and have practiced in the State for at least 6 years immediately preceding appointment; and [2015, c. 429, §21 (NEW).]

C. Two dentists who are members of the board, appointed by the chair of the board. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **Terms.** Each of the 3 members of the subcommittee who also are members of the board shall serve on the subcommittee for the duration of that member's term on the board. The term of a member of the subcommittee who is not a member of the board is 5 years.

[2015, c. 429, §21 (NEW) .]

3. **Duties.** The subcommittee shall:

A. Perform an initial review of all complaints involving denturists. Upon completion of its review of a complaint, the secretary of the subcommittee shall report to the board the subcommittee's recommended disposition of the complaint. The board shall adopt the subcommittee's recommended disposition of a complaint unless no fewer than 2/3 of the board members who are present and voting vote to reject that recommended disposition; and [2015, c. 429, §21 (NEW).]

B. Perform an initial review of all applications for licensure as a denturist and all submissions relating to continuing education of denturists. Upon completion of its review of an application or submission, the secretary of the subcommittee shall report to the board the subcommittee's recommended disposition of the application or submission, including issuance, renewal, denial or nonrenewal of a denturist license. The board shall adopt the subcommittee's recommended disposition of an application or submission unless no fewer than 2/3 of the board members who are present and voting vote to reject that recommended disposition. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

4. **Quorum; chair; secretary.** Notwithstanding any provision of law to the contrary, a majority of the members serving on the subcommittee constitutes a quorum. The subcommittee shall annually elect its chair and secretary.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18327. SUBCOMMITTEE ON DENTAL HYGIENISTS

The Subcommittee on Dental Hygienists, referred to in this section as "the subcommittee," is established. [2015, c. 429, §21 (NEW).]

1. **Membership.** The subcommittee consists of 5 members as follows:

A. A dental hygienist who is a member of the board; [2015, c. 429, §21 (NEW).]

B. Two dental hygienists, appointed by the Governor, who are legal residents of the State and have practiced in the State for at least 6 years immediately preceding appointment; and [2015, c. 429, §21 (NEW).]

C. Two dentists who are members of the board, appointed by the chair of the board. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **Terms.** Each of the 3 members of the subcommittee who also are members of the board shall serve on the subcommittee for the duration of that member's term on the board. The term of a member of the subcommittee who is not a member of the board is 5 years.

[2015, c. 429, §21 (NEW) .]

3. **Duties.** The subcommittee shall:

A. Perform an initial review of all complaints involving dental hygienists and dental hygienists with additional authority pursuant to section 18345, subsection 2. Upon completion of its review of a complaint, the secretary of the subcommittee shall report to the board the subcommittee's recommended disposition of the complaint. The board shall adopt the subcommittee's recommended disposition of a complaint unless no fewer than 2/3 of the board members who are present and voting vote to reject that recommended disposition; and [2015, c. 429, §21 (NEW).]

B. Perform an initial review of all applications for licensure as a dental hygienist or a dental hygienist with additional authority pursuant to section 18345, subsection 2 and all submissions relating to continuing education of dental hygienists. Upon completion of its review of an application or submission, the secretary of the subcommittee shall report to the board the subcommittee's recommended disposition of the application or submission, including issuance, renewal, denial or nonrenewal of a dental hygienist license. The board shall adopt the subcommittee's recommended disposition of an application or submission unless no fewer than 2/3 of the board members who are present and voting vote to reject that recommended disposition. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

4. **Quorum; chair; secretary.** Notwithstanding any provision of law to the contrary, a majority of the members serving on the subcommittee constitutes a quorum. The subcommittee shall annually elect its chair and secretary.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

Subchapter 3: LICENSING QUALIFICATIONS

§18341. APPLICATION; FEES; GENERAL QUALIFICATIONS

1. **Application.** An applicant seeking an initial or a renewed license must submit an application with the fee established under section 18323 and any other materials required by the board.

[2015, c. 429, §21 (NEW) .]

2. **Age.** An applicant must be 18 years of age or older.

[2015, c. 429, §21 (NEW) .]

3. **Time limit.** An applicant has 90 days after being notified of the materials needed to complete the application to submit those materials to the board. Failure to complete the application within that 90-day period may result in a denial of the application.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18342. DENTIST

1. **Dentist license.** Except as provided in section 18347, an applicant for licensure as a dentist must comply with the provisions of section 18341 and must provide:

A. Verification of a doctoral degree in dentistry from a dental school accredited as required by board rule; and [2015, c. 429, §21 (NEW).]

B. Verification of passing all examinations required by the board. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **Faculty dentist license.** An applicant for a faculty dentist license must comply with section 18341 and must provide:

A. Verification of an active dental license in good standing issued under the laws of another state or a Canadian province; and [2015, c. 429, §21 (NEW).]

B. Credentials, satisfactory to the board, including a letter from the employing school of dentistry, dental hygiene or denturism indicating that the applicant satisfies the credentialing standards of the school and that the applicant will teach:

(1) Dentistry, dental hygiene or denturism in this State as part of a clinical and didactic program for professional education for dental students and dental residents accredited by the American Dental Association Commission on Dental Accreditation or a successor organization approved by the board;

(2) Dental hygiene in this State as part of a clinical and didactic program for professional education for dental hygiene students and dental hygiene residents accredited by the American Dental Association Commission on Dental Accreditation or a successor organization approved by the board; or

(3) Denturism in this State as part of a board-approved clinical and didactic program for professional education for denturism students. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

3. **Limited dentist license.** An applicant for a limited dentist license must comply with section 18341 and must provide:

A. Verification of a doctoral degree in dentistry from a dental school accredited as required by board rule; [2015, c. 429, §21 (NEW).]

B. Verification that the applicant has been licensed as a dentist in good standing issued under the laws of this State or has an active dental license in good standing issued under the laws of another state or a Canadian province; [2015, c. 429, §21 (NEW).]

C. Verification of passing all examinations required by board rule; and [2015, c. 429, §21 (NEW).]

D. Verification that the applicant will be practicing dentistry in a nonprofit dental clinic without compensation for work performed at the clinic. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

~~**4. Clinical dentist educator license.** An applicant for a clinical dentist educator license must comply with section 18341 and must provide:~~

~~A. Verification of an active dental license in good standing issued under the laws of another state or a Canadian province; and [2015, c. 429, §21 (NEW).]~~

~~B. An outline of the clinical education program to be offered to practitioners in this State. [2015, c. 429, §21 (NEW).]~~

~~[2015, c. 429, §21 (NEW) .]~~

~~**5. Charitable dentist license.** An applicant for a charitable dentist license must comply with section 18341 and must provide:~~

~~A. Verification of a doctoral degree in dentistry from a dental school accredited as required by board rule; [2015, c. 429, §21 (NEW).]~~

~~B. Verification that the applicant has been licensed as a dentist in good standing under the laws of this State or has an active dental license in good standing issued under the laws of another state or a Canadian province; [2015, c. 429, §21 (NEW).]~~

~~C. Verification of passing all examinations required by board rule; and [2015, c. 429, §21 (NEW).]~~

~~D. Verification that the purpose of the license is to offer free dental care in conjunction with a charitable or social organization. [2015, c. 429, §21 (NEW).]~~

[2015, c. 429, §21 (NEW) .]

4. Visiting Dentist License. An applicant for a visiting dentist license must comply with section 18341 and must provide:

A. Verification that the applicant is licensed as a dentist in good standing issued under the laws of this State or has an active dental license in good standing issued under the laws of another state or a Canadian province; [2015, c. 429, §21 (NEW).]

C. Verification of passing all examinations required by board rule; and [2015, c. 429, §21 (NEW).]

6. Resident dentist license. An applicant for a resident dentist license must comply with section 18341 and must provide:

A. Verification of a doctoral degree in dentistry from a dental school accredited as required by board rule; [2015, c. 429, §21 (NEW).]

B. Verification of passing all examinations required by board rule; [2015, c. 429, §21 (NEW).]

C. Verification that the applicant will be practicing dentistry in a board-approved practice setting within the State; and [2015, c. 429, §21 (NEW).]

D. A statement from the sponsoring dentist that demonstrates that the level of supervision and control of the services to be performed by the applicant are adequate and that the performance of these services are within the applicant's dental knowledge and skill. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18343. DENTAL RADIOGRAPHER

1. **Dental radiographer license.** Except as provided in section 18347, an applicant for a dental radiographer license must comply with section 18341 and must provide:

A. Verification of a high school diploma or its equivalent as determined by the board; and [2015, c. 429, §21 (NEW).]

B. Verification of passing an examination in dental radiologic technique and safety required by board rule. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18344. EXPANDED FUNCTION DENTAL ASSISTANT

1. **Expanded function dental assistant license.** Except as provided in section 18347, an applicant for an expanded function dental assistant license must comply with section 18341 and must provide:

A. Verification of a high school diploma or its equivalent as determined by the board; [2015, c. 429, §21 (NEW).]

B. Verification of one of the following:

(1) A current certificate as a certified dental assistant from a board-approved certificate program;

(2) An active dental hygiene license in good standing issued under the laws of this State; or

(3) An active dental hygiene license in good standing issued under the laws of another state or a Canadian province; [2015, c. 2, §22 (COR).]

C. Verification of having successfully completed training in a school or program required by board rule; and [2015, c. 429, §21 (NEW).]

D. Verification of passing all examinations required by board rule. [2015, c. 429, §21 (NEW).]

[2015, c. 2, §22 (COR) .]

SECTION HISTORY
RR 2015, c. 2, §22 (COR). 2015, c. 429, §21 (NEW).

§18345. DENTAL HYGIENIST

1. **Dental hygienist license.** Except as provided in section 18347, an applicant for a dental hygienist license must comply with section 18341 and must provide:

A. Verification of having successfully passed all examinations required by board rule and one of the following:

(1) Verification of an associate degree or higher in dental hygiene from a ~~school~~ program accredited by the American Dental Association Commission on Dental Accreditation, or its successor organization; or

(2) Verification of having completed at least 1/2 of the prescribed course of study in an accredited dental college as a dental student. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **Additional authority.** A dental hygienist licensed under this section or section 18347 who applies for additional authority must comply with section 18341 and must provide:

A. For independent practice dental hygienist authority:

(1~~) If the applicant has a bachelor's degree or higher in dental hygiene from a dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation or its successor organization, v~~Verification of 2,000 work hours of clinical practice ~~during the 4 years preceding the application; or~~

~~(2) If the applicant has an associate degree in dental hygiene from a dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation or its successor organization, verification of 5,000 work hours of clinical practice during the 6 years preceding the application.~~

For purposes of meeting the clinical practice requirements of this paragraph, the applicant's hours in a private dental practice or nonprofit setting under the supervision of a dentist may be included as well as the applicant's hours as a public health dental hygienist or, prior to the effective date of this Act, as a dental hygienist with public health supervision status; [2015, c. 429, §21 (NEW).]

B. For public health dental hygienist authority:

(1) A copy of the written agreement between the applicant and a supervising dentist that outlines the roles and responsibilities of the parties, which must include, but is not limited to, the level of supervision provided by the dentist, the practice settings, the standing orders and the coordination and collaboration that each party must undertake if additional patient care is needed; and

(2) Verification that the services will be offered in a public health setting; [2015, c. 429, §21 (NEW).]

C. For dental hygiene therapist authority:

(1) Verification of having successfully completed a dental hygiene therapy program that:

(a) Is accredited by the American Dental Association Commission on Dental Accreditation or a successor organization;

(b) Is a minimum of 4 semesters;

(c) Is consistent with the model curriculum for educating dental hygiene therapists adopted by the American Association of Public Health Dentistry or a successor organization;

(d) Is consistent with existing dental hygiene therapy programs in other states approved by the board; and

(e) Meets the requirements for dental hygiene therapy education programs adopted by board rule;

(2) Verification of a bachelor's degree or higher in dental hygiene, dental hygiene therapy or dental therapy from a school accredited by the American Dental Association Commission on Dental Accreditation or a successor organization;

(3) Verification of passing a clinical examination and all other examinations required by board rule. The clinical examination must be a comprehensive, competency-based clinical examination approved by the board and administered independently of an institution providing dental hygiene therapy education;

(4) Verification of having engaged in 2,000 hours of supervised clinical practice under the supervision of a dentist and in conformity with rules adopted by the board, during which supervised clinical practice the applicant is authorized to practice pursuant to paragraph F.

For purposes of meeting the clinical requirements of this subparagraph, an applicant's hours of supervised clinical experience while enrolled in the dental hygiene therapy program under subparagraph (1) may be included as well as hours completed under the supervision of a dentist licensed in another state or a Canadian province, provided that the applicant was operating lawfully under the laws and rules of that state or province; and

(5) A copy of the written practice agreement and standing orders required by section 18377, subsection 3; [2015, c. 429, §21 (NEW).]

D. For local anesthesia authority:

(1) Verification of having successfully completed a course of study required by board rule; and

(2) Verification of passing all examinations required by board rule; [2015, c. 429, §21 (NEW).]

E. For nitrous oxide analgesia authority:

(1) Verification of having successfully completed a course of study required by board rule; and

(2) Verification of passing all examinations required by board rule; and [2015, c. 429, §21 (NEW).]

F. For provisional dental hygiene therapist authority:

(1) Verification of meeting the requirements of paragraph C, subparagraphs (1) to (3); and

(2) A copy of the written agreement between the applicant and a dentist who will provide levels of supervision consistent with the scope of practice outlined in section 18377 and in conformity with rules adopted by the board.

During the period of provisional authority the applicant may be compensated for services performed as a dental hygiene therapist. The period of provisional authority may not exceed 3 years. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

3. **Faculty dental hygiene license.** An applicant for a faculty dental hygienist license must comply with section 18341 and must provide:

A. Verification of an active dental hygiene license in good standing issued under the laws of another state or a Canadian province; and [2015, c. 429, §21 (NEW).]

B. Credentials, satisfactory to the board, including a letter from the employing school of dentistry, dental hygiene or denturism indicating that the applicant satisfies the credentialing standards of the school and that the applicant will teach:

(1) Dental hygiene or denturism in this State as part of a clinical and didactic program for professional education for dental students and dental residents accredited by the American Dental Association Commission on Dental Accreditation or a successor organization approved by the board;

(2) Dental hygiene in this State as part of a clinical and didactic program for professional education for dental hygiene students and dental hygiene residents accredited by the American Dental Association Commission on Dental Accreditation or a successor organization approved by the board; or

(3) Denturism in this State as part of a board-approved clinical and didactic program for professional education for denturism students. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18346. DENTURIST

1. **Denturist license.** Except as provided in section 18347, an applicant for a denturist license must comply with section 18341 and must provide:

A. Verification of a high school diploma or its equivalent as determined by the board; [2015, c. 429, §21 (NEW).]

B. Verification of a diploma from a board-approved denturism postsecondary institution; and [2015, c. 429, §21 (NEW).]

C. Verification of passing all examinations required by board rule. The content of one examination must have a clinical component and a written component concerning, but not limited to, dental materials, denture technology, United States Department of Health and Human Services, Centers for Disease Control and Prevention guidelines, basic anatomy and basic pathology. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **Faculty denturist license.** An applicant for a faculty denturist license must comply with section 18341 and must provide:

A. Verification of an active denturist license in good standing issued under the laws of another state or a Canadian province; and [2015, c. 429, §21 (NEW).]

B. Credentials, satisfactory to the board, including a letter from the employing school of dentistry, dental hygiene or denturism indicating that the applicant satisfies the credentialing standards of the school. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18347. ENDORSEMENT; APPLICANTS AUTHORIZED TO PRACTICE IN ANOTHER JURISDICTION

The board is authorized, at its discretion, to waive the examination requirements and issue a license or grant an authority to an applicant who is licensed under the laws of another state or a Canadian province who furnishes proof, satisfactory to the board, that the requirements for licensure under this chapter have been met. Applicants must comply with the provisions set forth in section 18341. [2015, c. 429, §21 (NEW).]

1. **Applicants licensed in another jurisdiction.** An applicant for licensure or seeking authority under this chapter who is licensed under the laws of another jurisdiction is governed by this subsection.

A. An applicant who is licensed in good standing at the time of application to the board under the laws of another state or a Canadian province may qualify for licensure by submitting evidence to the board that the applicant has held a substantially equivalent, valid license for at least 3 consecutive years immediately preceding the application to the board at the level of licensure applied for in this State. [2015, c. 429, §21 (NEW).]

B. An applicant who does not meet the requirements of paragraph A but is licensed in good standing at the time of application to the board under the laws of another state or a Canadian province may qualify for licensure by submitting evidence satisfactory to the board that the applicant's qualifications for licensure are substantially similar to the requirements in this chapter for the relevant license. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18348. REGISTRATION REQUIREMENTS

~~**1. Dentist externship registration.** A dentist may register under that dentist's license a student for the purpose of providing clinical supervision outside of the academic setting. A registration under this section expires one year from the date the registration is granted. An applicant must comply with section 18341 and must provide:~~

~~A. Verification that the student has an academic affiliation and good academic standing as a dental student in a school approved by the board; [2015, c. 429, §21 (NEW).]~~

~~B. Verification from the dental school that the student has completed satisfactory training and is ready to perform limited dental services outside of the school setting under the supervision of a dentist; and [2015, c. 429, §21 (NEW).]~~

~~C. A statement from the supervising dentist that outlines the level of supervision that the dentist will provide and that attests that the performance of these services by the student will add to the student's knowledge and skill in dentistry. [2015, c. 429, §21 (NEW).]~~

[2015, c. 429, §21 (NEW) .]

2. **Sedation and general anesthesia registration.** A dentist who holds a permit to administer sedation pursuant to section 18379 may register another dentist under that dentist's license for the purpose of providing clinical supervision in administering sedation or general anesthesia under direct supervision. A registration under this subsection expires one year from the date the registration is granted. Applicants must comply with section 18341 and must submit a letter from the supervising dentist describing the practice settings in which supervision will occur as well as attesting that these arrangements are commensurate with the registrant's education, training and competency.

[2015, c. 429, §21 (NEW) .]

3. **Local anesthesia/nitrous oxide analgesia registration.** A dentist may register a dentist or dental hygienist under that dentist's license for the purpose of providing clinical supervision in administering local anesthesia or nitrous oxide analgesia under direct supervision. A registration under this section expires one year from the date the registration is granted. Applicants must comply with section 18341 and must submit a letter from the supervising dentist describing the practice settings in which supervision will occur as well as attesting that these arrangements are commensurate with the registrant's education, training and competency.

[2015, c. 429, §21 (NEW) .]

4. **Denturist ~~externship~~ trainee registration.** A denturist or dentist may register under that dentist's or denturist's license an individual who has completed the educational requirements ~~student~~ for the purpose of providing additional clinical supervision outside of the academic setting. A registration under this section expires one year from the date the registration is granted, but may be renewed for an additional year. An applicant must comply with section 18341 and must provide:

A. Verification that the ~~student~~ trainee ~~has an academic affiliation and good academic standing as a~~ successfully completed ~~denturist student in a~~ a denturist program approved by the board; [2015, c. 429, §21 (NEW).]

~~B. Verification from the denturist program that the student has completed satisfactory training and is ready to perform limited denturist services outside of the school setting under the supervision of a denturist or a dentist; and~~ [2015, c. 429, §21 (NEW).]

C. A letter from the supervising denturist ~~or dentist~~ that describes the level of supervision that the dentist will provide and that attests that the performance of these services by the ~~student~~ trainee will add to the ~~student's~~ their knowledge and skill in denturism to prepare them for full licensure. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18349. LICENSE RENEWAL; REINSTATEMENT

1. **Renewal.** Licenses under this chapter expire at such times as the commissioner may designate. In the absence of any reason or condition that might warrant the refusal of granting a license, the board shall issue a renewal license to each applicant who meets the requirements of sections 18341 and 18350.

[2015, c. 429, §21 (NEW) .]

2. **Late renewals.** Licenses may be renewed up to 90 days after the date of expiration if the applicant meets the requirements of subsection 1 and pays a late fee established by the board pursuant to section 18323, subsection 3.

[2015, c. 429, §21 (NEW) .]

3. **Reinstatement.** A person who submits an application for reinstatement more than 90 days after the license expiration date is subject to all requirements governing new applicants under this chapter, except that the board may, giving due consideration to the protection of the public, waive examination if that renewal application is received, together with the penalty fee established by the board pursuant to section 18323, subsection 3, within 2 years from the date of the license expiration.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18350. CONTINUING EDUCATION

As a condition of renewal of a license to practice, an applicant must have a current cardiopulmonary resuscitation certification and complete continuing education during the licensing cycle prior to application for renewal. The board may prescribe by rule the content and types of continuing education activities that meet the requirements of this section. [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18351. INACTIVE STATUS

A licensee who wants to retain licensure while not practicing may apply for an inactive status license. The fee for inactive status licensure is set under section 18323, subsection 3. During inactive status, the licensee must renew the license and pay the renewal fee set under section 18323, subsection 3, but is not required to meet the continuing education requirements under section 18350. The board shall adopt rules by which an inactive status license may be reinstated. [2015, c. 429, §21 (NEW).]

An individual who practices under a clinical dentist educator license, a charitable dentist license or a resident dentist license or as a provisional dental hygiene therapist may not apply for inactive status. [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18352. DUTY TO REQUIRE CERTAIN INFORMATION FROM APPLICANTS AND LICENSEES

1. **Report in writing.** A licensee and an applicant for licensure shall report in writing to the board no later than 10 days after any of the following changes or events:

A. Change of name or address; [2015, c. 429, §21 (NEW).]

B. Criminal conviction; [2015, c. 429, §21 (NEW).]

C. Revocation, suspension or other disciplinary action taken in this State or any other jurisdiction against any occupational or professional license held by the licensee or applicant; or [2015, c. 429, §21 (NEW).]

D. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the board. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

Subchapter 4: SCOPE OF PRACTICE; SUPERVISION; PRACTICE REQUIREMENTS

§18371. DENTIST

1. **Scope of practice.** A dentist, ~~charitable dentist, clinical dentist educator~~, faculty dentist, limited dentist or resident dentist may:

A. Perform a dental operation or oral surgery or dental service of any kind, gratuitously or for a salary, fee, money or other compensation paid, or to be paid, directly or indirectly to the person or to any other person or agency who is a proprietor of a place where dental operations, oral surgery or dental services are performed; [2015, c. 429, §21 (NEW).]

B. ~~Take~~ Obtain impressions of a human tooth, teeth or jaws and perform a phase of an operation incident to the replacement of a part of a tooth; [2015, c. 429, §21 (NEW).]

C. Supply artificial substitutes for the natural teeth and furnish, supply, construct, reproduce or repair a prosthetic denture, bridge, appliance or any other structure to be worn in the human mouth; [2015, c. 429, §21 (NEW).]

D. Place dental appliances or structures in the human mouth and adjust or attempt or profess to adjust the same; [2015, c. 429, §21 (NEW).]

E. Furnish, supply, construct, reproduce or repair or profess to the public to furnish, supply, construct, reproduce or repair a prosthetic denture, bridge, appliance or other structure to be worn in the human mouth; [2015, c. 429, §21 (NEW).]

F. Diagnose or profess to diagnose, prescribe for and treat or profess to prescribe for and treat disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws or adjacent structure; [2015, c. 429, §21 (NEW).]

G. Extract or attempt to extract human teeth; [2015, c. 429, §21 (NEW).]

H. Correct or attempt to correct malformations of teeth and jaws; [2015, c. 429, §21 (NEW).]

I. Repair or fill cavities in the human teeth; [2015, c. 429, §21 (NEW).]

J. Diagnose malposed teeth and make and adjust appliances or artificial casts for treatment of the malposed teeth in the human mouth with or without instruction; [2015, c. 429, §21 (NEW).]

K. Use an x-ray machine for the purpose of taking dental x-rays and interpret or read or profess to interpret or read dental x-rays; [2015, c. 429, §21 (NEW).]

L. Use the words dentist, dental surgeon or oral surgeon and the letters D.D.S. or D.M.D. and any other words, letters, title or descriptive matter that represents that person as being able to diagnose, treat, prescribe or operate for a disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws or adjacent structures and state, profess or permit to be stated or professed by any means or method whatsoever that the person can perform or will attempt to perform dental operations or render a diagnosis connected with dental operations; [2015, c. 429, §21 (NEW).]

M. Prescribe drugs or medicine and administer local anesthesia, analgesia including nitrous oxide and oxygen inhalation and, with the appropriate permit issued by the board, administer sedation and general anesthesia necessary for proper dental treatment; and [2015, c. 429, §21 (NEW).]

N. Take case histories and perform physical examinations to the extent the activities are necessary in the exercise of due care in conjunction with the provision of dental treatment or the administration of anesthesia. A dentist is not permitted to perform physical examinations within a hospital licensed by the Department of Health and Human Services unless this activity is permitted by the hospital. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Limitations. Individuals practicing dentistry as described in this section who possess one of the following licenses shall adhere to the restrictions in this subsection.

~~A. An individual with a charitable dentist license may provide dental services only in conjunction with the charitable or social organization for which the license was issued by the board and may not accept remuneration for those services. Authority to practice as a charitable dentist may not exceed one year. [2015, c. 429, §21 (NEW).]~~

~~B. An individual with a clinical dentist educator license may provide dental services only as part of the clinical education program under which the license was issued by the board. Authority to practice as a clinical dentist educator may not exceed 7 days in any calendar year. [2015, c. 429, §21 (NEW).]~~

~~C~~A. An individual with a faculty dentist license may provide dental services only as part of the education program for which the license was issued by the board. [2015, c. 429, §21 (NEW).]

~~D~~B. An individual with a limited dentist license may provide dental services only in the nonprofit dental clinic for which the license was issued by the board and may not accept remuneration for those services. [2015, c. 429, §21 (NEW).]

C. An individual with a visiting dentist license may provide dental services. Authority to practice may not exceed one year.

~~E~~D. An individual with a resident dentist license may provide dental services only under the supervision of the sponsoring dentist and in accordance with the level of supervision and control for which the license was issued by the board. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

3. **Delegation authorized.** A dentist may delegate to an unlicensed person the activities listed in this subsection. A dentist who delegates activities as described is legally liable for the activities of that unlicensed person and the unlicensed person in this relationship is considered the dentist's agent.

A. A dentist may delegate the following activities to an unlicensed person as long as these activities are conducted under the general supervision of the delegating dentist:

(1) Changing or replacing dry socket packets after diagnosis and treatment planned by a dentist;

(2) For instruction purposes, demonstrating to a patient how the patient should place and remove removable prostheses, appliances or retainers;

(3) For the purpose of eliminating pain or discomfort, removing loose, broken or irritating orthodontic appliances;

(4) Giving oral health instructions;

(5) Irrigating and aspirating the oral cavity;

(6) Performing dietary analyses for dental disease control;

(7) Placing and recementing with temporary cement an existing crown that has fallen out as long as the dental assistant promptly notifies the dentist this procedure was performed so that appropriate follow-up can occur;

(8) Placing and removing periodontal dressing;

(9) Pouring and trimming dental models;

(10) Removing sutures and scheduling a follow-up appointment with the dentist within 7 to 10 days of suture removal;

(11) Retracting lips, cheek, tongue and other tissue parts;

(12) ~~Taking and pouring~~Obtaining impressions for study casts;

(13) Taking and recording the vital signs of blood pressure, pulse and temperature;

(14) Taking dental plaque smears for microscopic inspection and patient education; and

(15) Taking intraoral photographs. [2015, c. 429, §21 (NEW).]

B. If the unlicensed person has successfully passed a certification examination administered by a national dental assisting board, the dentist may delegate to that unlicensed person the following additional activities, as long as these activities are conducted under the general supervision of the dentist:

(1) Placing temporary fillings on an emergency basis as long as the patient is informed of the temporary nature of the fillings; and

(2) Removing excess cement from the supragingival surfaces of teeth. [2015, c. 429, §21 (NEW).]

C. A dentist may delegate to an unlicensed person the following intraoral activities, which must be conducted under the direct supervision of the delegating dentist:

(1) Applying cavity varnish;

(2) Applying liquids, pastes and gel topical anesthetics;

(3) Assisting a dentist who provides orthodontic services in preparation of teeth for attaching, bonding and cementing fixed appliances in a manner appropriate and according to manufacturer's directions;

(4) Delivering, but not condensing or packing, amalgam or composite restoration material;

(5) Fabricating temporary crowns and bridges, limiting handpiece rotary instrumentation used in the fabrication to extraoral use only, as long as the dentist checks the occlusion and fit prior to releasing the patient;

(6) Irrigating and drying root canals;

(7) Isolating the operative field;

(8) Performing ~~cold~~ pulp vitality testing with confirmation by the dentist;

(9) Performing electronic vitality scanning with confirmation by the dentist;

(10) Performing preliminary selection and fitting of orthodontic bands, with final placement and cementing in the patient's mouth by the dentist;

(11) Placing and cementing temporary crowns with temporary cement;

(12) Placing and removing matrix bands, rubber dams and wedges;

(13) Placing elastics and instructing in their use;

(14) Placing, holding or removing celluloid and other plastic strips prior to or subsequent to the placement of a filling by the dentist;

(15) Placing or removing temporary separating devices;

(16) Placing wires, pins and elastic ligatures to tie in orthodontic arch wires that have been fitted and approved by the dentist at the time of insertion;

(17) Preparing tooth sites and surfaces with a rubber cup and pumice for banding or bonding of orthodontic brackets. This procedure may not be intended or interpreted as an oral prophylaxis, which is a procedure specifically reserved to be performed by dental hygienists or dentists. This procedure also may not be intended or interpreted as a preparation for restorative material. A dentist or dental hygienist shall check and approve the procedure;

(18) Reapplying, on an emergency basis only, orthodontic brackets;

(19) Recording readings with a digital caries detector and reporting them to the dentist for interpretation and evaluation;

(20) Removing composite material using slow-speed instrumentation for debonding brackets, as long as the dentist conducts a final check prior to release of the patient;

(21) Removing excess cement from the supragingival surfaces of teeth;

(22) Removing gingival retraction cord;

(23) Removing orthodontic arch wires and tension devices and any loose bands or bonds, but only as directed by the dentist;

(24) Selecting and trying in stainless steel or other preformed crowns for insertion by the dentist;

(25) ~~Taking~~ Obtaining impressions for opposing models and retainers;

(26) ~~Taking~~ Obtaining impressions for single-arch athletic mouth guards, bleaching trays, custom trays and fluoride trays; and

(27) Taking intraoral measurements and making preliminary selection of arch wires and intraoral and extraoral appliances, including head gear. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

4. **Delegation not authorized.** A dentist may not delegate any dental activity not listed in subsections 3 or 6 to an unlicensed person.

[2015, c. 429, §21 (NEW) .]

5. **Supervision of dental hygiene therapists.** A dentist, referred to in this section as the "supervising dentist," who employs a dental hygiene therapist shall comply with this subsection.

A. A supervising dentist shall arrange for another dentist or specialist to provide any services needed by a patient of a dental hygiene therapist supervised by that dentist that are beyond the scope of practice of the dental hygiene therapist and that the supervising dentist is unable to provide. [2015, c. 429, §21 (NEW).]

B. The supervising dentist is responsible for all authorized services and procedures performed by the dental hygiene therapist pursuant to a written practice agreement executed by the dentist pursuant to section 18377. [2015, c. 429, §21 (NEW).]

C. Revisions to a written practice agreement must be documented in a new written practice agreement signed by the supervising dentist and the dental hygiene therapist. [2015, c. 429, §21 (NEW).]

D. A supervising dentist who signs a written practice agreement shall file a copy of the agreement with the board, keep a copy for the dentist's own records and make a copy available to patients of the dental hygiene therapist upon request. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

6. **Prescription for laboratory services.** A dentist who uses the services of a person not licensed to practice dentistry in this State to construct, alter, repair or duplicate a denture, plate, partial plate, bridge, splint, orthodontic or prosthetic appliance shall first furnish the unlicensed person with a written prescription, which must contain:

A. The name and address of the unlicensed person; [2015, c. 429, §21 (NEW).]

B. The patient's name or number. In the event the number is used, the name of the patient must be written upon the duplicate copy of the prescription retained by the dentist; [2015, c. 429, §21 (NEW).]

C. The date on which the prescription was written; [2015, c. 429, §21 (NEW).]

D. A description of the work to be done, with diagrams if necessary; [2015, c. 429, §21 (NEW).]

E. A specification of the type and quality of materials to be used; and [2015, c. 429, §21 (NEW).]

F. The signature of the dentist and the number of the dentist's state license. [2015, c. 429, §21 (NEW).]

The dentist shall retain for 2 years a duplicate copy of all prescriptions issued pursuant to this subsection for inspection by the board.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18372. DENTAL RADIOGRAPHER

1. **Scope of practice.** A licensed dental radiographer may practice dental radiography under the general supervision of a dentist or an independent practice dental hygienist.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18373. EXPANDED FUNCTION DENTAL ASSISTANT

1. **Scope of practice; direct supervision.** An expanded function dental assistant may perform the following reversible intraoral procedures authorized under the direct supervision of a dentist:

A. Apply cavity liners and bases as long as the dentist:

(1) Has ordered the cavity liner or base;

(2) Has checked the cavity liner or base prior to the placement of the restoration; and

(3) Has checked the final restoration prior to patient dismissal; [2015, c. 429, §21 (NEW).]

B. Apply pit and fissure sealants after an evaluation of the teeth by the dentist at the time of sealant placement; [2015, c. 429, §21 (NEW).]

C. Apply supragingival desensitizing agents to an exposed root surface or dentinal surface of teeth; [2015, c. 429, §21 (NEW).]

D. Apply topical fluorides recognized for the prevention of dental caries; [2015, c. 429, §21 (NEW).]

E. Cement provisional or temporary crowns and bridges and remove excess cement; [2015, c. 429, §21 (NEW).]

F. Perform ~~tooth~~ pulp vitality tests; [2015, c. 429, §21 (NEW).]

G. Place and contour amalgam, composite and other restorative materials prior to the final setting or curing of the material; [2015, c. 429, §21 (NEW).]

~~H. Place and remove periodontal dressing; [2015, c. 429, §21 (NEW).]~~

~~I.~~H Place and remove retraction cord; [2015, c. 429, §21 (NEW).]

~~J. Record readings with a digital caries detector and report them to the dentist for interpretation and evaluation; [2015, c. 429, §21 (NEW).]~~

~~K~~I. Size, place and cement or bond orthodontic bands and brackets with final inspection by the dentist; [2015, c. 429, §21 (NEW).]

~~L~~J. Supragingival polishing. A dentist or a dental hygienist must first determine that the teeth to be polished are free of calculus or other extraneous material prior to polishing. Dentists may permit an expanded function dental assistant to use only a slow-speed rotary instrument and rubber cup. Dentists may allow an expanded function dental assistant to use high-speed, power-driven handpieces or instruments to contour or finish newly placed composite materials; [2015, c. 429, §21 (NEW).]

~~M~~K. ~~Take and pour~~Obtain impressions for bleaching trays, athletic mouth guards, provisional or temporary crowns, bridges, custom trays and fluoride trays;and [2015, c. 429, §21 (NEW).]

L. Perform delegated duties as listed in Section 18371(3).

~~N. Apply cavity varnish; [2015, c. 429, §21 (NEW).]~~

~~O. Apply liquids, pastes and gel topical anesthetics; [2015, c. 429, §21 (NEW).]~~

~~P. Assist a dentist who provides orthodontic services in preparation of teeth for attaching, bonding and cementing fixed appliances in a manner appropriate and according to the manufacturer's directions; [2015, c. 429, §21 (NEW).]~~

~~Q. Fabricate temporary crowns and bridges, limiting handpiece rotary instrumentation used in the fabrication to extraoral use only, as long as the dentist checks the occlusion and fit prior to releasing the patient; [2015, c. 429, §21 (NEW).]~~

~~R. Irrigate and dry root canals; [2015, c. 429, §21 (NEW).]~~

~~S. Isolate the operative field; [2015, c. 429, §21 (NEW).]~~

~~T. Perform cold vitality testing with confirmation by the dentist; [2015, c. 429, §21 (NEW).]~~

~~U. Perform electronic vitality scanning with confirmation by the dentist; [2015, c. 429, §21 (NEW).]~~

~~V. Place and remove matrix bands, rubber dams and wedges; [2015, c. 429, §21 (NEW).]~~

~~W. Place elastics and instruct in their use; [2015, c. 429, §21 (NEW).]~~

~~X. Place, hold or remove celluloid and other plastic strips prior to or subsequent to the placement of a filling by the dentist; [2015, c. 429, §21 (NEW).]~~

~~Y. Place or remove temporary separating devices; [2015, c. 429, §21 (NEW).]~~

~~Z. Place wires, pins and elastic ligatures to tie in orthodontic arch wires that have been fitted and approved by the dentist at the time of insertion; [2015, c. 429, §21 (NEW).]~~

~~AA. Prepare tooth sites and surfaces with a rubber cup and pumice for banding or bonding of orthodontic brackets. This procedure may not be intended or interpreted as an oral prophylaxis, which is a procedure specifically reserved to be performed by dental hygienists or dentists. This procedure also may not be intended or interpreted as a preparation for restorative material. A dentist or dental hygienist shall check and approve the procedure; [2015, c. 429, §21 (NEW).]~~

~~BB. Reapply, on an emergency basis only, orthodontic brackets; [2015, c. 429, §21 (NEW).]~~

~~CC. Remove composite material using slow-speed instrumentation for debonding brackets, as long as the dentist conducts a final check prior to release of the patient; [2015, c. 429, §21 (NEW).]~~

~~DD. Remove orthodontic arch wires and tension devices and any loose bands or bonds, but only as directed by the dentist; [2015, c. 429, §21 (NEW).]~~

~~EE. Select and try in stainless steel or other preformed crowns for insertion by the dentist; [2015, c. 429, §21 (NEW).]~~

~~FF. Take impressions for opposing models and retainers; and [2015, c. 429, §21 (NEW).]~~

~~GG. Take intraoral measurements and make preliminary selection of arch wires and intraoral and extraoral appliances, including head gear. [2015, c. 429, §21 (NEW).]~~

~~[2015, c. 429, §21 (NEW).]~~

2. **Scope of practice; general supervision.** An expanded function dental assistant may perform the following procedures under the general supervision of a dentist:

~~A. Place temporary fillings on an emergency basis as long as the patient is informed of the temporary nature of the fillings; [2015, c. 429, §21 (NEW).]~~

~~B. Remove excess cement from the supragingival surfaces of teeth; [2015, c. 429, §21 (NEW).]~~

~~C~~. ~~Change or replace dry socket packets after diagnosis and treatment planned by a dentist; [2015, c. 429, §21 (NEW).]~~

A. Perform delegated duties as listed in Section 18371(3).

~~D. For instruction purposes, demonstrate to a patient how the patient should place and remove removable prostheses, appliances or retainers; [2015, c. 429, §21 (NEW).]~~

~~E. For the purpose of eliminating pain or discomfort, remove loose, broken or irritating orthodontic appliances; [2015, c. 429, §21 (NEW).]~~

~~F. Give oral health instructions; [2015, c. 429, §21 (NEW).]~~

~~G. Irrigate and aspirate the oral cavity; [2015, c. 429, §21 (NEW).]~~

~~H. Perform dietary analyses for dental disease control; [2015, c. 429, §21 (NEW).]~~

~~I. Place and recement with temporary cement an existing crown that has fallen out as long the dental assistant promptly notifies the dentist this procedure was performed so that appropriate follow-up can occur; [2015, c. 429, §21 (NEW).]~~

~~J. Place and remove periodontal dressing; [2015, c. 429, §21 (NEW).]~~

~~K. Pour and trim dental models; [2015, c. 429, §21 (NEW).]~~

~~L. Remove sutures and schedule a follow-up appointment with the dentist within 7 to 10 days of suture removal; [2015, c. 429, §21 (NEW).]~~

~~M. Retract lips, cheek, tongue and other tissue parts; [2015, c. 429, §21 (NEW).]~~

~~N. Take and pour impressions for study casts; [2015, c. 429, §21 (NEW).]~~

~~O. Take and record the vital signs of blood pressure, pulse and temperature; [2015, c. 429, §21 (NEW).]~~

~~P. Take dental plaque smears for microscopic inspection and patient education; and [2015, c. 429, §21 (NEW).]~~

~~Q. Take intraoral photographs. [2015, c. 429, §21 (NEW).]~~

~~[2015, c. 429, §21 (NEW) .]~~

3. **Procedures not authorized.** An expanded function dental assistant may not engage in the following activities:

A. Complete or limited examination, diagnosis or treatment planning; [2015, c. 429, §21 (NEW).]

B. Surgical or cutting procedures of hard or soft tissue; [2015, c. 429, §21 (NEW).]

C. Prescribing drugs, medicaments or work authorizations; [2015, c. 429, §21 (NEW).]

D. Pulp capping, pulpotomy or other endodontic procedures; [2015, c. 429, §21 (NEW).]

E. Placement and intraoral adjustments of fixed or removable prosthetic appliances; or [2015, c. 429, §21 (NEW).]

F. Administration of local anesthesia, parenteral or inhalation sedation or general anesthesia. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18374. DENTAL HYGIENIST

1. **Scope of practice; direct supervision.** A dental hygienist and faculty dental hygienist may perform the following procedures under the direct supervision of a dentist:

A. Administer local anesthesia or nitrous oxide analgesia, as long as the dental hygienist or faculty dental hygienist has authority to administer the relevant medication pursuant to section 18345, subsection 2, paragraph D or E; [2015, c. 429, §21 (NEW).]

~~B. Irrigate and dry root canals; [2015, c. 429, §21 (NEW).]~~

~~C. Record readings with a digital caries detector and report them to the dentist for interpretation and evaluation; [2015, c. 429, §21 (NEW).]~~

~~D. Remove socket dressings; [2015, c. 429, §21 (NEW).]~~

~~E. Take cytological smears as requested by the dentist; and [2015, c. 429, §21 (NEW).]~~

~~F~~B. ~~Take~~ Obtain impressions for nightguards and occlusal splints~~ as long as the dentist takes all measurements and bite registrations~~. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **Scope of practice; general supervision.** A dental hygienist and faculty dental hygienist may perform the following procedures under the general supervision of a dentist:

A. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse; [2015, c. 429, §21 (NEW).]

~~B. Apply cavity varnish; [2015, c. 429, §21 (NEW).]~~

~~C~~B. Apply desensitizing agents to teeth; [2015, c. 429, §21 (NEW).]

~~D.~~C. Apply fluoride to control caries; [2015, c. 429, §21 (NEW).]

~~E. Apply liquids, pastes or gel topical anesthetics; [2015, c. 429, §21 (NEW).]~~

~~F~~D. Apply sealants~~, as long as a licensed dentist first makes the determination and diagnosis as to the surfaces on which the sealants are applied; [2015, c. 429, §21 (NEW).]~~

~~G. Cement pontics and facings outside the mouth;~~ [2015, c. 429, §21 (NEW).]

~~H. Change or replace dry socket packets after diagnosis and treatment planned by a dentist; [2015, c. 429, §21 (NEW).]~~

~~I. Deliver, but not condense or pack, amalgam or composite restoration material; [2015, c. 429, §21 (NEW).]~~

~~J~~E. Expose and process radiographs; [2015, c. 429, §21 (NEW).]

~~K. Fabricate temporary crowns and bridges, limiting handpiece rotary instrumentation used in the fabrication to extraoral use only, as long as the dentist checks the occlusion and fit prior to releasing the patient; [2015, c. 429, §21 (NEW).]~~

~~L. For instruction purposes, demonstrate to a patient how the patient should place and remove removable prostheses, appliances or retainers; [2015, c. 429, §21 (NEW).]~~

~~M. For the purpose of eliminating pain or discomfort, remove loose, broken or irritating orthodontic appliances; [2015, c. 429, §21 (NEW).]~~

~~N. Give oral health instruction; [2015, c. 429, §21 (NEW).]~~

~~O~~F. Interview patients and record complete medical and dental histories; [2015, c. 429, §21 (NEW).]

~~P. Irrigate and aspirate the oral cavity; [2015, c. 429, §21 (NEW).]~~

~~Q. Isolate operative fields; [2015, c. 429, §21 (NEW).]~~

~~R~~G. Obtain bacterial sampling when treatment is planned by the dentist; [2015, c. 429, §21 (NEW).]

~~S~~H. Perform all procedures necessary for a complete prophylaxis, including root planing; [2015, c. 429, §21 (NEW).]

~~T. Perform cold vitality testing with confirmation by the dentist; [2015, c. 429, §21 (NEW).]~~

~~U~~I. Perform complete periodontal and dental restorative charting; [2015, c. 429, §21 (NEW).]

~~V. Perform dietary analyses for dental disease control; [2015, c. 429, §21 (NEW).]~~

~~W. Perform electronic vitality scanning with confirmation by the dentist; [2015, c. 429, §21 (NEW).]~~

~~X~~J. Perform oral inspections, recording all conditions that should be called to the attention of the dentist; [2015, c. 429, §21 (NEW).]

~~Y~~K. Perform postoperative irrigation of surgical sites; [2015, c. 429, §21 (NEW).]

~~Z. Perform preliminary selection and fitting of orthodontic bands, as long as final placement and cementing in the patient's mouth are done by the dentist; [2015, c. 429, §21 (NEW).]~~

~~AA. Place and recement temporary crowns with temporary cement; [2015, c. 429, §21 (NEW).]~~

~~BB. Place and recement with temporary cement an existing crown that has fallen out; [2015, c. 429, §21 (NEW).]~~

~~CC~~L. Place and remove gingival retraction cord without vasoconstrictor; [2015, c. 429, §21 (NEW).]

~~DD. Place and remove matrix bands, periodontal dressing, rubber dams and wedges; [2015, c. 429, §21 (NEW).]~~

~~EE. Place elastics or instruct in their use; [2015, c. 429, §21 (NEW).]~~

~~FF. Place, hold or remove celluloid and other plastic strips prior to or subsequent to the placement of a filling by the dentist; [2015, c. 429, §21 (NEW).]~~

~~GG~~M. Place localized delivery of chemotherapeutic agents when treatment is planned by the dentist; [2015, c. 429, §21 (NEW).]

~~HH. Place or remove temporary separating devices; [2015, c. 429, §21 (NEW).]~~

~~II. Place wires, pins and elastic ligatures to tie in orthodontic arch wires that have been fitted and approved by the dentist at the time of insertion; [2015, c. 429, §21 (NEW).]~~

~~JJ. Place temporary restorations as an emergency procedure, as long as the patient is informed of the temporary nature of the restoration; [2015, c. 429, §21 (NEW).]~~

~~KK. Pour and trim dental models; [2015, c. 429, §21 (NEW).]~~

~~LL~~N. Prepare tooth sites and surfaces with a rubber cup and pumice for banding or bonding of orthodontic brackets. This procedure may not be interpreted as a preparation for restorative material; [2015, c. 429, §21 (NEW).]

~~MM. Reapply, on an emergency basis only, orthodontic brackets; [2015, c. 429, §21 (NEW).]~~

~~NN. Remove composite material using slow-speed instrumentation for debonding brackets, as long as the dentist conducts a final check prior to release of the patient; [2015, c. 429, §21 (NEW).]~~

~~OO. Remove excess cement from the supragingival surfaces of teeth; [2015, c. 429, §21 (NEW).]~~

~~PP. Remove orthodontic arch wires and tension devices and any loose bands or bonds, but only as directed by the dentist; [2015, c. 429, §21 (NEW).]~~

~~QQ. Remove sutures; [2015, c. 429, §21 (NEW).]~~

~~RR. Retract lips, cheek, tongue and other tissue parts; [2015, c. 429, §21 (NEW).]~~

~~SS. Select and try in stainless steel or other preformed crowns for insertion by the dentist; [2015, c. 429, §21 (NEW).]~~

~~TT.~~O. Smooth and polish amalgam restorations; [2015, c. 429, §21 (NEW).]

~~UU. Take and record the vital signs of blood pressure, pulse and temperature; [2015, c. 429, §21 (NEW).]~~

~~VV~~P. ~~Take and pour~~Obtain impressions for study casts, athletic mouth guards, custom trays, bleaching trays, fluoride trays, opposing models, retainers and stents; [2015, c. 429, §21 (NEW).]

Q. Perform delegated duties as listed in Section 18371(3).

~~WW. Take dental plaque smears for microscopic inspection and patient education; [2015, c. 429, §21 (NEW).]~~

~~XX. Take intraoral measurements and make preliminary selection of arch wires and intraoral and extraoral appliances, including head gear; and [2015, c. 429, §21 (NEW).]~~

~~YY. Take intraoral photographs. [2015, c. 429, §21 (NEW).]~~

~~[2015, c. 429, §21 (NEW) .]~~

3. **Limitation.** An individual with a faculty dental hygienist license may provide the services described in this section only as part of the education program for which the license was issued by the board.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18375. INDEPENDENT PRACTICE DENTAL HYGIENIST

1. **Scope of practice.** An independent practice dental hygienist may perform only the following duties without supervision by a dentist:

A. Interview patients and record complete medical and dental histories; [2015, c. 429, §21 (NEW).]

B. Take and record the vital signs of blood pressure, pulse and temperature; [2015, c. 429, §21 (NEW).]

C. Perform oral inspections, recording all conditions that should be called to the attention of a dentist; [2015, c. 429, §21 (NEW).]

D. Perform complete periodontal and dental restorative charting; [2015, c. 429, §21 (NEW).]

E. Perform all procedures necessary for a complete prophylaxis, including root planing; [2015, c. 429, §21 (NEW).]

F. Apply fluoride to control caries; [2015, c. 429, §21 (NEW).]

G. Apply desensitizing agents to teeth; [2015, c. 429, §21 (NEW).]

H. Apply topical anesthetics; [2015, c. 429, §21 (NEW).]

I. Apply sealants; [2015, c. 429, §21 (NEW).]

J. Smooth and polish amalgam restorations, limited to slow-speed application only; [2015, c. 429, §21 (NEW).]

~~K. Cement pontics and facings outside of the mouth; [2015, c. 429, §21 (NEW).]~~

~~L~~K. ~~Take~~ Obtain impressions for athletic mouth guards and custom fluoride trays; [2015, c. 429, §21 (NEW).]

~~M~~L. Place and remove rubber dams; [2015, c. 429, §21 (NEW).]

~~N~~M. Place temporary restorations in compliance with the protocol adopted by the board; [2015, c. 429, §21 (NEW).]

~~O~~N. Apply topical antimicrobials, including fluoride but excluding antibiotics, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The independent practice dental hygienist shall follow current manufacturer's instructions in the use of these medicaments; [2015, c. 429, §21 (NEW).]

~~P~~O. Expose and process radiographs, including but not limited to vertical and horizontal bitewing films, periapical films, panoramic images and full-mouth series, under protocols developed by the board as long as the independent practice dental hygienist has a written agreement with a licensed dentist that provides that the dentist is available to interpret all dental radiographs within 21 days from the date the radiograph is taken and that the dentist will sign a radiographic review and findings form; and [2015, c. 429, §21 (NEW).]

~~Q~~P. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse. For the purposes of this paragraph, "topical" includes superficial and intraoral application. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **Practice standards.** An independent practice dental hygienist has the duties and responsibilities set out in this subsection with respect to each patient seen in an independent capacity.

A. Prior to an initial patient visit, an independent practice dental hygienist shall obtain from the patient or the parent or guardian of a minor patient written acknowledgment of the patient's or parent's or guardian's understanding that the independent practice dental hygienist is not a dentist and that the service to be rendered does not constitute restorative care or treatment. [2015, c. 429, §21 (NEW).]

B. An independent practice dental hygienist shall provide to a patient or the parent or guardian of a minor patient a written plan for referral to a dentist for any necessary dental care. The referral plan must identify all conditions that should be called to the attention of the dentist. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18376. PUBLIC HEALTH DENTAL HYGIENIST

1. **Scope of practice.** A public health dental hygienist may perform the following procedures in a public health setting under a supervision agreement with a dentist that outlines the roles and responsibilities of the collaboration:

A. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse; [2015, c. 429, §21 (NEW).]

B. Apply cavity varnish; [2015, c. 429, §21 (NEW).]

C. Apply desensitizing agents to teeth; [2015, c. 429, §21 (NEW).]

D. Apply fluoride to control caries; [2015, c. 429, §21 (NEW).]

E. Apply liquids, pastes or gel topical anesthetics; [2015, c. 429, §21 (NEW).]

F. Apply sealants; [2015, c. 429, §21 (NEW).]

G. Apply topical antimicrobials, including fluoride but excluding antibiotics, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The public health dental hygienist shall follow current manufacturer's instructions in the use of these medicaments. For the purposes of this paragraph, "topical" includes superficial and intramuscular application; [2015, c. 429, §21 (NEW).]

~~H. Cement pontics and facings outside the mouth; [2015, c. 429, §21 (NEW).]~~

~~I~~H. Expose and process radiographs upon written standing prescription orders from a dentist who is available to interpret all dental radiographs within 21 days and who will complete and sign a radiographic review and findings form; [2015, c. 429, §21 (NEW).]

~~J~~I. For instruction purposes, demonstrate to a patient how the patient should place and remove removable prostheses, appliances or retainers; [2015, c. 429, §21 (NEW).]

~~K~~J. For the purposes of eliminating pain or discomfort, remove loose, broken or irritating orthodontic appliances; [2015, c. 429, §21 (NEW).]

~~L.~~K. Give oral health instruction; [2015, c. 429, §21 (NEW).]

~~M~~L. Interview patients and record complete medical and dental histories; [2015, c. 429, §21 (NEW).]

~~N~~M. Irrigate and aspirate the oral cavity; [2015, c. 429, §21 (NEW).]

~~O~~N. Isolate operative fields; [2015, c. 429, §21 (NEW).]

~~P~~O. Perform all procedures necessary for a complete prophylaxis, including root planing; [2015, c. 429, §21 (NEW).]

~~Q~~P. Perform complete periodontal and dental restorative charting; [2015, c. 429, §21 (NEW).]

~~R~~Q. Perform dietary analyses for dental disease control; [2015, c. 429, §21 (NEW).]

~~S~~R. Perform temporary filling procedures without a dentist present under protocols adopted by board rule; [2015, c. 429, §21 (NEW).]

~~T~~S. Perform oral inspections, recording all conditions that should be called to the attention of the dentist; [2015, c. 429, §21 (NEW).]

~~U~~T. Perform pulp tests pursuant to the direction of a dentist; [2015, c. 429, §21 (NEW).]

~~V~~U. Place and remove gingival retraction cord without vasoconstrictor; [2015, c. 429, §21 (NEW).]

~~W~~V. Place and remove matrix bands for purposes of fabricating or placing temporary restorations; [2015, c. 429, §21 (NEW).]

~~X~~W. Place and remove rubber dams; [2015, c. 429, §21 (NEW).]

~~Y~~X. Place and remove wedges for purposes of fabricating or placing temporary restorations; [2015, c. 429, §21 (NEW).]

~~Z~~Y. Place temporary restorations in compliance with the protocol adopted by board rule; [2015, c. 429, §21 (NEW).]

~~AA~~Z. Remove excess cement from the supragingival surfaces of teeth; [2015, c. 429, §21 (NEW).]

~~BB~~AA. Retract lips, cheek, tongue and other tissue parts; [2015, c. 429, §21 (NEW).]

~~CC~~BB. Smooth and polish restorations, limited to slow-speed application only; [2015, c. 429, §21 (NEW).]

~~DD~~CC. Take and record the vital signs of blood pressure, pulse and temperature; [2015, c. 429, §21 (NEW).]

~~EE~~DD. Take dental plaque smears for microscopic inspection and patient education; [2015, c. 429, §21 (NEW).]

~~FF~~EE. ~~Take~~ Obtain impressions for and deliver athletic mouth guards and custom fluoride trays; and [2015, c. 429, §21 (NEW).]

~~GG~~FF. Take intraoral photographs. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18377. DENTAL HYGIENE THERAPIST

1. **Scope of practice.** A dental hygiene therapist may perform the following procedures in limited practice settings, if authorized by a written practice agreement with a dentist licensed in this State pursuant to subsection 3.

A. To the extent permitted in a written practice agreement, a dental hygiene therapist may provide the care and services listed in this paragraph only under the direct supervision of the supervising dentist:

(1) Perform oral health assessments, pulpal disease assessments for primary and young teeth, simple cavity preparations and restorations and simple extractions;

(2) Prepare and place stainless steel crowns and aesthetic anterior crowns for primary incisors and prepare, place and remove space maintainers;

(3) Provide referrals;

(4) Administer local anesthesia and nitrous oxide analgesia;

(5) Perform preventive services;

(6) Conduct urgent management of dental trauma, perform suturing, extract primary teeth and perform nonsurgical extractions of periodontally diseased permanent teeth if authorized in advance by the supervising dentist;

(7) Provide, dispense and administer anti-inflammatories, nonprescription analgesics, antimicrobials, antibiotics and anticaries materials;

(8) Administer radiographs; and

(9) Perform other related services and functions authorized by the supervising dentist and for which the dental hygiene therapist is trained. [2015, c. 429, §21 (NEW).]

B. To the extent permitted in a written practice agreement, a dental hygiene therapist may provide the care and services listed in section 18374, subsections 1 and 2 under the general supervision of the supervising dentist. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **Supervision responsibilities.** A dental hygiene therapist may be delegated a dentist's responsibility to supervise up to 2 dental hygienists and 3 unlicensed persons in any one practice setting through a written practice agreement pursuant to subsection 3.

[2015, c. 429, §21 (NEW) .]

3. **Practice requirements.** A dental hygiene therapist must comply with the following practice limitations.

A. A dental hygiene therapist may provide services only in a hospital; a public school, as defined in Title 20-A, section 1, subsection 24; a nursing facility licensed under Title 22, chapter 405; a residential care facility licensed under Title 22, chapter 1663; a clinic; a health center reimbursed as a federally qualified health center as defined in 42 United States Code, Section 1395x(aa)(4) (1993) or that has been determined by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services to meet the requirements for funding under Section 330 of the Public Health Service Act, 42 United States Code, Section 254(b); a federally qualified health center licensed in this State; a public health setting that serves underserved populations as recognized by the federal Department of Health and Human Services; or a private dental practice in which at least 50% of the patients who are provided services by that dental hygiene therapist are covered by the MaineCare program under Title 22 or are underserved adults. [2015, c. 429, §21 (NEW).]

B. A dental hygiene therapist may practice only under the direct supervision of a dentist through a written practice agreement signed by both parties. A written practice agreement is a signed document that outlines the functions that the dental hygiene therapist is authorized to perform, which may not exceed the scopes of practice specified in subsections 1 and 2. A dental hygiene therapist may practice only under the standing order of the supervising dentist, may provide only care that follows written protocols and may provide only services that the dental hygiene therapist is authorized to provide by the written practice agreement. [2015, c. 429, §21 (NEW).]

C. A written practice agreement between a supervising dentist and a dental hygiene therapist must include the following elements:

(1) The services and procedures and the practice settings for those services and procedures that the dental hygiene therapist may provide, together with any limitations on those services and procedures;

(2) Any age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;

(3) Procedures to be used with patients treated by the dental hygiene therapist for obtaining informed consent and for creating and maintaining dental records;

(4) A plan for review of patient records by the supervising dentist and the dental hygiene therapist;

(5) A plan for managing medical emergencies in each practice setting in which the dental hygiene therapist provides care;

(6) A quality assurance plan for monitoring care, including patient care review, referral follow-up and a quality assurance chart review;

(7) Protocols for administering and dispensing medications, including the specific circumstances under which medications may be administered and dispensed;

(8) Criteria for providing care to patients with specific medical conditions or complex medical histories, including requirements for consultation prior to initiating care; and

(9) Specific written protocols, including a plan for providing clinical resources and referrals, governing situations in which the patient requires treatment that exceeds the scope of practice or capabilities of the dental hygiene therapist. [2015, c. 429, §21 (NEW).]

D. Revisions to a written practice agreement must be documented in a new written practice agreement signed by the supervising dentist and the dental hygiene therapist. [2015, c. 429, §21 (NEW).]

E. A dental hygiene therapist shall file a copy of a written practice agreement with the board, keep a copy for the dental hygiene therapist's own records and make a copy available to patients of the dental hygiene therapist upon request. [2015, c. 429, §21 (NEW).]

F. A dental hygiene therapist shall refer patients in accordance with a written practice agreement to another qualified dental or health care professional to receive needed services that exceed the scope of practice of the dental hygiene therapist. [2015, c. 429, §21 (NEW).]

G. A dental hygiene therapist who provides services or procedures beyond those authorized in a written agreement engages in unprofessional conduct and is subject to discipline pursuant to section 18325. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

4. Dental coverage and reimbursement. Notwithstanding Title 24-A, section 2752, any service performed by a dentist, dental assistant or dental hygienist licensed in this State that is reimbursed by private insurance, a dental service corporation, the MaineCare program under Title 22 or the Cub Care program under Title 22, section 3174-T must also be covered and reimbursed when performed by a dental hygiene therapist authorized to practice under this chapter.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18378. DENTURIST

1. Scope of practice. A denturist and faculty denturist may:

A. ~~Take~~ Obtain denture impressions and bite registrations for the purpose of or with a view to the making, producing, reproducing, construction, finishing, supplying, altering or repairing a denture to be fitted to an edentulous or partially edentulous arch or arches; [2015, c. 429, §21 (NEW).]

B. Fit a denture to an edentulous or partially edentulous arch or arches, including by making, producing, reproducing, constructing, finishing, supplying, altering or repairing dentures without performing alteration to natural or reconstructed tooth structure. A denturist may perform clinical procedures related to the fabrication of a removable tooth-borne partial denture, including cast frameworks; [2015, c. 429, §21 (NEW).]

C. Perform procedures incidental to the procedures specified in paragraphs A and B, as specified by board rule; and [2015, c. 429, §21 (NEW).]

D. Make, place, construct, alter, reproduce or repair nonorthodontic removable sports mouth guards and provide teeth whitening services, including by fabricating whitening trays, providing whitening solutions determined to be safe for public use and providing any required follow-up care and instructions for use of the trays and solutions at home. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Limitation. An individual with a faculty denturist license may provide the services described in this section only as part of the education program for which the license was issued by the board.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18379. SEDATION AND GENERAL ANESTHESIA PERMITS

The board shall adopt by rule the qualifications a dentist must have to obtain a permit from the board authorizing the administration of sedation and general anesthesia. The board shall also adopt the guidelines

for such administration, including but not limited to practice setting requirements. [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

Subchapter 5: PRACTICE STANDARDS

§18391. AMALGAM BROCHURES; POSTERS

1. **Brochure; poster.** The Director of the Bureau of Health within the Department of Health and Human Services shall develop a brochure that explains the potential advantages and disadvantages to oral health, overall human health and the environment of using mercury or mercury amalgam in dental procedures. The brochure must describe what alternatives are available to mercury amalgam in various dental procedures and what potential advantages and disadvantages are posed by the use of those alternatives. The brochure may also include other information that contributes to the patient's ability to make an informed decision when choosing between the use of mercury amalgam or an alternative material in a dental procedure, including, but not limited to, information on the durability, cost, aesthetic quality or other characteristics of the mercury amalgam and alternative materials. The director shall also develop a poster that informs patients of the availability of the brochure.

The Director of the Bureau of Health shall, in consultation with the Department of Environmental Protection, adopt the brochure and the poster described in this subsection through major substantive rules pursuant to Title 5, chapter 375, subchapter 2-A.

[2015, c. 429, §21 (NEW) .]

2. **Display.** A dentist who uses mercury or a mercury amalgam in any dental procedure shall display the poster adopted by the Department of Health and Human Services, Bureau of Health under this section in the public waiting area of the practice setting and shall provide each patient a copy of the brochure adopted by the bureau under this section. The Department of Health and Human Services shall also post on its publicly accessible website a copy of the brochure that is suitable for downloading and printing by dentists, patients and other interested parties.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18392. REMOVABLE DENTAL PROSTHESIS; OWNER IDENTIFICATION

1. **Identification required.** Every complete upper and lower denture and removable dental prosthesis fabricated by a dentist or denturist, or fabricated pursuant to the dentist's or denturist's work order or under the dentist's or denturist's direction or supervision, must be marked with the name and social security number of the patient for whom the prosthesis is intended. The markings must be made during fabrication and must be permanent, legible and cosmetically acceptable. The exact location of the markings and the methods used to apply or implant the markings must be determined by the dentist or dental laboratory fabricating the prosthesis. If, in the professional judgment of the dentist or dental laboratory, this identification is not practical, identification must be provided as follows:

A. The social security number of the patient may be omitted if the name of the patient is shown; [2015, c. 429, §21 (NEW).]

B. The initials of the patient may be shown alone, if use of the name of the patient is impracticable; or [2015, c. 429, §21 (NEW).]

C. The identification marks may be omitted in their entirety if none of the forms of identification specified in paragraphs A and B are practicable or clinically safe. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **Applicability.** A removable dental prosthesis in existence prior to September 23, 1983 that was not marked in accordance with subsection 1 at the time of its fabrication must be marked in accordance with subsection 1 at the time of a subsequent rebasing.

[2015, c. 429, §21 (NEW) .]

3. **Violation.** Failure of a dentist or denturist to comply with this section constitutes grounds for discipline pursuant to section 18325, as long as the dentist or denturist is charged with the violation within 2 years of initial insertion of the dental prosthetic device.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18393. CONFIDENTIALITY

1. **Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Confidential communication" means a communication not intended to be disclosed to 3rd persons other than those present to further the interest of the patient in the consultation, examination or interview or persons who are participating in the diagnosis and treatment under the direction of the dentist, including members of the patient's family. [2015, c. 429, §21 (NEW).]

B. "Patient" means a person who consults or is examined or interviewed by a dentist or dental auxiliary. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. **General rule of privilege.** A patient has a privilege to refuse to disclose and to prevent another person from disclosing confidential communications made for the purpose of diagnosis or treatment of the patient's physical, mental or emotional conditions, including alcohol or drug addiction, among the patient, the patient's dentist and persons who are participating in the diagnosis or treatment under the direction of the dentist, including members of the patient's family.

[2015, c. 429, §21 (NEW) .]

3. **Who may claim the privilege.** The privilege under subsection 2 may be claimed by the patient, by the patient's guardian or conservator or by the personal representative of a deceased patient. The dentist or dental auxiliary at the time of the communication is presumed to have authority to claim the privilege, but only on behalf of the patient.

[2015, c. 429, §21 (NEW) .]

4. **Exceptions.** Notwithstanding any other provision of law, the following are exceptions to the privilege under subsection 2.

A. If the court orders an examination of the physical, mental or emotional condition of a patient, whether a party or a witness, communications made in the course of the examination are not privileged under this

section with respect to the particular purpose for which the examination is ordered unless the court orders otherwise. [2015, c. 429, §21 (NEW).]

B. There is not any privilege under this section as to communications relevant to an issue of the physical, mental or emotional condition of a patient in a proceeding in which the condition of the patient is an element of the claim or defense of the patient or of a party claiming through or under the patient or because of the patient's condition or claiming as a beneficiary of the patient through a contract to which the patient is or was a party or, after the patient's death, in a proceeding in which a party puts the condition in issue. [2015, c. 429, §21 (NEW).]

C. There is not any privilege under this section as to information regarding a patient that is sought by the Chief Medical Examiner or the Chief Medical Examiner's designee in a medical examiner case, as defined by Title 22, section 3025, in which the Chief Medical Examiner or the Chief Medical Examiner's designee has reason to believe that information relating to dental treatment may assist in determining the identity of a deceased person. [2015, c. 429, §21 (NEW).]

D. There is not any privilege under this section as to disclosure of information concerning a patient when that disclosure is required by law, and nothing in this section may modify or affect the provisions of Title 22, sections 4011-A to 4015 and Title 29-A, section 2405. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

PROPOSED CHANGES TO RDH SCOPE OF PRACTICE 32 MRS § 18374

APRIL 28, 2017

This document references clinical standards as identified in the American Dental Hygienists' Association's "Standards for Clinical Dental Hygiene Practice" 2016.

A. Assessment:

Health history: obtain a health history assessment for the purpose of collecting data verifies key elements of health status. Such data may include, but is not limited to demographics, vital signs, physical characteristics, social history, medical history, and pharmacologic history.

Clinical assessment – conduct a thorough and systematic observation to include an inspection of the head and neck and oral cavity including an oral cancer screening, documentation of normal or abnormal findings, and assessment of the temporomandibular function. Assessments include but are not limited to a current, complete and diagnostic set of radiographs for a comprehensive dental and periodontal examination, complete a full-mouth periodontal charting, a comprehensive hard-tissue evaluation that includes the charting of existing conditions and oral habits, and radiographs that supplement the data. Conduct a risk assessment to identify risks to general and oral health and to help develop and design strategies for preventing or limiting disease and promoting health.

B. Interpretation of Assessment

Interpretation of assessment is the identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. This requires evidence-based critical analysis and interpretation of assessments in order to reach conclusions about the patient's dental hygiene treatment needs. The interpretation of assessment provides the basis for the dental hygiene care plan.

The formulation of a care plan focuses on dental hygiene education, patient self-care practices, prevention strategies, and treatment and evaluation protocols to focus on patient or community oral health needs. Analyzing and interpreting all data, formulating dental hygiene plan, communicating the plan with patients, determining patient needs that can be improved through dental hygiene care, and identifying referrals are all necessary steps when interpreting patient assessments.

C. Planning:

1. The dental hygiene care plan should be a vehicle for care that is safe, evidence-based, clinically sound, high-quality, and equitable. The plan should be personalized according to the individual's unique oral health needs, general health status, values, expectations, and abilities. When formulating the plan, dental hygienists should be sensitive and responsive to the patient's culture, age, gender, language, and learning style. They should demonstrate respect and compassion for individual patient choices and priorities.

D. Implementation:

1. A dental hygiene care plan may be implemented in one preventive/wellness visit or several therapeutic visits before a continuing or maintenance plan is established. Health promotion and self-care are integral aspects of the care plan that should be customized and implemented according to patient interest and ability.

2. General supervision. A dental hygienist shall practice under the general supervision of a dentist. Examples of dental hygiene practice requiring general supervision include, but are not limited to:

i. Performing a prophylaxis including complete removal of hard, soft deposits, , cement, and stains by scaling, polishing, and perform root planing and periodontal debridement procedures;
ii. Applies agents: locally delivered chemotherapeutic agents such as desensitizing agents, topical anesthetics, topical antimicrobials, irrigation, and fluorides;
iii. Places dental sealants;
iv. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse; and
v. Expose and process dental radiographs.

3. Direct supervision. A dental hygienist shall practice under the direct supervision of a dentist when administering local anesthesia or nitrous oxide analgesia, as long as the dental hygienist has obtained the authority to administer the relevant medication pursuant to section 18345, subsection 2, paragraph D or E.

E. Evaluation

1. Evaluation is the measurement of the extent to which the patient has achieved the goals specified in the dental hygiene care plan. The dental hygienist uses evidence-based decisions to continue, discontinue, or modify the care plan based on the ongoing reassessments and subsequent diagnoses. The evaluation process includes reviewing and interpreting the results of the dental hygiene care provided and may include outcome measures that are physiologic (improved health), functional, and psychosocial (quality of life, improved patient perception of care). Evaluation occurs throughout the process as well as at the completion of care.