DEPARTMENT OF
Professional & Financial Regulation
STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF LICENSING AND REGISTRATION

Report of the Commissioner of Professional and Financial Regulation

To the

Joint Standing Committee on
Business, Research and Economic Development

Sunrise Review of Oral Health Care Issues

Submitted Pursuant to Resolve 2007, Ch. 85

February 15, 2008

Sunrise Review of Oral Health Care Issues

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Sunrise Review of Oral Health Care Issues
submitted to
Joint Standing Committee on Business, Research and Economic Development
by
Commissioner of Professional and Financial Regulation

I. *Introduction*

Four legislative proposals relating to the practice of dental hygiene, denturism and dental practice received public hearings before the Joint Standing Committee on Business, Research and Economic Development during the First Regular Session of the 123rd Maine Legislature.

LD 1246 proposed to expand the scope of practice of dental hygienists by creating a mid-level dental hygienist license category; **LD 550** proposed to allow dental hygienists to practice independently without supervision of licensed dentists; **LD 1472** proposed to establish a new licensing board within the Department of Professional and Financial Regulation for denturists which would operate separately from the Maine Board of Dental Examiners; and **LD 1129** proposed to allow dental graduates of foreign universities that are not accredited to become licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners.

Each proposal would either expand an existing scope of practice or otherwise make changes to the regulatory program of the Board of Dental Examiners. Because each bill would trigger the sunrise review requirement of 5 MRSA § 12015, the Committee converted LD 1129 to a resolve directing the Department of Professional and Financial Regulation to conduct an independent assessment of the four concepts described above and submit a consolidated sunrise report to the Committee by February 15, 2008 with recommendations and proposed legislation, if necessary.

The resolve was enacted as Resolve **2007, chapter 85**.[1] This report reflects the independent assessment of the Department as to whether the health, welfare and safety of Maine citizens warrant significant revisions to the practice of dentistry and oral health, as well as the regulation of the profession as a whole.

II. *Sunrise Review*

Pursuant to 5 MRSA § 12015(3), "sunrise review" must be undertaken whenever proposed legislation would license or otherwise regulate an occupation or profession that is not currently regulated in order to determine whether such regulation is necessary to protect the health, safety and welfare of the public.

[1] Copy of R. 2007, ch. 85 attached as Appendix A.

Sunrise review is a tool for state policymakers to systematically assess proposals to expand the scope of practice of a regulated profession or establish new regulatory requirements for a previously unregulated profession. The purpose of sunrise review is to analyze whether the proposed regulation is necessary to protect the health, safety and welfare of the public.

A sunrise review also seeks to identify the potential impact of the proposed regulation on the availability and cost of services to consumers. The rationale underlying the requirement for sunrise review is that the State of Maine should impose only the minimum level of regulation necessary to ensure public health and safety. Regulation should not be used for economic purposes to create unnecessary barriers of entry to a profession that could limit access to services or increase their cost. The Department's conclusion in each sunrise review study is an attempt to balance the competing demands of maximum access, minimizing cost and adequately protecting public health, safety and welfare.

Under Maine law, the sunrise review process may be conducted in one of three ways:

1. The Joint Standing Committee of the Legislature considering the proposed legislation may hold a public hearing to accept information addressing the sunrise review evaluation criteria;

2. The Committee may request the Commissioner of Professional and Financial Regulation to conduct an independent assessment of the applicant's answers to the evaluation criteria and report those findings back to the Committee; or

3. The Committee may request that the Commissioner establish a technical review committee to assess the applicant's answers and report its finding to the commissioner.

Copies of 5 MRSA § 12015(3) and a summary of the sunrise review process are included in Appendix B.

III. *Charge from the Joint Standing Committee on Business, Research and Economic Development*

Public Law 2007, chapter 85, requires the Commissioner of the Department of Professional and Financial Regulation to conduct an independent assessment pursuant to the provisions of 32 MRSA § 60-K, of the proposals to expand existing state regulation or establish new state regulation of the practice of dental care. This report documents the methodology of the Commissioner's assessment and includes recommendations for consideration by the Joint Standing Committee on Business, Research and Economic Development during the 123rd Legislature.

IV. *Independent Assessment by Commissioner*

The requirements for an independent assessment by the Commissioner are set forth in 32 MRSA § 60-K. The Commissioner is required to apply the specified evaluation criteria set forth in 32 MRSA § 60-J to all answers and information submitted to, or collected by, the Commissioner. After conducting the independent assessment, the Commissioner must submit a report to the Committee setting forth recommendations, including any draft legislation necessary to implement the report's recommendations.

The Commissioner's report to the Joint Standing Committee on Business, Research and Economic Development must contain an assessment of whether responses in support of the proposed regulation are sufficient to support some form of regulation. In addition, if there is sufficient justification for regulation, the report must recommend an agency of State government to be responsible for the regulation and the level of regulation to be assigned to the applicant group. Finally, the report must reflect the least restrictive method of regulation consistent with the public interest.

The Process

To begin the assessment process, the Department forwarded a sunrise survey instrument to applicant groups as well as other organizations and individuals that provided testimony on one or more of the four previously described legislative proposals during public hearings held on April 13, 2007 by the Business, Research and Economic Development Committee. Survey responses are attached as Appendix C, and may be accessed on the Department's website at http://www.maine.gov/pfr/legislative/index.htm.

The responses received from the applicant groups and interested parties were reviewed by the Acting Commissioner and other staff of the Department, and a series of additional questions was developed.

The Department's analysis tracks the evaluation criteria set forth in 32 MRSA § 60-J, and is presented in this report as follows:

1. The evaluation criteria, as set forth in statute;

2. A summary of responses received from the applicant group and interested parties; and

3. The Department's assessment of the response to the evaluation criteria.

The Applicant Groups

The independent assessment process requires the Commissioner to review and evaluate responses to the criteria submitted by the applicant group and interested parties. In this study, the applicant group includes the following organizations and individuals involved in the provision of dental and oral health care:

- **Maine Dental Hygienist Association** (MDHA) has 169 dental hygienist members in Maine. It was founded in 1926, and its stated mission is to: "improve the public's total health, the mission of the Maine Dental Hygienist's Association is to advance the art and science of dental hygiene by ensuring access to quality oral health care, increasing awareness of the cost-effective benefits of prevention, promoting the highest standards of dental hygiene education, licensure, practice and research, and representing and promoting the interests of dental hygienists."

- **Maine Dental Association** (MDA) is a professional membership organization of licensed dentists founded in 1867 whose stated mission is to "provide representation, information and other services for the dentist members and, through the dentist members, promote the health and welfare of the people of the State of Maine." MDA has 590 practicing members (dentists) and 133 retired members as of the end of 2007.

- **Maine Society of Denturists** (MSD)

- **National Association of Denturists**

- **International Federation of Denturists**

- **Maine Primary Care Association** (MPCA) was established over 25 years ago to strengthen and sustain Maine's Primary Care Safety Net. The Association includes Federally Qualified Health Centers (FQHCs) and Indian Health Centers which provide high quality primary care to underserved areas and underserved populations of the State where healthcare options are limited, and barriers to access would otherwise prevent the delivery of care. MPCA also has a number of affiliate members; these are generally community-based agencies that provide some but not all of the health services that are required for FQHCs.

- **Maine Board of Dental Examiners** (MBODE)

- **Maine Center for Disease Control,** Department of Health and Human Services (MCDC/DHHS)

- **Joan Davis**, Registered Dental Hygienist

- **Catherine J. Kasprak**, Registered Dental Hygienist

- **Stephen Mills**, DDS, specializing in pediatric dental care

- **Jane Walsh**, J.D., RDH, Assistant Professor, University of New England, Dental Hygiene Program

V. *Legislative History of Dental Practice Laws/Current Regulatory Environment in Maine*

The Board of Dental Examiners was established in 1891 by the Maine Legislature to protect the health, safety and welfare of Maine citizens through regulation of licensed dentists and the practice of dentistry. In 1917, the Legislature amended the law to permit dentists to employ "dental hygienists" to assist them in their individual practices. Educational qualifications for licensure, an annual renewal requirement and renewal fee for dental hygienists were added to the law in 1929 and, in 1964, the Legislature enacted Revised Statutes of 1964 in which dental hygiene licensure provisions were recodified within the overall dentistry law. Several subsequent recodifications of the dental practice law that affected licensed dental hygienists have been enacted by the Legislature since 1964, including a statutory amendment in 1965 which removed the restriction limiting license eligibility for dental hygienists to females.

In 1977, the Legislature enacted a legislative proposal to add licensure of denturists to the regulatory structure of the Board of Dental Examiners.

In 2003, as a result of State Government Evaluation Act review of the Board of Dental Examiners, the Legislature amended the law to create a Subcommittee on Dental Hygienist Submissions within the Board of Dental Examiners. The subcommittee was granted authority to conduct initial review of applications for dental hygiene licensure, continuing education submissions and submissions (subsequently changed to notifications) for public health supervision status of dental hygienists. The subcommittee has five members (one dental hygienist board member, two licensed dental hygienists who are not board members and two dentist board members). Its recommendations can be overruled only by a 2/3 vote of Board members present and voting.

At the same time, the Legislature also created within the Board a Subcommittee on Denturist Discipline. This subcommittee, comprised of one denturist board member, one dentist board member and two licensed denturists who are not board members, has authority to review all complaints filed against licensed denturists. The Board of Dental Examiners must accept the recommended disposition of the denturist subcommittee unless 2/3 of Board members present and voting reject the recommendation.

VI. *The Proposals*

A. Proposal to Create a New Pathway to Licensure for Foreign-Trained Applicants for Dentist Licensure

LD 1129 proposed that the Maine Board of Dental Examiners establish a mechanism for evaluating non-accredited foreign dental schools so that foreign-trained and educated applicants could more quickly become licensed in Maine. The intent of the proposal was

to increase the number of licensed dentists who can practice in Maine, thus addressing, to some extent, the shortage of licensed dentists that Maine and many other states are experiencing. The proposal at issue would have the effect of creating a new Dental Board function that would require a new level of specialized staff and significantly higher level of Board financial resources to conduct evaluations of programs in countries outside the United States.

Current Maine law provides that to qualify for a dentist license, "*a person must be at least 18 years of age and must be a graduate of or have a diploma from a dental college, school or dental department of a university accredited by an agency approved by the board*." (32 MRSA § 1082). The accrediting agency approved by the Board is the American Dental Association's Commission on Dental Accreditation (CODA). CODA accredits dental educational institutions in the United States and Canada. CODA "is a peer review mechanism that includes the involvement of members of the discipline, the broad educational community, employers, practitioners, the dental licensing community and public members. All of these groups participate in a process designed to ensure educational quality."

Applicants for licensure in Maine who have *not* graduated from a CODA-accredited dental institution are required to complete a two-year equivalency program at a CODA-accredited dental program. The Board has provided information indicating that between 2003 and 2007 it has licensed 16 foreign-educated applicants, all of whom completed the required two-year academic program designed to ensure that applicants have received the level of education and clinical training provided by CODA-accredited dental programs in the United States and Canada. (Appendix D)

Only two states, California and Minnesota, have enacted laws that require their state dental board to license graduates of foreign dental programs by "accrediting" non-US dental programs. California has only approved one non-US program, the University De LaSalle in Leon, Guanajuato, Mexico. Minnesota's law has been in place for six years and is now the subject of a bill to repeal this directive at the request of the Minnesota Dental Board.

Proponents:

The **Maine Primary Care Association** (MPCA) is the strongest proponent of the proposal to require the Board of Dental Examiners to create a new mechanism for evaluating the qualifications of dentists trained in foreign countries for the specific purpose of increasing the number of dentists serving in our State. The MPCA represents Maine's Federally Qualified Health Centers and is, therefore, in a position to observe the impact of a shortage of licensed dentists in Maine. In its response to the sunrise survey, the MPCA asserts that if an evaluation mechanism for non-US dental programs were in place, up to six additional dentists could have been licensed by the Board and would now be practicing in Maine.

Other responders were generally supportive of the concept of easing the current licensure requirements for foreign-trained dentists by allowing applicants from non-CODA approved programs to sit for the North East Regional Board examination but only if patient care and public safety were not compromised as a result.

Information about the British dental licensing system was submitted by the **Maine Society of Denturists**. The General Dental Council (GDC) is the organization that licenses and regulates all practicing dentists in the United Kingdom. GDC is the national equivalent of the US state-by-state licensing system which has developed a process for evaluating "overseas" or foreign-trained dentists.

GDC has established a two-day clinical examination called the *Overseas Registration Examination* (ORE) which serves as the basis of its evaluation process. The ORE tests the clinical skills and knowledge of dentists from outside the Eastern European Area whose qualifications are not recognized for full registration (licensure) by the General Dental Council. Candidates are tested against the standard expected of graduate dentists which means that UK graduates and overseas dentists are expected to have the same basic level of knowledge and skills. The examination is based on the UK dental curriculum and uses modern assessment methods to ensure a consistent examination. Dentists who pass the ORE become eligible to apply for full registration to practice in the UK. For additional information about this regulatory process, please visit http://www.gdc-uk.org/Potential+registrant/Examination+for+Overseas+Qualified+Dentists.

The **Maine Dental Hygienists Association** generally supports any proposal to increase the number of licensed dentists in Maine "as long as these providers adhere to the same standards of care as regimented by the curriculum of comparable professionals in this country."

Jane Walsh on behalf of the **University of New England** generally supports any proposal that "respects an accreditation process that requires a minimum level of competency to maintain our standard of care."

Catherine J. Kasprak, a registered public health dental hygienist, supports the concept of loosening current requirements for foreign trained dentists and suggests requiring them to "follow guidelines for out-of-state dentists to become licensed in Maine."

A representative for the **Maine Center for Disease Control** within the Department of Health and Human Services noted that although the agency would be supportive of the proposal because "it would facilitate the employment of foreign-trained dentists in federally qualified health centers, in private non-profit dental centers, by other dentists in private practice and eventually . . . [in]self-employment [as] independently practicing dentists," the agency would, however, be concerned about whether an adequate evaluation process of foreign training could be developed.

Opponents:

The **Maine Board of Dental Examiners** and the **Maine Dental Association** oppose the concept of requiring the Board to, in effect; become an accrediting organization for non-CODA accredited dental programs. The Board cites the success of the current process by which U.S. and Canadian dental programs are accredited by ADA-CODA and the availability of two-year completion programs that graduates of non-CODA accredited dental programs can readily access. The Board asserts that these completion programs are "an extension of their education at a CODA approved dental program that ensures that their training, education and clinical skills meet the minimum standards required of all US and Canadian educated candidates for licensure."

The Maine Dental Association strongly opposes the concept of creating a new pathway to licensure for foreign-trained dentists for the same reason, but also cites the great variation in the quality of dental education programs in foreign countries as compared to dental programs in the US and Canada. It also cautions that it has serious doubts that the Maine Board of Dental Examiners has "the expertise or resources to take on this huge task." The Association indicates that "CODA is now offering its accreditation review to any foreign dental school that wishes to apply and go through the process."

***Department Assessment*:**

As noted previously, the purpose of sunrise review is to determine whether a proposed change in regulation is required to safeguard the public health and welfare against harm. The Department must analyze the impact on public health and welfare of creating a new, potentially less stringent licensing mechanism or standard for graduates of foreign dental educational institutions than is used to measure the qualifications of graduates of CODA-accredited dental programs.

There is no question that the current number of licensed dentists practicing in Maine is not adequate to meet the demand for dental care in all areas of the State. Furthermore, studies indicate that within the next three to five years retiring Maine dentists will not be replaced by new licensees at the same pace.

Other significant factors that the Department considered include:

- availability and accessibility of two-year dental education completion programs at CODA-accredited dental school programs in the US, two of which are located in Massachusetts;

- experience of the two states that have undertaken a state-supported accreditation process for foreign dental educational institutions (California and Minnesota);

- number of foreign trained applicants licensed in Maine since 2003 using the Board-approved CODA accreditation process; and

- cost that would be incurred by the Board to construct its own CODA-like accreditation program to evaluate the quality of foreign dental education programs.

These factors are addressed below:

Information provided by the Board of Dental Examiners indicates that between January 2003 and August 2007, applications from sixteen (16) foreign trained and educated applicants for dental licensure were received, evaluated and approved. All sixteen applicants received dental licenses. Of those, four applicants attended a two-year completion program at Tufts University in Boston, ten completed a program at Boston University, one completed the University of the Pacific program and another completed the University of British Columbia program in Canada.

Of these sixteen original applicants, five have either allowed their Maine licenses to lapse or have withdrawn from the Maine licensure pool voluntarily. The Board also provided anecdotal information indicating that some of the applicants themselves recognized that their level of education and clinical experience in their home countries was not of the same caliber as that of CODA-accredited dental education programs and benefited greatly from the two-year completion program that the Board requires.

A review of the statutes and experiences of other states that have addressed licensure of international dental graduates is instructive; particularly the statutes of California and Minnesota, two states that currently require their dental board to evaluate and license foreign dental graduates.

California Experience: In the mid-1970's, the California Legislature created a new pathway to state dental licensure for graduates of foreign dental programs. Foreign graduates were required to take and pass an exam called the "Restorative Techniques (RT) Examination." If the applicant passed the RT exam, he or she could then take the state licensure examination without any additional coursework at a CODA-accredited institution. Over time, the RT exam route to licensure fell into disfavor after complaints about varying skill levels of foreign trained California dentists were reported to the California Dental Board. A sunset date was attached to the use of the RT exam, but as that date approached the California Dental Board's financial situation became unstable and the board was unable to offer foreign graduates the required number of re-examinations required by law. (Each individual was given three attempts to pass the exam.)

The sunset date for taking the RT exam has been extended to December 31, 2008, but access to the exam is limited to applicants who have met all applicable license requirements including passage of the National Board Exam. The California Dental Board has accredited only one international dental school, the Universidad De La Salle Bajio, located in Leon, Mexico.

Minnesota Experience: In 2001, the Minnesota Legislature enacted a law that required its state dental board to create an accreditation process for foreign dental programs in an

effort to increase the number of practicing dentists in that state. After six years of experience attempting to act as an accrediting agency for foreign dental programs, the Minnesota Board recently announced that it no longer has confidence in its ability to ensure that only competent foreign-educated and trained dentists are licensed in Minnesota and more important, that it has not ensured that applicants who are not competent have been denied licenses as a result of the board's program. The Minnesota Board has now asked the Minnesota Legislature to relieve it of the responsibility for evaluating foreign dental programs in the interest of public safety. The Minnesota Board has submitted a legislative proposal to repeal the section of law that requires it to evaluate and license foreign dental graduates.

Other States: The majority of states, including Maine, require foreign dental graduates to complete a two-year course of study at a CODA-accredited dental school, among other requirements, in order to be considered eligible for a dental license. The two-year completion program requirement has served states well in their efforts to ensure that all applicants for a dentist license are measured against one standard of competency. There is little question that the American Dental Association's Commission on Dental Accreditation offers states an efficient and cost effective way to safeguard the health and welfare of their citizens and protect against substandard dental care.

Although the cost of developing a stand-alone accrediting system for foreign dental grads has not been specifically quantified for purposes of this report, the Department believes a Maine accreditation process would be prohibitively expensive and time-consuming. The Department concludes that the existing approach to licensure for foreign dental graduates is a reasonable and workable method of ensuring that foreign dental graduates are licensed by the Maine Board of Dental Examiners only after they have received the benefit of an additional two years of dental education and clinical training at a CODA-approved dental school.

New information provided by the American Dental Association indicates that the ADA's Commission on Dental Accreditation now offers accreditation services to foreign institutions that wish to assist their graduates in achieving licensure in the United States. The foreign institution may choose to receive an independent assessment which will allow them to benchmark to US programs, or full accreditation. As of this date, twelve foreign nations have indicated significant interest in this process. Like US dental programs accredited by CODA, foreign institutions seeking CODA accreditation would be required to pay the costs associated with either type of review.

Given the current economic environment in Maine and the other factors considered here, the Department believes the perceived benefit of a minimal increase in the number of licensed dentists in Maine that such a program might produce is greatly outweighed by the cost and liability to the Board of Dental Examiners if it were directed by the Legislature to undertake a state-supported accreditation process for foreign dental programs.

Based on the analysis above, the Department considers the current process used by the Maine Board of Dental Examiners to license foreign-trained dental graduates to be appropriate to ensure public protection and recommends that no change in the process be made.

B. Proposal to establish a new licensing entity to regulate denturists and dental hygienists

LD 1472 proposed to establish a new licensing entity, separate from the Board of Dental Examiners, to license and regulate denturists. The proposal would make the regulation of denturists the statutory responsibility of the Board of Complementary Health Care Providers, which currently has regulatory authority over acupuncturists and naturopathic doctors.

A similar proposal has been made by the **Maine Regulatory Fairness Board**. In its 2007 Annual Report, the Regulatory Fairness Board strongly recommended that the Legislature establish a new Board of Associated Dental Professions whose responsibility would be to regulate denturists and dental hygienists. The stated rationale for this recommendation relates to what the Regulatory Fairness Board refers to as "discord between the various dental professions that has gone on for several years." (2007 Annual Report, Maine Regulatory Fairness Board, p. 1)

As noted in the introduction, the Board of Dental Examiners was established in 1891 to license and regulate the conduct of dentists. Licensure provisions for dental hygienists were added to the Board's responsibilities in 1917 and in 1977, provisions authorizing the Board to license denturists were enacted.

In 2003, the Joint Standing Committee on Business, Research and Economic Development held public hearings on the Board of Dental Examiners' **State Government Evaluation Act Report**. Denturists and dental hygienists testified that they had experienced mistreatment by the Board, both individually and collectively, and further that the concerns of dental hygienists and denturists did not receive appropriate Board attention. The BRED Committee addressed this issue by proposing legislation to create two subcommittees within the Board structure. These subcommittees were designed to facilitate communication and a better working relationship among the three groups of licensees within the Board and to provide both denturists and dental hygienists with a more direct voice in Board decision-making with respect to these two components of dental care.

As of January 10, 2008, the Maine Board of Dental Examiners reported that there are 658 dentists, 836 dental hygienists, and 15 denturists licensed and actively practicing in Maine.

Proponents:

The **Maine Society of Denturists**, the **National Association of Denturists** and the **International Federation of Denturists** are solidly in support of a licensing entity distinct from the Board of Dental Examiners that would be responsible for licensing and regulating denturists. The reason most often cited for changing the current regulatory framework is that dentists are in direct competition with denturists for patients and therefore, the current regulatory structure is not equitable and impartial to denturists. Following this rationale, proponents of a separate licensing entity feel that dentists cannot be impartial because they are in a position of authority as employers of denturists.

Second, proponents assert that a separate board is required because, currently, the dentists on the Board control the decision-making process with regard to the scope of practice for denturists. Third, proponents contend that because the Commission on Dental Accreditation does not accredit denturism educational institutions or programs, denturism in Maine is not permitted to expand to provide lower cost dental care to underserved populations. Finally, proponents assert that denturists have no voice in determining the required curriculum for denturism programs and therefore, a new regulatory structure is required.

The **Maine Association of Dental Hygienists** and two registered dental hygienists (**Joan Davis and Catherine Kasprak**) also support the concept of separating regulation of dental hygienists from the regulation of dentists. The Association asserts that the Board does not keep pace with the dental access needs of Maine people. Citing the 2007 Annual Report of the Regulatory Fairness Board, the Association agrees with the assessment that the current regulatory structure is ineffective because of discord between dental professionals which prevents resolution of on-going problems. Finally, the Association contends that dental hygienists fear retaliation from their dentist employers if they report what they view as unprofessional conduct to the Board.

Similarly, the **University of New England** supports the creation of a separate licensing board to regulate dental hygienists particularly because new issues related to the concept of a mid-level dental hygiene practitioner will cause the current heavy workload of the Board to increase even further. UNE, however, does not support a combined licensing board to regulate both denturists and dental hygienists because the focus, technical skills and practices of these two groups are different.

Opponents:

The **Maine Dental Association** (MDA) opposes the establishment of additional licensing entities because it believes all dental practitioners, regardless of the specific focus of dental care, should be regulated by a single licensing entity. Further, the MDA asserts that creating separate licensing boards for different groups of professionals involved in providing dental care would confuse the public, cause more expense for the State and not result in public benefit.

The **Maine Board of Dental Examiners** (MBODE) similarly opposes the establishment of one or more additional licensing boards, pointing out that dental hygienists are not trained in denturism and conversely, denturists are not trained in prevention, so rather than resolving issues, this arrangement would actually create more challenges including conflicts of interest. Ultimately, however, the Board believes dentists, denturists and dental hygienists all provide important dental services and it views any effort that would end the link between the three groups by dividing up regulation as potentially counterproductive.

The Board notes that the subcommittee concept adopted by the Business, Research and Economic Development Committee in its 2003 legislation following the Board's sunset review hearing has facilitated a closer and more productive working relationship among the three groups of dental professionals. The Board also indicated that it is open to consideration of expanding the existing responsibilities of each subcommittee for licensure and discipline.

The **Maine Center for Disease** Control within the Department of Health and Human Services neither supports nor opposes the concept of a new regulatory structure but questions the "utility of separating the regulation of dental professionals who should be functioning together as 'team members' as much as possible." DHHS also questions whether the conclusion on this point reached by the Maine Regulatory Fairness Board was based on a broad enough "sample of opinion and experience."

***Department Assessment*:**

States have several options for exercising their police powers to protect citizens from unscrupulous and incompetent individuals and entities that provide services to the public.

1) State legislatures can appoint one official to regulate an industry. In Maine, for example, the Superintendent of Insurance regulates the insurance industry.

2) Many states choose the licensing board model that provides for gubernatorial appointments of members of the profession to be regulated, along with members of the public, to a licensing board, which acts as the final decision-making entity with regard to issues relating to public protection.

3) Some states are now moving to a hybrid form of regulation which provides for an advisory committee to assist a single administrator who is granted authority to implement licensing standards and impose discipline, when warranted.

4) In some instances, multiple professions are regulated by one licensing board populated with members of each profession and public members. The Board of Architects, Landscape Architects and Interior Designers regulates three different groups of licensees in Maine that have only a tangential connection with each other.

These variations are largely the product of the political climate and other factors in play in a particular state when a licensure proposal is presented to a state legislature. There is no right or wrong methodology for state protection of its citizens. The starting point, however, when analyzing a proposal to create new licensing boards must be an examination of the current structure and two questions must be addressed.

Question 1: Does the operation of the Maine Board of Dental Examiners, with regulatory authority to implement standards and requirements for dentists, denturists, dental hygienists, dental radiographers and expanded function dental assistants adequately protect the public from harm associated with substandard dental care?

Question 2: Would the public be better served if dental hygienists and denturists were regulated by an entity other than the Board of Dental Examiners?

In this discussion, the burden is on proponents to show that the public is being harmed by the existing regulatory structure.

Licensing Standards: In reviewing the survey information provided by proponents on this point, the Department was unable to identify any information to suggest that the standard of care in the dental and oral health area is somehow diminished by the Board's operation pursuant to statutory direction. The Department was not able to identify any requirement for licensure that was out of line with most other states' licensure requirements. Nor was it able to identify any requirement that served as a barrier to entry into the dental field.

Disciplinary Actions: With respect to the disciplinary process, it does not appear that the Board has been lax about taking action against licensees who have violated the statutes and rules of the Board, although allegations have been made in the past by denturists that the Board treats them unfairly by assessing larger fines and sanctions on denturists than on dentists.

A review of all disciplinary actions taken by the Board between 1989 to the end of 2007 indicates that adverse actions have been taken against 100 licensed dentists, 4 licensed dental hygienists, and 5 licensed denturists.

- Substance abuse was the subject in 3 of the 4 actions against dental hygienists. A fourth dental hygienist was cited for providing service to a patient who was not a "patient of record" of the supervising dentist. Only the fourth action might be considered a practice violation.

- Inappropriate advertising was the subject in two of five actions taken against licensed denturists. A third action was taken against a denturist for exceeding the bounds of a denturist's scope of practice. Two actions involved failure of an applicant for a denturist license to disclose disciplinary action in another jurisdiction.

- Many of the 100 actions taken against dentists are for serious practice violations, some involving practitioner incompetence. All Board disciplinary actions can be reviewed online at www.mainedental.org under "Adverse Action Reports."

Taken as a whole, the Board's disciplinary history does not appear to be unfair or discriminatory to denturists or dental hygienists. There is also no specific evidence or information to indicate that the public at large is dissatisfied or placed at risk as a result of the current regulatory arrangement.

Business Competition: The argument that dental hygienists and denturists should be regulated by a separate board because they are in direct competition with dentists for business is not persuasive. The Department has found no evidence that dentists directly or indirectly act to prevent denturists from practicing denturism. On the contrary, dentists have testified before the Committee on several occasions that they enjoy good working relationships with denturists and hope those relationships continue.

The need for many different categories of dental care, including the services provided by denturists, dental hygienists and dentists, is ever increasing. Given access to care realities in Maine, dental professionals should be investigating ways in which to work as teams. In the context of the larger medical community, of which dental treatment is a significant segment, all focus is on developing team approaches to providing health and dental care. It is therefore unclear why separating the dental profession into three groups, each with its own regulatory body, could possibly result in a benefit to the public.

Scope of Practice Issues: With regard to the perceived control of dentists over the scope of practice of dental hygienists and denturists, the medical model is instructive. Physicians have the broadest scope of practice in the medical community. The Board of Licensure in Medicine licenses and regulates physicians and physician assistants. Physician assistants are employed by physicians and regulated by the Board of Licensure in Medicine. The physician determines the scope of practice of a licensed physician assistant based on the assistant's level of training and experience. The physician can perform the same functions and procedures that may be within the scope of practice of a physician assistant. Similarly, the advanced practice registered nurse (APRN) has a broader scope of practice than a registered nurse that is employed by the APRN. APRNs are regulated by the Board of Nursing and may employ in their practice a registered nurse whose scope of practice is a subset of the practices and procedures an APRN is authorized to perform.

An employment relationship between two individuals in two different license categories performing different functions related to the same profession is one that is replicated in many other licensing board structures. Occupational therapists employ occupational therapy assistants and both are regulated by one licensing board. Licensed pharmacists employ licensed pharmacy technicians and both are regulated by the Board of Pharmacy. Licensed psychologists employ psychological examiners and both are regulated by the Board of Examiners of Psychologists.

The Committee's Government Evaluation Act review of the Board of Dental Examiners resulted in enacted legislation that underscores and supports the importance of dental hygienists and denturists to the provision of oral health care in Maine. The dental hygienist subcommittee and the denturist subcommittee are operational and functioning appropriately. The Board has testified publicly and in response to the Department's survey that it supports expanding the role of each subcommittee to include authority to make licensing decisions as well as disciplinary decisions.

Currently, Maine law authorizes the Dental Hygienist Subcommittee to review licensing issues including public health supervision and continuing education submissions from dental hygienists but does not provide similar authority for review and investigation of complaint and disciplinary matters. The reverse is true of the Denturist Subcommittee. It has authority to make decisions in the disciplinary process but does not have authority to make decisions involving license applications. It would be worth exploring how the authority of each subcommittee could be expanded to afford a greater opportunity for issues relating to denturism and dental hygiene to be resolved.

In summary, the Department finds that the current regulatory structure is appropriate and places public protection above the professional agendas and professional associations of denturists, dental hygienists and dentists.[2] In the Department's view, and with due respect to the work of the Maine Regulatory Fairness Board, discord among groups of dental professionals is not a valid justification for expanding State government and establishing new licensing programs. Professional discord exists among sub-groups in all regulated professions and, in this case, is greatly outweighed by the State's responsibility to maintain one standard of care for dental services provided to Maine citizens. Creating a new licensing structure is not the appropriate response to real and perceived problems, nor is it warranted. However, it is critically important for these three groups to continue to work collaboratively to improve communications and function as teams whenever possible to ensure public safety in all dental care settings.

The Legislature appropriately established the dental hygienist and denturist subcommittees within the Board structure. Other states have adopted a similar approach. Although challenges are associated with these subcommittees for Board members and staff, as well as professionals appointed to those subcommittees, the expanded Board with its subcommittees needs more time to work through practice issues, particularly now that the Board has greater staff resources to manage its day to day operations. In addition, the Board has expressed willingness to expand the role of each subcommittee and the Department agrees that such adjustments should be considered by the Legislature.

[2] It is not necessary to address other regulatory options, including direct administrative of dental hygienists and denturists by the Department. Nor is it necessary to analyze or assess the possibility of combining dental hygienists and denturists with any other licensing category for the sole purpose of excising public protection responsibility for those two license categories from the statute of the Board of Dental Examiners.

C. Proposal to Allow Licensed Dental Hygienists to Provide Dental Hygiene Services Independent of Supervision by Licensed Dentists

Background: LD 550 would provide statutory authority for licensed dental hygienists to offer dental services within their current scope of practice as set forth in Board rule (Chapter 2) but without either direct or general supervision of licensed dentists. The language of the proposal does not indicate specifically how the word "independent" is to be defined. The bill also refers to "independent practice" without elaborating on the meaning of the phrase.

Current Maine law allows certain licensed dental hygienists to work in a public health setting with limited supervision by licensed dentists. Public Health Supervision is a legal status within current law that permits dental hygienists to provide a range of educational and preventive dental services coupled with post-service reporting requirements outside the traditional dental office setting.

Chapter 1 of Board Rules states:

"Public Health Supervision" means that:

A. The dentist provides general supervision to a dental hygienist who is practicing in a Public Health Supervision status under Chapter 2 of these rules, with the exception that the patient being treated shall not be deemed to be a patient of record of the dentist providing Public Health Supervision; and

B. The dental hygienist has an active Maine license and practices in settings other than a traditional dental practice, provided that the service is rendered under the supervision of a dentist with an active Maine license. These settings may include but are not necessarily limited to public and private schools, medical facilities, nursing homes, residential care facilities, dental vans, and any other setting where adequate parameters of care, infection control, and public health guidelines can and will be followed."

Whereas licensed dental hygienists working in a traditional dental practice perform specific functions with either direct or general dentist supervision, Public Health dental hygienists are permitted to perform many of the same functions and procedures (within the RDH scope of practice) without general supervision of a dentist. Under Maine statute, there must be a documented relationship between the licensed dental hygienist who wishes to practice in a public health setting and a licensed dentist.

For purposes of this study, the Department assumes that the drafters of the proposal intended to move beyond public health supervision status to permit any currently licensed dental hygienist to practice truly independent of a licensed dentist, in a non-traditional

setting, that is, without supervision of any kind, pursuant to rules promulgated by the Board of Dental Examiners.

Evaluation Criterion #1: Data on group proposed for regulation. 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 expanded 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.

Responses:

The Maine Dental Hygienists' Association (MDHA), founded in 1926, has 169 official members (dental hygienists). Its stated mission is to "improve the public's total health…by ensuring access to quality oral health care, increasing awareness of the cost-effective benefits of prevention, promoting the highest standards of dental hygiene education, licensure, practice and research, and representing and promoting the interests of dental hygienists."

Founded in 1867, the Maine Dental Association (MDA) is a professional membership organization of licensed dentists whose stated mission is to "provide representation, information and other services for the dentist members and, through the dentist members, promote the health and welfare of the people of the State of Maine." MDA has 590 practicing members (dentists) and 133 retired members as of the end of 2007.

Department Assessment: There are currently 1257 dental hygienists licensed by the Board to practice in Maine. There is no way to determine at this time how many current licensees would be inclined to pursue independent practice status because the bill outlines neither the parameters of independent practice nor the additional education and training requirements for such practice.

Evaluation Criterion #2: Specialized skill. Whether practice of the profession or occupation proposed for 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.

MDHA commented that it supports the concept of independent practice for dental hygienists provided the level of supervision by a dentist is defined and the outcome is linked to the concepts outlined in LD 1246.

MDA commented that it is not opposed conceptually to investigating how dental hygienists with a minimum of a bachelor's degree might be allowed to practice traditional dental procedures (preventive/educational) in an independent setting; however, the organization believes licensed dental hygienists would need additional diagnostic training and certification in order to protect the public from harm. In addition, MDA

recommended that collaborative arrangements with licensed dentists be included in any rules promulgated by the Board.

MBODE expressed no position on the proposal assuming that the current scope of practice for dental hygienists is not expanded beyond the current level of required education, experience and skill. However, in response to additional questions on this issue, the Board noted that "Dental hygienists, presently trained, are not educated in pathology and medicine and are not taught to perform and carry out the detailed history and physical examination necessary to diagnose and establish a safe and reliable treatment plan."

Joan Davis and Catherine Kasprak, both Registered Dental Hygienists, support the bill and commented that the assurance of minimum qualifications has already been met when an individual is licensed in Maine as a dental hygienist.

The Maine Society, National Association and International Federation of Denturists strongly support the bill and comment that testing for minimum qualifications would be important to protect the public. In addition, these organizations noted that independent practice dental hygienists are active in other countries without apparent problems.

The Maine Center for Disease Control (MCDC/DHHS) expressed no position on the concept of independent practice, but noted that additional information would be helpful in determining whether Maine would have the necessary infrastructure to support independent practice. Further, MDCD/DHHS noted that the independent practice of dental hygiene must still have "an explicit connection to the practice of dentistry to assure diagnosis, treatment and follow-up of dental and oral conditions."

Stephen Mills, DDS, opposes the bill because in his experience "dental hygienists are not trained to be independent" and comments that these decisions "cannot be made by anyone other than a qualified dental professional."

Jane Walsh, University of New England, indicates that UNE supports independent practice with the "caveat that the independent practice should be available for the newly created ADHP (Advanced Dental Hygiene Practitioner) proposed by the American Dental Hygienists' Association." Alternatively, Ms. Walsh asserts that independent practice pursuant to the current scope of practice for dental hygienists be limited to those licensees who have a Bachelor of Science degree in Dental Hygiene and at least two years experience in a traditional dental practice setting, in order to maintain the current standard of care. In her response to additional questions on this point, Ms. Walsh noted that "Dental hygienists are well qualified and licensed to deliver dental hygiene services..." "As with other independent practitioners. . . an appropriate amount of experience would make independent care more palatable as graduating students who pass their licensing exam meet minimum qualifications only."

Department Assessment: Dental hygienists have traditionally worked in private practice dental office settings under direct and general supervision of licensed dentists. The fact that the bill does not contain information that would allow respondents to comment more specifically about non-traditional work settings, or the education and experience requirements of a licensee working independent of a dentist, should not prevent consideration of the concept of independent practice for dental hygienists. Education and experience requirements will be addressed in the Conclusions and Recommendations section of this report.

Evaluation Criterion #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.

MDA indicated that no harm to the public will occur if current laws and rules are not expanded**,** however, if dental hygienists are permitted to practice on an independent basis, public safety could be jeopardized. It recommends that additional diagnostic training and a collaborative agreement between hygienist and dentist be required.

MBODE notes that Colorado has allowed independent practice of dental hygienists for many years without significant change in the traditional practice model. Further, the Board indicates that the evolution of the dental hygienist as part of a dental delivery team has occurred because it works. Greater efficiency, productivity and continuity of quality care, according to the Board, cannot be achieved by this additional "independent" avenue of dental hygiene practice.

MDHA says there is virtually no risk of harm to the public in expanding the scope of practice for dental hygienists who receive education and training comparable to that proposed in the ADHP competencies. The risk of harm to the public is in maintaining the status quo.

Joan Davis, RDH states that the citizens of Maine will not be provided with optimum accessibility if the regulation for dental hygienists is not expanded to that of independent practice. The foundation for oral health care is performed by the services of dental hygienists: education, prevention and therapeutic treatment. An expansion will lead to a "considerable decrease in oral disease…as will the need for intervention." Ms. Davis has no knowledge of any complaints or harm done by a dental hygienist in Maine.

Catherine Kasprak, RDH would "allow a hygienist to practice to the full extent of their license and education which is difficult in settings with supervision according to what many dentists allow." Ms. Kasprak is not aware of any complaints or harm to the public caused by a hygienist.

The National Denturist Association (NDA) contends that registered dental hygienists are capable of expanded duties and are no less ethical than dentists. All dental professionals are required to refer patients to the appropriate health care practitioner when confronted with a condition beyond their competency.

The International Federation of Denturists (IFD) explains that independent dental hygiene practice is permitted "in various locations around the world as well as in the USA and Canada with no jurisdiction ever abandoning this model after implementation."

Stephen Mills, DDS, Pediatric Dentistry, opposes independent practice on the basis of the potential for misinformation, lack of background knowledge and no back up for treatment needs. He provided no specific examples of harm.

Jane Walsh from UNE indicates that not allowing experienced Bachelor of Science dental hygienists working in their current scope of practice to work independently without supervision of a licensed dentist would continue to compound the access to care issues that exist in this State.

MDCD/DHHS sees no potential harm to the public if dental hygienists in Maine do not practice independently, but would be concerned that without appropriate standards for licensing, education, training and continuing education, the probability of harm would increase with independent practice.

Department Assessment: Independent practice by dental hygienists without appropriate education and clinical experience would place the public at risk. With an appropriate level of education and clinical experience, however, the risk to the public would be virtually the same as it is now under current practice requirements relating to public health supervision.

Evaluation Criterion #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.

Department Assessment: Dental hygienists are already subject to State licensure laws. It is worth noting, however, that the Maine Dental Hygienists Association has a strong record of advocating for expanded functions for dental hygienists.

Evaluation Criterion #5. Costs and benefits of regulation. 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.

Respondents expressed varying views about whether allowing dental hygienists to practice independent of dentist supervision would reduce or increase service fees charged to consumers.

Stephen Mills, DDS, noted that independent practice would require hygienists to charge fees that are lower than those charged in traditional dental office settings. Otherwise, there would be no incentive for the public to access the services in an independent setting. Only lower fees would attract the segment of the Maine population that cannot access hygienist services in the dental office. It is hoped that lower fees would result in greater access to the services.

MCDC noted that it is not possible to respond because there is little impact information coming from other states and because it is impossible to estimate the number of current dental hygienists who might opt for independent practice if it were permitted by law. Further, MCDC suggested that increased access to preventive dental hygiene services today will reduce the need for and cost of restorative dental services in years to come.

MDHA notes that direct reimbursement to individual dental hygienists practicing independent of a licensed dentist or an agency is key to the success of independent practice. In addition, MDHA provided information on how access to preventive oral care leads to a healthier population and suggests expanding insurance company coverage of the cost of dental care.

Department Assessment: It is difficult to predict the impact on service fees of permitting dental hygienists to practice independent of dentists for the reasons given by respondents. It is not known whether the costs associated with investing in one's own small business would allow an independent dental hygienist to offer lower rates for services initially or over time.

Several states currently allow for less restrictive supervision of dental hygienists by dentists. However, only Colorado permits licensed dental hygienists to practice independent of dentists regardless of the setting. Independent practice status for hygienists in that state was enacted into law in 1987. Information about the impact indicates that fees charged by dental practices for dental hygiene services in Colorado were comparable in most cases to those charged by independent practice dental hygienists. So while there appears to be no discernible negative impact on patient safety when dental hygienists practice independently, neither is there any reduction in fees as a result of unlinking preventive and educational services from the licensed dentists in traditional private practices. This factor calls into question whether independent practice

presents an economic model that would attract dental hygienists who may not be comfortable taking on the risks associated with starting a small business.

Evaluation Criterion #6: Service availability under 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.

MDHA contends that independent practice by dental hygienists would increase the availability of services.

IFD states that independent practice would increase the number of service providers thereby increasing access to care.

Joan Davis, RDH says independent practice would shorten waiting time for an appointment. Additionally, independent hygienist-owned practices could choose hours of service favorable to working parents and children. Ms. Davis also notes that hygienists live all over the State and would therefore increase access in various locations.

Catherine Kasprak, RDH suggests that independent practice would allow for services now limited by employer/employee relationship and eliminate conflicts of interest.

NDA states that a progressive delivery scheme would attract more hygienists to Maine.

MBODE contends that given the limited number of hygienists who may choose to practice independently, the amount of preventive care being delivered would not increase. There is a finite number of hygienists seeing a finite number of patients for prevention and education. Traditional or independent setting "has no effect on the numbers of services currently being delivered. Maine needs more qualified hygienists, not hygienists in independent practice."

Stephen Mills, DDS says independent practice would increase access for basic preventive and diagnostic services only.

Jane Walsh from UNE suggests that independent practice could provide more locations for preventive services thus increasing access to dental care and awareness of the importance of oral hygiene. She states that greater independence would create more opportunity for Maine citizens to seek treatment, continue preventive care and receive referrals for further care.

Department Assessment: Although it is true that there is no way to estimate or predict how many current dental hygienists might pursue a career in independent practice, it is also true that if circumstances favorable to forming new small businesses such as community dental clinics and direct reimbursement for certain services were in place, independent practice could become a mechanism for incrementally increasing access to oral preventive care. The fact that there has not been a demonstrated overall increase in access to care in Colorado as a result of allowing hygienists to practice independent of

dentists, does not mean that the public realizes no benefit from the Colorado model. Independent practices might make access easier by offering more flexible hours that accommodate working patients. Regardless of whether access to care is increased, there is ample evidence that patient satisfaction with independent practice dental hygienist in Colorado is notable.[3]

Evaluation Criterion #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 non-regulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated practitioners.

MDHA says that many Maine citizens who do not have access to health care have no legal redress. Legal redress in the context of sunrise review refers to the legal process whereby consumers may file complaints against practitioners. Groups responding to this criterion focused on "lack of access to oral health care" as a condition that deserves redress or relief of some sort.

Catherine Kasprak, RDH, asserts that a board comprised of dental hygienists would be better positioned to act on complaints against dental hygienists regardless of the practice setting.

Jane Walsh (UNE) acknowledges that the Board of Dental Examiners can regulate dental hygienists in independent practice but a dental hygienist board separate from dentists makes more sense and could more effectively regulate dental hygienists. A dental hygiene board would allow the existing board to focus on advances in dentistry.

The three denturist professional associations (NDA, IFD, MSD) contend that the existing law and composition of the Dental Board are inadequate to prevent harm resulting from denturists being regulated by a Board dominated by dentists. They believe the existing subcommittee is inadequate to serve the many needs of the denturist profession. According to these organizations, no profession should be regulated by its competition. An independent board or governance through the Department of Professional and Financial Regulation would bring more denturists and hygienists into the State.

MBODE, MCDC/DHHS, and MPCA suggest that existing legal remedies are adequate to prevent or redress the kinds of harm potentially resulting from independent practice of dental hygienists. They recommend regulation through the Board of Dental Examiners.

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[3] Brown, LF, House DR, Nash KD. ***The economic aspects of unsupervised private hygiene practice and its impact on access to care.*** Dental Health Policy Analysis Series, Chicago: American Dental Association, Health Policy Resources Center; 2005 and ADHA's **Response to ADA Study: The Economic Impact of Unsupervised Dental Hygiene Practice and its Impact on Access to Care in the State of Colorado, 2005.**

Department Assessment: No respondents presented specific information demonstrating that existing law, legal remedies and regulatory structure of the existing licensing Board are inadequate to redress potential harm. Since dental hygienists are currently regulated, consumers have legal remedies by filing complaints with the Board. If dental hygienists are permitted to practice independently, the same legal remedy exists. The question of whether those within Maine's population who cannot access dental care have been deprived of a legal right or remedy is beyond the scope of this report.

Evaluation Criterion #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.

The three denturist associations (NDA, MSA, IFS) state that no independent dental profession should be regulated by its competition. They recommend an independent board or governance by the Department.

Joan Davis, RDH, states that allowing hygienists to practice independently will expand access to preventive care, which will decrease dental disease and reduce the cost of services.

MDHA contends that Maine citizens need greater access to quality oral health care; and independent practice will broaden the availability of preventive services.

Department Assessment: Dental hygienists are required by Maine law to be licensed and their conduct is regulated by the Board of Dental Examiners. The Department does not view this proposal to permit dental hygienists to practice independent of dentists, as proposing a new method of regulation, rather, it proposes to expand the permissible practice settings and reduce the supervision for dental hygienists.

Evaluation Criterion #9: Other states. Please provide 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.

See attached Appendix E.

Evaluation Criterion #10: Previous efforts to regulate. Please provide the details of any previous efforts in this State to implement regulation of the profession or occupation.

Not applicable. Dental hygienists are currently regulated.

Evaluation Criterion #11: Minimal competence. Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

Not applicable. The proposal as drafted appears to be based on current standards of minimal competence.

Evaluation Criterion #12: Financial analysis. Please describe 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.

Department Assessment: All costs associated with regulation of the dental professions, as well as costs associated with changes in regulation, would be borne by licensees of the licensing entity.

Evaluation Criterion #13: Mandated Benefits. Please describe whether the profession or occupation plans to apply for mandated benefits.

Department Assessment. The term "mandated benefits" in the context of sunrise review refers to a process by which insurance companies are required by State law to provide insurance coverage for certain services or procedures rendered to consumers. The phrase implies State-required insurance coverage for the service provided.

Interested parties including the Maine Dental Hygienists Association make reference in their responses to the need for "direct reimbursement" of dental hygienists working in an independent practice. Currently, reimbursement may be directed to an "agency" for certain dental services provided, however, individual dental hygienists cannot receive direct payment under their own billing number. Those responses also state that "direct reimbursement" as a payment mechanism is a "requisite to expanding the scope of practice and access to care."

It is worth noting that when a legislative proposal calls for mandated insurance coverage and required payment to providers for certain procedures, the proposal is forwarded to the Joint Standing Committee on Insurance and Financial Services. That Committee typically requests a separate study conducted by the Department's Bureau of Insurance which reviews the proposal and files a report on the estimated cost of the mandate, were it to be enacted into law.

D. Establishment of Licensing Category for Mid-Level, Expanded Scope Dental Hygienist

The proposal under consideration would require the Board of Dental Examiners to establish a new license category requiring additional education, clinical training and experience beyond what is needed to obtain a dental hygienist license under current statute. The new license category, referred to in this report as a "mid-level dental hygienist" would be open to 1) licensed dental hygienists who 2) document completion of a one-year internship with either a Maine-licensed dentist or a dental hygienist already certified in this license category; and who 3) document completion of a recommended

number of hours of "didactic and clinical training" in an educational institution accredited by the American Dental Association's Commission on Dental Accreditation; and who 4) provide evidence of liability insurance.

The new license category envisioned by the proponents would have an expanded scope of practice allowing licensees to provide oral health services including triage, case management and dental hygiene prevention; administration of local anesthesia, including nitrous oxide; cavity prevention; simple restoration; pulpotomies; deciduous extractions; as well as the prescribing of antimicrobials, fluoride and antibiotics. It appears that the intent of the proponents is for these services to be provided outside the traditional dental office setting to low-income persons and MaineCare recipients without supervision by a licensed dentist, although the proposal is somewhat ambiguous on this point.[4]

The Board of Dental Examiners would be responsible for promulgating major substantive rules to provide meaningful guidance to licensees and applicants interested in obtaining this specialized license. The rules would include specific details with regard to the parameters of an acceptable internship and required hours and substantive elements of didactic and clinical training required for this category.

Note: Although many individuals and groups that participated in the BRED committee's public hearing on this bill may to some degree support some form of mid-level license category for dental hygienists, there was strong opposition to the establishment of any new program or regulation targeted at Maine's low-income and MaineCare eligible population. The bill's focus on this segment of Maine's population was undoubtedly well-intentioned but almost all public hearing participants noted that there should be only one standard of care for dental or oral health services provided in Maine regardless of an individual's ability to pay for those services and that the low-income individuals should not receive a lower standard of care than other segments of Maine's population.

Evaluation Criterion #1: Data on group proposed for regulation. 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 expanded 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.

Background: The subject group targeted for expanded State regulation is the license category of "dental hygienist" which would include individuals currently licensed and, hypothetically, those who may be licensed in the future. The bill implies that only Maine-licensed dental hygienists with additional training and education would be eligible

[4] Given that LD 1246 directed the Board of Dental Examiners to adopt rules setting forth practical limitations on the scope of practice and licensing requirements including whether certain procedures may be performed under direct or general supervision of a licensed dentist, reference to these services being provided "outside the traditional dental office" implies at most indirect supervision. It is unlikely, however, that the proposal envisioned advanced or expanded scope dental hygiene practice entirely independent of supervision by a licensed dentist.

for the new license category and the expanded scope of practice. There are currently 1257 Maine-licensed dental hygienists. Of that number, 819 are in active Maine practice. Also affected indirectly by the proposed legislation would be 830 Maine-licensed dentists, of which 658 are in active practice in Maine.[5]

Responses:

The Maine Dental Hygienists' Association, founded in 1926, has 169 official members (dental hygienists). Its stated mission is to "improve the public's total health…by ensuring access to quality oral health care, increasing awareness of the cost-effective benefits of prevention, promoting the highest standards of dental hygiene education, licensure, practice and research, and representing and promoting the interests of dental hygienists."

Founded in 1867, the Maine Dental Association (MDA) is a professional membership organization of licensed dentists whose stated mission is to "provide representation, information and other services for the dentist members and, through the dentist members, promote the health and welfare of the people of the State of Maine." MDA has 590 practicing members (dentists) and 133 retired members as of the end of 2007.

Department Assessment*:*

There is no way of determining how many, if any, currently licensed dental hygienists would work toward becoming eligible for this expanded scope mid-level dental hygienist license category.

Evaluation Criterion #2: Specialized skill. Whether practice of the profession or occupation proposed for 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.

Responses:

All responding parties agreed that setting minimum qualifications for a mid-level dental hygienist would be critical to protecting the public from harm.

Department Assessment: Currently, there are minimum license requirements and standards for dental hygienists practicing in certain public settings (public health supervision) and also for hygienists practicing in traditional dental office settings. More stringent license requirements, including a higher level of education and training, would be necessary for a mid-level dental hygienist whose scope of practice would include dental services and procedures that involve diagnosis and treatment and go substantially beyond the preventive and oral education services permitted by current statute.

[5] Licensure statistics were provided by the Maine Board of Dental Examiners on January 10, 2008.

Evaluation Criterion #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.

Responses:

The Maine Dental Hygienists' Association asserts that the "threat to the public of having no care or maintaining the status quo and the harm caused by complete lack of care is far worse than any outside risk associated with an expanded scope of practice." MDHA also provided several examples of tragic deaths of children in Georgia and Maryland resulting from untreated dental infections. Further, MDHA asserts that "the threat to the public's health, safety or welfare is that the scope of practice for dental hygienists remains the same thereby perpetuating the access to care crisis."

The Maine Board of Dental Examiners comments that the public will not be subject to any more risk than it is today, if the scope of practice for dental hygienists is not expanded. However, if the scope of practice is expanded without corresponding increases in educational levels and sufficient levels of clinical experience and training, the Board fears that the public health and welfare would certainly be jeopardized.

The Maine Dental Association agrees that the public will not be placed at risk if the scope of practice is not expanded and it opposes LD 1246, as drafted, but it "looks forward to the creation of a new category of licensee—envisioned to be a masters level clinician who would be appropriately educated, trained and tested to work in a collaborative arrangement in the dental community, providing specifically identified procedures now only allowed by a dentist." Further, the MDA comments that "this would require the development of an entirely new master's level curriculum in an accredited educational institution that meets the educational standards of the ADA Commission on Dental Accreditation to teach the necessary skill sets. These skills will need to include not only technical dental skills, but also academic understanding and…training in clinical judgment...focusing on pediatric aspects of dentistry."

Catherine Kasprak, RDH, asserts that there is "more potential harm to the public by not allowing a mid-level dental hygienist. This [level] would allow more care accessibility for citizens in Maine. There is a shortage of dentists which is making it difficult for many to access care."

Stephen Mills, DDS, comments that "if dental care is not provided by the highest level, the chance for perioperative problems are high and children may suffer."

MCDC/DHHS contends that much more information about the proposed change in scope of practice would be necessary in order to properly evaluate the impact on the public. The scope should be evaluated based on "best practices, education and training standards, quality assurance mechanisms, licensure and continuing education requirements." Focus on clinical training and outcomes should also be included.

Jane Walsh, (UNE) supports the concept of expanding the scope of practice of dental hygienists but proposes the creation of two new levels of licensure rather than just one—one for a mid-level advanced practice dental hygienist (ADHP) and another for a mid-level practitioner. The two categories would be distinguished by the entry level degree requirement. A bachelor's degree in dental hygiene and completion of another degree program that is the equivalent of a master's level of education would be required for the ADHP level and a Bachelor of Science degree and a master's level degree in another area would be required for the mid-level practitioner category. These two levels of licensure would correlate to the nurse practitioner and physician assistant levels, respectively, in the medical model.

Ms. Walsh explains UNE's vision that the Advanced Practice Dental Hygienist would be a licensed dental hygienist with a Bachelor of Dental Hygiene degree who then graduates from a program with a curriculum that tracks the draft curriculum set forth by the American Dental Hygienists Association (attached as Appendix F). The ADHP would be permitted to practice within the expanded scope of practice outlined in LD 1246 as part of a health care team, or on an independent basis, if the ADHP could demonstrate completion of two years of clinical experience in a traditional dental office setting.

The mid-level practitioner envisions an individual who is not a licensed dental hygienist but who has a Bachelor of Science degree and who has graduated from an accredited dental Mid-Level/Master's program "similar to but not exactly like" the curriculum proposed by the American Dental Hygienists Association. The mid-level practitioner would practice dentistry under the supervision of a licensed dentist who would determine the specific duties and functions of the mid-level practitioner.

Ms. Walsh agrees with other respondents that the threat to public safety arises if the current scope of practice of dental hygienists is not expanded and access to oral health care continues to be limited.

Department Assessment: Not applicable. The proposed license category does not currently exist.

Evaluation Criterion #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.

Responses:

MDHA notes that it has been actively involved in advocating for legislation that has culminated in 1) permitting licensed dental hygienists to administer local anesthesia under direct supervision after receiving special certification to do so by the Board of Dental Examiners; 2) removing certain supervision requirements in public health settings and 3) expanding the permissible practice sites for public health supervision work.

MBODE acknowledges that there is an active but relatively small group of dental hygienists who are members of the Maine Dental Hygienists' Association and consequently the American Dental Hygienists Association. The Board notes that the Association has drawn less than one quarter of all licensed hygienists to its membership and indicates that MDHA does not represent the "vast majority of practicing hygienists in Maine."

Department Assessment: Dental hygienists have been licensed and regulated through the Board of Dental Examiners since 1917. This question may be more relevant in situations where regulation of a previously unregulated profession is proposed.

Evaluation Criterion #5. Costs and benefits of regulation. 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.

Responses:

MCDC/DHHS notes that the potential impact of this proposal on costs of services is difficult to estimate since there is still limited experience from other states; because it is unknown how many dental hygienists would pursue status as mid-level providers; and since it is not known how many would need to practice at this level to have an appreciable, measurable impact. However, it may be reasonable to assume that over the long term, since prevention is cost-effective, such services should reduce the volume of more involved and expensive restorative and operative care and the overall impact would be to reduce costs of services.

Stephen Mills, DDS, notes that if this kind of position is used in a dental office, it could reduce costs and increase productivity. Further, he asserts that "the future for this position could be, someday, very positive."

Catherine Kasparek, RDH, states that costs may be the same or less than what is now incurred, and there will be more competition and more access to care which will reduce medical care costs and increase the overall health of Maine citizens.

MBODE asserts that "creation of a mid-level dental hygienist license category will have little impact on costs of services…far too few hygienists will be interested in attaining

mid-level status to make any real difference." Further, the Board notes that it does not envision private practices employing this level of licensee.

MDHA takes the position that in order for this level of care to prosper, a direct reimbursement option would need to be identified. The mid-level practitioner would need an independent revenue stream in order to succeed financially.

Department Assessment: The effect of a new level of license authority on cost of services to consumers is not known.

Evaluation Criterion #6: Service availability under 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.

Responses:

MBODE takes the position that "if enough hygienists are willing to undergo the time and expense to become mid-level practitioners, there can be a positive effect on access to care for Maine's underserved population." However, it would take a large number of interested dental hygienists (between 100-200) placed in high need areas to make a significant impact on access. The Board does not foresee fee-for-service patients becoming "a staple in the practice of a mid-level hygienist" and is concerned that hygienists will keep pressing to expand their scopes of practice, thus, creating the potential for negative outcomes if educational requirements are not increased at the same time.

MDA is hopeful that by establishing a mid-level dental hygienist position, the timeliness of care to currently underserved pediatric patients will be enhanced.

Catherine Kasparek, RDH, hopes that a mid-level hygienist will increase the availability of services to the public and will allow increased access in more locations.

Stephen Mills, DDS, asserts that creating a mid-level position for hygienists "would increase availability at a frightening decrease in quality."

MCDC/DHHS asserts that there is a growing understanding of the need to expand the dental workforce with the development of a mid-level practitioner who will be able to provide preventive care and other services as yet undefined that will maximize the use of skills possessed by dental professionals. Hopefully, if all dental professionals are permitted to practice to the limit of their skills and scope of practice, overall access to care will increase.

Jane Walsh (UNE) believes a mid-level dental provider (either ADHP or mid-level practitioner) would increase availability of oral health services to the public. Students would have patients to treat in their school clinic setting and would hopefully allow

expansion of the UNE dental clinic. Upon graduation, ADHPs could "potentially double the restorative output of the private practice dental office."

MDHA asserts that three factors must come together to result in increased access: 1) new reimbursement policies; 2) supervision that is appropriate to the skill level; and 3) an expanded scope of practice with supplemental education requirements.

Department Assessment: In general, imposing additional regulation on an already regulated group results in a decrease in licensee numbers. In this case, however, given that the proposal to allow dental hygienists to upgrade to mid-level dental hygienist status envisions the upgrade to be voluntary, rather than mandatory, the impact on availability of services could be less severe. Although there might be a decrease in actively practicing dental hygienists for some period of time during which hygienists might limit their work hours to obtain additional education and experience, the number of new dental hygienists licensed by the Board increases each year.

Evaluation Criterion #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 non-regulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated practitioners.

Responses:

MDHA indicates that Mainers who cannot access dental care have no legal remedy. Only Mainers who are fortunate enough to have dental care have a legal remedy and can file complaints with the Board.

Jane Walsh (UNE) asserts that as dental technology increases, so does the need for regulation of dental hygienists to be separate from the regulation of dentists, even though there is a link between the two types of dental practices. Existing regulation is not sufficient to allow for new technologies that must be learned through expanded educational requirements.

MCDC/DHHS and MBODE contend that existing legal remedies are adequate to prevent or redress the kinds of harm potentially resulting from the proposed legislation.

Department Assessment: No responses presented specific information demonstrating that existing law, legal remedies and regulatory structure of the existing licensing Board are inadequate to redress potential harm. Since dental hygienists are currently regulated, consumers have access to legal remedies by filing complaints with the Board. The question of whether those within Maine's population who cannot access dental care have been deprived of a legal right or remedy is beyond the scope of this report.

Evaluation Criterion #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.

Responses:

MCDC/DHHS states that all three groups of dental professionals share concerns about access to oral health services particularly for low income Mainers and children, and about the adequacy of the oral health care workforce. The agency questions whether a new licensing board can address those issues and suggests that shared concerns can best be addressed by the professions working closely together rather than developing their own, separate methods of regulation.

Jane Walsh (UNE) says licensing is the regulatory method of choice for the medical and dental professions because the scope of practice and level of expertise demand a regulatory body that understands the nuances of daily practice and the issues practitioners face in an evolving field.

Department Assessment: Because the concept of an advanced practice dental hygienist is theoretical, it would be premature to address this criterion.

Evaluation Criterion #9: Other states. Please provide 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.

Responses:

Jane Walsh (UNE) notes that the position of advanced practice dental hygienist does not yet exist in any other state. ADHP is a concept created and proposed by the American Dental Hygienists Association. No state has yet adopted the advanced practice dental hygienist as a license category.

Department Assessment: To date, no state has established a license category for a mid-level or advanced practice dental hygienist with an expanded scope of practice as proposed.

Evaluation Criterion #10: Previous efforts to regulate. Please provide the details of any previous efforts in this State to implement regulation of the profession or occupation.

Department Assessment: No assessment necessary. Dental hygienists are currently subject to state regulation.

Evaluation Criterion #11: Minimal competence. Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

Responses:

MDHA states that as proposed by the American Dental Hygienists Association, the ADHP licensing requirements would exceed minimum standards currently set forth in Maine statute.

Jane Walsh (UNE) notes that both the advanced practice dental hygienist and the mid-level practitioner would be subject to a new higher level of education and training, thus creating a new standard of minimal competence.

MCDC/DHHS indicates that standards describing competence for a mid-level dental hygienist would exceed current requirements for licensing of dental hygienists under Maine law. Such standards do not currently exist in Maine and should be developed with consideration of the various models being proposed by other states and at the national level to facilitate reciprocity with other states in light of developing best practices.

Stephen Mills, DDS, states that this is a new designation; no standards exist.

Catherine Kasparek, RDH, says standards would exceed current level of minimal competence following the proposed guidelines of the American Dental Hygienists Association.

MBODE raises concerns that the proposed requirements for regulation are not fully researched, identified, and agreed upon by professional educators to assure that appropriate knowledge, skill and experience will be guaranteed in the educational process of any new level of dental care provider. Board members feel strongly that before any such legislation is considered, recommended levels of education and training must be agreed upon. In addition, the legislation should include a mechanism for testing minimal competence and a re-evaluation of appropriate continuing education requirements.

Department Assessment: LD 1246, if enacted as drafted, would require a new minimum standard of eligibility for mid-level dental hygienists for the purpose of public protection. The new minimum standards would require a substantially higher level of advanced education and clinical experience to ensure that public health and safety would not be jeopardized by mid-level dental hygienists providing dental services with minimal supervision by licensed dentists.

Evaluation Criterion #12: Financial analysis. Please describe 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.

Responses:

MBODE notes that any change resulting from this legislation "must be borne directly by the licensees via licensing and renewal fees and indirectly by the patients who avail themselves of these dental services by way of the fees charged for services rendered."

Department Assessment: All costs associated with regulation of the dental professions, as well as costs resulting from changes in regulation, would be borne by licensees of the licensing entity.

Evaluation Criteria #13 Mandated benefits. Please describe whether the profession or occupation plans to apply for mandated benefits.

Department Assessment: Although MDHA indicates that direct reimbursement of dental hygienists is critical to increasing access to oral health care, it does not indicate whether its members have or will submit legislation that would mandate dental or health insurance providers to reimburse mid-level dental hygienists for services provided.

VII. Department Conclusions and Recommendations

State sunrise review law requires the Commissioner to engage in a two-step evaluation process guided by 13 statutory evaluation criteria. First, the Commissioner must evaluate information provided by the applicant group in support of its proposal to regulate or expand regulation of a profession, as well as information from individuals or organizations opposing new regulation and other interested parties. Second, the Commissioner must recommend whether the Committee should take action on a legislative proposal. If the Commissioner's recommendation supports regulation or expansion, the report must include any legislation required to implement that recommendation. The recommendation must reflect the least restrictive method of regulation consistent with the public interest.

The purpose of a licensing board is singular in nature; 10 MRSA § 8009 provides that "*The sole purpose of an occupational and professional regulatory board is to protect the public health and welfare. A 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 regulated professions by examining, licensing, regulating and disciplining practitioners of those regulated professions. Other goals or objectives may not supersede this purpose.* (Emphasis added)

The role of a licensing board is frequently misunderstood. Licensing boards implement legislatively set public policy in the form of licensing standards and they apply practice statutes to complaints of misconduct. Their role is to carry out the directives of the Legislature by licensing applicants who satisfy license requirements and disciplining professionals whose relative skills cannot be assessed or evaluated by the public at large. Licensing boards do not set State policy—they carry out policy decisions made by the Legislature.

Licensing programs offer the public assurance that professionals who receive a state license possess a minimum level of skill and competence. Beyond those minimum standards, members of the public who interact with licensed professionals bear the responsibility for bringing to the boards' attention incidences of misconduct or substandard care. The Board of Dental Examiners carries out its legislative and statutory authorities and responsibilities in a professional manner, with careful analysis and within the due process safeguards of Maine's Administrative Procedure Act.

The purpose of the sunrise review process with respect to additional regulation of dental practitioners as described in Resolve 2007, Chapter 85 is to assess the public need for expanded regulation; and the consequences to the public of the expansion of an existing regulatory program. It is worth noting further that sunrise assessments evaluate the public's need for regulation or expanded regulation, not a profession's desire for heightened professional status and respect.[6]

In this regard, the four concepts examined in this report present unique difficulties given the nature of the profession under review. There is universal agreement that segments of Maine's population in unserved or underserved parts of the State have little or no access to dental care. Each proposal can be justified with the statement that Maine citizens need more access to dental care. However, the sunrise process focuses on when and how the State protects the public from individuals who have been issued a license. Much of the material and information submitted by interested parties makes a case that the State of Maine must act to provide wider access to dental and oral care. The Department suggests that the discussion of State health policies goes beyond the scope of this report and should be addressed by agencies other than the Department of Professional and Financial Regulation. The Department's task is to separate regulatory issues subject to sunrise from State financial and health policies that are within the purview of other segments of Maine government.

It is against this backdrop that the Department evaluates the four proposals described in the resolve.

[6] The Department does not suggest that professional associations are precluded from urging regulatory change on the Legislature but it should be understood that in the context of a sunrise review, the motivation to seek more regulation does not emanate from Maine's general public seeking more protection from dishonest or incompetent professionals. Rather, it comes from groups within the already regulated dental community whose associations seek greater respect and greater independence from licensed dentists for their members.

A. International Applicants for Maine Dental Licenses

Discussion and Conclusion:

The Department understands and appreciates the efforts of many interested groups and individuals working hard to attract new and transitioning dental professionals to Maine to increase the level of available dental care. Any licensing proposal that has the potential for producing even a handful of foreign-educated applicants for dental licenses seems worthy of consideration.

The information requested and received from the two states that have had experience with a state alternative to the CODA accreditation program shows that such a program is unreasonably expensive for a state dental board, and its ability to license only qualified applicants is highly questionable. As noted earlier in the report, California has a long history of administering a state-created restorative techniques examination intended to test the clinical skills of graduates of foreign dental programs. The California Board of Dental Examiners has expended considerable time and resources offering this exam which has resulted in the licensing of dentists who may not have skills and training that are equivalent to graduates of CODA-accredited dental programs. Moreover, California has only granted accreditation to one foreign dental program, located in Mexico.

Minnesota has also undertaken an effort to evaluate foreign dental programs only to admit that its program may not be successful in ensuring that only qualified foreign graduates are licensed to practice in that state.

Maine is fortunate, however, to be located close to two highly rated dental completion programs in Massachusetts which have produced quality applicants for licensure during the past six years.

Additionally, the Commission on Dental Accreditation is now offering accreditation services for international dental programs. CODA's interaction with foreign jurisdictions may eventually benefit Maine, as graduates are measured against the competency standards used to evaluate graduates of CODA-accredited US dental programs.

Recommendation:

The cost of creating and implementing a state accreditation program to evaluate dental education programs located outside the United States for the few applicants who do not qualify under existing licensure standards greatly outweighs the potential benefit. The Department therefore recommends that the Committee on Business, Research and Economic Development decline to act on this proposal.

B. Proposal to establish a new licensing entity to regulate denturists and dental hygienists

Discussion and Conclusion:

The Department finds that the public would not benefit from separating State regulation of denturists and dental hygienists from regulation of dentists. In fact, the Department suggests that the public would be harmed by such a separation given that the three license categories within the purview of this report are integral to the provision on oral and dental care in Maine. Separating regulation of dental hygiene and denturism from dental practice could impact negatively on the public if the professional and administrative connection between and among the three types of licensees was lost.

An instructive example of the benefit of regulating different segments of the same profession is the effectiveness of the Board of Counseling Professionals Licensure. Four distinct but related categories of practitioners are licensed and regulated by one licensing board. Licensed professional counselors, licensed clinical professional counselors, marriage and family therapists and pastoral counselors share a common code of ethics and distinct but related scopes of practice all focused on the goal of licensing qualified practitioners to provide Maine citizens with counseling services. Questions and concerns about the future of each segment of the regulated counselor community were raised in 1992 when the Legislature established the consolidated counselor licensing program. Those concerns, however, have been addressed and resolved. It is important that the dental profession reach the same level of comfort with a single licensing board.

Moreover, the Department finds allegations of mistreatment, decision-making based on competitive advantage and lack of attention against the Board of Dental Examiners by dental hygienists and denturists unfounded and unhelpful to the State's efforts to protect the public from unethical, unsafe and incompetent dental practitioners. The Department could not confirm that denturists are unable to work closely with dentists in Maine, and that dental hygienists do not generally have excellent working relationship with dentists. No interested party has submitted concrete, specific information to substantiate allegations of mistreatment by dentists or the Board as an administrative regulatory body.

The Maine Society of Denturists asserts that the Board has not made efforts to develop or establish denturist educational programs in Maine therefore creating a barrier to expansion of denturism. The Department notes that the development of new educational programs for students who are interested in becoming denturists, dental hygienists or dentists is not within the statutory purpose or regulatory purview of the Board. It is incumbent on existing public and private educational institutions to either create a new program or expand their existing dental health programs to include denturism education if they view it as viable. Husson College, for example, recently announced the establishment of a pharmacy degree program that will allow students to graduate with a Pharmacy Doctorate as a way of addressing the reported shortage of licensed pharmacists. The Maine Board of Pharmacy did not have statutory or regulatory responsibility for establishing such a program.

Denturists and dental hygienists were given ample opportunity to share information with the Business, Research and Economic Development Committee during legislative hearings on the Board of Dental Examiners 2003 Government Evaluation Act Review. The Committee accepted some recommendations and rejected others for improvements in the Board's regulatory process. The Committee considered separating denturists and dental hygienists but determined that doing so was not warranted and the Department agreed with that determination.

A few, but not all, licensed denturists then approached the Maine Regulatory Fairness Board because of their views that denturists were being prevented from flourishing in Maine for competitive reasons by dentists. Similarly, some, but not all, dental hygienists also testified that they are dominated by dentists for competitive reasons. Although the interested parties have the right to petition the Legislature at any time, and the Regulatory Fairness Board appropriately offered the parties a forum for discussing the concerns of denturists and dental hygienists, the Department respectfully disagrees with the Regulatory Fairness Board's recommendation that creation of a separate licensing board(s) is appropriate. The recommendation is based on the views of a narrow segment of the regulated community rather than an examination of a broader base of opinion and experience. The Department could not identify efforts by any group to prevent denturists and dental hygienists from providing services to the public.

Recommendation:

The Department recommends that the Committee on Business, Research and Economic Development take no action on this proposal. It does, however, suggest that the Committee strengthen and standardize the roles of the Dental Hygiene and Denturism Subcommittees within the structure and operation of the Dental Board. The Board has indicated its willingness to expand the role and function of these subcommittees. The public would be better served by strengthening the connection between dentists, denturists and dental hygienists rather than splintering the dental profession into three parts.

The Denturist subcommittee should be empowered not only to make disciplinary decisions on complaints against denturists, but also to address licensure and practice issues relative to denturism practice in collaboration with the Board. Similarly, the Dental Hygienist Subcommittee should be empowered not only to make decisions on hygienist applications, but also to consider and act on practice and disciplinary issues.

The Department is satisfied with the efforts of the Board to implement significant statutory changes made by the Legislature in 2003 to address issues of collaboration that resulted in the establishment of subcommittees. The Board and all interested groups of practitioners would benefit from additional time to work together to solidify the statutory improvements implemented by the Board at the direction of the Legislature.

C. Proposal to Allow Licensed Dental Hygienists to Provide Dental Hygiene Services Independent of Supervision by Licensed Dentists

Discussion and Conclusion:

A comparative analysis of the dental hygiene regulatory programs in other states and the Maine regulatory program indicates conclusively that the scope of practice of Maine dental hygienists is broader than that of most states.

Under current law, a Maine dental hygienist may work under direct or general supervision of a dentist in a traditional private dental practice or in a variety of public health settings under less restrictive supervision. Moreover, dental hygienists who demonstrate appropriate training and proficiency may administer local anesthesia in traditional dental offices. They may also, having demonstrated appropriate training and proficiency, administer nitrous oxide in traditional practice settings under direct supervision.

Only one state, Colorado, has a broader scope of dental hygiene practice because state law permits a dental hygienist to practice "independent" of a licensed dentist. The term "independent practice" in the context of this report means a dental hygienist may engage in a privately owned independent practice without any supervision, either direct or general, by a licensed dentist. Although the Department could find no study or external examination of the impact of independent practice by dental hygienists on patient outcomes in Colorado, it is likely that if negative outcomes had been documented in that state, those reports would be available.[7] The Colorado Board of Dental Examiners recently notified the Department that it is not aware of any study or report that has been released on this topic.

The Department suggests that the success of the existing public health supervision program is the most relevant indicator of the potential benefit and the low level of potential risk to the public of independent practice of dental hygienists. Under public health supervision, dental hygienists provide oral care services independent of dentist supervisions in large part. (See Appendix F.)

It is the Department's understanding that no significant practice issues or problems have been reported to the Board as a result of dental hygienists practicing pursuant to public health supervision, outside the traditional private office setting. The Board is currently providing educational support for dental hygienists who indicate an interest in working in a public health setting.

A review of disciplinary actions taken by the Board against licensed dental hygienists supports the Department's conclusion that Maine dental hygienists have no difficulty

[7] The Department notes that this sunrise report contains a prior reference to a study commissioned by the American Dental Association with respect to how independent practice of Colorado dental hygienists has affected overall access to oral health care in that state. That report did not contain a conclusion or recommendation about the impact of independent practice of dental hygienists on patient outcomes.

meeting minimum standards of care and competency outlined in existing statute and rule. Of the four adverse actions taken against dental hygienists in the Board's history, three actions were based on substance abuse issues that are not uncommon to health-related professions, and one action involved a dental hygienist who treated a patient who was not a "patient of record" of the licensee's supervising dentist.

Concerns raised by interested parties about independent practice of dental hygienists in Maine focused not on whether the proposal would benefit the public but on whether dental hygienists would need additional education or clinical experience in order to practice at a higher skill level as independent practitioners.

A final factor considered by the Department was whether permitting independent practice by dental hygienists would decrease access by the public to essential oral health care while interested practitioners obtain more qualifying education or more clinical experience. The Department concludes that any initial decrease in numbers of actively practicing dental hygienists as a result of this proposal would be minimal and would not result in a negative impact on the public with respect to access to care.

The Department concludes that the proposal to permit independent practice of preventive care and oral health education by dental hygienists who meet certain licensing qualifications should be considered by the Committee on Business, Research and Economic Development pursuant to the following recommendation.

Recommendation:

The Department recommends that statutory provisions be drafted to establish a license category for "independent practice dental hygienist" with a scope of practice limited to preventive care and oral health education on an independent basis without supervision by licensed dentists:

1) License Qualifications (in addition to requirements already applicable to dental hygienists including continuing education)

- licensed dental hygienist with a bachelor degree from an accredited dental hygiene program who demonstrate one year or 2,000 work hours of clinical practice in a traditional private dental practice or dental clinic completed within the two years preceding application for independent status; or

- licensed dental hygienist with an associate degree from an accredited dental hygiene program who demonstrate three years or 6,000 hours clinical practice in a traditional private dental practice or dental clinic completed within six years preceding application for independent status;

2) Scope of practice of the independent practice dental hygienist will include the following exclusive list of permissible functions and tasks limited to preventive oral care and oral health education:

- Interview patients and record complete medical and dental histories;
- Take and record the vital signs of blood pressure, pulse and temperature;
- Perform oral inspections, recording all conditions that should be called to the attention of a dentist;
- Perform complete periodontal and dental restorative charting;
- Perform all procedures necessary for a complete prophylaxis, including root planing;
- Apply fluoride to control caries;
- Apply desensitizing agents to teeth;
- Apply liquids, pastes or gel topical anesthetics;
- Apply sealants;
- Smooth and polish amalgam restorations, limited to slow speed application only;
- Cement pontics and facings outside the mouth;
- Take impressions for athletic mouth guards, and custom fluoride trays;
- Place and remove rubber dams;
- Place temporary restorations in compliance with the protocol adopted by the Board of Dental Examiners; and
- Apply topical antimicrobials (excluding antibiotics), including fluoride 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. For the purposes of this section, "topical" includes superficial and intrasulcular application.

3) A dental hygienist providing services on an <u>independent basis</u> shall perform the following duties:

- Provide to the patient, parent or guardian a written plan for referral or an agreement for follow-up by the patient, recording all conditions that should be called to the attention of a dentist;
- Have each patient sign an acknowledgment form that informs the patient that the practitioner is not a dentist and that the service to be rendered does not constitute restorative care or treatment;
- Inform each patient who may require further dental services of that need;

4) An independent practice dental hygienist may be the proprietor of a place where independent dental hygiene is performed and may purchase, own, or lease equipment necessary to perform independent dental hygiene.

5) Make conforming changes to the dental practice statute for the license category of independent practice dental hygienist including a definition of "independent practice."

Attached as Exhibit H is a draft legislative proposal to effectuate this recommendation.

D. Establishment of Licensing Category for Mid-Level, Expanded Scope Dental Hygienist

Discussion and Conclusion:

The fourth proposal envisions the creation of a license category that falls somewhere between a licensed dental hygienist and a licensed dentist. This new level of practitioner would have an expanded scope of practice that approaches the traditional practice of general dentistry. Survey responses on this proposal indicated that dental hygienists and their professional associations are enthusiastic about the concept as a way to expand access to oral health care based on advancing the interest of dental hygienists in becoming accepted as dental professionals educated and licensed to provide dental services beyond prevention and oral health education, including "diagnostic, preventive, restorative and therapeutic services directly to the public."[8]

The purpose of sunrise review is not to assess whether access to oral health care should be expanded, but rather to indicate whether proponents have made a case for creating a new licensing category because the public health and welfare is threatened without it. The Department concludes that the case for an advanced practice dental hygienist has not been made.

The proposal is premature for the following reasons:

1) The concept of a mid-level dental hygienist is, at this time, simply a concept.

No state has created such a license category; nor is there any generally accepted standard educational curriculum in place today that could be evaluated.

2) Educational curricula have not been established.

Although the American Dental Hygienist Association has compiled a list of "competencies" that describe the ADHA's vision of the advanced skill level, the Department was unable to find any educational institution that offers degree programs based on these draft competencies.

[8] Excerpt from "The American Dental Hygienists' Association's Draft Competencies for the Advanced Dental Hygiene Practitioner, June 2007, p. 6. (Appendix F).

3) Educational infrastructure is not in place to support the concept.

There are two associate degree programs in Maine that award associate degrees in dental hygiene—the University of Maine (Bangor) and the University of New England in Westbrook. Both educational institutions offer a bachelor's degree in dental hygiene but those two programs are open only to applicants who have already received an associate's degree in dental hygiene.

There is no educational institution in Maine that offers a direct entry Bachelor's or Master's Degree in Dental Hygiene. The concept advanced by the American Dental Hygiene Association envisions a Master's Degree in Dental Hygiene as the entry level degree for a mid-level dental practitioner. Although there are 15 master's programs in dental hygiene in the United States, it is unclear whether these programs focus on preparing students for this advanced license designation.

4) The Board of Dental Examiners is not the appropriate entity to evaluate curriculum and make determinations about educational and experiential requirements.

As noted previously, it is not within the statutory mission of the Board to either implement or recommend course curriculum for students who wish to eventually become mid-level practitioners in a license category that does not exist today. In the Department's view, it is the responsibility of private and public educational institutions to respond to the demand for new programs. Moreover, the Department is not aware of any established state or national examination focused on this subset of the dental profession.

Recommendation:

For the reasons discussed above, the Department recommends that the Committee on Business, Research and Economic Development take no action on this proposal.

Resolve, Directing the Commissioner of Professional and Financial Regulation To Conduct a Sunrise Review of Oral Health Care Issues

Sec. 1 Oral health care and sunrise review. Resolved: That the Commissioner of Professional and Financial Regulation shall conduct an independent assessment pursuant to the Maine Revised Statutes, Title 32, chapter 1-A, subchapter 2 of the following oral health care issues: the proposal for expansion of the scope of practice of dental hygienists to create a mid-level dental hygienist license category, as well as the proposal to permit dental hygienists to practice independently without the supervision of a licensed dentist in order to increase access to preventive dental care across the State; the proposal to expand licensing requirements to permit graduates of a foreign university considered satisfactory to the Board of Dental Examiners to practice dentistry in this State, including a review of other states' models for evaluation of foreign-trained dentists; and the proposal that the regulatory structure for denturists and dental hygienists include placing denturists and dental hygienists under the jurisdiction of a new board within the Department of Professional and Financial Regulation; and be it further

Sec. 2 Reporting date established. Resolved: That no later than February 15, 2008 the Commissioner of Professional and Financial Regulation shall submit a report following the independent assessment under section 1 to the Joint Standing Committee on Business, Research and Economic Development. That committee is authorized to introduce legislation on the subject matter of the report to the Second Regular Session of the 123rd Legislature.

Title 32, Chapter 1-A, GENERAL PROVISIONS

Subchapter 2: SUNRISE REVIEW PROCEDURES (HEADING: PL 1995, c. 686, §2 (new))

§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).]

PL 1995, Ch. 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).]

PL 1995, Ch. 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).]

PL 1995, Ch. 686, §2 (NEW).

Department of Professional and Financial Regulation Office of the Commissioner
Doug Dunbar, Assistant to the Commissioner

Sunrise Review Survey: *Oral Health Issues*
LD 1129 Resolve

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JUL 23 2007
Department of Professional & Financial Regulation

General Information

1. Dental Hygienist

2. **Support LD 550** (Permitting dental hygienists to practice independently without supervision of a licensed dentist)

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. **Data on group proposed for regulation.**

   Independent Practice of Dental Hygiene practicing under the LAWS and RULES RELATING TO THE PRACTICE OF DENTISTRY, DENTAL HYGIENE, AND DENTURISM; M.R.S.A. Title 32, Chapter 16 and Rules of the Board of Dental Examiners to practice with out supervision of a dentist

   (a) There are 1200 registered dental hygienists in the State of Maine. A guess would be that (6-10%) would practice as independent

   (b) Maine Dental Hygiene Association, American Dental Hygiene Association

   (c) I believe there are 200 active members in the state of Maine

2. **Specialized skill.**

   Dental Hygienists practicing independently without supervision of a licensed dentist: The assurance of minimum qualifications has been met already when one becomes a licensee in the State of Maine.

   M.S.R.A. Title 32, Chapter 16 and by the Rules of the Board of Dental Examiners

   Department of Professional and Financial Regulation Board of Dental Examiners, Chapter 2: Rules Relating To Dental Hygienists, page 25, of LAWS and RULES RELATING TO THE PRACTICE OF DENTISTRY, DENTAL HYGIENE, AND DENTURISM

3. Threat to public health, safety, or welfare.

a. The **welfare** of the citizens of Maine will not be provided with ***optimum accessibility***, if the regulation for dental hygienists is not expanded to that of independent practice. The foundation for oral health care is preformed by the services of dental hygienists: Education, Prevention, and Therapeutic Treatment. Making the availability to access these dental hygiene services should be a given right to the citizens of Maine. Also, over time a considerable decrease in oral disease will be seen, as will the need for intervention

b. I know of no complaints or harm done by a dental hygienist in the state of Maine

4. Voluntary and past regulatory efforts.

Unknown

5. Costs and Benefits of regulation.

The independent practice of dental hygienists would ***decrease*** the cost of services of oral health care because there would be greater accessibility to the citizens of Maine.

Greater Access would:

1. Make the fees for service competitive, (more practitioners more choices for the citizens)

2. Hygienist practicing where they reside could base fees according to the economics of locality

The overall economic impact would be great for the State of Maine. Proprietorship of an independent hygienist would generate the need for: office space (buy, rent, build), purchase of dental equipment, purchase of office equipment, and the employment of staff. All of which, is tax revenue for the state, as well, as revenue for small businesses. The continual need to purchase supplies (dental and office), the continual maintenance of the property (building, grounds seasonal care) all of which generates more jobs and the making of money for other businesses.

The cost to consumers would be less because of the increase to access creating competitive fees for service. The distance traveled for service less, save on fuel cost.

Also, the loss of wages to the consumer would be less, since an independent hygienist could offer the hours of service to accommodate the working consumer.

6. Service availability under regulation.

With the expanded regulation of dental hygienists practicing independently the service availability of oral health services would be increased to the public in three ways:

a. Waiting period for an appointment would be considerably less

b. Independent hygienist having proprietorship could chose the hours of service to accommodate the working and children during the school year

c. Access by location, hygienist live all over the state of Maine

7. Existing laws and regulations.

Regulation of independent dental hygienist can be provided through M.R.S.A. Title 32, Chapter 16 with amendments:

Subchapter 3, §1081, 3. Definitions; persons excepted

3. Proprietor. The term proprietor, as used in this chapter, includes a person who: **D. or *is a practicing independent dental hygienist*** [1]

Subchapter 4, §1098-D. Licensure requirements for graduates of accredited programs

3. Licensure for independent dental hygienist. For licensure, the applicant must have 3 years of clinical practice under the supervision of a dentist (s) proof by written statement by the dentist (s) or by W-2's [2]

[1] LAWS AND RULES RELATING TO THE PRACTICE OF DENTISTRY, DENTAL HYGIENE, AND DENTURISM; pages 5-6

[2] Same; page 14

8. Method of regulation.

License to practice as an independent dental hygienist is being proposed for the reason of giving more availability for the citizens of Maine to access preventive dental care with the goal in mind to decrease dental disease. To allow the citizens access to professional oral hygiene care in a setting that is safe from infection, comfortable, in a well-equipped stationary facility; where they are treated with dignity. Also, this proposal will keep the cost down for the citizens.

9. Other states.

The state of Colorado has licensed practicing unsupervised dental hygiene, which is what would be the equivalent to the practice of independent dental hygiene.
Enclosed is a copy of THE DENTAL PRACTICE LAW OF COLORADO FOR your review. Page 7, 12-35-122.5. **What constitutes practicing unsupervised dental hygiene.** Note that under 12-35-122.5, (3) proprietorship is an integrated part of licensed dental hygienists.

10. Previous efforts to regulate.

Unknown

11. Minimal competence.

As proposed, LD 550 has met the professional standards for an independent practicing dental hygienist. Under Evaluation Criteria number 7, Existing laws and regulations, I proposed a higher standard by recommending a 3 year clinical experience under the direct supervision of a dentist before being able to be licensed to practice independent dental hygiene.

12. Financial analysis.

The licensing fee established for the level of independent dental hygiene status would pay for this regulation. The fee would be higher than the licensing of regular status dental hygiene. As should the licensure fee for the public health supervision status, which produces the most paper work for the dental board.

13. **Mandated benefits.**

No mandated benefits. This professional entity should be self –sustaining.

Date: July 19, 2007

Completed by: Joan E. Davis, C.D.A., R.D.H.

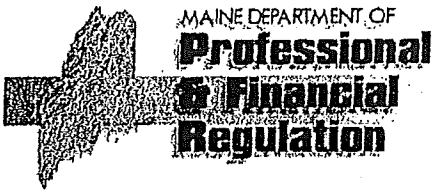
Dental Hygienist

315 Lowell Town Road
Wiscasset, Maine 04578

E-mail address: pollobicho@yahoo.com

Enclosures: LAWS AND RULES RELATING TO THE PRACTICE OF DENTISTRY, DENTAL HYGIENE, AND DENTURISM M.R.S.A. Title 32, Chapter 16 and Rules of the Board of Dental examiners

THE DENTAL PRACTICE LAW OF COLORADO



RECEIVED
JUL 23 2007
Department of Professional
& Financial Regulation

Sunrise Review: Request for Information from Interested Parties

LD 1129 "Resolve, Directing the Commissioner of Professional and Financial Regulation to Conduct a Sunrise Review of Oral Health Care Issues"

Department of Professional and Financial Regulation
Office of the Commissioner
June 21, 2007

Sunrise Review Survey: Oral Health Issues

Please return the completed survey to the Commissioner's Office by July 20, 2007. You may respond to any or all questions. The survey should be e-mailed to Doug Dunbar, Assistant to the Commissioner. The address is doug.dunbar@maine.gov. An electronic version of the survey is available by contacting the Commissioner's Office.

General Information

1. **Group or organization you represent (if any):**
Myself - MDHA Past President, RDH for 25th years, CDA (Certified Dental Assistant) - 3yrs

• Public Health
• General
• Periodontal fields
• Program Mgr Public Health Schools + Comm. Hlth. Ctr.

2. **Position on proposed legislation.** Does this group or organization support or oppose:

• Expanding the scope of practice of dental hygienists by creating a mid-level dental hygienist* license category (LD 1246):
Support

• Permitting dental hygienists to practice independently without supervision of a licensed dentist (LD 550): Support

• Permitting dental graduates of foreign universities to become licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):
Support - similar to other State dental grads coming to ME requirements

• Creating a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):
Support

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. **Data on group proposed for regulation.** Please provide a description of the professional or occupational groups proposed for regulation, including:
Dental Hygienists, Denturists

(a) The number of individuals or business entities that would be subject to regulation;
Dental Hygienists in ME - 1257
Denturists - 56

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and MDHA - Michelle Gallant Rockport until 11/2/07 then Mary Lynne Murray-Ryder Herman, ME

* In this sunrise review, "mid-level dental hygienist" means a dental hygienist with an expanded scope of practice similar to the scope of practice proposed in LD 1246.

(c) An estimate of the number of potential licensees in each group.

1257 - Hygienists
576 - Dentists

2. **Specialized skill.** Please describe whether the proposed law changes in the areas of oral health care outlined below require such a specialized skill that the public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met:

- a mid-level dental hygienist license category (LD 1246): follow guidelines as outlined in the ADHA (American Dental Hygienists' Association) Advanced Dental Hygiene Practitioner (ADHP) - Draft June 2006
- dental hygienists practicing independently without supervision of a licensed dentist (LD 550): To be licensed in ME - a DH has to meet criteria and pass National & Regional Boards - the specialized skill is there now. Many Office Hyg.+ Public Health Hyg work alone now.
- dental graduates of foreign universities becoming licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129): follow guidelines for out of state dentists to become licensed in ME.

3. **Threat to public health, safety, or welfare.** Please describe:

(a) The nature and extent of potential harm to the public, if any, if regulation of the practitioners listed below is not expanded:

- a mid-level dental hygienist: - more potential harm to public by not allowing a mid-level DH. This would allow more care accessibility for citizens in ME, there is a shortage of dentists which is making it difficult for many to access care.
- dental hygienists practicing independently without supervision of a licensed dentist: Would allow a hygienist to practice the full extent of their license and education. This is difficult in settings with supervision according to what many dentists allow.
- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners: follow the guidelines for out of State Dentists will allow all to be qualified and not harm the public

(b) The extent to which there is a threat to the public's health, safety or welfare (*Please provide evidence of the 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 dental hygienists or dental graduates of foreign universities in *this State* within the past 5 years).

I am not aware of any -

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by dental hygienists or dental graduates of foreign universities 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.

• Dtt increase in continuing Education, professional organizations help protect the public

• Dental Grads - foreign - I cannot comment on this other than I feel they should meet the same requirements as any out of State grad would to protect the public

5. **Costs and benefits of regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below will increase the cost of services provided by those practitioners, and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

• a mid-level dental hygienist: costs may be the same or less than what is now incurred, there will be more competition and more access to care which will reduce medical care costs + increase the overall health of ME citizens

• dental hygienists practicing independently without supervision of a licensed dentist: Same as above

• dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners: that now exists for out of State grads

• a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners:
Will work as it does now - license fees

6. **Service availability under regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below would increase or decrease the availability of oral health services to the public.

• a mid-level dental hygienist: will increase the availability of services to the public
more access in more locations -

• dental hygienists practicing independently without supervision of a licensed dentist:
would allow for services that are now limited by supervision/employer + eliminate conflict of interest

• dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:
not sure of how many foreign dental grads are requesting licensing in ME.

• a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):
Would allow both professions to work to their level of expertise - full scope of practice -

7. **Existing laws and regulations.** Please discuss the extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from

non-regulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated practitioners.
Each profession knows the most about their profession making them the best to regulate the practice and education.

8. **Method of regulation.** Please describe 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. National + Regional boards of the Professions set the standard Each Profession that has these requirements would best be appropriate to regulate themselves.

9. **Other states.** Please provide a list of other states that regulate the profession, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on commercial leasing agents in terms of a before-and-after analysis.
There are about 17 states that have DH participatim in regulation, Iowa, Florida, Connecticut, Arizona, New Mexico, Nevada, Missouri, Montana, Michigan, Maryland, OKlahoma, Washington + a few others - ADHA should have this info - MDHA may submit it

10. **Previous efforts to regulate.** Please provide the details of any previous efforts in *this State* to implement regulation or expand regulation of the occupations (or proposed occupations) listed below:

- a mid-level dental hygienist: Public Health DH -

- dental hygienists practicing independently without supervision of a licensed dentist:
MBDE - DH subcommitte

- dental graduates of foreign universities:
do not know

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):
not sure of previous history

11. **Minimal competence.** Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.
Yes the standards will exceed standards of minimal competence following the guide of the Am DH Assoc. Advanced DH Practitioner Curriculum draft at an entry level/Certificate level to help access sooner than later to completion of ADHP Master's level

12. **Financial analysis.** Please describe 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.
This should be covered through licensing fees.

13. **Mandated benefits.** Please describe whether the profession or occupation plans to apply for mandated benefits.

Date: 7/18, 2007

Completed by:

Catherine J Kasprak, RDH

Name: Catherine J Kasprak, RDH, AAS

Title: Registered Dental Hygienist
Public Health

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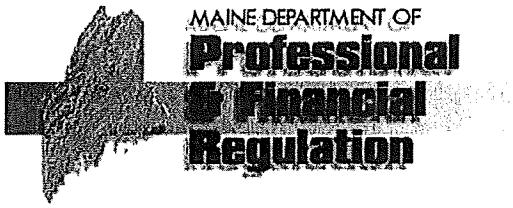
Fryeburg, ME
04037-1142

E-mail address: ckasprak@fairpoint.net



Sunrise Review: Request for Information from Interested Parties

LD 1129 "Resolve, Directing the Commissioner of Professional and Financial Regulation to Conduct a Sunrise Review of Oral Health Care Issues"

Department of Professional and Financial Regulation
Office of the Commissioner June 21, 2007

Sunrise Review Survey: Oral Health Issues

Please return the completed survey to the Commissioner's Office by July 20, 2007. You may respond to any or all questions. The survey should be e-mailed to Doug Dunbar, Assistant to the Commissioner. The address is doug.dunbar@maine.gov. An electronic version of the survey is available by contacting the Commissioner's Office.

General Information

1. Group or organization you represent (if any):

International Federation of Denturists

2. Position on proposed legislation. Does this group or organization support or oppose:

- Expanding the scope of practice of dental hygienists by creating a mid-level dental hygienist license category (LD 1246):
- Permitting dental hygienists to practice independently without supervision of a licensed dentist (LD 550):

Support

- Permitting dental graduates of foreign universities to become licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

Support

- Creating a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

Support

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. Data on group proposed for regulation. Please provide a description of the professional or occupational groups proposed for regulation, including:

(a) The number of individuals or business entities that would be subject to regulation;

Denturists: 50+ Licensees, 15 practicing in Maine

In this sunrise review, "mid-level dental hygienist" means a dental hygienist with an expanded scope of practice similar to the scope of practice proposed in LD 1246.

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and

International Federation of Denturists
P.O. Box 46132 RPO Westdale
Winnipeg MB R3R 3S3
Canada

National Denturist Association/USA
PO Box 308 Tonawanda, PA
18848

Maine Society of Denturists
81 Webster St. Lewiston, ME

(c) An estimate of the number of potential licensees in each group.

Maine could easily accommodate 50 practicing Denturists. The most limited scope of independent practice in the USA combined with being under the control of dentists has created conditions in which Maine has lost several practitioners to the west coast. It is very difficult to recruit new Denturists given the circumstances.

2. Specialized skill. Please describe whether the proposed law changes in the areas of oral health care outlined below require such a specialized skill that the public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met:

• a mid-level dental hygienist license category (LD 1246):

All dental professionals are tested for minimal competency and that should not change.

• dental hygienists practicing independently without supervision of a licensed dentist (LD 550):

All dental professionals are tested for minimal competency and that should not change.

• dental graduates of foreign universities becoming licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

All dental professionals are tested for minimal competency and that should not change.

3. **Threat to public health, safety, or welfare.** Please describe:

(a) The nature and extent of potential harm to the public, if any, if regulation of the practitioners listed below is not expanded:

• a mid-level dental hygienist:

Various governments, including the United Kingdom, the Republic of Ireland, Denmark, Canada and many more have recognized the fact that the public are not best served by dental monopolies. To benefit the public welfare, these countries are proposing or implementing schemes which allow for competition within dentistry such as exist in the medical profession.

• dental hygienists practicing independently without supervision of a licensed dentist:

This delivery scheme is practiced in various locations around the world as well as in the USA and Canada with no jurisdiction ever abandoning this model after implementation.

• dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

To suggest that the USA, which ranks 42nd in the world for health care, is the only acceptable venue for educating dentists is parochial at best. Testing, independent of the ADA's CODA, should be available for evaluating and licensing foreign trained dentists.

(b) The extent to which there is a threat to the public's health, safety or welfare (*Please provide evidence of the 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 dental hygienists or dental graduates of foreign universities in *this State* within the past 5 years).

Data unavailable.

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by dental hygienists or dental graduates of foreign universities 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.

Data unavailable.

5. **Costs and benefits of regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below will increase the cost of services provided by those practitioners, and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

• a mid-level dental hygienist:

The Irish Competition Authority as well as the United Kingdom's Fair Trade Office have both issued reports calling for expanding competition within the dental profession as a method of bringing down costs as well as increasing access to care. As a consumer of dental services, government has a vested interest in controlling costs.

• dental hygienists practicing independently without supervision of a licensed dentist:

See previous answer.

• dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

Competition usually brings cost down.

• a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners:

Costs should be covered by licensing fees and should not impact fees paid by the public.

6. **Service availability under regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below would increase or decrease the availability of oral health services to the public.

- a mid-level dental hygienist:
- dental hygienists practicing independently without supervision of a licensed dentist:

Would increase the number of practitioners who could provide these services and thereby increase access to care.

• dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

See previous answer.

• a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

See previous answer.

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

An autonomous dental board, dominated by dentists, unregulated by government except for sunset review every ten years has not served denturists, hygienists, and the public well. Every advance that has been made on behalf of denturists (for example, independent practice and the disciplinary subcommittee) has been as a result of the unflagging efforts of denturists and in spite of the dental board.

8. **Method of regulation.** Please describe 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.

See previous answer.

9. **Other states.** Please provide a list of other states that regulate the profession, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on commercial leasing agents in terms of a before-and-after analysis.

Oregon: Board of Denture Technology Idaho: Board of Denturitry Arizona: Board of Dentistry. Montana: Board of Dentistry. Washington: Board of Denture Technology Canada: Provinces have Denturist regulatory bodies.

10. Previous efforts to regulate. Please provide the details of any previous efforts in *this State* to implement regulation or expand regulation of the occupations (or proposed occupations) listed below:

• a mid-level dental hygienist:

Unknown

• dental hygienists practicing independently without supervision of a licensed dentist:

Unknown

• dental graduates of foreign universities:

Unknown

• a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

Several attempts within the last 20 years.

11. Minimal competence. Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

N/A

12. Financial analysis. Please describe 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.

Most jurisdictions require the licensees to fund regulation.

13. Mandated benefits. Please describe whether the profession or occupation plans to apply for mandated benefits.

Unknown

Date: August 21, 2007 Completed by:

_____ Name:

Paul M. Levasseur, LD

Title:

President, **International Federation of Denturists**

Mailing Address:
PO Box 58 **Standish, Maine 04084**

E-mail address:
plevasseur@fairpoint.net

MAINE BOARD OF DENTAL EXAMINERS

TO: ACTING COMMISSIONER OF THE DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION, ANNE HEAD

ASSISTANT TO THE COMMISSIONER, DOUG DUNBAR

FROM: TENEALE E. JOHNSON, BOARD ASSISTANT

SUBJECT: SUNRISE REVIEW SURVEY

DATE: AUGUST 8, 2007

Please find attached the Boards response to questions posed in the Sunrise Review Survey document. If you have any questions, please do not hesitate to contact the Board office.

Thank you,

Teneale E. Johnson, Board Assistant

143 STATE HOUSE STATION
161 CAPITOL STREET
AUGUSTA, ME 04333-0143
PHONE: 207-287-3333/FAX: 207-287-8140

Sunrise Review

June 2007

General Information

1. Group or organization you represent:

State of Maine Board of Dental Examiners

2. Position on proposed legislation:

- LD1246 – The Board of Dental Examiners can neither support nor oppose the creation of a mid-level hygienist license category at this time. While the possible expansion of the scope of practice has been reviewed, there are no educational criteria available to evaluate. Expanding the scope of practice for hygienists cannot be possible without expanding the educational requirements as well. Education, minimal competency testing, and continuing education requirements will all need to be addressed prior to the Maine Board of Dental Examiners taking a position on the expansion of the scope of practice for hygienists. As the present legislation is written, the Board has serious reservations about a mid-level practitioner performing extractions, pulpotomies, and restorations without being able to review educational criteria.

- LD 550 – The Board takes no position on LD 550 providing that the current scope of practice for dental hygienists does not expand beyond the current level of education, experience, and skill.

- LD1129 – The standards acceptable to the Maine Board of Dental Examiners already exist in our statute and rules. In order to apply for licensure in Maine, candidates must be graduates of accredited schools who have received that status from the Council of Dental Accreditation (CODA) of the American Dental Association. CODA has the expertise and resources to evaluate facilities, curriculum, faculty, and patient care in the institutions that request their review. Additionally, periodic CODA review and approval is necessary as an ongoing measure of a schools ability to provide certain educational standards. There is no other entity that the Board would find acceptable. Any foreign university would need to meet CODA standards and as such any of its graduates would be eligible for licensure in Maine providing all other requirements, such as successful completion of a regional or national dental examination, are met.

  There is currently a mechanism in place for licensing of graduates of foreign dental programs. In fact, each year, the Board of Dental Examiners issues licenses to a number of individuals who were educated in foreign schools or universities. This existing pathway to licensure requires graduates of foreign dental schools or universities to complete an extension of their education at a CODA approved dental program that ensures that their training, education, and clinical skills meet the minimum standards required of all U.S. and Canadian educated candidates for licensure. During a recent interview with the Board, a foreign educated and trained graduate who completed a CODA approved dental program for international students stated that she would not have been competent to enter practice based upon her foreign education and training alone. The applicant confirmed what the Board has long known, that no mechanism exists to evaluate foreign universities or dental schools. That is why the CODA approved system has been the Board's standard for educational requirements for licensure.

- LD1462 – The Maine Board of Dental Examiners would oppose the creation of a new licensing board for denturists and hygienists. While there are certainly adequate numbers of hygienists in Maine to support their own board, hygienists in their educational training and experience have no knowledge of the practice of denturism. Conversely, denturists are not prevention specialists either. These two specialties of dentistry are so far removed from each other that they cannot

support one another in a board setting. The number of practicing denturists in Maine is so low that there could not help but be continuing conflicts of interest in rule making, licensing, and disciplinary issues. For example, there are approximately 14 actively practicing denturists in Maine. There are two business entities that involve 9 of those 14. The numbers suggest that conflict of interest issues alone would preclude the formation of a separate board. Recent legislation has created subcommittees of the Maine Board of Dental Examiners to give the denturists and hygienists more voice and control over licensure and disciplinary issues for these licensees. Both committees are chaired by the respective licensees and both committees have a majority of either denturists or hygienists. A super majority vote of the entire Maine Board of Dental Examiners is required to reject their recommendations to the Board. This has never happened to date and as such the present system seems to be working very well. The Board of Dental Examiners is open to the concept of expanding the existing responsibilities of the current subcommittees on dental hygiene and denturism. The Board believes that the responsibilities of the subcommittees should be uniform as they relate to their specific area of dentistry. Such a change would permit the Board to create equality of responsibility of the subcommittees in the completion of their duties.

Evaluation Criteria:

1. Data on group proposed for regulation

a. There are currently:

14 licensed denturists in Maine of which our records indicate are actively practicing

819 licensed dental hygienists in Maine of which our records indicate are actively practicing

b. Names and Addresses:

Maine Denturism Society
7 Moore Street
Hartland, ME 04945
207-938-5870

Maine Dental Hygiene Association
Michelle O'Clair Gallant, RDH, (Current President)
37 Chickawaukie Pond Road
Rockport, ME 04856

2. Specialized Skill:

- Mid-level dental hygienists category (LD1246) – The creation of this category of dental care giver would allow certain restorative procedures as well as some oral surgery procedures to be performed by a person other than a licensed dentist which is now the case. Clearly, the public does not have the knowledge and expertise to assess the competency of these individuals without assurance of minimal competency. There are currently no levels of licensure under the dental practice act that do not require assurance of minimal qualifications.

- Dental hygienists practicing independently (LD550) – All hygienists are currently required to provide proof of minimal qualifications and meet continuing educational standards. The Board would not expect LD550 to change this standard.

- Dental graduates of foreign universities (LD1129) – This is a potentially dangerous piece of legislation for the citizens of the State of Maine. With no assurance of the depth, breadth, and quality of an education in a foreign country the public cannot be expected to be able to select a competent individual to be their dentist. The education of a dentist is too complex and interdependent on academic vs. clinical vs. ethical training that the public could never make the determination of an individual's competency on it own. To think otherwise would support the notion that no healthcare provider in Maine need provide assurances that minimal qualifications have been met.

3. Threat to Public Health, Safety, or Welfare:

- If such proposed legislation on the expansion of scope of practice for dental hygienists and /or the licensing of graduates of foreign universities is not enacted, there will be no potential harm to the public. The single argument that this proposed legislation makes is that access to care for underserved Maine Citizens will be expanded. That argument assumes far more than this legislation proposes. The assumption is that a significant number of dental hygienists will undergo the additional training that will be required to become a mid-level dental hygienist. In order to make any impact on the underserved need, upwards to one hundred hygienists would need to commit their careers to this change. This in itself would not guarantee that they would choose to work where they were most needed. The legislation does not address the re-imbursement rates for MaineCare services that are woefully inadequate. Simply put, the access to care issue is more complex than the creation of a new category of caregiver can address.

  It is the understanding of the Board that states such as Colorado, that have allowed the independent practice of dental hygiene have seen no significant change in the traditional practice model. The evolution of the dental hygienist as part of a dental delivery team has occurred because it works. Greater efficiency, productivity, and continuity of quality care cannot be achieved by this additional avenue of dental hygiene practice. The Board predicts that, if enacted, a disappointing few hygienists will take advantage of this model which will have no measurable impact on the access to care issues facing Maine citizens.

  In regards to licensing graduates of foreign universities, the Board believes that the protection of the citizens of Maine should be paramount. As a Board committed to the health and safety of Maine citizens, we cannot stress enough, the need for any training program – foreign or domestic – to meet existing standards for educating potential licensees of dentistry. A review of any dental educational program can only be done through an independent evaluation of published and acceptable standards by the Commission on Dental Accreditation of the American Dental Association.

- Because each of these proposed expansions in the regulation of hygienists and graduates of a foreign university are new, the Board can cite no specific evidence of harm including complaints where the public's health, safety or welfare has been threatened. Having been precluded by statute from these duties, hygienists or graduates of foreign (non CODA approved) institutions have not delivered this dental care to the public.

  There has been some concern however, about a recent expansion of duties for Public Health Supervision (PHS) hygienists who, while having a supervising dentist on paper, essentially work alone in non-traditional settings. Recent legislation has allowed PHS hygienists to place temporary fillings in teeth that they deem can benefit from the procedure. The Board has received several concerns – not rising to the level of complaints – that some PHS hygienists are placing these temporary fillings outside the parameters of the treatment algorithms set up for them by the Board. The Board views this as an educational/training issue rather than a disciplinary one and is working with all parties of interest to improve the situation. Clearly any expansion of the scope of practice for any license category will result

in more potential for improper treatment or improper treatment selection. The Board would hope that as the learning curve expands such improper treatment would decrease.

4. Voluntary and Past Regulatory Efforts

The Board can make no comment about what graduates of foreign universities may have done to protect the public because it is unaware of any. In regard to dental hygiene, there is an active, but relatively small number of hygienists in Maine who belong to the Maine Dental Hygiene Association and its parent organization, the American Dental Hygiene Association. It is quite clear that this professional organization has drawn less than one quarter of the licensed hygienists in Maine into its membership. The Board finds this disappointing in that membership in a professional organization provides many educational and professional enhancements. It also indicates that the dental hygiene organizations do not represent the vast majority of practicing hygienists in Maine. The Board is in no position to draw inferences from this as to whether this is a good or a not-so-good thing for Maine citizens.

5. Costs and Benefits of Regulation

- **a mid-level dental hygienist:** The creation of a mid-level dental hygienist will, in the opinion of the Board, have little impact on dental costs and benefits. We come to that conclusion based on our belief that far too few hygienists will be interested in attaining mid-level status to make any real difference. Unless they become employees of already established and subsidized public health clinics, the financial realities of mid-level practice will drive most of these potential licensees back to more traditional delivery systems. The Board does not see private fee-for-service practices employing this level of licensee.

- **dental hygienists practicing independently:** Again the potential numbers of hygienists willing to go this route is so small that no positive or negative financial impact can be predicted. If the Board is wrong in it's assumption, then the cost to Maine citizens for dental care could possibly increase. Here's how it might work. If a large number of hygienists opt to leave the traditional model of hygiene delivery for independent practice, there will be severe shortage of qualified staff to fill the void. Private fee-for-services practices will be competing more than ever for this shrinking pool of qualified employees. Salaries and benefits would increase due to the supply and demand algorithm and these costs would be passed on to the public in terms of higher fees for the services rendered. The Board wishes to restate that we don't believe there will be a stampede of hygienists from the traditional model and therefore does not expect this to happen. In addition, for the same reasons, the Board does not believe that significant numbers of hygiene professionals would be attracted to Maine.

- **dental graduates of foreign universities:** The Board sees no effect on costs and benefits as it sees no change in the number of foreign dental graduates being licensed presently.

- **a new licensing board for denturists and hygienists:** Clearly, the costs of maintaining another board with its staff and expenses has to come from licensing fees for hygienists and denturists. The Board feels that its present costs are not going to decrease proportionally from the loss of revenue from denturists and hygienists. Therefore even if denturist and hygiene registration fees stay the same, registration fees for dentists in Maine will have to go up significantly which will likely be offset by higher fees passed on to patients. This will likely result in higher fees for procedures and an increased financial burden on the public.

6. Service Availability Under Regulation:

- **a mid-level dental hygienist:** If enough hygienists are willing to undergo the time and expense to become mid-level practitioners, there can be a positive effect on access to care for

Maine's underserved population. In our opinion, this would take an estimated 100-200 positions located in high need areas to accomplish this goal. The Board does not see fee-for-service patients becoming a staple in the practice of a mid-level hygienist. Most people in moderate to higher income levels will opt to stay in their traditional settings where the scope of practice exists to meet all of their families' dental needs. The clear source of untapped patient care is with the segment of our population that cannot afford care in a traditional setting. Even then, a mid-level practitioner can only meet a portion of their needs. The Board foresees a constant push to expand their scope of practice and is very concerned that educational training requirements will not keep pace.

- **dental hygienists practicing independently:** The limited number of hygienists that may choose to practice independently will not increase the amount of preventive care that is now being delivered. There is a finite number of hygienists and they are currently seeing a finite number of patients for prevention and education. Whether they remain in traditional settings or work independently will have no effect on the numbers of services currently being delivered. If this is the goal then more qualified licensees is the answer, not whether or not they practice independently.

- **dental graduates of foreign universities:** Unless more foreign universities have their dental programs reviewed and approved by the Council on Dental Accreditation (CODA) of the American Dental Association (ADA), this legislation will have no effect on the number of dentists that will be licensed in Maine.

- **a new board for denturists and hygienists:** The Board believes this will have no effect on the number of patients who may receive care here in Maine. The Board does not see this as an avenue to attract more practitioners to Maine. That is much more likely to occur only if future legislatures create a more "business friendly" climate.

7. Existing Laws and Regulations:

The Maine Board of Dental Examiners feels that existing legal remedies are adequate to prevent or redress the kinds of harm potentially resulting from this proposed legislation.

8. Method of Regulation:

No Comment

9. Other States:

? Colorado and Washington

10. Previous Efforts to Regulate:

- **a mid-level dental hygienist:** None.

- **dental hygienists practicing independently:** Multiple (The Board does not have specific data on this)

- **dental graduates of foreign universities:** ? None.

- **a new licensing board for denturists and hygienists:** ? Legislature created the standing subcommittees for denturism and dental hygienists in 2003.

11. Minimal Competence

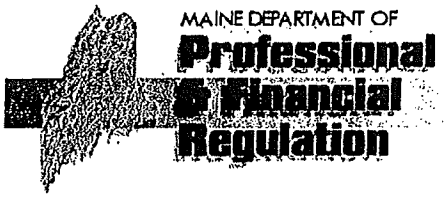
The Board is most concerned that proposed requirements for regulation are not fully researched, identified, and agreed upon by professional educators to assure that appropriate knowledge, skill, and experience will be guaranteed in the educational process of any new level of dental care provider. The Board feels strongly that before any such legislation should be considered that recommended levels of education and training must be an integral part of the legislation. The Board would urge the legislature not to pass any legislation with the intention of requesting the Board to define the educational piece at a later date. There must also be a mechanism for an independent minimal competency testing prior to the entrance of any new level of dental care provider into the oral health care work force. This is currently done for all licensees and must remain consistent for any new category of provider. Continuing education standards must also be clarified prior to the passage of legislation.

12. Financial Analysis:

Any change occurring from this proposed legislation must be born directly by the licensees via licensing and renewal fees and indirectly by the patients who avail themselves of these dental services by way of the fees charged for services rendered.

13. Mandated Benefits:

The Board has no comment on what any profession or occupation may plan to apply for mandated benefits.



Sunrise Review: Request for Information from Interested Parties

LD 1129 "Resolve, Directing the Commissioner of Professional and Financial Regulation to Conduct a Sunrise Review of Oral Health Care Issues"

Department of Professional and Financial Regulation
Office of the Commissioner
June 21, 2007

Sunrise Review Survey: Oral Health Issues

Please return the completed survey to the Commissioner's Office by July 20, 2007. You may respond to any or all questions. The survey should be e-mailed to Doug Dunbar, Assistant to the Commissioner. The address is doug.dunbar@maine.gov. An electronic version of the survey is available by contacting the Commissioner's Office.

General Information

1. **Group or organization you represent (if any):**

Maine Dental Association, PO Box 215, Manchester, ME 04351

Tel. 207-622-7900; e-mail: jbastey@medental.org (John Bastey, Director of Governmental Affairs)

2. **Position on proposed legislation.** Does this group or organization support or oppose:

- Expanding the scope of practice of dental hygienists by creating a mid-level dental hygienist* license category (LD 1246):

While opposed to the language of LD 1246 as written to create a "mid-level dental hygienist," the Maine Dental Association looks forward to the creation of a new category of licensee—envisioned to be a Master's level clinician who would be appropriately educated, trained, and tested to work in a collaborative arrangement in the dental community, providing specifically identified procedures now only allowed by a dentist. This would require the development of an entirely new master's level curriculum in an accredited educational institution that meets the educational standards of the ADA Commission on Dental Accreditation (CODA), to teach the necessary skill sets. These skills will need to include not only technical dental skills, but also academic understanding and, most importantly, training in clinical judgment. We envision this program to focus on the pediatric aspects of dentistry.

The Maine Dental Association looks forward to discussing and participating in the development of such a new curriculum.

- Permitting dental hygienists to practice independently without supervision of a licensed dentist (LD 550):

While opposed to the language of LD 550 as written, MDA is not opposed to investigating allowing hygienists with a minimum of a Baccalaureate degree to practice traditional dental hygiene procedures (preventive/educational, such as teeth cleanings, applications of fluoride treatments and sealants, oral hygiene instruction, etc.) in an independent setting. We have some concerns about the lack of training in diagnostic procedures currently provided in accredited dental hygiene programs, so we envision that

* In this sunrise review, "mid-level dental hygienist" means a dental hygienist with an expanded scope of practice similar to the scope of practice proposed in LD 1246.

some form of certification in diagnostic procedures be mandated, and would presume that the Maine State Board of Dental Examiners would be charged with developing Rules to accomplish this. Our other concern is for the ability of the patients seen by independent hygienists to receive necessary follow-up restorative care; we would therefore recommend that a provision for a collaborative arrangement with a dentist be included in any Rules developed.

- Permitting dental graduates of foreign universities to become licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

MDA is strongly opposed to permitting graduates of foreign (unaccredited) dental schools to become licensed in Maine. The American Dental Association's Commission on Dental Accreditation (CODA) has long been recognized as the standard in the United States for accrediting dental schools, and dental hygiene, dental assisting and dental laboratory technology programs. CODA's comprehensive evaluation process assures the standardization and quality of dental education programs. Current Maine dental licensing law requires graduation from a CODA-accredited program, along with testing mechanisms, to assure that dentists entering the state meet minimum competency levels to assure the safety of Maine citizens. Foreign-trained dentists currently have the opportunity to attend many US dental schools for an "abbreviated" program as international students...ie. two years instead of the regular four-year program....to receive a degree from a CODA-accredited dental school. There are several foreign-trained dentists licensed in Maine who all went through this type of training.

The quality of dental education in foreign countries varies greatly....from legitimate to "diploma mill." The task of evaluating foreign dental schools that have not been CODA-accredited would fall on the shoulders of the Maine State Board of Dental Examiners; we have serious doubts that they have the expertise or resources to take on this huge task.

CODA is now offering its accreditation review to any foreign dental school that wishes to apply and go through the process.

- Creating a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

MDA believes that all aspects of dental care should be regulated by a single licensing Board and therefore opposes attempts to break away various providers under separate boards. No matter who is providing oral health services, there should be one standard of care for Maine citizens, governed by one board of oversight. Having separate boards will potentially confuse the public, will be costly for the State, and has no benefit to Maine citizens.

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. **Data on group proposed for regulation.** Please provide a description of the professional or occupational groups proposed for regulation, including:

(a) The number of individuals or business entities that would be subject to regulation;

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and

(c) An estimate of the number of potential licensees in each group.

2. **Specialized skill.** Please describe whether the proposed law changes in the areas of oral health care outlined below require such a specialized skill that the public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met:

- a mid-level dental hygienist license category (LD 1246):

See response to Question 1 for suggestions about minimum qualifications.

- dental hygienists practicing independently without supervision of a licensed dentist (LD 550):

See response to Question 1 for suggestions about minimum qualifications.

- dental graduates of foreign universities becoming licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

Maine Board of Dental Examiners is not able to assess the quality of foreign dental schools.

3. **Threat to public health, safety, or welfare.** Please describe:

(a) The nature and extent of potential harm to the public, if any, if regulation of the practitioners listed below is not expanded:

- a mid-level dental hygienist:

No harm to the public if current laws/regulations are NOT expanded or changed.

- dental hygienists practicing independently without supervision of a licensed dentist:

No harm to the public if current laws/regulations are NOT expanded or changed.

- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

No harm to the public if current laws/regulations are NOT expanded or changed.

(b) The extent to which there is a threat to the public's health, safety or welfare (*Please provide evidence of the 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 dental hygienists or dental graduates of foreign universities in *this State* within the past 5 years).

Since hygienists in Maine now practice under some form of dentist supervision (either Direct, General, or Public Health), it is likely that the majority of complaints against hygienists would actually be filed under the name of the responsible supervising dentist, rather than against an individual hygienist. The Maine Dental Association is aware (anecdotally) of complaints of improper treatment by hygienists in Public Health Supervision settings. These involve inappropriate placement of temporary fillings (likely due to lack of diagnostic training) and sub-standard care. In considering allowing independent hygiene practice, the potential for harm to the public must be considered; thus the MDA recommendations in Question 1 for additional training in diagnostics and a "collaborative practice" arrangement between independent hygienists and a dentist.

Since Maine does not issue licenses to dental graduates of foreign dental schools, there would be no State Board complaints against such dentists. However, we are very concerned about the potential for harm to the public if the State Board of Dental Examiners issues licenses to graduates of foreign schools that have not met formal accreditation standards to assure minimum competency. The variation in curriculum in foreign schools is vast. How will the State Board be able to evaluate effectively? Maine citizens will certainly be put at risk.

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by dental hygienists or dental graduates of foreign universities 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.

5. **Costs and benefits of regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below will increase the cost of services provided by those practitioners, and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

- a mid-level dental hygienist:

- dental hygienists practicing independently without supervision of a licensed dentist:

- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners:

6. **Service availability under regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below would increase or decrease the availability of oral health services to the public.

- a mid-level dental hygienist:

Could hopefully increase the timeliness of currently underserved pediatric patients to receive care.

- dental hygienists practicing independently without supervision of a licensed dentist:

- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

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

8. **Method of regulation.** Please describe 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.

9. **Other states.** Please provide a list of other states that regulate the profession, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on commercial leasing agents in terms of a before-and-after analysis.

No other state currently licenses a mid-level hygiene practitioner as defined in LD 1246.

Only Colorado currently allows the independent practice of dental hygiene.

To the best of our knowledge, only California has recently considered licensing graduates of one dental school in Mexico. We are unsure how this experiment has worked.

10. **Previous efforts to regulate.** Please provide the details of any previous efforts in *this State* to implement regulation or expand regulation of the occupations (or proposed occupations) listed below:

- a mid-level dental hygienist:

- dental hygienists practicing independently without supervision of a licensed dentist:

- dental graduates of foreign universities:

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

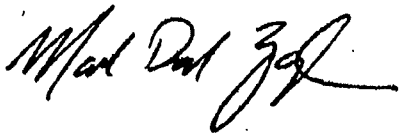
11. **Minimal competence.** Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

12. **Financial analysis.** Please describe 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.

13. **Mandated benefits.** Please describe whether the profession or occupation plans to apply for mandated benefits.

Date: 7/27/07, 2007

Completed by:



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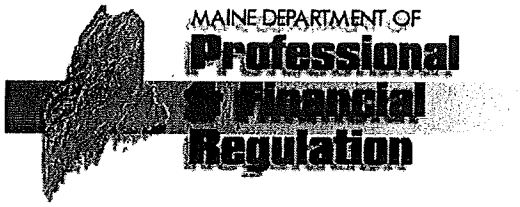

Sunrise Review: Request for Information from Interested Parties

LD 1129 "Resolve, Directing the Commissioner of Professional and Financial Regulation to Conduct a Sunrise Review of Oral Health Care Issues"

Department of Professional and Financial Regulation
Office of the Commissioner
June 21, 2007

General Information

1. **Group or organization you represent (if any):**

ME Center for Disease Control, Department of Health & Human Services, Oral Health Program

2. **Position on proposed legislation.** Does this group or organization support or oppose:

- Expanding the scope of practice of dental hygienists by creating a mid-level dental hygienist* license category (LD 1246):

We are inclined to support measures that would expand the scope of practice of dental hygienists by creating a mid-level dental hygienist. However, we cannot, at this time, extend that support to the specific scope of practice proposed in LD 1246. Our position is that a scope of practice is not appropriately described in statute, but would be better defined in rules; that scope should be established after assessing factors such as, but not necessarily limited to, best practices, education and training standards, quality assurance mechanisms, licensure and continuing education requirements, and so on. Moreover, certain of the specific duties proposed seem to us to involve clinical skills and knowledge that may generally be beyond those of dental hygienists.

In addition, as written, LD 1246 as proposed called for the establishment of a "low-income dental health program," a label that we cannot support. It suggests that we (Maine) endorse a program of care for low income people that does not provide the same level of care at the same standards that other people can get [it may be true that they don't get it now, but should we institutionalize or codify it?]. It would also have a fiscal impact on MaineCare; although this should not be the determining factor, it needs to be taken into consideration as we move forward. Hygienists in Maine are not presently directly reimbursed by either private insurers or by MaineCare. MaineCare will reimburse for services provided by hygienists practicing with public health supervision status in "public health settings" but reimburses an "entity," not the individual provider (the billing provider, not the servicing provider). To our knowledge, public health supervision has facilitated an increase in the provision of preventive services, and apparently to those who otherwise would have had great difficulty in obtaining those services, but there have been concerns about follow-up and some about quality of care. We are very supportive of hygienists practicing under public health supervision and we need to continue having their contribution to providing more preventive care to more Maine residents.

- Permitting dental hygienists to practice independently without supervision of a licensed dentist (LD 550):

We do not take a position either in support or opposition on LD 550; we feel that more information about the nature of such a practice status would be needed in order for us to support or oppose. We have concerns about the sufficiency of an infrastructure to support the independent practice of hygiene as well as concerns about financial considerations (3rd party reimbursement), quality assurance mechanisms, and about the description, via rules (as proposed in LD 550) of the scope of practice. In our view, the independent practice of dental hygiene must still have an explicit connection to the practice of dentistry to assure diagnosis, treatment and follow-up of dental and oral conditions – which dentists are trained and qualified to perform.

- Permitting dental graduates of foreign universities to become licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

* In this sunrise review, "mid-level dental hygienist" means a dental hygienist with an expanded scope of practice similar to the scope of practice proposed in LD 1246.

We are inclined to support measures such as the change proposed by LD 1129 in 32 MRSA in it would facilitate the employment of foreign-trained dentists in federally qualified health centers, in private non-profit dental centers, by other dentists in private practice, and eventually, we might expect, as self-employment as independently practicing dentists. There would be a resulting positive effect on the supply of dentists in the state (which is a matter of concern) and by extension on access to dental services. However, we also have concerns about the standards and processes by which foreign training can be evaluated in order for that training to be "considered satisfactory." Therefore, we are supportive of the concept or the spirit of LD 1129, and its intent to help minimize barriers to professional licensure in Maine, but we also want to absolutely assure that all practitioners are adequately and appropriately educated and trained, and practice according to the standards of the Maine Dental Practice Act.

- Creating a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1472):

We do not take a position either in support or opposition on LD 1472; we feel that not only would more information about the relationship of such a Board to the Department be needed in order for us to support or oppose, but that this issue in particular is outside of our purview. However, given that we are specifically concerned with protecting the public's health and assuring access to appropriate and quality health services, we do question the utility of separating the regulation (and all that might entail relative to licensing and continuing education requirements and the like) of dental professionals who should be functioning together as "team" members as much as possible. There are issues that all of these professions have in common and splitting their regulation between or among different boards may contribute to a piecemeal approach that does not necessarily contribute to the coordination needed for the assurances noted above; neither would it likely be cost-effective, in terms of resources, process or time. In addition, we are not clear whether the report of the Regulatory Fairness Commission is based on a broad enough sample of opinion and experience, particularly relative to dental hygienists; and there are relatively few denturists in the state.

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. **Data on group proposed for regulation.** Please provide a description of the professional or occupational groups proposed for regulation, including:

Responses to items a, b, and c should be available from other sources, i.e., the professional associations involved, and the numbers of licensees from the Board of Dental Examiners.

(a) The number of individuals or business entities that would be subject to regulation;

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and

(c) An estimate of the number of potential licensees in each group.

2. **Specialized skill.** Please describe whether the proposed law changes in the areas of oral health care outlined below require such a specialized skill that the public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met:

- **a mid-level dental hygienist license category (LD 1246):**
  The skills of dental professionals are highly specialized. Our view is that the general public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met. We rely on licensure by recognized authorities for such assurances. A mid-level hygienist would be a "new" practitioner, for which there are several emerging models in the US and elsewhere. Oral health is increasingly recognized as an integral component of overall health; as the public recognizes this, there need to be assurances that all providers of oral health care have met minimum qualifications and practice according to accepted standards.

- **dental hygienists practicing independently without supervision of a licensed dentist (LD 550):**
  Again, the skills of dental professionals are highly specialized, and our view is that the general public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met. We rely on licensure by recognized authorities for such assurances. Oral health is increasingly recognized as an integral component of overall health; as the public recognizes this, there need to be assurances that all providers of oral health care have met minimum qualifications and practice according to accepted standards.

- **dental graduates of foreign universities becoming licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):**
  Again, the skills of dental professionals are highly specialized, and our view is that the general public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met. We rely on licensure by recognized authorities for such assurances. Oral health is increasingly recognized as an integral component of overall health; as the public recognizes this, there need to be assurances that all providers of oral health care have met minimum qualifications and practice according to accepted standards.

3. Threat to public health, safety, or welfare. Please describe:

(a) The nature and extent of potential harm to the public, if any, if regulation of the practitioners listed below is not expanded:

- **a mid-level dental hygienist:**
  It is clear from discussions at the national level, and during the hearings and work sessions on the bills that are covered by this survey, that there is a growing understanding of the need to expand the dental workforce with the development of a mid-level practitioner. This practitioner, whose scope of practice is yet to be defined (and there may be more than one accepted definition), will be able to provide preventive services and other services yet to be delineated that will serve to maximize the use of the skills that each dental professional can provide; each professional will be able to practice to the maximum level of the skills for which s/he is trained and licensed. This efficient use of our dental health workforce would have clear implications for access to oral health services and ultimately to containing costs related to the provision of those services. We do not see potential harm to the public if there is no provision for mid-level dental hygienists in Maine; but it is likely that the serious problems we presently experience related to access to care and to costs related to delays in obtaining services would be exacerbated.

- **dental hygienists practicing independently without supervision of a licensed dentist:**
  We do not see potential harm to the public if dental hygienists in Maine do not practice independently.

- **dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:**
  We do not see potential harm to the public if there is no provision for dental graduates of foreign universities to be licensed in Maine. However, as noted above, it is our view that there would be a resulting positive effect on the supply of dentists in the state (which is a matter of concern) and by extension on access to dental services (see section 1, item 2).

(b) The extent to which there is a threat to the public's health, safety or welfare (*Please provide evidence of the 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 dental hygienists or dental graduates of foreign universities in *this State* within the past 5 years).

We are not an agency with which such complaints are filed, and we are not privy to the numbers or nature of such complaints. When such complaints are made to us, unless they are made directly and in writing, they are treated as anecdotal and in all cases are referred to the appropriate agency. We are concerned that without appropriate standards for licensing, education, training, continuing

education, etc., that the probability of threats to the public's health, safety or welfare could increase.

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by dental hygienists or dental graduates of foreign universities 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.

   No comment.

5. **Costs and benefits of regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below will increase the cost of services provided by those practitioners, and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

- **a mid-level dental hygienist:**
  DHHS is not able to comment specifically on potential increases in costs. However, we would note that as above, there would likely be considerations for costs to the State through MaineCare. Overall, we would want to see such a practice status structured to assure against duplication of services, and for appropriate provision of services by appropriate providers to consumers. In that a mid-level dental professional (dental hygienist) would likely be providing preventive services, we would suggest that over the long term since prevention is cost-effective and such services should reduce the volume of more involved and expensive restorative and operative care that is usually associated with lack of preventive care, the overall impact could contribute to reducing or at least containing health care costs. The services provided could well allow more people more timely access to needed dental care and, we would suggest, to earlier, less costly interventions and care. The potential impact is difficult to estimate since there is still limited experience from other states to draw from and because it is unknown how many dental hygienists would pursue status as mid-level providers and how many would need to practice at this level to have an appreciable, measurable impact.

- **dental hygienists practicing independently without supervision of a licensed dentist:**
  DHHS is not able to comment specifically on potential increases in costs. To the extent that independent practice would enhance and expand the provision of preventive services, the comment directly above applies here as well. However, there are other considerations related to independent practice without the supervision of a dentist that have been noted in other responses.

- **dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:**
  DHHS is not able to comment specifically on potential increases in costs. However, as noted above, it is our view that there would be a resulting positive effect on the supply of dentists in the state (which is a matter of concern) and by extension on access to dental services (see section 1, item 2). This in turn would allow more people more timely access to needed dental care and, we would suggest, to earlier, less costly interventions and care.

- **a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners:**
  DHHS is not able to comment specifically on potential increases in costs related to a new licensing board.

6. **Service availability under regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below would increase or decrease the availability of oral health services to the public.

- **a mid-level dental hygienist:**
  As noted above, it is clear from discussions at the national level, and during the hearings and work sessions on the bills that are covered by this survey, that there is a growing understanding of the

need to expand the dental workforce with the development of a mid-level practitioner. This practitioner, whose scope of practice is yet to be defined (and there may be more than one accepted definition), will be able to provide preventive services and other services yet to be delineated that will serve to maximize the use of the skills that each dental professional can provide; each professional will be able to practice to the maximum level of the skills for which s/he is trained and licensed. This efficient use of our dental health workforce would have clear implications for increasing access to oral health services and ultimately to containing costs related to the provision of those services.

- **dental hygienists practicing independently without supervision of a licensed dentist:** The extent to which dental hygienists would choose this status is unknown to DHHS. Therefore, we cannot suggest the extent to which this might increase the availability of services.

- **dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:** As noted above, it is our view that there would be a resulting positive effect on the supply of dentists in the state (which is a matter of concern) and by extension on access to dental services (see section 1, item 2). This in turn would allow more people more timely access to needed dental care and, we would suggest, to earlier, less costly interventions and care.

- **a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1472):** DHHS is not able to comment specifically how a new licensing board might or might not expand the availability of oral health services to the public.

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

   It is the view of DHHS that with the information currently available to us, existing legal remedies re adequate to prevent or redress the kinds of harm described.

8. **Method of regulation.** Please describe 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.

   It is our understanding that there have been longstanding issues regarding licensure and regulation between and among these three professions. It is also our understanding that all three of these professions share concerns, as do we, about access to oral health services particularly for lower-income Mainers and children, and about the adequacy of the oral health care workforce. We question, however, whether these alternatives, particularly that of a new licensure board, can address those issues. We would suggest that the shared concerns can best be addressed by the professions working closely together rather than developing their own, separate methods of regulation.

9. **Other states.** Please provide a list of other states that regulate the profession, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on commercial leasing agents in terms of a before-and-after analysis.

   This information should be available from other sources, e.g., the professional associations involved. Dental hygienists may practice independently in Colorado, and under certain circumstances (such as in public health settings) in several other states, such as Connecticut and Washington. The language in various states' regulations is not always consistent and further analysis would be helpful.

10. **Previous efforts to regulate.** Please provide the details of any previous efforts in *this State* to implement regulation or expand regulation of the occupations (or proposed occupations) listed below:

- **a mid-level dental hygienist:** none to our knowledge

- **dental hygienists practicing independently without supervision of a licensed dentist:** Legislation was proposed in about 1999 for independent practice. The bill was replaced by a Resolve that directed the Board of Dental Examiners to engage with specified interested parties in consensus based rule-making to further develop and describe Public Health Supervision Status for hygienists.

- **dental graduates of foreign universities:** none to our knowledge

- **a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1472):** none to our knowledge

11. **Minimal competence.** Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

    Standards describing competence for a mid-level dental hygienist would exceed current requirements for licensure for hygienists (as per the Dental Practice Act). Such standards do not currently exist in Maine and should be developed with consideration of the various models being proposed by other states and at the national level, for consistency and congruence – to facilitate reciprocity with other states – and in light of developing best practices.

    Our comments above related to licensing dental graduates of foreign universities and to a new, separate licensing board within DPFR also address this item.

12. **Financial analysis.** Please describe 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.

    DHHS does not have the information to respond to this item.

13. **Mandated benefits.** Please describe whether the profession or occupation plans to apply for mandated benefits.

    DHHS does not have sufficient information to respond to this item.

Date: August 17, 2007

Completed by:
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Director, Oral Health Program, ME CDC

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Maine Dental Hygienists' Association

General Information

1. Group or organization you represent (if any):

This survey response is submitted on behalf of the Maine Dental Hygienists' Association (hereinafter "MDHA" for ease of reference). MDHA is an active member of the American Dental Hygienists' Association (hereinafter "ADHA" for ease of reference.)

The MDHA was founded in 1926. Its mission is to improve the publics' total health, advance the art and science of dental hygiene by ensuring access to quality oral health care, increasing awareness of the cost-effective benefits of prevention, promoting the highest standards of dental hygiene education, licensure, practice and research, and representing and promoting the interests of dental hygienists.

MDHA may be contacted through its Counsel:

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(207) 622-6124
jdoyle@doylenelson.com

2. Position on proposed legislation. Does this group or organization support or oppose:

- Expanding the scope of practice of dental hygienists by creating a mid-level dental hygienist license category (LD 1246):

MDHA **supports** LD 1246 because it will increase access to basic / primary dental care for this State, which is long overdue given Maine's dental health care crisis. Maine's dental health care crisis began over a decade ago. In June 1997, the Maine Children's Alliance stated:

> Access to dental services in Maine for many children and adults is increasingly limited. In some areas and for certain populations, the

situation is reaching crisis proportions. Low income people particularly have difficulty finding a dentist who will treat them or their children, and frequently have to travel significant distances in order to get the care they need. Because of these barriers to access, they often wait to seek out care until the problem has become unbearable. Child Health Care Access Project: Maine's Crisis In Access To Dental Care, page 2, (updated April 11, 2007) http://www.mainechildrensalliance.org/am/publish/printer_65.shtml, See "**Exhibit A**" attached hereto.

Maine's oral health care crisis has been studied and discussed in numerous reports and summits over the past ten (10) years. It is time to do something about it. LD 1246 offers the legislature that opportunity by expanding the scope of practice[1] for Maine's dental hygienists. At the Maine Oral Health Summit in 2003, one of the primary action steps repeatedly proposed in order to deal with the oral health care crisis included, "Workforce Development: Expanding the functions and roles of providers. . . Expanding Access: Expanded roles – Hygienists and assistants, Look at a "mid-level" type practitioner (international model). . ." Maine's Oral Health Crisis: Developing an Action Agenda for 2003-2004, page 9, (April 7, 2003), See "**Exhibit B**" attached hereto.

Moreover, the November 14, 2005 Conference Report for "Oral Health in Maine Planning for the Future" proposed as "Outcomes" or "Actions" that Maine should "Maximize Productivity of Existing Dental Workforce by Shifting Roles within the Profession" including, but not limited to "ADHPs (Advanced Dental Hygiene Practitioners)" who "were noted as a national model." Craig Freshley, Oral Health in Maine Planning for the Future Conference Report (Good Group Decisions November 14, 2005), See "**Exhibit C**" attached hereto.

It is important to recognize that expanding the role of hygienists as a solution to the access to care crisis is not a new or novel idea. In fact, it is long overdue. As of January 1965, the Forsyth trustees approved a proposal for a new study of expanding the duties for dental hygienists. Ralph R. Lobene with Alix Kerr, The Forsyth Experiment An Alternative System for Dental Care, pages 117 and 138, (Harvard University Press 1979)(concluding that the advanced skills hygienists

[1] Expanded scope of practice is synonymous with the "advanced practice concept" which is not new. Established precedents in oral health exists in New Zealand, Canada, parts of Europe, and over 40 other countries. In the medical arena, positions such as the nurse practitioner, nurse midwife, and clinical nurse specialist exist.

working under the direct supervision of the dentist provided services of high quality, equal to those of dentists working under the same conditions of peer review,) See "**Exhibit D**" attached hereto.

Additionally, in the January 2004 issue of the Journal of Dental Education, David A. Nash, DMD, MS, EdD, published an article entitled, "Developing a Pediatric Oral Health Therapist to Help Address Oral Health Disparities Among Children" which advocated for the development of an "oral health therapist." David A. Nash, Developing and Deploying a New Member of the Dental Team: A Pediatric Oral Health Therapist, page 48, *Journal of Public Health Dentistry*, Vol. 65, No. 1 (Winter 2005). See "**Exhibit E**" attached hereto. According to Dr. Nash, the development of an oral health therapist "is not necessarily the 'bold, new solution' to the access problem for low income and minority children called for in a 2002 National Council of State Legislatures' (NCSL) report entitled: 'Access to Oral Health Services for Low Income People.' Id. Rather, it is an *old* solution that was *boldly* undertaken by the New Zealand Dental Association when, in 1921, they led in the development of the now internationally famous New Zealand school dental nurse, the progenitor of the pediatric oral health therapist." Id.

Each of the services proposed in LD 1246 is also incorporated in the ADHA's Draft Competencies for the Advanced Dental Hygiene Practitioner (ADHP) (June 2007), which includes a draft curriculum. See "**Exhibit F**" attached hereto.

	LD 1246	ADHA Curriculum for Advanced Dental Hygiene Practitioner
1.	Triage	Page 10, Competencies 1-2
2.	Case Management	Page 11, Competency 3
3.	Current Dental Hygiene Preventive Services	Current dental hygiene rules and regulations (already regulated)
4.	Administering local anesthesia, including nitrous oxide [2] [3]	Page 11, Competency 2-14

[2] In 1993, 9 states permitted licensed dental hygienists to administer nitrous oxide. As of 2007, 26 states now permit the administration of nitrous oxide by licensed dental hygienists. See ADHA Dental Hygiene Legislative Activity, (June 11, 2007), www.adha.org.

5.	Cavity preparation	Page 11, Competency 2-7
6.	Simple restorations	Page 11, Competency 2-7
7.	Pulpotomies and restorations	Page 11, Section 2-7
8.	Deciduous extractions	Page 11, Competency 2-8
9.	Space maintainers	Page 11, Competency 2-12
10.	Prescribing antimicrobials, fluoride and antibiotics	Page, Competency 2-13

MDHA supports the ADHA's proposed competencies and curriculum for an Advanced Dental Hygiene Practitioner (hereinafter "ADHP" for ease of reference.) This is a master's level curriculum that builds upon the foundation of existing dental hygiene education. The ADHP curriculum will take approximately 18 – 24 months of full-time education at the post-baccalaureate level. The proposed curriculum and competencies are presently in draft form and are expected to be ready for final adoption at the ADHA March 2008 Board of Trustees meeting. Maine can still change its laws now to allow for the preventive and restorative services proposed in LD 1246, provided that third party assessment is regulated by hygienists and/ or dental board. Additionally, LD 1246 could be amended to reference the credentialing standards in the draft ADHP Competencies.

Incorporating the ADHP Competencies into LD 1246 will have the additional benefit of contributing to the "Standardization of the professional norms across

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[3] Over the seven year period, from 1993 to 2000, in the 50 states and District of Columbia that were examined in the HRSA Study, "the most change occurred in expanded functions for dental hygienists including monitoring of nitrous oxide, administration of local anesthesia, and administration of nitrous oxide. Most health professionals have experienced expansion in scope of practice due to increased educational levels, increased technology available to perform and monitor services, and increased recognition of the skill of the profession." HRSA Study at page 67.

States. . . which enables effective practice while still providing safeguards to the public." HRSA Study at 28.

Across the nation, there are currently 15 Master's Degree programs in dental hygiene. Minnesota State Colleges and Universities' system approved a Master's degree dental hygiene education program modeled after the ADHP. Additionally, the Fones School of Dental Hygiene in Connecticut and the University of New England are also nearing completion of Master's degree programs with ADHP components taken into consideration.

With the supplemental education proposed by the ADHP, Maine's dental hygienists would have the education and training necessary to expand their scope of services as proposed in LD 1246. "Expanded functions are permitted in many more States than in the early part of the decade. These privileges enable the hygienist to provide multiple points of entry to oral health services in locations that expand access to care." The Professional Practice Environment of Dental Hygienists in the Fifty States and the District of Columbia, 2001, page 73, National Center for Health Workforce Analysis, Bureau of Health Professions, Health Resources and Services Administration, (April 2004)(hereinafter referred to as the "HRSA Study" for ease of reference)(See **"Exhibit J"** attached hereto).[4]

The expanded scope of practice proposed in LD 1246 for the hygienists' profession would contribute to access to care for low-income persons and MaineCare recipients just as the nursing model of practice wherein "licensed vocational nurses, registered nurses and advanced practice nurses provide services within different scopes of practice under varying levels of delegation and supervision depending on their educational and clinical preparation, certification, and licensure." HRSA Study at 52.

Opponents of LD 1246 argue that it would create two levels of dental care, one for the poor and one for everyone else. However, this argument completely disregards the fact that the expanded function hygienist would have the additional education and training necessary to provide the same quality of care received in a private dental office and that access to preventive and restorative treatment is far better than no care at all.

[4] One of the primary goals of the HRSA Study was to assess the impact of dental hygienists on access to care for underserved populations. See HRSA Study at 1.

- Permitting dental hygienists to practice independently without supervision of a licensed dentist (LD 550):

MDHA **supports** LD 550, to the extent it correlates with LD 1246. The definition of independent practice needs to be further clarified in the proposed legislation. For example, does independent practice mean without any supervision or under general supervision or does it propose that hygienists have the ability to set up their own practice outside of a dental office provided that there is general supervision, etc.

> The required level of supervision for hygienists is a central aspect of access to care. If hygienists are required by law or rule to be directly supervised, hygienists are limited in the circumstances in which they can provide service. Direct supervision confines the hygienist to situations where the dentist is physically present. HRSA Study at 59.

LD 1246 proposes the provision of preventive and restorative services "outside the dental office." See LD 1246 which could be construed as "independent practice" See LD 550. However, MDHA believes that the preventive and restorative services proposed in LD 1246 should be provided under the general supervision of a dentist and or consistent with the recommendations of the ADHA Competencies and Curriculum which is based on a collaborative model wherein the expanded function dental hygienist can serve as the liaison to the dentist for patient treatment that requires a higher level of expertise. See ADHA Draft Competencies for the Advanced Dental Hygiene Practitioner, page 6, lines 222-224 (June 2007).

In considering the level of supervision necessary to balance access to care and public safety, it is important to keep in mind the following:

> The standard of unsupervised practice for hygienists in the provision of preventive oral health services was adopted as the theoretically optimal configuration for practice. This benchmark is based on the assumption that a licensed and regulated health professional who meets educational and certification standards can provide services within the scope of his/her clinical training with autonomy without endangering public safety or public health. This seems a fair assumption considering the legal and regulatory safeguards that establish parameters for practice of health professionals across States. Also worthy of consideration is the constraint and good

> judgment that is engendered in the education and training process of clinicians. Standards of prudent care are also part of the credentialing and certification process for clinical professions. Each of these processes, education, certification and licensure, provide inherent safeguards that foster clinical practice standards with a primary goal of doing no harm to patients. These extrinsic professional standards create implicit controls for professionals that probably do not need to be so explicitly legislated. HRSA Study at 23.

Essentially, for preventive services not referenced in LD 1246, that hygienists are already doing in the public setting and which do not require expanded scope licensing and certification, an independent practice by a hygienist may be appropriate. Moreover, direct supervision as a condition for practice is "unnecessarily restrictive to appropriate preventive oral health care when certain hygiene services are provided." HRSA Study at 49.

- Permitting dental graduates of foreign universities to become licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

MDHA would support this legislation, if the appropriate educational piece was added to the language of the bill. Obviously, MDHA supports increasing access to care and LD 1129, potentially, will bring more providers into the State of Maine. That is great, as long as these providers adhere to the same standards of care as regimented by the curriculum of comparable professionals in this country. Basically, if the dental graduates of foreign universities can pass the board certifications administered by this state, those graduates should be able to practice here.

For example, if a New Zealand school dental nurse could pass the certification examinations administered under the ADHP Competencies, he/she should be able to work as an ADHP in Maine.

- Creating a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

MDHA **supports** LD 1462. The First Annual Report of the Maine Regulatory Fairness Board, states as an "Immediate" priority that "Discord between the various dental professions has gone on for several years. It is clear the current system of regulation by a single board has not worked well and has not been able to successfully resolve

these ongoing problems. **Therefore the formation of a separate board to regulate denturists and hygienists should be considered a highest and urgent priority of the Legislature." (Emphasis Added).** Marge Kilkelly, Larry Schneider, Timothy Carter, Peter Bowman, Debbie Elliott, Eliot Stanley, Ed Phillips, First Annual Report of the Maine Regulatory Fairness Board, page 3, (March 2007).

MDHA supports the aforementioned finding of the Maine Regulatory Fairness Board. Furthermore, across the nation "Hygienists express concern that their profession is singular among clinical professions in that another clinical profession regulates it. A fundamental goal for the profession is self-regulation through independent Boards of Dental Hygiene or Dental Hygiene Committees with powers of determination for the profession. It is incumbent for the profession to have some control over scope of practice, requirements for supervision, establishing educational standards, and licensing requirements. Self-regulation would permit more standardization of practice across States as well as provide a measure of security and control for the profession." HRSA Study at 52-53.

> According to the American Association of Dental Examiners 2007 Composite, in 2005 there were 828 dentists, 1257 dental hygienists, 1211 dental assistants, and 56 denturists licensed in Maine. Maine's citizens would benefit from the state establishing a separate board focused on the regulation of the dental hygiene profession.
>
> Dental hygienists are experts on dental hygiene education and practice. Dentists are oral health generalists, with additional concentrated training in restorative skills. Dental hygienists spend a minimum of 2 years almost exclusively learning dental hygiene theory and practice – essentially honing a skill set that is unlike that of any other member of the oral health care team. A separate dental hygiene board charged with regulating the practice of dental hygiene would have more time to focus on hygiene-specific issues, which typically do not get that much attention on state dental boards comprised primarily of dentists and whose priority is dental practice issues. The public would benefit from increased attention to the regulation of the dental hygiene profession and issues related to it. Additionally, establishing a separate dental hygiene board would eliminate the conflict of interest that exists today when employer dentists regulate their own employees. Decisions made by dental boards are often times based on the economics of the private dental office rather than access to

care and competence assurance. The public would also benefit from the cost effectiveness of a dental hygiene board. Licensees fees fund the cost of regulation and dental hygiene licensure fees would be directly linked to the cost of dental hygiene regulation.

The general public would benefit from an increased focus on dental hygiene regulation matters if a separate dental hygiene board were established. Dental hygienists are the most qualified population to make decisions about the profession and are best placed to make decisions about education, examination, and practice requirements. The public would be served by increased attention to the practice and regulation of dental hygiene professionals.

A separate dental hygiene board should be self-sustaining, as the bulk of licensure fees charged to the over 1200 dental hygienists in Maine would be used to operate the board and its staff.

As previously stated, Maine is in the midst of an oral health care crisis, as many residents are unable to access even basic oral health care services. Establishing a separate dental hygiene board would serve as a forum for dental hygiene and other oral health care professionals to discuss ways in which access to preventive oral health care services administered by dental hygienists can be increased. The existing dental board has jurisdiction over a wide range of practice and regulatory issues, which can make it difficult for all issues to be addressed at the level of detail necessary to affect meaningful change in the delivery of care. A dental hygiene board would have a more focused purpose, and therefore would have more time to devote to the discussion of solutions to increase the availability of services to the people of Maine.

The creation of a dental hygiene board to regulate the profession of dental hygiene would be adequate to ensure the competence of dental hygiene professionals and vet any complaints filed against dental hygiene practitioners.

Currently in 17 states dental hygienists have some form of self regulation. Megan Fitzpatrick, Manager, Governmental Affairs, ADHA, 444 N. Michigan, Suite 3400, Chicago, IL 60611, Telephone No. (312) 440-8914.

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. Data on group proposed for regulation. Please provide a description of the professional or occupational groups proposed for regulation, including:

(a) The number of individuals or business entities that would be subject to regulation.

There are approximately 1257 dental hygienists in Maine that would be subject to the proposed legislation.

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and

Maine Dental Hygienists' Association
Michelle J. Gallant, RDH
MDHA, President
37 Chickawaukie Pond Road
Rockport, ME 04856
mgallant500@adelphia.net
207-593-9158
http://mawaonline.org

American Dental Hygienists' Association
444 North Michigan Avenue, Suite 3400
Chicago, Illinois 60611
(800) 243-2342
http://www.adha.org/

(c) An estimate of the number of potential licensees in each group.

The potential licensees would be the hygienists who meet the additional ADHP Competencies and/or comparable education. In Maine, there are 1257 hygienists who could potentially complete the proposed master's level education in order to expand their scope of practice.

2. Specialized skill. Please describe whether the proposed law changes in the areas of oral health care outlined below require such a specialized skill that the public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met:

- a mid-level dental hygienist license category (LD 1246):

MDHA does believe that to expand the scope of practice, as proposed in LD 1246, specialized skill is required as previously discussed in this response pursuant to the ADHP Competencies and or an equivalent education and training.

- dental hygienists practicing independently without supervision of a licensed dentist (LD 550):

Same as above.

- dental graduates of foreign universities becoming licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

Same as above.

3. Threat to public health, safety, or welfare. Please describe:

(a) The nature and extent of potential harm to the public, if any, if regulation of the practitioners listed below were not expanded:

- a mid-level hygienist:

The threat to the public of having no care and or maintaining the status quo and the harm caused by complete lack of care is far worse than any outside risk associated with an expanded scope of practice. Pat Jones is a registered dental hygienist in Maine who works in public health clinics for MaineCare children. She worked for the Maine Bureau of Health for 25 years and recently retired. For 6 of her 25 years at the Bureau, she managed the Maine's school dental health program. Pat Jones has seen many families who have untreated advanced decay and dental infections who could not access dental care to treat these diseases at earlier stages. Recent Department of Health and Human Services data shows that 65,580 MaineCare children did not access dental care in 2006. That is three times the population of Augusta.

This past year a six year old boy in Georgia died from an infection caused by abscessed teeth. An 11 year old boy in Maryland also died, essentially, as a result of lack of access to preventive dental care. In her testimony to the legislature regarding LD 1246, Pat Jones stated, "I believe that this can easily happen here in Maine unless we take action to address providing professional services early on."

Three years ago, Mary Henderson, Executive Director for Maine Equal Justice, reported to the legislature that "Here at Maine Equal Justice we receive calls regularly from families desperate to find care." Recently, Sara Gagne-Holmes, Executive Director for

Maine Equal Justice states, "for people of low income access to care still remains a chronic and acute problem."

Maine Equal Justice specializes in representing Mainers with low income on issues that affect their daily lives. Opponents of LD1246, who do not have the experience of those at Maine Equal Justice, tout as their main argument that this legislation will create two levels of dental care, one for the poor and another for everyone else. This is a smoke screen designed to perpetuate an unnecessary turf battle. People like Pat Jones and those at the Maine Equal Justice project work daily with Maine's low income families, give them a voice and that voice is calling for implementation of legislation that will expand access to care. LD 1246 serves that purpose.

"The health of the mouth and surrounding tissues affects us physically, emotionally, mentally, and socially and is integral to overall health status." HRSA Study, at 12.

"Oral health is much more than healthy teeth. The mouth is a central organ and a sentinel of disease processes in the body. The mouth enables social interaction through speech and expression. It is the pathway for nutrition, and it provides key indicators of overall health status. Many systemic illnesses manifest in the oral cavity. Accurate and early diagnosis by medical and dental providers can alter the progression and treatment of more pervasive disease." Oral Health in America: A Report of the Surgeon General, Department of Health and Human Services, U.S. Public Health Service, Rockville, MD, 2000, pages 1, 7, and 53.

There is virtually no risk of harm to the public in expanding the scope of practice for dental hygienists who receive education and training comparable to that proposed in the ADHP Competencies. The risk of harm to the public is in maintaining the status quo.

- dental hygienists practicing independently without supervision of a licensed dentist:

Same as above / previously addressed in survey question 1.

- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

Same as above / previously addressed in survey question 1.

(b) The extent to which there is a threat to the public's health, safety or welfare *(Please provide evidence of the 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 dental hygienists or dental graduates of foreign universities in *this State* within the past 5 years).

According to the ADHA:

> Oral health has been described as one of the 'single greatest unmet health care needs' in the country. Over 50 million Americans particularly children, the elderly and working poor are not getting the care they need. Tooth decay is the nation's most common chronic disease – five times more common than asthma.
>
> The *Oral Health in America – Report of the United States Surgeon General* in 2000 stated that 'additional flexibility and capacity of the oral health care workforce is sorely needed'. The dental hygiene profession is projected to grow at a rate of 43% over the next decade according to the U.S. Department of Labor.
>
> The National Association of Community Health Centers recently indicated that a survey of over 100 Federally Qualified Health Centers (FQHC) found that 'restorative and preventive oral health services' were the 'top two' most needed services across the country.
>
> The American Academy of Pediatrics recently added oral health as a top tier issue in their strategic plan priorities.

The threat to the public's health, safety or welfare is that the scope of practice for dental hygienists remains the same thereby perpetuating the access to care crisis.

4. Voluntary and past regulatory efforts. Please provide a description of the voluntary efforts made by dental hygienists or dental graduates of foreign universities 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.

MDHA has a long history of regulatory efforts via active legislative involvement. Doyle and Nelson has represented MDHA in its lobbying efforts for the past 7 years. MDHA's

regulatory efforts extend well beyond the scope of this survey answer. MDHA is actively involved at the federal regulatory level via its affiliation with the ADHA.

In 1995, MDHA advocated for an expansion in scope of practice to allow for the administration of local anesthesia.

One of MDHA's major regulatory victories began in 1999 when MDHA introduced LD 2128, "An Act to Amend the Laws Governing the Licensure of Dental Hygienists" to the 119th Maine Legislature. LD 2128 proposed increased access to oral health care for unserved and underserved populations by removing existing supervision requirements that are barriers to preventative care, increased access to preventive oral health care for Maine's children by expanding locations where dental hygienists can practice, protect the health, safety and welfare of the public by ensuring that the citizens of Maine receive preventive oral health care from duly licensed and appropriately educated dental hygienists practitioners, and define the dental hygiene scope of practice and educational licensure requirements in the statute to remove public confusion concerning providers of dental services.

Ultimately, LD 2128 resulted in a Resolve, Regarding Public Health Supervision of Dental Hygienists, approved by the Governor on April 10, 2000. The resolve gave the Board of Dental Examiners until January 1, 2001, to amend the rule regarding public health supervision of dental hygienists in order to provide less restrictive public health supervision of dental hygienists. The purpose of the rule change was to encourage greater utilization of services in institutional, public health and other settings outside a dental office.

This regulatory work fostered by MDHA and with the hard work of the BRED Committee enabled public health dental hygienists to treat over 8000 children in Maine who had never been seen by a dentist. However, there is till a lot of work ahead as most of these children are still looking for a dental home which could be accomplished by expanding the scope of practice through LD 1246 and allowing hygienists to practice independently / without direct supervision, as proposed in LD 550.

5. Costs and benefits of regulation. Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below will increase the cost of services provided by those practitioners, and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

   - a mid-level dental hygienist:

Direct reimbursement for dental hygienists' services is another key in expanding access to care. HRSA Study at 72. More autonomous practice by hygienists or an ADHP would require some mechanism for direct reimbursement in order for these professionals to provide care. See Id. Generally, "oral health services are billed by dentists to public and private payers. Dentists, therefore, receive the professional reimbursement for the prophylactic and preventive services provided by the hygienists in their employ. Since reimbursement is generally contingent on an arrangement with a dentist, hygienists are limited to providing services to locations and patients with whom their employing dentists are engaged." Id. at 71.

The provision of oral health benefits to children and people who are elderly and chronically disabled would prevent unnecessary emergency room visits, hospitalizations, downstream health care costs and reduce Medicaid spending. See Glassman P, Folse G. Financing Oral Health Services for People with Special Needs: Projecting National Expenditures. CDA 33(9): 731-740. Moreover, "untreated dental disease leads to chronic infections, medical complications, pain and even death." Folse G. Oral Health Shame: A Call to Action. Exceptional Parent Magazine. Accepted for Publication. July 2005. See also Pacific Center for Special Care. Sarah's Story. A 4 minute video describing Sarah's admission to a locked facility, dental treatment, and return to her community. http://www.pacificspecialcare.org/sarah.htm. Accessed June 20, 2005.

Furthermore, "there is increasing evidence that poor oral health leads to costly general health problems including diabetes, heart disease, pneumonia, stroke, premature and low birth weight infants, and other conditions. These health care expenses can be reduced by preventing or treating oral infections." Special Care Dentistry Association, Reducing Medicare & Medicaid Spending: The Special Care Dentistry Act. http://www.SCDonline.org. See also Association of State and Territorial Health Officials. Health Focus. Medicaid: Covering Dental Care Could Lower Heart Disease Costs. http://www.statepublichealth.org/index.php?template=view_story.php&fs_id=16&PHPSESSID=592a584e08d591ae3f3f9e199360flc7. June 13, 2005. See also Desvarieux M, Demmer RT, Rundek T, et. al. Periodontal microbiota and carotid intima-media thickness. Circulation. 111:576-582, 2005. See also Krol D. Edelstein B, De Biasi A. Periodontal Disease Association With Poor Birth Outcomes: State of the Science and Policy Implications. Children's Dental Health Project. June 4, 2003 http://www.cdhp.org/downloads/Publications/Policy/PTLBW.pdf. Accessed June 15, 2005.

Even insurance companies who provide health plans are expanding benefits to cover dental care in order to reduce spending on medical problems in the long run. See Kaiser Daily Health Policy Report (September 19, 2006)(citing the Wall Street Journal September 19, 2006)(stating that Cigna, Aetna and Blue Cross Blue Shield are expanding coverage to include dental care because, 'We can save medical costs by getting people to have dental care at the right time in their lives.')

- dental hygienists practicing independently without supervision of a licensed dentist:

Same as above / previously addressed.

- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

To the extent that this legislation expands access to care, MDHA's response is the same as above / previously addressed.

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners:

Same as above / previously addressed.

6. Service availability under regulation. Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below would increase or decrease the availability of oral health services to the public.

- a mid-level dental hygienist:

"Access to care is directly affected by the reimbursement policies mandated in law and regulations." HRSA Study at 72. Moreover, self-regulation and or having their own licensing board, supervision at an appropriate level that balances patient safety and access to care, and expanded scope of practice for dental hygienists who obtain supplemental education / training could increase access to preventive oral health services for people of low income and or compromised access: children, elderly, homeless, and people of certain racial, ethnic and socioeconomic groups. Id. at 171.

The legislature has before it 4 bills that can serve as the vehicle to increase access to care for the citizens of Maine.

- dental hygienists practicing independently without supervision of a licensed dentist:

Same as above / previously addressed.

- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

Same as above / previously addressed.

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

Same as above / previously addressed.

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

People of Maine who cannot afford dental care or cannot access care because of their geographic location have no legal remedy to prevent or redress the harms caused by lack of preventive and restorative dental services. The proposed legislation would actually give the people of Maine a method of redress in that, if sub-standard care was rendered to a patient, that patient could file a complaint with the dental or hygienist board. Presently, many Mainers do not even receive basic preventive services. Therefore, these Mainers have no legal remedy for the harms they suffer as a result of having no care at all.

8. Method of regulation. Please describe 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.

Same as above / previously addressed.

9. Other states. Please provide a list of other states that regulate the profession, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on commercial leasing agents in terms of a before-and-after analysis.

Please refer to the HRSA Study which provides a comprehensive analysis of The Professional Practice Environment of Dental Hygienists in the Fifty States and the District of Columbia. Also, please see **Exhibit G**: Dental Hygiene Participation in Regulation. Additionally, on June 20, 2007, the Federal Trade Commission announced a consent order settling charges brought in September 2003 that the South Carolina State Board of Dentistry unlawfully restrained competition in violation of Section 5 of the Federal Trade Commission Act by adopting a rule that required a dentist to examine every child before a dental hygienist could provide preventive care. See http://www.ftc.gov/opa/2007/dentists.shtm. Also attached hereto as **Exhibit H**. Finally, please refer to "Bills Relating to Dental Hygiene Sent to the Governor July 1, 2006 – June 1, 2007 attached hereto as **Exhibit I**.

10. Previous efforts to regulate. Please provide the details of any previous efforts in *this State* to implement regulation or expand regulation of the occupations (or proposed occupations) listed below:

- a mid-level dental hygienist:

Same as above / previously addressed.

- dental hygienists practicing independently without supervision of a licensed dentist:

Same as above / previously addressed.

- dental graduates of foreign universities:

Same as above / previously addressed.

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

Same as above / previously addressed.

11. Minimal competence. Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

Please See MDHA's previous discussion of the ADHP Competencies. Also, please refer to the ADHP Competencies attached hereto as **Exhibit F**.

12. Financial analysis. Please describe 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.

The proposed regulations will be financed by current and proposed licensees.

13. Mandated benefits. Please describe whether the profession or occupation plans to apply for mandated benefits.

Mandated benefits, as in direct reimbursement as discussed in survey question 5 above and more comprehensively addressed in HRSA Study at pages 71 – 73 is a requisite to expanding scope of practice and access to care.

Date: 7/27/07

Completed by:

Jennifer M. Bryant, Esq. (Maine Bar No. 9160)
o/b/o MAINE DENTAL HYGIENISTS' ASSOCIATION

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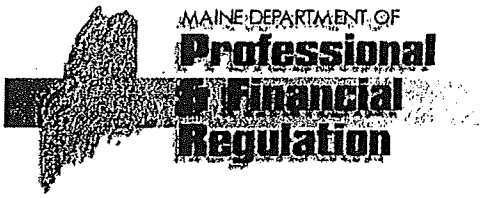


Sunrise Review: Request for Information from Interested Parties

LD 1129 "Resolve, Directing the Commissioner of Professional and Financial Regulation to Conduct a Sunrise Review of Oral Health Care Issues"

Department of Professional and Financial Regulation
Office of the Commissioner
June 21, 2007

Sunrise Review Survey: Oral Health Issues

Please return the completed survey to the Commissioner's Office by July 20, 2007. You may respond to any or all questions. The survey should be e-mailed to Doug Dunbar, Assistant to the Commissioner. The address is doug.dunbar@maine.gov. An electronic version of the survey is available by contacting the Commissioner's Office.

General Information

1. **Group or organization you represent (if any): Maine Primary Care Association**

2. **Position on proposed legislation.** Does this group or organization support or oppose:

- Expanding the scope of practice of dental hygienists by creating a mid-level dental hygienist* license category (LD 1246):

- Permitting dental hygienists to practice independently without supervision of a licensed dentist (LD 550):

- Permitting dental graduates of foreign universities to become licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129): MPCA supports this expansion of dentists eligible for licensure.

- Creating a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. **Data on group proposed for regulation.** Please provide a description of the professional or occupational groups proposed for regulation, including:

(a) The number of individuals or business entities that would be subject to regulation; This is unknown at this time as the Board has prevented licensure of dental graduates of foreign universities, but it would probably be few in number.

* In this sunrise review, "mid-level dental hygienist" means a dental hygienist with an expanded scope of practice similar to the scope of practice proposed in LD 1246.

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and
This depends upon what the Maine Board of Dental Examiners would find acceptable. If limited to public health dentistry, then the Maine Primary Care Association represents all of the state's Federally Qualified Health Centers.
Maine Primary Care Association
73 Winthrop Street
Augusta, ME 04330

(c) An estimate of the number of potential licensees in each group. As mentioned above, this is difficult to determine at this time since the Board has prevented licensure in the past. There probably wouldn't be more than six such licensees.

2. **Specialized skill.** Please describe whether the proposed law changes in the areas of oral health care outlined below require such a specialized skill that the public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met:

- a mid-level dental hygienist license category (LD 1246):

- dental hygienists practicing independently without supervision of a licensed dentist (LD 550):

- dental graduates of foreign universities becoming licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129): Yes, indeed, the practice of dentistry requires such specialized skill that the public is not qualified to select a competent individual without assurances that minimum qualifications have been met.

3. **Threat to public health, safety, or welfare.** Please describe:

(a) The nature and extent of potential harm to the public, if any, if regulation of the practitioners listed below is not expanded:

- a mid-level dental hygienist:

- dental hygienists practicing independently without supervision of a licensed dentist:

- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners: The severe shortage of dentists has led to long waiting lists for

oral health and dental care which does impose harm to the public. Moreover, Maine residents without access to dental care are utilizing the emergency rooms of hospitals to ameliorate pain and/or deal with infections of teeth and gums that could be averted through available dental care. As much as $1 million of hospital costs in one small CAH was attributable to such otherwise avoidable ER visits.

(b) The extent to which there is a threat to the public's health, safety or welfare (*Please provide evidence of the 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 dental hygienists or dental graduates of foreign universities in *this State* within the past 5 years). None known.

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by dental hygienists or dental graduates of foreign universities 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.

These efforts would be adequate to protect the public, but insufficient for the licensure to occur by the present Board of Examiners. Combined by Board of Examiners licensure, these are the necessary and sufficient efforts to protect the public.

5. **Costs and benefits of regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below will increase the cost of services provided by those practitioners, and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

- a mid-level dental hygienist:

- dental hygienists practicing independently without supervision of a licensed dentist:

- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:
the Maine Board of Dental Examiners only recognizes professional training within CODA accredited schools, and therefore, it is unknown what costs would be associated with an expansion to recognize the legitimacy of training in other accredited schools (i.e., international). There would be a significant positive economic impact of increasing the pool of licensed dentists to consumers as greater access to dental care translate into reduced oral health complications, reduced absences from work and school, and improved performance at school and on the job.

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners:

6. **Service availability under regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below would increase or decrease the availability of oral health services to the public.

- a mid-level dental hygienist:

- dental hygienists practicing independently without supervision of a licensed dentist:

- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners: As mentioned above, the ability for properly trained dental graduates of foreign universities to practice in Maine would increase the supply of dentists, and therefore increase the availability of oral health services to the public.

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

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

This regulation should be provided by the existing Maine Board of Dental Examiners.

8. **Method of regulation.** Please describe 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.

This proposal doesn't change the need to license dentists, but adds who might qualify for licensure review by allowing foreign trained dentists to sit for the NERBs and prove their competency in line with their dental training.

9. **Other states.** Please provide a list of other states that regulate the profession, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on commercial leasing agents in terms of a before-and-after analysis.

Massachusetts

10. **Previous efforts to regulate.** Please provide the details of any previous efforts in *this State* to implement regulation or expand regulation of the occupations (or proposed occupations) listed below:

- a mid-level dental hygienist:

- dental hygienists practicing independently without supervision of a licensed dentist:

- dental graduates of foreign universities: None known

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

11. **Minimal competence.** Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

The existing requirements restrict those eligible to apply for licensure to only those trained at CODA schools and summarily dismiss other qualified applicants.

12. **Financial analysis.** Please describe 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.

The financing of a minimal increase in those eligible for licensure would presumably be nominal, and would conceivably be financed by current licenses through dedicated revenue mechanisms.

13. **Mandated benefits.** Please describe whether the profession or occupation plans to apply for mandated benefits.

This doesn't create a new class of profession, but rather adds to who may be licensed as dentists, provided they present the proper preparation, ability, training and knowledge.

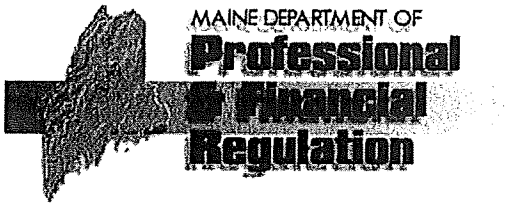
Date: ___July 20_____, 2007 Completed by:

Name: Kevin A. Lewis

Title: Executive Director

Mailing Address: Maine Primary Care Association
73 Winthrop Street
Augusta, ME 04330

E-mail address: kalewis@mepca.org



Sunrise Review: Request for Information from Interested Parties

LD 1129 "Resolve, Directing the Commissioner of Professional and Financial Regulation to Conduct a Sunrise Review of Oral Health Care Issues"

Department of Professional and Financial Regulation
Office of the Commissioner June 21, 2007

Sunrise Review Survey: Oral Health Issues

Please return the completed survey to the Commissioner's Office by July 20, 2007. You may respond to any or all questions. The survey should be e-mailed to Doug Dunbar, Assistant to the Commissioner. The address is doug.dunbar@maine.gov. An electronic version of the survey is available by contacting the Commissioner's Office.

General Information

1. Group or organization you represent (if any):

Maine Society of Denturists
81 Webster St. Lewiston,
ME

2. Position on proposed legislation. Does this group or organization support or oppose:

- Expanding the scope of practice of dental hygienists by creating a mid-level dental hygienist license category (LD 1246):
- Permitting dental hygienists to practice independently without supervision of a licensed dentist (LD 550):

SUPPORT

- Permitting dental graduates of foreign universities to become licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

SUPPORT

- Creating a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

The Maine Society of Denturists strongly supports the formation of a new licensing board within the Department of Professional and Financial Regulation ("DPFR") for denturists and dental hygienists separate from the Board of Dental Examiners. In the alternative, the Maine Society of Denturists would also support direct administration by DPFR much like the structure recently implemented for massage therapists. DPFR would provide administrative services to allow denturists to self-regulate and would receive technical support from an advisory committee of denturists. The hygienists could be regulated in much the same way.

In this sunrise review, "mid-level dental hygienist" means a dental hygienist with an expanded scope of practice similar to the scope of practice proposed in LD 1246.

Much like the medical profession, dental professionals deserve to be regulated by a board of their peers. Medical doctors, osteopathic doctors, podiatrists, nurses, optometrists, acupuncturists, chiropractors, massage therapists, naturopathic doctors, and radiologic technicians each have their own board. Denturists and hygienists deserve also to have boards of their own or at least to be self-regulated.

Denturists currently are an independent profession regulated by a licensing board on which they have one member. What cannot continue to occur is for the denturists to be regulated by their competition—dentists—or for hygienists to be regulated by their employers—dentists. Each profession understands best its own training, standard of care, and proper extent of its scope of practice. No other profession should be making these decisions in place of the profession being regulated.

Importantly, an independent board (Board of Regulatory Fairness) created by the Legislature to review regulatory fairness issued a report to the Legislature in March of this year, which highly recommended the formation of a separate board to regulate denturists and hygienists. After undertaking a rigorous fact-finding process—much like the Department's sunrise review process—the Board concluded, among other things, that the formation of such a board "should be considered a highest and urgent priority in the Legislature." See Attachment A, "First Annual Report of the Maine Regulatory Fairness Board," March 2007, p. 1.

No matter what the composition of this new licensing board, if it will regulate both denturists and hygienists, it must have an equal number of these professions on the board. Importantly, it must also have a strong public presence and no more than one dentist. The focus should always be on protecting the public and doing what is in the best interest of the public.

A proposal acceptable to us would be a board composed of three (3) denturists, three (3) dental hygienists, two (2) members of the public, and one (1) dentist. Each profession could also have a subcommittee charged with all discipline and scope of practice issues.

Because of rapidly rising costs in dental health care and lack of access, Maine should consider all available options in order to increase access and lower costs. A prime opportunity is before us – denturists can independently practice in certain areas and provide the same services at a lower cost than dentists. A realignment of the dental professions in Maine could provide wider access to affordable dental health. As a result, Maine should follow the wisdom of the Board of Regulatory Fairness and the lead of all the Canadian provinces, Washington, Oregon, and Idaho, which already have independent denturist licensing boards, and provide a proper licensing board for denturists and hygienists.

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. Data on group proposed for regulation. Please provide a description of the professional or occupational groups proposed for regulation, including:

(a) The number of individuals or business entities that would be subject to regulation;

Over 50 denturists are licensed in the State of Maine, with 15 actively practicing in Maine.

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and

National Denturist Association/USA
PO Box 308 Tonawanda, PA 18848

International Federation of Denturists
P.O. Box 46132 RPO Westdale
Winnipeg MB R3R 3S3 Canada

(c) An estimate of the number of potential licensees in each group.

2. Specialized skill. Please describe whether the proposed law changes in the areas of oral health care outlined below require such a specialized skill that the public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met:

- a mid-level dental hygienist license category (LD 1246):
- dental hygienists practicing independently without supervision of a licensed dentist (LD 550):
- dental graduates of foreign universities becoming licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

3. Threat to public health, safety, or welfare. Please describe:

(a) The nature and extent of potential harm to the public, if any, if regulation of the practitioners listed below is not expanded:

- a mid-level dental hygienist:

- dental hygienists practicing independently without supervision of a licensed dentist:

• dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

(b) The extent to which there is a threat to the public's health, safety or welfare (*Please provide evidence of the 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 dental hygienists or dental graduates of foreign universities in *this State* within the past 5 years).

1 **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by dental hygienists or dental graduates of foreign universities 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.

2 **Costs and benefits of regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below will increase the cost of services provided by those practitioners, and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

- a mid-level dental hygienist:
- dental hygienists practicing independently without supervision of a licensed dentist:
- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:
- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners:

The Maine Society of Denturists believes that the creation of a new board within DPFR or direct administration by DPFR can be accomplished by not significantly raising the licensing fees for denturists or hygienists. As a result, the denturists commit to not passing on to its patients any increase in licensing fees as a result of self-regulation.

Additionally, an independent board for denturists would most certainly attract more denturists to the State of Maine. Every profession desires to be self-regulated, and such

an opportunity would provide Maine licensees not practicing in Maine the means to come home. More denturists would provide a greater access to dental care, and more competition would provide lower costs for dental care to the citizens of Maine.

6. **Service availability under regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below would increase or decrease the availability of oral health services to the public.

- a mid-level dental hygienist:
- dental hygienists practicing independently without supervision of a licensed dentist:
- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:
- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

As stated in #5, an independent board for denturists would most certainly attract more denturists to the State of Maine. Every profession desires to be self-regulated, and such an opportunity would provide Maine licensees not practicing in Maine the means to come home. More denturists would provide a greater access to dental care, and more competition would provide lower costs for dental care to the citizens of Maine.

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

The Maine Society of Denturists believes that existing law—the existing Board structure—is inadequate to prevent the harm that results from the denturists being regulated on a board dominated by the dentists. The subcommittees of the Board of Dental Examiners for denturists and hygienists were originally opposed by the Maine Dental Association before the Legislature decided that significant changes to the BODE were necessary. However, each of these subcommittees are limited in their scope—e.g., the denturist subcommittee is limited to disciplinary issues—and are therefore inadequate to serve the many needs of the denturist profession. Denturists desire a proper forum in which to deliberate not only disciplinary issues, but training, standard of care, scope of practice, and other critical issues.

In addition, inadequacies in denturist training and regulation exist, as a result of the existing Board of Dental Examiners. There is currently no approved educational program for training denturists.

1 **Method of regulation.** Please describe 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.
2 **Other states.** Please provide a list of other states that regulate the profession, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on commercial leasing agents in terms of a before-and-after analysis.

Oregon: Full scope of practice. Board of Denture Technology
Washington: Full scope of practice. Board of Denture Technology
Montana: Full dentures; Partial dentures with Oral Health Certificate. Board of Dentistry.
Idaho: Full dentures and partial denture repairs. Board of Denturitry
Arizona: Full scope of practice under general supervision. Board of Dentistry.

All Canadian provinces allow full scope of practice and have independent denturist regulating bodies.

10. Previous efforts to regulate. Please provide the details of any previous efforts in *this State* to implement regulation or expand regulation of the occupations (or proposed occupations) listed below:

- a mid-level dental hygienist:
- dental hygienists practicing independently without supervision of a licensed dentist:
- dental graduates of foreign universities:
- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

Efforts to create a licensing board for denturists and to expand the scope of practice for denturists have been ongoing since 1995. In 2001, a bill was killed that would have created an independent board for denturists. In 2003, sunset review of the BODE resulted in the development of the now existing subcommittees for denturists and hygienists. The sunset review legislative hearings also resulted in a bill providing for sunrise review to study the feasibility of expanding the scope of practice for denturists to provide partial dentures among other things.

Additionally, during the legislative hearings regarding the sunset review, the Maine Society of Denturists proposed various reforms to the structure of the Board of Dental Examiners. One of the changes was to equalize the Board, by having each dental

profession have equal representation on the Board. The Society, at that time, proposed a Board with two dentists, two hygienists, two denturists, and one member of the public. This proposal was rejected by the Business, Research, and Economic Development Committee.

11. Minimal competence. Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

12. Financial analysis. Please describe 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.

License fees would cover the cost of a licensing board for denturists and hygienists, and the fees would also cover the costs if, in the alternative, denturists were directly administered by DPFR.

13. Mandated benefits. Please describe whether the profession or occupation plans to apply for mandated benefits.

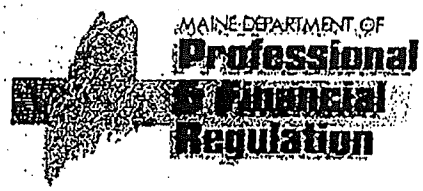
Date: August 19, 2007 Completed by:

_____ Name: Daniel Hollis

Title: President, Maine Society of Denturists

Mailing Address:
33 Granite Rock Circle North
Surry, ME 04684

E-mail address: ddc100@gwi.net



Sunrise Review: Request for Information from Interested Parties

LD 1129 "Resolve, Directing the Commissioner of Professional and Financial Regulation to Conduct a Sunrise Review of Oral Health Care Issues"

Department of Professional and Financial Regulation
Office of the Commissioner
June 21, 2007

Sunrise Review Survey: Oral Health Issues

Please return the completed survey to the Commissioner's Office by July 20, 2007. You may respond to any or all questions. The survey should be e-mailed to Doug Dunbar, Assistant to the Commissioner. The address is doug.dunbar@maine.gov. An electronic version of the survey is available by contacting the Commissioner's Office.

General Information

1. **Group or organization you represent (if any):**
   I AM IN PRIVATE PRACTICE BUT I AM A MEMBER OF THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY AND THE MAINE SOCIETY OF PEDIATRIC DENTISTRY.
2. **Position on proposed legislation.** Does this group or organization support or oppose: THESE QUESTIONS I WILL ANSWER AS AN INDIVIDUAL

- Expanding the scope of practice of dental hygienists by creating a mid-level dental hygienist* license category (LD 1246): I OPPOSE THIS AS THERE IS NO ACCEPTED CURRICULUM OR TRAINING IN PLACE AND NO OBJECTIVE TESTING CRITERIA FOR LICENSURE. ALSO, AS THESE PEOPLE ARE TO TREAT CHILDREN, I DON'T THINK THE DIFFICULTY OF TREATING CHILD WAS CONSIDERED.
- Permitting dental hygienists to practice independently without supervision of a licensed dentist (LD 550): I OPPOSE THIS. IN MY EXPERIENCE HYGIENISTS ARE NOT TRAINED TO BE INDEPENDENT.
- Permitting dental graduates of foreign universities to become licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):
  IN GENERAL I ACCEPT THIS IN LIGHT OF OUR ACCESS PROBLEM.
- Creating a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):
  I DON'T KNOW ENOUGH ABOUT DENTURISTS.
  I DON'T HAVE A PROBLEM WITH HYGIENISTS REGULATING THEMSELVES BUT THEY CAN'T INDEPENDENTLY CREATE RULES FOR NEW HYGIENE DESIGNATIONS.

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. **Data on group proposed for regulation.** Please provide a description of the professional or occupational groups proposed for regulation, including:

(a) The number of individuals or business entities that would be subject to regulation;
I DON'T KNOW

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and ?

* In this sunrise review, "mid-level dental hygienist" means a dental hygienist with an expanded scope of practice similar to the scope of practice proposed in LD 1246.

(c) An estimate of the number of potential licensees in each group.

7.

2. **Specialized skill.** Please describe whether the proposed law changes in the areas of oral health care outlined below require such a specialized skill that the public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met:

- a mid-level dental hygienist license category (LD 1246): ABSOLUTELY THE PUBLIC IS NOT QUALIFIED TO SELECT SUCH A PERSON.

- dental hygienists practicing independently without supervision of a licensed dentist (LD 550): AGAIN ABSOLUTELY THIS CANNOT BE DECIDED BY ANY ONE OTHER THAN A QUALIFIED DENTAL PROFESSIONAL.

- dental graduates of foreign universities becoming licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129): THIS IS TOO OBVIOUS. IT IS ONLY TO BE DONE BY A DENTAL PROFESSIONAL

3. **Threat to public health, safety, or welfare.** Please describe:

(a) The nature and extent of potential harm to the public, if any, if regulation of the practitioners listed below is not expanded:

- a mid-level dental hygienist: IF DENTAL CARE IS NOT AT THE HIGHEST LEVEL THE CHANCE FOR PERIOPERATIVE PROBLEMS ARE HIGH AND CHILDREN MAY SUFFER.

- dental hygienists practicing independently without supervision of a licensed dentist: POTENTIAL MISINFORMATION, LACK OF BACKGROUND INFORMATION AND NO BACK UP FOR TREATMENT NEEDS

- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners: IT IS POSSIBLE THAT EDUCATIONAL STANDARDS IN OTHER COUNTRIES DON'T COME TO U.S. LEVELS.

(b) The extent to which there is a threat to the public's health, safety or welfare (*Please provide evidence of the 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 dental hygienists or dental graduates of foreign universities in *this State* within the past 5 years).

I CANNOT GIVE A SPECIFIC EXAMPLE

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by dental hygienists or dental graduates of foreign universities 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.

I CANNOT ANSWER THIS.

5. **Costs and benefits of regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below will increase the cost of services provided by those practitioners, and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

- a mid-level dental hygienist: THIS POSITION, IF UTILIZED IN A DENTIST'S OFFICE, COULD LESSEN COSTS AND INCREASE PRODUCTIVITY. THE FUTURE FOR THIS POSITION COULD BE, SOMEDAY, VERY POSITIVE.
- dental hygienists practicing independently without supervision of a licensed dentist: COULD LESSEN COSTS TO CONSUMERS.
- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners: PROBABLY NO GREAT IMPACT
- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners: NO OPINION.

6. **Service availability under regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below would increase or decrease the availability of oral health services to the public.

- a mid-level dental hygienist: THIS WOULD INCREASE AVAILABILITY AT A FRIGHTENING DECREASE IN QUALITY
- dental hygienists practicing independently without supervision of a licensed dentist: INCREASE ACCESS FOR BASIC PREVENTIVE AND DIAGNOSTIC SERVICES ONLY
- dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners: COULD INCREASE ACCESS FOR ALL DENTAL SERVICES
- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462): NO IMPACT

7. **Existing laws and regulations.** Please discuss the extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from

non-regulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated practitioners.

I CANNOT ANSWER THIS

8. **Method of regulation.** Please describe 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. I DON'T THINK IT IS.

9. **Other states.** Please provide a list of other states that regulate the profession, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on commercial leasing agents in terms of a before-and-after analysis.

ASK THE ME. DON'T. ASSOC.

10. **Previous efforts to regulate.** Please provide the details of any previous efforts in *this State* to implement regulation or expand regulation of the occupations (or proposed occupations) listed below:

I DON'T KNOW.

- a mid-level dental hygienist:

- dental hygienists practicing independently without supervision of a licensed dentist:

- dental graduates of foreign universities:

- a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

11. **Minimal competence.** Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

I AM NO EXPERT IN THIS BUT IT SEEMS THAT AS THIS IS A NEW DESIGNATION NO STANDARDS EXIST.

12. **Financial analysis.** Please describe 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.

13. **Mandated benefits.** Please describe whether the profession or occupation plans to apply for mandated benefits.

Date: 18 JULY, 2007 Completed by:

STEPHEN C. MILLS DDS
Name:

Title: PEDIATRIC DENTIST

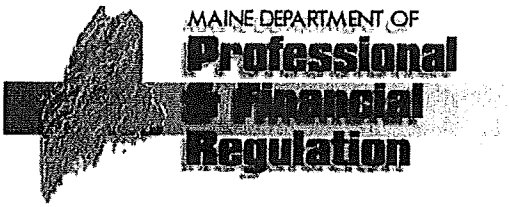
Mailing Address: 300 TECHNOLOGY WAY.
SCARBOROUGH, ME
04074

E-mail address:
LMILLS5977@aol.com.

I AM SIMPLY A QUALIFIED SPECIALIST IN PEDIATRIC DENTISTRY, I AM NOT WELL VERSED IN THE PROCEDURAL, LEGISLATIVE AND FINANCIAL QUESTIONS ASKED. I SIMPLY FEEL THAT THE NEW HYGIENIST DESIGNATION IS VERY PREMATURE AND AT PRESENT, ILL ADVISED. THE TREATMENT OF CHILDREN PROPERLY IS ONE OF THE MOST DIFFICULT THINGS TO DO WELL, TO SUBJECT THIS HELPLESS POPULATION TO QUESTIONABLE CARE IS THE HEIGHT OF IRRESPONSIBILITY.

WHEN AN ACCEPTED TRAINING PROGRAM WITH NATIONALLY ACCEPTED TESTING GUIDELINES EXIST, I WILL SUPPORT THE DESIGNATION, NOT TO PRACTICE INDEPENDENTLY BUT TO PARTNER WITH DENTISTS TO TREAT MORE CHILDREN.

Stephen C Mills DDS



Sunrise Review: Request for Information from Interested Parties

LD 1129 "Resolve, Directing the Commissioner of Professional and Financial Regulation to Conduct a Sunrise Review of Oral Health Care Issues"

Department of Professional and Financial Regulation
Office of the Commissioner June 21, 2007

General Information

1. **Group or organization represented:** The University of New England

2. **Position on Proposed legislation:**

   a. **LD 1246:** We recognize that many benefits may come from expanding the scope of practice for the dental hygienist by creating a mid-level license category. Changes could be made to this legislation that creates both a mid-level advanced dental hygiene practitioner, (ADHP) and a mid-level practitioner. (Comparable to the Nurse Practitioner and a Physician's Assistant respectively.) The ADHP should obtain a Bachelor in Dental Hygiene degree and complete another degree program that is the equivalent of a master's level of education. This would directly correlate to the requirements of a Nurse Practitioner. Also, the second mid-level practitioner would require a Bachelor of Science and a required Master's level program. (Similar to but not identical to the ADHP curriculum). This should also be created with this legislation to provide similar services. (Specific Curriculum to be determined by a task force) This practitioner would be comparable to the Physician's Assistant. These categories would better maintain the standard of care for the people of Maine than what is proposed in the current language of the bill.

   b. **LD 550:** We support this legislation with the caveat that the independent practice should be available for the newly created ADHP (created by LD 1246) only after two years of practice in a traditional dental setting. This position would then be comparable to that of the independent Nurse practitioner. This would enable ***only*** the ADHP to diagnose and manage most common and chronic "dental-illnesses" (to be defined by the task force), ***either*** independently or as part of a health care team. Also, independent practice within the current scope of practice for the dental hygienist should be allowed provided the hygienist has a Bachelor of Science in Dental hygiene and at least two years experience in a traditional dental setting. Maintaining the standard of care for the people of the State of Maine is essential and this can best be accomplished with a highly qualified and educated group of providers.

   c. **LD 1129:** On its face, this proposed legislation seems to address many of the access to care issues in the State of Maine. However, it creates many questions as well. The "acceptable standards" of the Maine Board of Dental Examiners will need to be framed to address the great differences in foreign education standards. Some Dental schools in the United States already have transitional programs in place to train these students to provide the quality and standard of care that is expected. The University of New England is pleased to support any type of legislation that respects an accreditation process that requires a minimum level of competency to maintain our standard of care. In light of this and other proposed pieces of legislation that seek to expand the

existing dental care providers, it would be beneficial to the Board of Dental Examiners to have among its rank a member who can focus not only on dental care issues that come before the board but on dental education and curriculum issues.

d. **LD 1462:** There could be benefits to the quality and delivery of patient care with a separate board for Dental Hygiene. When nursing became independent not so long ago, measures such as "nursing orders" allowed nurses to provide better care to their patients without waiting for a doctor's order. A separate board for Dental Hygiene could do the same for their patients. Dental hygienists and the ADHP developed by LD 1246 should have their own board within the Department of Professional and Financial Regulation. As stated above the medical model provides a wonderful example of self regulation with the nursing profession. This provides a convenient template that would work effectively for dental hygiene, the proposed ADHP and Dentists.

There is no practical reason to combine denturists and hygienists as the technical skills and practices do not naturally go together. However, the denturists could be added to the Board of Complementary Health Care Providers.

Evaluation Criteria:

1. **(a) Dental Hygienists:** This professional group is responsible for providing preventive, educational and therapeutic services for the control of oral diseases and the promotion of oral health. These practitioners are licensed after obtaining an Associate of Science degree at an accredited institution and passing all State, Regional and National exam requirements.
Mid-level Practitioners: There should be two distinct groups.
(b) The Advanced Practice Dental Hygienist (ADHP)
Licensed dental hygienists with a Bachelor in Dental Hygiene who graduate from a program with this proposed curriculum (or something similar to be determined by a dental task force) See www.adah.org/downloads/ADHP_Draft_Curriculum.pdf
This Mid-level practitioner would be licensed to practice within the expanded scope of the proposed LD 1246 either as part of a health care team or, independently, ***only after*** two years of clinical experience in a traditional dental setting. The ADHP, like the Dental Hygienist would be licensed and regulated by the separate board created for hygiene by the passage of LD 1462.
AND
(c)The Mid-level Dental practitioner:
A person with a Bachelor of Science degree who has graduated from an accredited dental Mid-level/ Master's program, similar to but not exactly like, the proposed Curriculum above. (To be determined by the task force) This practitioner would be a licensed dental professional who practices dentistry under the supervision of a Dentist. This provider

provides a broad range of dental care services that were traditionally performed by a dentist. Before beginning employment in Maine, this practitioner must be registered with a Primary Supervising dentist by completing and submitting a Form registration (similar to that required for Physician's Assistant to complete). These Mid-level practitioners would conduct dental exams, diagnose and treat dental-illnesses, order and interpret X-rays, counsel on preventive dental care, assist in dental surgery. These providers *must* work under the supervision of a dentist and their duties are determined by the supervising dentist. However, this practitioner may be the principal care providers in places where a physician is present for only 1 or 2 days each week/ (month?). In such cases, this practitioner maintains contact with the supervising dentist and other dental professionals as needed or as required by law. This practitioner would be licensed by the Maine Board of Dental Examiners.

Evaluation criteria 1(a)

(a) The number of individual mid-level practitioners subject to these regulations would be determined by the number of individuals who successfully complete the proposed required educational components and yet to be created licensing exams. The number of business entities subject to regulation would be determined by how and where the mid-level practitioners choose to practice. At present time there are approximately 1200 active registered dental hygienist and 80 inactive registered dental hygienists. See Office Of Health Data And Program Management > 2004 Maine Hygienists Tables (with approximately 90 students a year since 2004 graduating from in State Hygiene schools added). Of these 77 have graduated from the University of New England with Bachelor of Science degrees in Dental Hygiene. See also www.maine.gov/dhhs/bohodr/documents/SER13_2.pdf

(b) Groups representing potential licensees:
American Dental Hygienists' Association / Maine Dental Hygiene Association
444 North Michigan Avenue, Suite 3400
Chicago, Illinois 60611
(800) 243-2342

(c) The current number of potential licensees for the dental hygiene mid-level practitioner students is approximately 77.
The number of potential licensees for the dental mid-level practitioner with a B.S. degree from a Maine institution who complete all the requirements is approximately 1600 a year as of 2005 See www.nces.ed.gov/programs/digest/d05/dt05_303.asp, from a U.S. institution as of 2005 that number would be approximately 300,000. See Id.

2. **Specialized Skill:**
Mid-level hygienist/dental mid-level practitioner (LD 1246) the changes proposed would require the specialized skills comparable to those of a hygienist and a dentist. As with these groups, the public would not be qualified to select a competent provider without the assurances provided by that of a licensing board. The best person to answer this question would be the Public member of the Maine Board of Dental Examiners, Thomas R. Palmer. He can be reached at:
143 State House Station 161 Capitol Street
Augusta, ME 04333-0143

Phone: 207-287-3333 • Fax: 207-287-8140

The Dental Hygienist practicing independently without supervision of a licensed dentist (LD 550) same as above.

3. **Threat to public health, safety, or welfare:**

(a) The threat to public dental health, safety and welfare by not expanding the scope of the hygienist to create this mid-level practitioner and by not allowing other types of mid-level practitioners is great and unnecessary:

> "Maine does not have a dental school or dental residency program, the best source for newly trained dentists who want to continue living and practicing in our state. This leaves Maine dependent on other states to increase their number spaces reserved for non-resident students, something not likely to happen as the number of Dental Health Professional Shortage Areas (DHPSA) increases. Large numbers of dentists are expected to retire here in Maine in the next few years. Because of this, demand is expected to grow substantially through 2012."

See The Maine Department of Labor Special Report 2006 health Care occupations. Pages 51-64. www.maine.gov/labor/lmis/pdf/HealthcareReport.pdf (note this was written before the University of New England had a residency program in place) A mid- level of practitioner could more easily move into an established rural practice and double the amount of restorative care provide without forcing the existing dentist to take on a partner or pay another dentist's fee thus helping to address this impending shortage. New dentists, with an average of $200,000 in school loans and the estimated cost of $250,000 to open a new office, cannot fill the need for dental care in the more rural areas of Maine as easily with this kind of debt. (See id. at 55.) The success of the medical models of the PA and the Nurse Practitioner prove that a mid-level practitioner increases access to care without sacrificing the standard of care, if their scope of practice is carefully crafted. As the baby-boomers age and keep more and more of their teeth (a growing trend reflecting the success of the preventive measures of oral hygiene) the need for more restorative work will continue to increase as the number of providers decrease. The ADHP (hygienist's whose numbers are expected to increase in the next few years. see www.maine.gov/labor/lmis/pdf/HealthcareReport.pdf) and proposed mid-level practitioner would be poised to fill this void.

Not allowing both experienced Bachelor of Science dental hygienists working in their current scope of practice, and the ADHP with experience (amount to be determined by the task force) to practice independently without supervision of a licensed dentist would continue to compound the access to care issues that exist in this State. Combined with the decrease in the number of dentist expected by the year 2012, the dental profession's ability to treat the already underserved communities in Maine could threaten not only our population's dental health but their overall health as well. More and more evidence points to the relationships between cardiovascular disease,

oral inflammation, and dental hygiene. See Journal of Practical Hygiene Volume 16/Number 4, May 2007, There are also connections between pre-term birth rates and oral care not to mention the sociocconomic impact that poor dental care can have on employment to name only a few issues. It is time for state government to forward a policy that protects the dental care of the people by increasing access to care. These proposed Mid-level dental providers are based on the evidence of success of the model (see the medical mid-levels) and dental initiatives successfully treating patients in our own country, see www.dhfs.wisconsin.gov/health/Oral_Health/taskforce/pdf/modelsummary.pdf and throughout the world. see www.bium.univparis5.fr/sfhad/iahd/iahd01e.htm

The Threat to public health, safety or welfare if regulation of dental graduates of foreign universities to become licensed is not expanded, is in the details of the proposed language of the bill. That language provides that licensure be "pursuant to standards acceptable to the Maine Board of Dental Examiners." It is the profession's regulatory board's duty to oversee the standard of care. However, the Maine Board of Dental examiners at this time, does not require any of its members to have an educational background. Having at least one member with this experience would allow the board to act with a better understanding of the various levels of education that are provided to foreign trained dentists(depending on where they were educated) and how those various levels compare to our accreditation and competency standards here in the United States. Further, if the Board were to decide that a residency program, like the one currently established at the University of New England, were needed, then having a licensed member familiar with the process and procedures of curriculum would be most beneficial. Beyond just passing a licensing exam, careful monitoring of the educational background of these foreign educated dentists is essential. Otherwise, an increase in access to dental care may come at the cost of a diminished standard of care; a price too high for the people of Maine to pay.

(b) I was only able to find one complaint handled by the Board of Dental Examiners concerning a hygienist with a substance abuse problem. I did not find any legal cases against hygienists in the state of Maine in the last 5 years.

4. **Voluntary and past regulatory efforts.**
Dental hygienists have made successful past efforts to protect the public by supporting the expansion of the scope of hygiene practice in a public health setting. See www.mainedha.org They would like to add self-regulation to their efforts with LD 1462. Combined with a greater scope of practice and independent practice comes the responsibility of self regulation by a body of peers who understand the parameters of the hygienist's new and changing roles.

5. **Costs and benefits of regulation**
I personally am not qualified to answer this set of questions. Our legal department at the University would need more time than is available to answer this set of questions.

6. **Service availability under regulation**

A mid-level dental provider (either the ADHP or the mid-level dental practitioner described above) would increase availability of oral health services to the public. To begin with, these students would have to have patients to treat in their school setting. This would allow the University of New England to expand their dental hygiene clinic to provide restorative work as well as other services that a task force might see fit to add to their scope of practice. After graduation and licensing, the mid-level providers could potentially double the restorative output of the private practice dental office. Further, after two years of experience, the ADHP could open their own office providing a greater opportunity to reach the more rural areas. This is not to mention in the alternative, continuing to run a practice with established patients taken over from a retiring dentist who could not sell his or her practice to another dentist.
Dental Hygienists practicing independently without supervision as described above could provide more locations for preventive care as well thus increasing access to dental care and to education of the importance of oral hygiene on overall health. With the estimated number of hygienists expected to increase by 2012, this would not create a deficiency in existing offices but would, with the provided recommendations create more opportunity for the people of Maine to seek treatment, continue preventive treatment and receive referrals from these appointments. This independence then goes hand in hand with the mid-level practitioner. If you treat more patients and find more decay early, you will need more practitioners to treat them; an issue solved with the creation of the mid –level practitioners.

7. **Existing laws and regulations:**

Applicable statutes determine whether the risks that would generate this board exist, and if so, determine if the board will operate in the most efficient but least restrictive manner possible. Providing dental hygiene care can, in some cases, involve life endangering situations that require the application of knowledge, skill, judgment and therapeutic ability. Daily, patients can be exposed to significant risks. Incompetence in management of dental hygiene assessment and treatment can have serious consequences and most patients are not equipped with the knowledge or ability to "shop around" for competent care when they are in need of dental services. All of this justifies public regulation in the field. The types of harm that could come from either the proposed ADHP or the hygienist could be regulated through the Maine Board of Dental Examiners but not as effectively as a board comprised of members of their own professions.

This new Board would need membership from those working in the hygiene field and the mid-level practices in order to ensure that the changes in these professions are adequately reflected in its expertise. This seems to be a natural fit as the advanced practitioners are hygienists who will have graduated from an approved postgraduate program and will have passed a State/national certification examination in an area beyond that required for hygiene licensure. Also, a dental mid-level educator should also be on the board to provide some insight to the requirements for accreditation and evaluation of the professions' continuing change. This Board should be given the normal powers and duties of a regulatory board such as the power to approve educational programs, the power to examine licensees and applicants, to grant renewals and permits, to adopt rules and most significantly, the power to discipline licensees where appropriate.

With regard to the proposed hygiene board substantial risk to the public welfare exists and would increase without close regulation of the proposed ADHP and hygienists. The scope of practice of the dental hygienist has increased over time. Downward delegation from dentists has increased in many instances (administration of Nitrous Oxide, local anesthesia and public health responsibilities, etc.). A trend towards more education for hygienists has developed, as dentists increasingly specialize and the ranks of the general practitioner are declining. New areas of need have developed (lack of access for children and rural residents as well as an increasingly older population that are keeping their teeth longer). All of these trends have created a greater need for qualified ADHPs and hygienists of all types.

Dental technology and knowledge of disease has increased, so that caretakers must be even more well-informed and trained. For these reasons it is clear that hygiene practice should be regulated by practitioners who are up to date on their own profession/s and not by Dentists who have to remain current in their own field let alone hygiene and the proposed ADHP. This new board would also allow the composition of the Dental board to change and include more dental specialists (a growing group of dentists) instead of requiring two hygienists. This would increase the benefit to the public on two boards and not just one. Composition of this board could be determined by a task force but again, should include at least one educator as the ADHA curriculum is new and approval of educational programs would be within its powers.

8. **Method of regulation:**

Licensing is being proposed as it effectively deals with the threat to public health, safety and welfare in most of the other medical and dental fields. The scope of practice and the level of expertise demand a regulatory body that understands the nuances of daily practice and the issues that practitioners face in a technical and evolving field.

9. **Other States:**

No other state regulates an ADHP as it does not yet exist. As for hygiene, it is traditionally regulated under the Dental Board of examiners in Maine. California has established the Committee on Dental Auxiliaries (COMDA) under the jurisdiction of their Dental Board, see www.info.sen.ca.gov/pub/07-08/bill/sen/sb_0501-0550/sb_534_cfa_20070423_181148_sen_commhtml and Alaska is still attempting to create one as well. The Board of Nursing is self regulated in the state of Maine and Dental Hygiene is attempting to split from dentistry as Nursing did from Medicine. The benefit from the split for Nursing has been two-fold. One, the profession is regulated by professionals who understand the ever expanding role first hand as it is comprised primarily of Nurses and two, the public's benefit comes from allowing nurses to establish and administer "nursing orders" for example that allow nurses to administer over the counter medications to patients as needed without waiting for a doctor's order. Although the Board of Dental Examiners will miss the funds generated by the hygiene licensing fees, if LD 1246 passes as proposed in this packet, they would receive licensing fees for one of the two created mid-level practitioners.

10. **Previous efforts to regulate:**

I have not been involved in the process long enough to comment on this question.

11. **Minimal Competence:**

Only the dental hygienist working independently pursuant to proposed LD 550 would be required to exceed the standards of minimal competence for that of a Dental Hygienist. Each of the new categories of mid-level practitioner would establish a new standard and would set the "minimum standard" for those roles but, the Hygienist who works independently will be required to meet all the minimum standards for a Registered Dental Hygienist in the State of Maine ***AND***

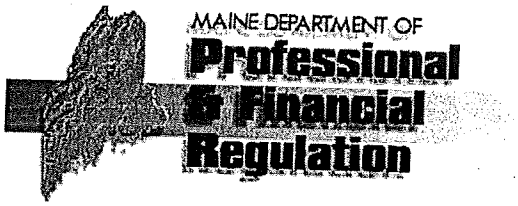
1. have a bachelor's degree in dental hygiene
2. have two years experience (or a minimum number of hours)

12. Financial Analysis:

No Comment

13. Mandated Benefits:

No Comment



Sunrise Review: Request for Information from Interested Parties

LD 1129 "Resolve, Directing the Commissioner of Professional and Financial Regulation to Conduct a Sunrise Review of Oral Health Care Issues"

Department of Professional and Financial Regulation
Office of the Commissioner June 21, 2007

Sunrise Review Survey: Oral Health Issues

Please return the completed survey to the Commissioner's Office by July 20, 2007. You may respond to any or all questions. The survey should be e-mailed to Doug Dunbar, Assistant to the Commissioner. The address is doug.dunbar@maine.gov. An electronic version of the survey is available by contacting the Commissioner's Office.

General Information

1. Group or organization you represent (if any):

National Denturist Association/USA

2. Position on proposed legislation. Does this group or organization support or oppose:

- Expanding the scope of practice of dental hygienists by creating a mid-level dental hygienist license category (LD 1246):
- Permitting dental hygienists to practice independently without supervision of a licensed dentist (LD 550):

The NDA/USA strongly supports this proposal.

- Permitting dental graduates of foreign universities to become licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

The NDA/USA strongly supports this proposal.

- Creating a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

The NDA/USA strongly supports this proposal.

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. Data on group proposed for regulation. Please provide a description of the professional or occupational groups proposed for regulation, including:

(a) The number of individuals or business entities that would be subject to regulation;
RDH's: 1200 + Denturists: 50+ Licensees, 15 practicing in Maine Foreign trained Dentists: Unknown

In this sunrise review, "mid-level dental hygienist" means a dental hygienist with an expanded scope of practice similar to the scope of practice proposed in LD 1246.

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and

National Denturist Association/USA
PO Box 308 Tonawanda, PA 18848

Maine Society of Denturists
81 Webster St. Lewiston, ME

International Federation of Denturists
P.O. Box 46132 RPO Westdale
Winnipeg MB
R3R 3S3
Canada

(c) An estimate of the number of potential licensees in each group.

The generally accepted ratio of Denturists needed by the population is 1 in 25,000. This would suggest that Maine's population of 1.3 M should need 52 denturists.

2. **Specialized skill.** Please describe whether the proposed law changes in the areas of oral health care outlined below require such a specialized skill that the public is not qualified to select a competent individual or entity without assurances that minimum qualifications have been met:

• a mid-level dental hygienist license category (LD 1246):

The safety of the public requires testing of minimum qualifications.

• dental hygienists practicing independently without supervision of a licensed dentist (LD 550):

The safety of the public requires testing of minimum qualifications.

• dental graduates of foreign universities becoming licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners (LD 1129):

The safety of the public requires testing of minimum qualifications.

3. **Threat to public health, safety, or welfare.** Please describe:

(a) The nature and extent of potential harm to the public, if any, if regulation of the practitioners listed below is not expanded:

- a mid-level dental hygienist:
- dental hygienists practicing independently without supervision of a licensed dentist:

There is a critical shortage of dentists and dental professionals in Maine and most of the USA. It is time for the monopoly enjoyed by dentists to end. RDH's are perfectly capable of expanded duties and are no less ethical than dentists. All dental professionals are required to refer patients to the appropriate health care practitioner when confronted with a condition beyond their competency.

• dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

There is need for recognition of international qualifications beyond the jurisdiction of the Council on Dental Accreditation, which has not yet even recognized the profession of Denturism.

(b) The extent to which there is a threat to the public's health, safety or welfare (*Please provide evidence of the 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 dental hygienists or dental graduates of foreign universities in *this State* within the past 5 years).

Unknown

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by dental hygienists or dental graduates of foreign universities 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.

Unknown

5. **Costs and benefits of regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below will increase the cost of services provided by those practitioners, and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

- a mid-level dental hygienist:
- dental hygienists practicing independently without supervision of a licensed dentist:

Monopolies tend to raise prices, competition tends to lower prices.

• dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

Any possibility of an increase in the number of dentists should be investigated. Monopolies tend to raise prices, competition tends to lower prices.

• a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners:

No independent dental professional should be regulated by their competition. An independent board or governance through the Dept. of PFR would bring more Denturists into the state.

6. **Service availability under regulation.** Please describe the extent to which regulation or expanded regulation of the occupations (or proposed occupations) listed below would increase or decrease the availability of oral health services to the public.

• a mid-level dental hygienist:

Would provide for better use of dentists' training and skills. Along with Denturists, mid-level RDH's would free up dentist's time to see more patients who may need the skills that only a dentist has now.

• dental hygienists practicing independently without supervision of a licensed dentist:

Would attract RDH's into the state to take advantage of a progressive delivery scheme.

• dental graduates of foreign universities licensed in Maine pursuant to standards acceptable to the Maine Board of Dental Examiners:

More dentists would certainly help ease the crisis in access to care.

• a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

Would attract Denturists and RDH's into the state to take advantage of a progressive delivery scheme.

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

No independent dental professional should be regulated by their competition. An independent board or governance through the Dept. of PFR would bring more Denturists and RDH's into the state.

8. **Method of regulation.** Please describe 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.

No independent dental professional should be regulated by their competition. An independent board or governance through the Dept. of PFR would be more appropriate.

9. **Other states.** Please provide a list of other states that regulate the profession, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on commercial leasing agents in terms of a before-and-after analysis.
All Canadian provinces allow full scope of practice and have denturist regulating bodies.

Oregon: Full scope of practice. Board of Denture Technology Washington: Full scope of practice. Board of Denture Technology Montana: Full dentures; Partial dentures with Oral Health Certificate. Board of Dentistry. Idaho: Full dentures and partial denture repairs. Board of Denturitry Arizona: Full scope of practice under general supervision. Board of Dentistry.

10. **Previous efforts to regulate.** Please provide the details of any previous efforts in *this State* to implement regulation or expand regulation of the occupations (or proposed occupations) listed below:

• a mid-level dental hygienist:

Unknown

• dental hygienists practicing independently without supervision of a licensed dentist:

Unknown

• dental graduates of foreign universities:

Unknown

• a new licensing board within the Department of Professional and Financial Regulation for denturists and dental hygienists separate from the Board of Dental Examiners (LD 1462):

Attempts to increase scope of practice and create a new board have been ongoing since 1995.

11. Minimal competence. Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

N/A

12. Financial analysis. Please describe 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.

License fees would pay for any associated cost of regulation.

13. Mandated benefits. Please describe whether the profession or occupation plans to apply for mandated benefits.

Unknown

Date: August 21, 2007 Completed by:

_____ Name:

Connie Gerrity
Title:
Executive Director, National Denturist Association/USA

Mailing Address:

PO Box 308
Tonawanda, PA 18848

E-mail address:

denture@sosbbs.com

FOREIGN TRAINED LICENSEES

			LICENSE INFORMATION			
NAME	COUNTRY OF ORIGIN	2-YEAR PROGRAM	LICENSE #	ISSUE DATE	EXPIRATION DATE	LICENSE STATUS
LATYPOVA, Kateryna	Ukraine	Tufts	4042	8/22/2007	12/31/2007	Active
PAMIDIMUKKALA, Dheeraj	India	Boston University	3824	7/10/2006	12/31/2007	Active
MALLIPEDDI, Vani	India	Boston University	3817	6/2/2006	12/31/2007	Active
GUPTA, Nidhi	India	Boston University	3814	5/26/2006	12/31/2007	Active
KANORWALLA, Yogita	India	Boston University	3751	1/27/2005	12/31/2007	Active
DIGGIKAR, Anand	India	U of British Columbia	3746	10/29/2004	12/31/2007	Active
BASH, Ammar	Syria	Boston University	3735	7/2/2004	1/31/2006	Lapsed
MEHTA, Vivek	India	Boston University	3732	6/28/2004	12/31/2005	Withdrawn
BECKER, Marina	Russia	Boston University	3731	6/28/2004	12/31/2007	Active
JEBODA, Oluleke	Nigeria	Tufts	3728	6/4/2004	12/31/2005	Withdrawn
PAVULURU, Praveen	India	Boston University	3710	11/19/2003	12/31/2007	Active
BHUPATIRAJU, Prameela	India	Boston University	3708	9/25/2003	12/31/2003	Withdrawn
ODIMAYO, Olurotimi	Nigeria	Boston University	3707	9/22/2003	12/31/2007	Active
KRAMER, Dorina	Romania	U of Pacific (CA)	3702	8/4/2003	12/31/2007	Active
PARDO, Diana	Columbia	Tufts	3699	7/25/2003	12/31/2007	Active
AJALA, Joachim	Nigeria	Tufts	3686	1/28/2003	1/31/2006	Lapsed

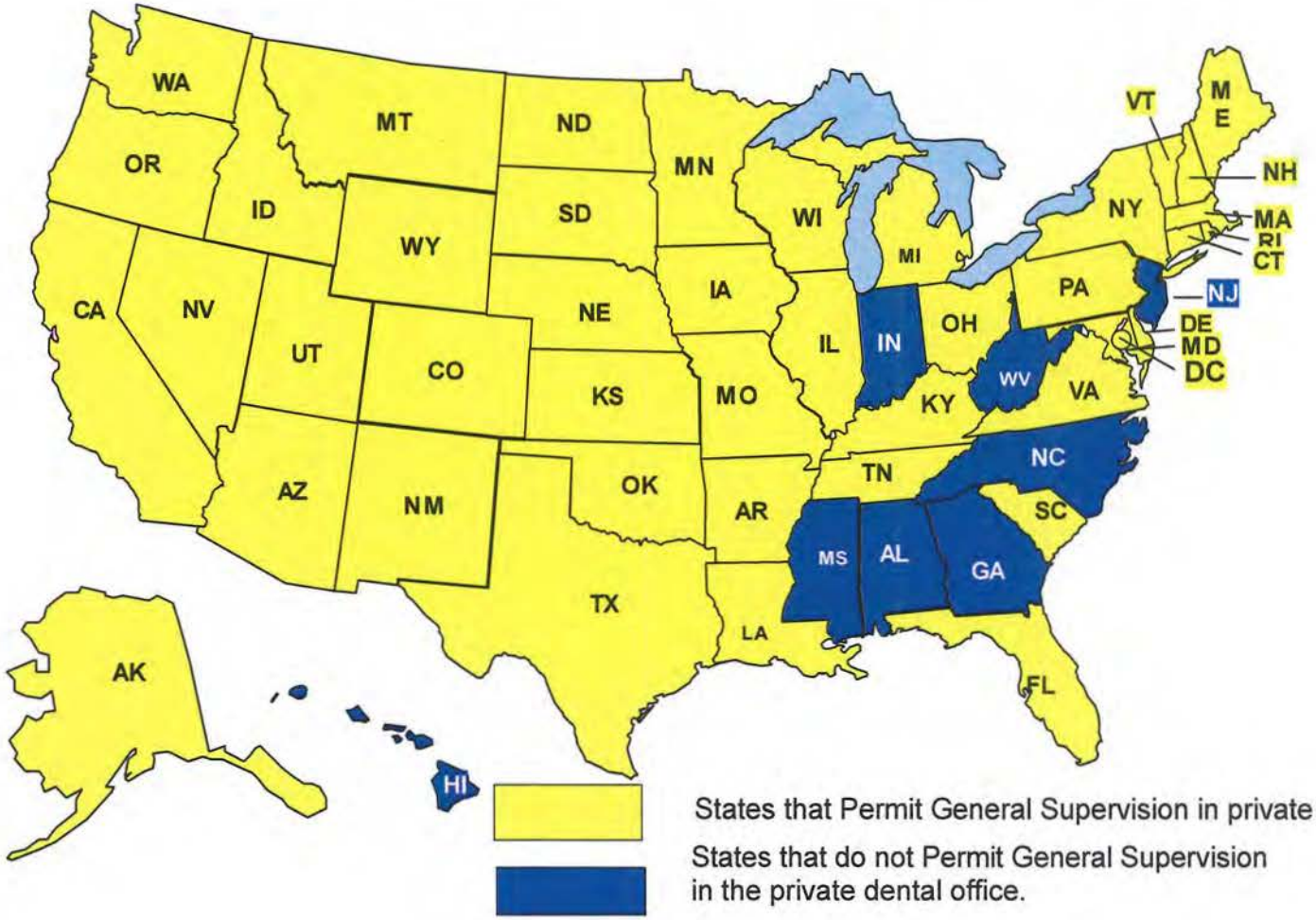
There are 32 schools that offer a two-year international dental program.

The majority of the foreign trained dentists licensed in Maine completed the following programs:

Boston University – Annual Tuition = $49,514.

Tufts University – 1st Year = $37,166.
2nd Year = $79,750.

States that Permit General Supervision in the Dental Office



American Dental Hygienists' Association

Direct Supervision *means that a dentist must be present in the facility when a dental hygienist performs procedures.* ***General Supervision*** *means that a dentist has authorized a dental hygienist to perform procedures but need not be present in the treatment facility during the performance of those procedures.* ***November 7, 2006***

www.adha.org

ADHA PRACTICE ACT OVERVIEW CHART OF PERMITTED FUNCTIONS AND SUPERVISION LEVELS BY STATE

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS
PROPHYLAXIS	P	N	N	N	N/U	U	N/U	N	N	N	P	P/N	N	N	P	N	N	N	P/N	N	N	N	N/U	N	P
X-RAYS	P	N	N	N	N/U	N	N/U	N	N	N	P	P/N	N	N	P	N	N	N	P/N	N	N	N	N/U	N	P
LOCAL ANESTHESIA		P	P		P	P	P		P			P	N	P		p	P	P	P	P		P		P	
TOPICAL ANESTHESIA	P	N	N		N/U	U	N/U	N	N	N	P	P/N	N	N	P	N	N	N	P/N	N	N	N	N/U	N	
FLUORIDE	P	N	N	N	N/U	U	N/U	N	N	N	P	P/N	N	N	P	N	N	N	P/N	N	N	N	N/U	N	P
PIT\FISSURE SEALANTS	P	N	N	N	N/U	U	N/U	N	N	P	P	P/N	N	N	P	N	N	N	P/N	N	N	N	N/U	N	P
ROOT PLANING	P	N	N	N	N/U	N	N/U	N	N	P	P	P/N	N	N	P	N	N	N	P/N	N	N	N	N/U	N	P
SOFT TISSUE CURETTAGE	P	N	N	N	P	U		N	N	P	P	P/N		N			N	N		N			P	N	P
ADMINISTER N_2O		P	P		P	P			P				P	P		p	N	P						P	
STUDY CAST IMPRESSIONS	P	N	N	N	N/U	N	N/U	N	N	P	P	P/N	P	N	P	N	N	N	P	N	N	N	N/U	N	P
PLACE PERIO DRESSINGS	P	N	P		N/U	N	N/U	N	P	N	P	P/N			P	N	N	N		P	N	N	N/U	N	P
REMOVE PERIO DRESSING	P	N	P	N	N/U	N	N/U	N	P	N	P	P/N	N	N	P	N	N	N	P/N	N	N	N	N/U	N	P
PLACE SUTURES		N	P									P/N													
REMOVE SUTURES	P	N	N	N	N/U	N	N/U	N	P	N	P	P/N	N	N	P	N	N	N	P/N	N	N	N	N/U	N	P
APPLY CAVITY - LINERS & BASES	P				N/U	N				P	P					N		N					N/U	N	
PLACE TEMPORARY RESTORATIONS	P	N	N		N/U	N				N	P	P/N				N		N		N	P	N	P	N	
REMOVE TEMPORARY RESTORATIONS	P	N	N		N/U	N				N	P	P/N				N		N				P	P	N	
PLACE AMALGAM RESTORATIONS						N							P					P				P	P	N	
CARVE AMALGAM RESTORATIONS						N							P					P					P	N	
FINISH AMALGAM RESTORATIONS						N							P					P					P	N	
POLISH AMALGAM RESTORATIONS	P	N	N		N/U	N	N/U	N	N	P	P	P/N	N			N	N	P	P	N	N	N	N/U	N	
PLACE & FINISH - -COMPOSITE RESIN SILICATE RESTORE						N							P					P							

KEY: P = PHYSICAL PRESENCE OF DENTIST IS REQUIRED
N = PHYSICAL PRESENCE OF DENTIST IS NOT REQUIRED
U = PHYSICAL PRESENCE NOT REQUIRED. NO PRIOR AUTHORIZATION BY DENTIST REQUIRED BUT THERE MAY BE REQUIREMENT FOR TYPE OF COOPERATIVE ARRANGEMENT WITH A DENTIST(S). SOME STATES REQUIRE EXPERIENCE OR SPECIAL EDUCATION BY RDH.
/ = WHERE TWO LETTERS ARE PRESENT IN A BOX THE FIRST INDICATES THE SUPERVISION LEVEL IN THE PRIVATE DENTAL OFFICE. THE SECOND INDICATES THE SUPERVISION LEVEL IN OTHER SETTINGS SUCH AS INDEPENDENT DENTAL PRACTICE, LONG-TERM FACILITIES, HOSPITALS, ETC. ON NON-AMBULATORY PATIENTS.

ADHA PRACTICE ACT OVERVIEW CHART OF PERMITTED FUNCTIONS AND SUPERVISION LEVELS BY STATE

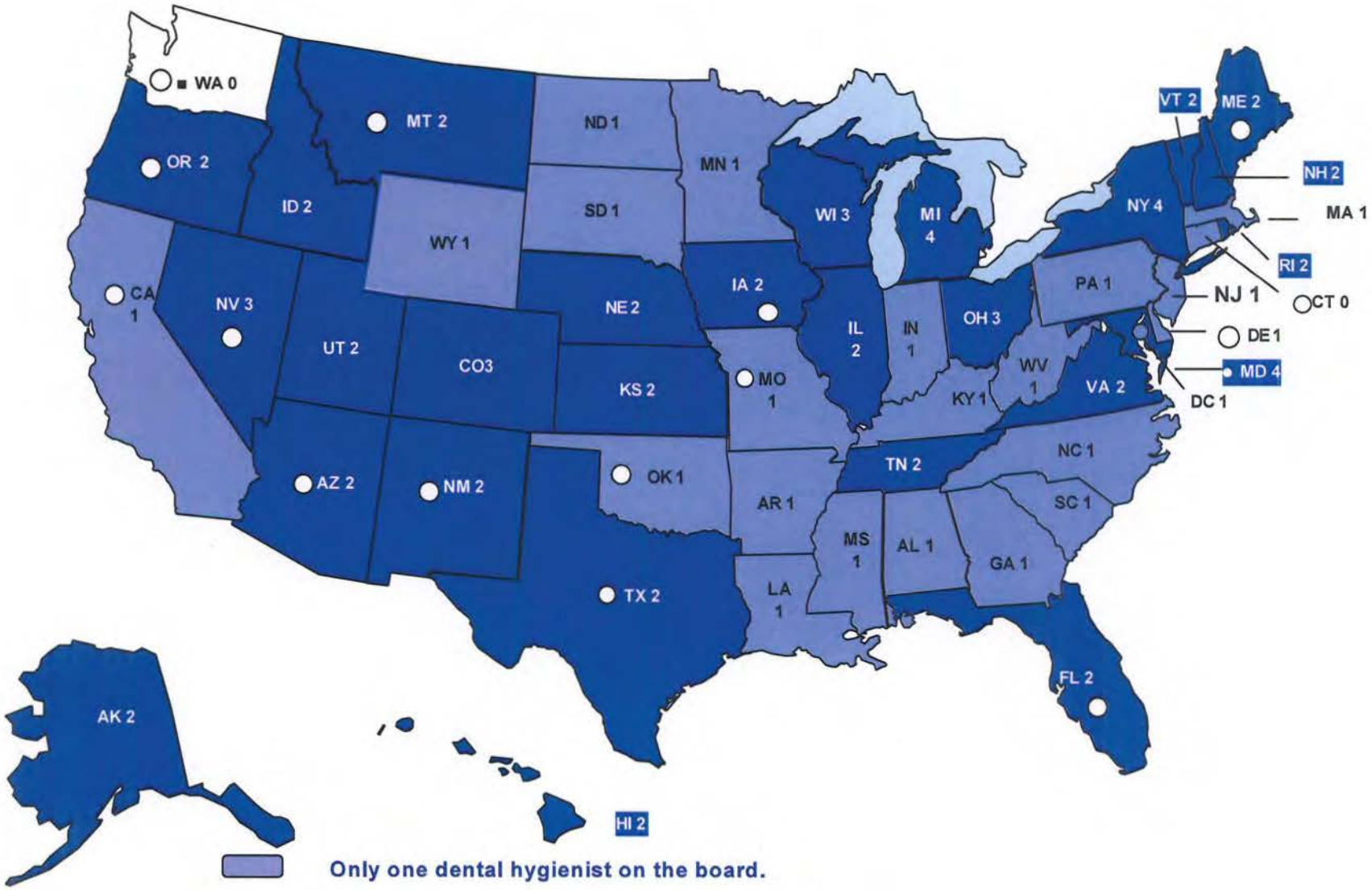
	MO	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
PROPHYLAXIS	N/U	N	N/U	N/U	N	P/N	N/U	N	P/N	N	N	N	N/U	P/N	N	N	N	N	N	N	N	N	N/U	P	N/U	N
X-RAYS	N	N	N	N/U	N	P/N	N/U	N	P/N	N	N	N	N/U	P/N	N	N	N	N	N	N	N	N	N	P	N	N
LOCAL ANESTHESIA	P	P	P	P/U	P*		P	P			P	P	N		P	P	P	P		P	P	P	P	P	p	P
TOPICAL ANESTHESIA	N	N	N	N/U	N	P/N	N	N	P	N	N	N	N/U	P/N	N	P	N	N	N	N	N	N	N	P	N	N
FLUORIDE	N/U	N	N/U	N/U	N	P/N	N/U	N	P/N	N	N	N	N/U	P/N	N	N	N	N	N	N	N	N	N/U	P	N	N
PIT\FISSURE SEALANTS	N/U	N	N/U	N/U	N	P	N	N	P/N	N	P	N	N/U	P/N	N	P/N	N	N	N	N	N	N	N/U	P	N	P
ROOT PLANING	N	N	N	P/U	N	N	N	N	P	N	P	N	N/U	P/N	N	P/N	N	N	N	N	N	N	N/U	P	N	N
SOFT TISSUE CURETTAGE	N	N	N	N			N			N	P	N	N/U				N	N		N			P/U			
ADMINISTER N_2O	P			P/U	P			P			P	P	P				P	P		P		P	P			P
STUDY CAST IMPRESSIONS	N	N	N	N/U	N	P	N	P	P	P	N	N	N/U	P	P	P		P	N	N	N	N	N	P	N	N
PLACE PERIO DRESSINGS	N	N	N	N/U		P		P		P	P	N	N/U		P				N	N	N	N	P	P	N	P
REMOVE PERIO DRESSING	P	N	N	N/U	N	P	N	P	P	P	N	N	N/U		P	P	N	P	N	N	N	N	P	P	N	P
PLACE SUTURES				-					P											N						
REMOVE SUTURES	N	N	N	N/U	N	P		P	P	P	P	N	N/U	P	P	P		P	N	N	N	N	P	P	N	N
APPLY CAVITY - LINERS & BASES	P				N				P									P						P		
PLACE TEMPORARY RESTORATIONS	P	N	N	N/U	N	P		P	P	P		N	N/U			P/N		P	N					P	N	N
REMOVE TEMPORARY RESTORATIONS	P	N	N		N			P	P	P								P	N							
PLACE AMALGAM RESTORATIONS	N				N								P					P					P			P
CARVE AMALGAM RESTORATIONS	P												P										P	P		P
FINISH AMALGAM RESTORATIONS	P												P										P			N
POLISH AMALGAM RESTORATION	N	N	N	N/U	N	P	N		P	P	P	N	N/U		P	P	N	P	N	N			U	P		N
PLACE & FINISH -- COMPOSITE RESIN SILICATE RESTORE	P												P										P			P

KEY: P = PHYSICAL PRESENCE OF DENTIST IS REQUIRED
N = PHYSICAL PRESENCE OF DENTIST IS NOT REQUIRED
U = PHYSICAL PRESENCE NOT REQUIRED. NO PRIOR AUTHORIZATION BY DENTIST REQUIRED BUT THERE MAY BE REQUIREMENT FOR TYPE OF COOPERATIVE ARRANGEMENT WITH A DENTIST(S). SOME STATES REQUIRE EXPERIENCE OR SPECIAL EDUCATION BY RDH.
/ = WHERE TWO LETTERS ARE PRESENT IN A BOX THE FIRST INDICATES THE SUPERVISION LEVEL IN THE PRIVATE DENTAL OFFICE. THE SECOND INDICATES THE SUPERVISION LEVEL IN OTHER SETTINGS SUCH AS INDEPENDENT DENTAL PRACTICE, LONG-TERM FACILITIES, HOSPITALS, ETC. ON NON-AMBULATORY PATIENTS.
* = RULES PENDING

Revised August, 2007 *www.adha.org*

adha American Dental Hygienists' Association

DENTAL HYGIENISTS ON STATE DENTAL BOARDS



Only one dental hygienist on the board.

More than one dental hygienist on the board.

Dental hygiene committee of some form exists.

0 RDH on WA board (Separate committee includes 3 RDHs, and 1 consumer member)

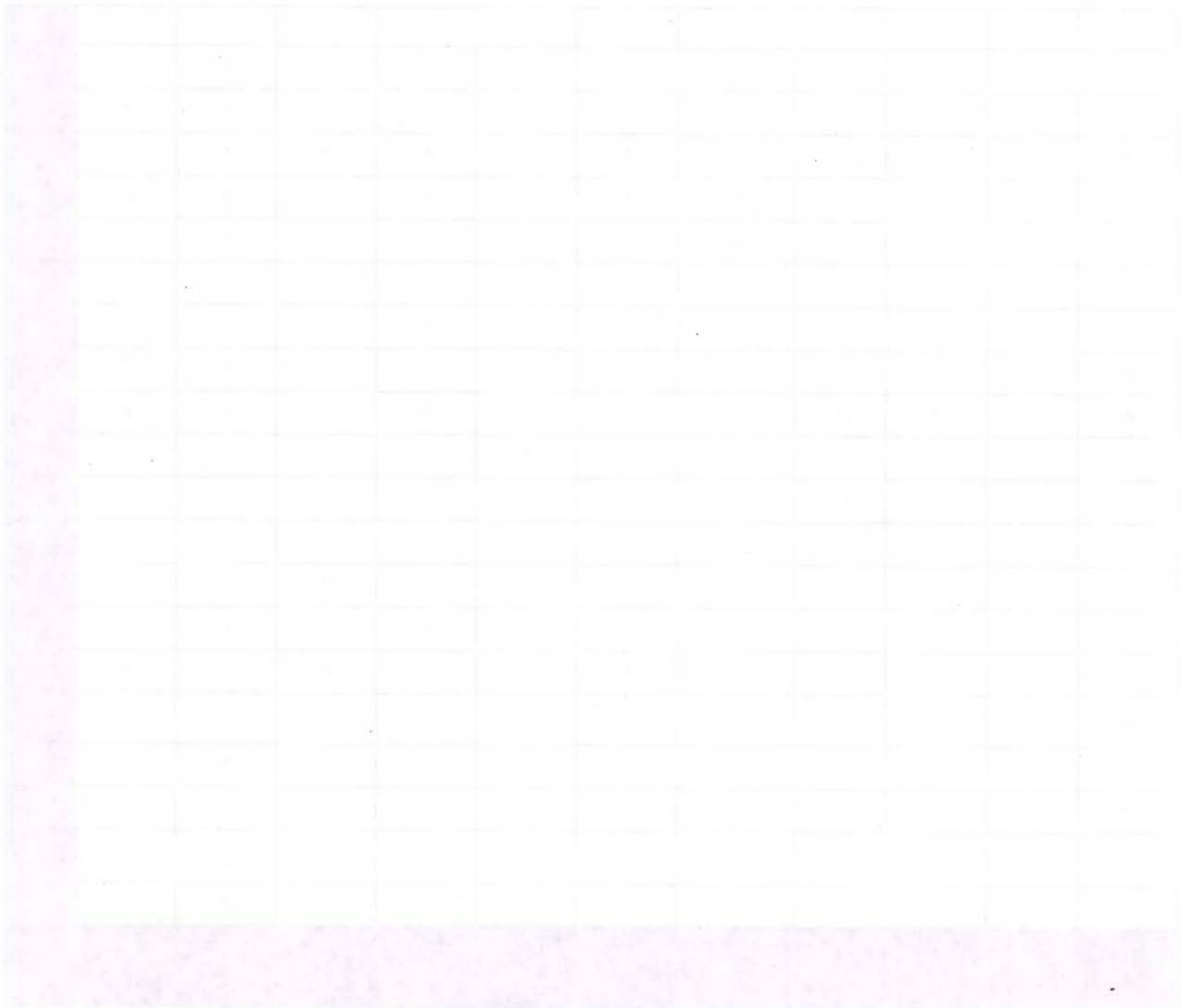
American Dental Hygienists' Association

June, 2007
www.adha.org

SETTINGS WHERE DENTAL HYGIENISTS CAN WORK OTHER THAN THE DENTAL OFFICE

	Nursing Homes	Schools	Public Health	Prisons	Public Inst.	Private Inst.	Hospitals/ Lic.Hlth Fac.	Industrial Clinics	Charitable Dental Facilities	Home Bound	No Limits on Settings
ALd.											√
AK		√	√	√	√				√		
AZ	√	√	√		√	√	√			√	
AR				√							
CA	√	√	√	√	√	√	√	√	√	√	√
CO											√
CT	√	√		√	√	√					
DE		√	√		√						
DC		√			√						
FL		√	√		√	√	√			√	
Gad			√	√							
HI	√	√	√		√		√		√		
ID	√	√	√								
ILd	√	√			√		√				
IN		√			√	√	√	√	√		
IA		√	√				√				
KS	√	√	√		√	√	√		√	√	
KY	√	√	√		√		√				
LA		√			√						
ME	√	√	√				√				√

	Nursing Homes	Schools	Public Health	Prisons	Public Inst.	Private Inst.	Hospitals/ Lic. Hlth Fac	Industrial Clinics	Charitable Dental Facilities	Home Bound	No Limits on Settings
MA		√			√	√	√				
MD		√	√		√		√		√		
MI											√
MS		√	√								
MO											√
MT	√		√		√	√	√				
MN	√	√	√	√	√		√			√	
NE			√								√
NV	√	√	√				√				
NH	√	√	√		√						
NJ		√	√		√	√					
NM	√	√	√	√	√	√	√	√	√	√	√
NY		√			√						√
NCd				√							
ND	√		√		√		√		√		
OH		√			√		√				
OK	√	√	√	√	√	√	√			√	
OR	√	√	√	√	√	√	√			√	√
PA	√	√	√		√	√	√				
RI		√			√						



	Nursing Homes	Schools	Public Health	Prisons	Public Inst.	Private Inst.	Hospitals/ Lic. Hlth Fac	Industrial Clinics	Charitable Dental FacilitX	Home Bound	No Limits on Settings
SC	√	√			√		√				
SD		√			√						
TN			√								
TX	√	√	√		√		√			√	√
UT	√		√		√		√				
VT		√			√	√					
VA					√						
WA	√	√	√	√	√	√	√		√		
WVd		√						√			
WI	√	√	√	√		√			√	√	√
WY					√	√					

Information on settings has been categorized for general information and comparison. Please check with the state licensing agencies for specific information on any one state.

Note: d = Indicates direct supervision in at least some alternative settings.
Some states may have special requirements to work in particular settings.

American Dental Hygienists' Association

Draft Competencies for the Advanced Dental Hygiene Practitioner (ADHP)

June 2007

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Vision Statement

Extending primary oral healthcare to all.

Mission Statement

To improve the underserved public's health, the advanced dental hygiene practitioner provides access to early interventions, quality preventive oral healthcare and referrals to dentists and other healthcare providers.

Background

Oral Health in the United States

Although most oral diseases are preventable, untreated dental disease remains prevalent throughout the United States. Disparities in oral health are most evident among populations with low income and educational levels, special needs, and those who live in communities without access to oral health services. Populations with the greatest need often do not receive dental care which negatively affects their success in school, the workplace, and their overall quality of life. The Surgeon General's Report (2000) referred to this problem as the "silent epidemic" and "oral health crisis."

Landmark reports suggest that the current dental care system in the United States is not effectively ensuring optimal oral health for all populations (Oral Health in America: A Report of the Surgeon General, 2000; Healthy People 2010: Understanding and Improving Health; National Call to Action (2003); Oral Health America Report Card, (2003)). Multiple factors exacerbate oral health disparities: the current structure of the oral healthcare delivery system; maldistribution of providers; lack of diversity among providers; restrictive regulatory statutes; geographic, educational and cultural barriers; oral health literacy; and financing of care (HRSA Professional Practice Environment, April 2004; Surgeon General's Report (2000), ADEA Unleashing the Potential (2006)). The provision of oral healthcare services has remained primarily a private sector entity, addressing the needs of a select population, while often remaining inaccessible to the populations with the highest prevalence of oral disease. However, considering the untreated oral disease in America, one goal is to ensure that underserved populations have a dental home, defined as a continuous relationship with a primary oral care provider who manages patient care (Surgeon General, 2000; National Call to Action, 2003; AAP, 2003; AAPD, 2004).

Oral diseases have been associated with a number of systemic conditions and chronic diseases such as diabetes, cardiovascular disease and preterm low birth weight babies, underscoring the importance of oral health services for all

individuals. Oral health is an integral part of overall health; dental disease prevention, oral health promotion and treatment of oral infection are essential elements of comprehensive, multidisciplinary healthcare. Prevention and early intervention are strategies long recognized across health disciplines as effective in terms of dollars spent and minimizing or eliminating human pain and suffering.

Oral Health Disparities

Over 45.6 million Americans live in dental health profession shortage areas (Shortage Designation Branch, Bureau of Health Professions, Health Resources and Services Administration, June 2006). The Surgeon General's Report states that oral health in the United States is rife with "profound and consequential disparities within the population." The population of racial and ethnic minority groups whose current oral health is already compromised will grow by almost 20% from 2000 to 2050 (source). About one in three adults living in poverty have untreated dental decay (source). Further, the number of adults over the age of 65 will continue to increase (U.S. Census Bureau, 2004). This group of adults has retained more of their teeth than previous cohorts in the same age group (source). It is logical to conclude that greater retention of natural teeth within this expanding population will stimulate demand for additional oral healthcare services.

Tooth decay remains the single most prevalent chronic disease of children. Children without access to regular preventive and restorative oral health services suffer needlessly from avoidable dental disease. Untreated decay is twice as prevalent in children and adolescents living in poverty when compared to their peers from families with higher incomes (NHANES 1999-2002).

Limited access to routine preventive and restorative dental services can result in chronic dental disease such as dental decay, abscess, and toothaches that can cause costly visits to hospital emergency rooms. Moreover, many children and adults, who have difficulty accessing dental care, postpone seeking services until conditions, such as toothache and facial abscess, become so debilitating that hospital visits occur. This result is not cost-effective and most importantly does not address dental disease management, since few hospitals deliver comprehensive dental services.

The Oral Health Workforce

In the United States, the numbers of graduating dentists are declining while the numbers of licensed dental hygienists are continuing to increase. As of 2007, there are 289 accredited dental hygiene programs and 56 accredited dental schools. According to the American Dental Education Association (2004), the number of graduates from dental hygiene programs continues to outpace those of dental schools. The U.S. Department of Labor, Bureau of Labor Statistics reported in 2004 that the "employment of dentists is projected to grow about as fast as average for all occupations through 2014" and that most of the available jobs will be the result of replacing the large number of retired dentists in the

nation. In contrast, dental hygiene "employment is expected to grow much faster than average for all occupations through 2014." The rate of growth for dental hygienists from 2004-2014 is projected at 43.3% while the predicted growth rate for dentists is 13.5%. The Bureau of Labor Statistics Report (2004) concluded that employment of dentists is not expected to keep pace with the escalating demand for dental services.

In addition, geographic maldistribution of dentists remains problematic in the United States. In large metropolitan areas, the dentist to population ratio was 61 per 100,000 as compared to 29 dentists per 100,000 in rural areas of the United States. A real concern in the rural areas is the expected increase in the number of retiring dentists. With the reported decline in the number of new dental graduates, a decrease in rural dental care may result (Health, United States, 2001 Urban and Rural Health Chartbook).

Effectiveness of Non-Dentist Providers

Internationally, non-dentists have provided direct dental care to patients for many years. As early as 1922, programs were established in New Zealand to prepare non-dentists to provide oral healthcare to children in school systems. Today, the role of the New Zealand Dental Therapist has expanded to include the delivery of care to those with limited access. The New Zealand as well as the Canadian and British dental therapist professionals, serve as models for others seeking solutions to improve access to care and to improve the oral health of the public.

In the 1960s and 1970s, studies were conducted in the United States to compare the effectiveness and quality of dentist and non-dentist providers in the delivery of irreversible and reversible procedures traditionally performed by dentists. These studies clearly demonstrated the effectiveness of using non-dental providers to increase the public's access to select oral health services. Studies supporting these findings were funded through federal and foundation grants, conducted in respected institutions, and employed sound research designs (Lobene, Sisty).

These pioneering programs, many still in operation, have shown that formally educated non-dentist providers can deliver quality, oral healthcare to underserved populations (Sisty, Lobene, British Dental Therapists Association, Canadian Dental Therapists Association, New Zealand Dental Therapists Association, Sicard, Perry). Furthermore, investigators concluded that the cost of educating these providers was less than the cost of dental education and that gains in clinical productivity outweighed costs.

Direct access can be a pipeline to bring people who need dental care into the healthcare system. Direct access to care allows dental hygienists to plan and initiate dental hygiene treatment without the specific authorization of a dentist primarily in nursing homes and schools. As of 2007, 20 states allow direct access to dental hygiene practitioners and services; this was ten (10) states just

seven years ago. In addition, as of 2007, 40 states allow dental hygienists to administer local anesthesia; 23 states allow the administration and monitoring of nitrous oxide analgesia; and 12 states reimburse dental hygienists for providing Medicaid services. These legislative developments in dental hygiene practice provide a foundation for the advanced dental hygiene practitioner. Further, these changes in oral healthcare delivery have been market-driven as the need for care intensifies among unserved populations.

Advanced Dental Hygiene Practitioner (ADHP)

The National Call to Action to Promote Oral Health (2003) identified the need to enhance oral health workforce capacity in the United States. The ADHP is proposed as a cost-effective response to the oral health crisis. The ADHP will work in partnership with dentists to advance the oral health of patients. This new practitioner will provide diagnostic, preventive, therapeutic and restorative services to the underserved public in a variety of settings and will refer those in need to dentists and other healthcare providers. In June 2004, the membership of the American Dental Hygienists' Association (ADHA) adopted the ADHP resolution calling for development of a curriculum to prepare dental hygienists who will practice at an advanced level. This master's degree curriculum builds upon the foundation of existing dental hygiene education.

Given the extent of unmet oral healthcare needs, the projected increased demand for oral healthcare services and the declining numbers and maldistribution of dentist providers, a natural niche for a collaborative care model between dentists and dental hygienists exists. The dental hygiene profession with its continuing growth offers a cadre of competent providers who can deliver comprehensive primary care services where they are most needed. In a collaborative model, the dental hygienist can serve as the liaison to the dentist for patient treatment that requires a higher level of expertise.

The concept of an advanced practitioner is well accepted in medicine and integrated into the healthcare arena. For example, the nursing profession developed advanced practice nurses in response to unmet public health needs. Thus, precedent has been set with providers that include nurse practitioners, certified nurse midwives, clinical nurse specialists and certified registered nurse anesthetists. The successful nurse practitioner paradigm is being used as the basis for the advanced dental hygiene practitioner model. While implementation of the ADHP allows dental hygienists to build upon their education and experience, the registered dental hygienist will remain an integral part of the oral healthcare team in private practice. Advanced practitioners focus on collaboration within a multidisciplinary network of health and social care providers to ensure a consistent oral health component in comprehensive healthcare.

Advanced dental hygiene practice merges the dental hygiene sciences with aspects of general dentistry. Because general dentistry is more comprehensive in nature than the limited restorative component of advanced dental hygiene

practice, advanced practitioners must have collaborative partnerships with general dentists and specialists for referral and consultations. In the collaborative framework, as suggested in the ADEA report, Unleashing the Potential, "the dental hygienist can substitute for the dentist when there is none" but also can serve as a key liaison to the dentist through consultation, triage and referral. In many ways, the ADHP can serve populations in settings where the number of practicing dentists is limited.

Those interested in working as advanced practitioners must have a clear understanding of community. Individuals may be a member of a community by choice, as with voluntary associations, geography, shared interests, values, experiences, or traditions; or by virtue of their innate personal characteristics, such as age, gender, race, socioeconomic status or ethnicity (adapted from IOM, 1995). Community can be defined in a various ways; including that one can belong to multiple communities, simultaneously. Understanding the concept of community will enable advanced practitioners to better target their efforts and work with community leaders and families in developing and implementing appropriate healthcare interventions. The ADHP must be engaged with the underserved communities to effectively assess and address community oral health needs. Furthermore, understanding that a community's cultural identity influences its "shared set of socially transmitted perceptions about the nature of the physical, social, and spiritual world (Airhihenbuwa, 1995)," the ADHP should be able to examine the differences and similarities in cultural perceptions of communities, so that interventions are appropriate for that particular cultural context. This appropriateness, often referred to as cultural sensitivity, means that interventions are developed "in ways that are consistent with a community's cultural framework (Airhihenbuwa, 1995)." In practice, the advanced dental hygiene practitioner will work to address the unmet oral health needs of underserved communities and whether these communities are urban or rural, it will be incumbent upon the ADHP to be vested in these communities to build relationships, gain trust and garner the respect needed to influence healthcare decision-making.

Summary

The challenge of delivering primary oral care to persons outside of the traditional oral healthcare system can be met with a multidisciplinary, collaborative approach that centers on eliminating the untreated dental diseases prevalent in various populations. The advanced practice model, with its emphasis on dentist and advanced dental hygiene practitioner collaboration, has the potential to serve populations characterized as low-income, underserved, and unserved. Internationally, non-dentists successfully have provided, and continue to provide, quality primary dental care directly to children and adults in Canada, New Zealand, and Great Britain. The advanced dental hygiene practitioner in the United States is positioned to:

- Increase the efficiency of the dental workforce;

- Potentially reduce the cost of dental services by providing primary oral healthcare within the scope of advanced dental hygiene practice;

- Extend primary dental care to disadvantaged and remote populations outside of the traditional private practice setting;

- Expand the capacity of community-based health personnel and facilities to meet the oral care needs; and

- Collaborate with dentists and other healthcare providers.

This plan builds on the strengths of the existing dental workforce and supports the value that advanced education is essential for delivering quality, safe, cost-effective oral health care. Ultimately education, prevention, early diagnosis, early intervention, and daily communication among dentists and advanced dental hygiene practitioners could be the foundation for managing untreated dental disease and improving oral health for the entire United States population.

Educational Framework

Advanced dental hygiene practice must be grounded in science and guided by research evidence, sound theories, best practices, and professional ethics. The ADHP master's degree curriculum allows for the acquisition of competencies that build upon the fundamental knowledge and skills achieved at the baccalaureate level. A rigorous graduate curriculum that fosters independent thinking and learning prepares individuals for a level of clinical decision-making, scope of practice and responsibility required of the ADHP. Moreover, the ADHP must hold an academic credential comparable to other mid-level practitioners in the primary care marketplace; e.g., nurse practitioners, occupational therapists, physician assistants, and physical therapists.

As a graduate level professional, the ADHP will exhibit refined analytical skills, broad-based perspectives, and enhanced abilities to integrate theory, research and practice. The ADHP will employ sound clinical judgment and evidence-based decision making to determine when patients can be treated within their scope of practice or when they require further diagnosis or treatment by a dentist or other healthcare provider (Joslin, 2006).

The foundation of the ADHP educational framework is organized by general domains (themes) and more specific competencies. Domains represent broad categories of professional responsibilities, knowledge and skills that define the ADHP. Five domains provide a logical structure for curriculum development:

I. Provision of Primary Oral Healthcare
II. Healthcare Policy and Advocacy
III. Management of Oral Care Delivery
IV. Translational Research
V. Professionalism.

Competencies describe the knowledge, skills and attitudes expected of the ADHP. They establish benchmarks for outcomes assessment and guide the development of relevant curriculum content (Chambers, 1993). Institutions of higher education will develop the ADHP graduate curriculum based on this national framework.

Domains and Competencies

DOMAIN I: Provision of Primary Oral Healthcare

The advanced dental hygiene practitioner demonstrates competence in providing primary oral healthcare and case management for diverse populations. Practitioners use the process of care and target the underserved including those with special needs using a multidisciplinary approach.

COMPETENCIES: (27 = 46% of total)

1. **Health Promotion and Disease Prevention**
   - 1-1 Apply health education, counseling and promotion theories to achieve positive health behaviors in individuals, families, and communities.
   - 1-2 Recognize health conditions and provide interventions that prevent disease and promote healthy lifestyles for individuals, families, and communities.
   - 1-3 Design care plans to reduce risk and promote health that are appropriate to age, developmental stage, culture, health history, ethnicity and available resources.
   - 1-4 Partner with patients to enhance informed decision-making, positive lifestyle change, and appropriate self-care.
2. **Provision of Primary Care**
   - 2-1 Demonstrate cultural competence in the process of care.
   - 2-2 Use a comprehensive approach to assess risk and health status throughout the process of care.
   - 2-3 Provide evidence-based diagnostic services to identify oral diseases/conditions.
   - 2-4 Formulate an ADHP diagnosis, prognosis and an individualized care plan based on assessment data, standards of care, and practice guidelines in collaboration with the patient and multidisciplinary healthcare team.
   - 2-5 Implement effective strategies for disease prevention and risk reduction.
   - 2-6 Provide non-surgical periodontal therapy for patients with gingival and periodontal diseases.

2-7 Provide restorative services that treat infection, relieve pain, promote function and oral health:

- Preparation of cavities and restoration of primary and permanent teeth using direct placement of appropriate dental materials.
- Placement of temporary restorations.
- Placement of pre-formed crowns.
- Temporary recementation of restorations.
- Pulp capping in primary and permanent teeth.
- Pulpotomies on primary teeth.
- Referral.

2-8 Perform extractions of primary teeth and uncomplicated extractions of permanent teeth (Appendix A).

2-9 Place and remove sutures.

2-10 Provide simple repairs and adjustments for patients with removable prosthetic appliances.

2-11 Recognize and refer patients with pathological conditions for diagnosis and treatment.

2-12 Prevent potential orthodontic problems by early identification and appropriate referral.

2-13 Prescribe pharmacologic agents for prevention, control of infection, and pain management utilizing established protocols or in consultation with a dentist or physician (Appendix B).

2-14 Utilize local anesthesia and nitrous oxide analgesia during the provision of care as appropriate.

2-15 Prevent, identify, and manage dental and medical emergencies and maintain current basic life support certification.

3. Case Management

3-1 Establish partnerships with dentists and other healthcare providers for management of patients with conditions requiring services beyond the scope of advanced dental hygiene practice.

3-2 Develop care plans that reflect an integration of patient assessment data and evidence-based knowledge to achieve desired outcomes.

3-3 Coordinate care so patients receive appropriate services in a timely manner within the healthcare system.

3-4 Use information technology and management systems to evaluate care outcomes.

3-5 Establish effective telehealth and referral networks to ensure case completion and continuity of care.

4. Multidisciplinary Collaboration

4-1 Initiate consultations and collaborations with dentists, health professionals and other stakeholders in the provision of evidence-based care.

4-2 Promote oral health as an integral component of multidisciplinary healthcare systems.

4-3 Use current technology to transfer patient data when collaborating with dentists and other health professionals.

DOMAIN II: Healthcare Policy and Advocacy

The advanced dental hygiene practitioner contributes to health policies that address disparities in oral health and access to care for the underserved. The practitioner supports and applies health policy at the institutional, local, state, regional, and national levels.

COMPETENCIES: (7 = 12% of total)

1. Healthcare Policy

1-1 Articulate health policies and advocate change from the perspectives of the underserved and other stakeholders.

1-2 Participate in coalitions to integrate oral healthcare within other health and social services organizations.

1-3 Promote the role of the advanced dental hygiene practitioner in the healthcare system.

2. Advocacy

2-1 Identify community resources to increase access to care (e.g., transportation, interpretation, translation).

2-2 Participate on committees, boards or task forces to advocate for the underserved.

2-3 Support legislative and regulatory efforts to enhance the access to effective oral healthcare.

2-4 Advocate for access to quality, cost-effective oral healthcare for the underserved.

DOMAIN III: Management of Oral Healthcare Delivery

The advanced dental hygiene practitioner integrates practice management, finance principles, and health regulations to analyze, design and develop initiatives that will improve clinical outcomes and the quality and safety of care. The practitioner demonstrates effective business skills for healthcare and practice environments.

COMPETENCIES: (9 = 16% of total)

1. Practice Management

1-1 Create business plans for oral healthcare delivery that enhance the fiscal viability of a practice.

1-2 Integrate principles of human and material resource management to create an efficient, effective, and equitable practice environment.

1-3 Adhere to reimbursement guidelines and regulations.

2. Quality Assurance

2-1 Implement protocols for records management, occupational and environmental safety, and periodic systems review.

2-2 Maintain accountability for quality to ensure patient safety and minimize liabilities.

2-3 Implement principles of continuous quality improvement.

3. Fiscal Management

3-1 Design and implement methods to monitor cost-effectiveness of care.

3-2 Partner with dentists, third-party providers and the government to establish fee schedules, preauthorization protocols, and direct reimbursement strategies.

3-3 Seek financial advice and sources of funding for operational expenses in the delivery of oral healthcare.

Domain IV: Translational Research

The advanced dental hygiene practitioner uses sound scientific methods and accesses evidence-based information when making decisions and providing patient care. The ADHP translates research findings into practical applications during patient care.

COMPETENCIES: (6 = 10% of total)

1. Evidence-based Practice

1-1 Utilize scientifically sound technologies and protocols during the process of care.

1-2 Evaluate professional literature related to advanced dental hygiene practice.

1-3 Analyze and interpret information to guide clinical problem solving and decision making.

2. Clinical Scholarship

2-1 Evaluate the outcomes of ADHP practice using appropriate methods and analyses such as benchmarking and utilization review.

2-2 Contribute to the development of best practices.

2-3 Disseminate findings of ADHP practice to all stakeholders.

Domain V: Professionalism

The advanced dental hygiene practitioner demonstrates professional behaviors consistent with dental hygiene parameters of care, legal regulations and the ADHA Code of Ethics. The advanced dental hygiene practitioner possesses the values and exhibits behaviors that embody service to the public, professional involvement, and lifelong learning.

COMPETENCIES: (9 = 16% of total)

1. Ethics and Professional Behavior

1-1 Demonstrate a professional and ethical consciousness by utilizing standards of practice that best serve the public.

1-2 Demonstrate professional, legal and ethical behavior by maintaining confidentiality of patient information and using secure information technology and communication networks.

1-3 Use the ADHA Code of Ethics to identify, analyze, and resolve dilemmas arising in the healthcare setting.

1-4 Assume responsibility for decisions made that affect the patient's health and welfare.

1-5 Apply leadership principles within groups and organizations to enhance community innovation and planned change.

1-6 Develop strategic relations with community stakeholders to optimize resources.

1-7 Promote diversity in the dental hygiene workforce.

2. Lifelong Learning

2-1 Foster lifelong professional development in self and others.

2-2 Participate in self-assessment and implement changes necessary to improve professional effectiveness.

Appendix A*: Extractions and Procedures that Require Referral

**The choice to perform an extraction will be a result of emergent needs.*

It is not possible or appropriate to describe an exhaustive list of situations that will require advanced dental hygiene practitioners to consult or refer to a dentist in a timely and appropriate manner. However, examples may include:

- If the infection has spread to deeper facial spaces or is in close proximity to vital structures.
- Ankylosis seen in retained primary molars.
- Multi-rooted teeth with divergent roots.
- Dense or necrotic bone.
- Periapical pathology.
- American Society of Anesthesiologists classifications III-V.
- Impacted teeth.
- Elective extractions.

Appendix B: Prescriptive Authority

Prescription drugs may be non-controlled or controlled substances. Non-Controlled substances are prescription drugs that have very little potential for abuse, but still require professional authorization in order to be dispensed. Common examples of non-controlled substances include antibiotics and fluoride. Controlled substances are substances that have the potential for abuse and must be regulated more closely. Controlled substances are ranked in five categories called schedules. A Schedule I (C-I) controlled substance is an illegal drug that cannot be issued under any circumstances except for experimental research. These would include cocaine, heroin, marijuana, etc. The remaining Schedules II through V (C-II- C-V) are all ranked by their potential for abuse, but are common prescription drugs that can be provided by a professional when they are required.

This table describes examples of pharmacologic agents that would be within the prescriptive authority of the ADHP. This document is a general reference and not a comprehensive list.

Non-Controlled Prescription Drugs

Pharmacologic Category	Generic Name	Brand Name
Antibiotic	Penicillin, Minocycline, Chlorhexidine Gluconate	Amoxicillin, Arestin, Peridex
Nutritional Supplement	Fluorides (Tablets or Topical)	EtheDent, Luride Lozi-Tab, Prevident Plus 5000, Perio-Med, Gel-Kam
Antifungal Agent	Fluconazole	Diflucan
Corticosteroid	Triamcinolone	Kenolog

Controlled Prescription Drugs

Schedule	Generic	Brand
C-I*	N/A	N/A
C-II	Oxycodone	Percocet
C-III	Codeine combination product 90 mg/du	Tylenol APAP w/Codeine
C-IV	Diazepam	Valium
C-V**	N/A	N/A

* Illegal and experimental drugs

** Anti-tussive and anti-diarrheal drugs

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Appendix C: Examples of ADHP Community-based Practice Settings

Acute and long-term care facilities
Age-related development centers
Ambulatory Care Clinics
Alternative living situations (i.e. group homes, retirement centers, hospice, and shelters)
City and county clinics
Community Health Centers
Correctional facilities
Day care facilities
Dental and Medical practices
Federally Qualified Health Centers (FQHC)
Head Start
Home care
Hospitals
Indian Health Service (IHS)
Migrant Health Centers
Mobile dental clinics
Ob-gyn practices
Pediatric practices
Rural health clinics
School and after school programs
School-based clinics
Women, Infants and Children (WIC) Programs/Centers

Appendix D: Comparative Scope of Practice *(IN DEVELOPMENT)*

	Dental Health Aide Therapist[1,2]	Registered Dental Hygienist[3]	Advanced Dental Hygiene Practitioner	Dentist[4]

Education	• New Zealand:
	  • Certificate in dental therapy and approved experience in the provision of dental therapy services, OR
	  • Diploma in dental therapy, OR
	  • Bachelor of Health Sciences, OR
	  • Undergraduate dental therapy degree or diploma.
	• 2400 hours of classroom education and clinical experience
	• 400 hour preceptorship (or 3 months of experience, whichever is longer)
		• Minimum of two academic years of full-time instruction at the post-secondary college-level (or its equivalent)
		• Certificate, Associate or Baccalaureate degree
		• 2007: 289 programs (2 certificate-only programs) in the United States
			• 18-24 months of full-time instruction
			• Master of Science degree
				• At least four academic years of instruction (or its equivalent)
				• Doctor of Dental Science (DDS) or Doctor of Medical Dentistry (DMD) degree
				• 56 dental schools in the United States

Preventive Scope	• Obtaining medical histories and consulting with other health practitioners as appropriate • Examination of oral tissues • Oral health education and promotion • Scaling (to remove deposits in association with gingivitis) • Polishing • Fissure sealants	• Obtaining medical histories and consulting with other health practitioners as appropriate • Examination of oral tissues • Oral health education and promotion • Fissure sealants[5] • Oral health education and preventive counseling, health promotion • Community dental/oral health • Medical and dental emergencies • Infection and hazard control management • Dental hygiene care for all types of classifications of periodontal disease including patients who exhibit moderate to severe periodontal disease • Fluoride administration	• Obtaining medical histories and consulting with other health practitioners as appropriate • Examination of oral tissues • Oral health education and promotion • Fissure sealants[5] • Oral health education and preventive counseling, health promotion • Community dental/oral health • Medical/dental emergencies • Infection and hazard control management • Fluoride administration • Provide non-surgical periodontal therapy for patients with periodontal diseases. • Implement strategies for disease prevention/risk reduction.	• Competent in providing oral healthcare within the scope of general dentistry, as defined by the school, for the child, adolescent, adult and geriatric patient including health promotion and disease prevention and periodontal therapy (CODA, Standard 2-25 (c and h)

1-Dental Council of New Zealand, Code of Practice, May 2007
2-Competency Standards and Performance Measures for Dental Therapists, Dental Council of New Zealand
3-Commission on Dental Accreditation, Standards for Dental Hygiene Education Programs
4-Commission on Dental Accreditation, Standards for Predoctoral Dental Education Programs
5-ADHA, Practice Act Overview Chart of Permitted Functions and Supervision Levels by State, 4-4-07, ADHA, Chicago, IL, www.adha.org.
6-ADHA, Sealant Application – Settings and Supervision Levels by State, 9-05, Chicago, IL, www.adha.org.
7-ADHA, Direct Access States, March 30, 2007, Chicago, IL, www.adha.org.
8-ADHA, Settings Where Dental Hygienists Can Work Other Than the Dental Office, 9-05, Chicago, IL, www.adha.org.

Appendix D: Comparative Scope of Practice *(IN DEVELOPMENT)*

Restorative Scope	• Diagnosis of dental caries
	• Preparation of cavities and restoration of primary and permanent teeth using direct placement of appropriate dental materials
	• Pulp capping in primary and permanent teeth
	• Pulpotomies on primary teeth.
	• Preparing teeth for, and placing stainless steel crowns on primary teeth.
		• Idaho, Minnesota, Oregon, Washington states allow limited restorative functions[5, 6]	• Provide restorative services that treat infection, relieve pain, promote function and oral health:
			  • Preparation of cavities and restoration of primary and permanent teeth using direct placement of appropriate dental materials.
			  • Placement of temporary restorations.
			  • Placement of pre-formed crowns.
			  • Temporary recementation of restorations.
			  • Pulp capping in primary and permanent teeth.
			  • Pulpotomies on primary teeth.
			  • Referral.
				• Comprehensive restorative care
				• Defined by the state practice act
				• Competent in providing oral healthcare within the scope of general dentistry, as defined by the school, for the child, adolescent, adult and geriatric patient including the restoration of teeth (CODA, Standard 2-25 (f))

Prescriptive Authority	• Dental therapy practice includes the administration of local anesthetics and the application of topical fluorides.
	• Clinical procedures undertaken as part of dental therapy practice may require the administration of prescription medications to their patients prior to, or following clinical procedures (i.e. antibiotic prophylaxis through standing orders by a dentist).
	• Controlled drugs are not administered or supplied by dental therapists as part of the practice of dental therapy.
	• Some of the substances commonly used in the practice of dental therapy:
		• Clinical procedures as part of dental hygiene treatment may require the administration of medicaments such as fluorides and other chemotherapeutics (i.e. those used for the treatment of certain periodontal conditions, local anesthetics, nitrous oxide analgesia)	• See Appendix B:
			• Specific Non-controlled substances:
			  • Antibiotic
			  • Antifungal
			  • Nutritional supplement
			  • Corticosteroid
			• Specific Controlled substances:
			  • Class II, III, IV
				• Defined by the state practice act

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2-Competency Standards and Performance Measures for Dental Therapists, Dental Council of New Zealand
3-Commission on Dental Accreditation, Standards for Dental Hygiene Education Programs
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5-ADHA, Practice Act Overview Chart of Permitted Functions and Supervision Levels by State, 4-4-07, ADHA, Chicago, IL, www.adha.org.
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Appendix D: Comparative Scope of Practice *(IN DEVELOPMENT)*

	• Lignocaine, prilocaine, felypressin, fluorides, adrenaline.			
Scope – Other:	• Recognition of abnormalities • Preparation of an oral care plan • Informed consent procedures • Administration of local anesthesia using dentoalveolar infiltration, inferior dental nerve block and topical local anesthetic techniques • Extraction of primary teeth • Referral as necessary to the appropriate practitioner/agency • Exposure and interpretation of radiographs	• Local Anesthesia (2007: 40 states) • Nitrous oxide (2007: 23 states) • Exposure of radiographs	• Local anesthesia • Nitrous oxide	• As defined by individual state practice act. • Competent in providing oral healthcare within the scope of general dentistry, as defined by the school, for the child, adolescent, adult and geriatric patient including anesthesia, and pain and anxiety control (CODA, Standard 2-25 (e))
License/Certification	• The scope of practice of dental therapy is described by the Dental Council of New Zealand of the Health Practitioners Competence Assurance Act • Certified by local Indian Health Services Board (Alaska): Federal Community Health Aide Certification Board	• Credentialed and state licensed • In most cases, additional education and or certification is necessary for certain procedures and settings	• Credentialed and state licensed as a dental hygienist • Certification as an ADHP	• Credentialed and state licensed
Supervision	• Dental therapists can practice independently for the care of children and adolescents up to age 18 years within the scopes of practice described for dental therapy. • Does not require the physical presence of a dentist or other health practitioner. • Dental therapists undertaking dental care for adult patients (over age 18 years) must be	• Supervision and other factors dependent on state law • 20 states allow direct access to dental hygienists[7] • 12 states directly reimburse dental hygienists for services provided to Medicaid populations[7]	• Collaborative arrangement with strong referral networks • Teledentistry	• NA

1-Dental Council of New Zealand, Code of Practice, May 2007
2-Competency Standards and Performance Measures for Dental Therapists, Dental Council of New Zealand
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Appendix D: Comparative Scope of Practice *(IN DEVELOPMENT)*

	registered with the Dental Council of New Zealand for the scope of practice adult dental care in dental therapy practice. • Dental therapists and dentists have a consultative working relationship. • Documented in an agreement between parties. • For conditions outside the education, training, and competence of the dental therapist, patients are referred for assessment and if necessary management by a dentist.			
Practice Settings	• New Zealand: school dental service, private practice, iwi or community health settings • Remote Alaskan villages	• Private practice, dental public health settings, hospitals, schools, community clinics, long-term care facilities[8]	• See Appendix A: Acute and long-term care facilities, Age-related development centers, Ambulatory Care Clinics, Alternative living situations, City and county clinics Community Health Centers, Correctional facilities, Day care facilities, Dental and Medical practices, Federally Qualified Health Centers (FQHC), Head Start, Home care Hospitals, Indian Health Service (IHS), Migrant Health Centers, Mobile dental clinics, Ob-gyn practices, Pediatric practices, Rural health clinics, School and after school programs, School-based clinics, Women, Infants and Children (WIC) Programs/Centers	• Private practice, dental public health settings, hospitals, schools, community clinics, long-term care facilities

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1-Dental Council of New Zealand, Code of Practice, May 2007
2-Competency Standards and Performance Measures for Dental Therapists, Dental Council of New Zealand
3-Commission on Dental Accreditation, Standards for Dental Hygiene Education Programs
4-Commission on Dental Accreditation, Standards for Predoctoral Dental Education Programs
5-ADHA, Practice Act Overview Chart of Permitted Functions and Supervision Levels by State, 4-4-07, ADHA, Chicago, IL, www.adha.org.
6-ADHA, Sealant Application – Settings and Supervision Levels by State, 9-05, Chicago, IL, www.adha.org.
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Appendix E: Sample ADHP Masters Degree Curriculum

Application Requirements

Applicants must be graduates of a dental hygiene program accredited by the ADA Commission on Dental Accreditation. They also must hold a baccalaureate degree in dental hygiene or related field, and hold a valid license to practice dental hygiene in at least one U.S. jurisdiction. In addition, applicants must meet the individual admission requirements of the degree-granting institution.

Information for Applicants

The total program consists of approximately 37 graduate credits. The curriculum includes didactic and clinical courses required of all graduate students.

Depending upon the institution, students who have previously taken dental hygiene courses that are part of the advanced curriculum or applicants who might be eligible for experiential learning may have the ability to test out of a specific course or waive specific courses or requirements. Furthermore, students who seek admission with existing graduate degrees in dental hygiene are eligible to pursue the ADHP curriculum.

A course in local anesthetic agents and nitrous oxide-oxygen administration may be required if the applicant is not certified for these procedures.

Sample Curriculum

Didactic Courses (21 credits)

Theoretical Foundations of Advanced Dental Hygiene Practice (3)
Translational Research (3)
Healthcare Policy, Systems and Financing for Advanced Practice Roles (3)
Management of Oral Healthcare Delivery (3)
Cultural Issues in Health and Illness (3)
Advanced Health Assessment and Diagnostic Reasoning (3)
Pharmacological Principles of Clinical Therapeutics (3)

Advanced Practice Clinical Courses (16 credits)

Community-based Primary Oral Healthcare I-IV (12)
Management of Dental Emergencies and Urgent Care (1)
Advanced Specialty Fieldwork (1)
Community Internship (Family, Pediatric, Women's Oral Health, Special Needs or Geriatric Dental Care) (2)

Course Descriptions and Competencies:
Didactic Courses:

Theoretical Foundations of Advanced Dental Hygiene Practice
3 credit hours

This course focuses on knowledge of primary dental care as the supporting framework for advanced professional practice. Emphasis is placed on the application of both dental and dental hygiene knowledge focusing on cultural competence with diverse patient populations and practice settings. Topics selected in this course are intended to provide dental hygienists with an understanding of the role of the advanced dental hygiene practitioner in disease prevention, treatment and referral. This course will introduce the theory and research related to the concepts of health promotion and risk reduction providing the student with the opportunity to incorporate strategies of risk analysis and reduction, screening, lifestyle change, and disease detection and prevention in the family oral healthcare.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Health Promotion and Disease Prevention: 1-1, 1-3, 1-4
Multidisciplinary Collaboration: 4-2
Domain V: Professionalism
Ethics and Professional Behavior: 1-3, 1-7
Lifelong Learning: 2-1, 2-2

Translational Research
3 credit hours

This course focuses on critical reading, understanding, and evaluation of the professional literature. Students learn how to access information electronically in order to make evidence-based decisions that contribute to the development of best practices.

Competencies:
Domain IV: Translational Research
Evidence-Based Practice: 1-1, 1-2, 1-3
Clinical Scholarship: 2-1, 2-2, 2-3

Healthcare Policy, Systems and Financing for Advanced Practice Roles
3 credit hours

This course prepares the practitioner to influence and interpret public health policy and recognize its role as a determinant of health. Students develop skills, participate in health policy development and political action, healthcare financing and delivery, and in the measurement of care delivery and practitioner

effectiveness. This course focuses on the political, ethical, societal, and professional issues in advanced practice.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Case Management: 3-4, 3-5

Domain II: Healthcare Policy and Advocacy
Healthcare Policy: 1-1, 1-3
Advocacy: 2-1, 2-3, 2-4

Domain III: Management of Oral Healthcare Delivery
Fiscal Management: 3-1, 3-2,I 3-3

Management of Oral Healthcare Delivery
3 credit hours

Theories will be used to develop skills in negotiation and conflict resolution. The student examines current and emerging advanced practice issues including entrepreneurship, fundamentals of tax laws, overhead costs, benefit packages, billing and negotiation with third party payers and facilities. Principles of management and community partnerships in clinical settings will be emphasized with focus on leadership skills, coalition building, and constructive use of power, influence, and politics.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Case Management 3-1, 3-3
Multidisciplinary Collaboration: 4-1, 4-2, 4-3

Domain II: Healthcare Policy and Advocacy
Healthcare Policy: 1-1, 1-2
Advocacy: 2-1, 2-2

Domain III: Management of Oral Healthcare Delivery
Practice Management: 1-1, 1-2, 1-2
Quality Assurance: 2-1, 2-2, 2-3

Domain V: Professionalism
Ethics and Professional Behavior: 1-5, 1-6

Cultural Issues in Health and Illness
3 credit hours

An exploration of cultural issues in healthcare delivery designed to enhance the delivery and quality of healthcare offered to diverse and disadvantaged communities. Topics will include how patient and provider ethnicity,

socioeconomic status, education, and cultural competence affect health, illness and the delivery of care.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Health Promotion and Disease Prevention: 1-1, 1-2, 1-3
Provision of Primary Care: 2-1

Advanced Health Assessment and Diagnostic Reasoning
3 credits hours

The course focuses on the significance of oral and systemic diseases in patients, and will include assessment, diagnosis, planning, treatment, referral and evaluation in advanced dental hygiene practice. Assessment of the patient in the context of the community will be stressed with focus on the management of common oral health problems.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Health Promotion and Disease Prevention 1-2, 1-3, 1-4
Provision of Primary Care 2-2, 2-3, 2-4, 2-5
Multidisciplinary Collaboration: 4-2

Pharmacological Principles of Clinical Therapeutics
3 credit hours

This course is designed to expand advanced dental hygiene practitioner knowledge of pharmacological principles. Knowledge, selection and application of pharmacologic agents based on patient assessment and prescriptive authority will be emphasized.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Provision of Primary Care: 2-13, 2-14

Advanced Practice Clinical Courses:

Community-Based Primary Oral Healthcare I
3 credit hours

This laboratory/clinical-based course is the first in a series of courses throughout the curriculum that provide opportunities for advanced dental hygiene clinical practice across the lifespan. Focus on assessment, medical emergencies prevention and planning, diagnosis, treatment planning and beginning instrumentation.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Provision of Primary Care: 2-1, 2-2, 2-3, 2-4, 2-5, 2-6, 2-11, 2-14, 2-15
Case Management: 3-2
Multidisciplinary Collaboration: 4-2
Domain V: Professionalism
Ethics and Professional Behavior: 1-1, 1-2, 1-4

Community-Based Primary Oral Healthcare II
3 credit hours

Continuation of Community-Based Primary Oral Healthcare I. This laboratory/clinical-based course is the second in a series of courses throughout the curriculum that provide opportunities for advanced dental hygiene clinical practice across the lifespan. Focus on assessment, medical emergencies prevention and planning, diagnosis, treatment planning, instrumentation, restorative procedures and dental material selection.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Provision of Primary Care: 2-1, 2-2, 2-3, 2-4, 2-5, 2-6, 2-7, 2-8, 2-9, 2-10, 2-11, 2-12, 2-13, 2-14, 2-15
Multidisciplinary Collaboration: 4-2
Domain V: Professionalism
Ethics and Professional Behavior: 1-1, 1-2, 1-4

Community-Based Oral Healthcare III
3 credit hours

Continuation of Community-Based Oral Healthcare II. This laboratory/clinical-based course is the third in a series of courses throughout the curriculum that provide opportunities for advanced dental hygiene clinical practice across the lifespan. Focus on assessment, medical emergencies prevention and planning, diagnosis, treatment planning, instrumentation, restorative and surgical procedures, dental material selection and evaluation.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Provision of Primary Care: 2-1, 2-2, 2-3, 2-4, 2-5, 2-6, 2-7, 2-8, 2-9, 2-10, 2-11, 2-12, 2-13, 2-14, 2-15
Multidisciplinary Collaboration: 4-2
Domain V: Professionalism
Ethics and Professional Behavior: 1-1, 1-2, 1-4

Community-Based Oral Healthcare IV
3 credit hours

Continuation of Community-Based Oral Healthcare III. This clinical-based course is the fourth in a series of courses throughout the curriculum that provide opportunities for advanced dental hygiene clinical practice across the lifespan. Focus on assessment, medical emergencies prevention and planning, diagnosis, treatment planning, instrumentation, restorative and surgical procedures, dental material selection and evaluation.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Provision of Primary Care: 2-1, 2-2, 2-3, 2-4, 2-5, 2-6, 2-7, 2-8, 2-9, 2-10, 2-11, 2-12, 2-13, 2-14, 2-15
Multidisciplinary Collaboration: 4-2
Domain V: Professionalism
Ethics and Professional Behavior: 1-1, 1-2, 1-4

Management of Dental Emergencies and Urgent Care
1 credit hour

The focus of this course is on the diagnosis, treatment and referral of dental emergencies.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Provision of Primary Care: 2-14, 2-15
Domain V: Professionalism
Ethics and Professional Behavior: 1-1

Advanced Specialty Community Fieldwork
1 credit hour

This clinical course provides the opportunity for concentrated clinical practice in the advanced dental hygiene practice role with specific target population in a variety of settings.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Health Promotion and Disease Prevention: 1-1, 1-2, 1-3, 1-4
Provision of Primary Care: 2-1, 2-2, 2-3, 2-4, 2-5, 2-6, 2-7, 2-8, 2-9, 2-10, 2-11, 2-12, 2-13, 2-14, 2-15
Multidisciplinary Collaboration: 4-2

Domain III: Management of Oral Healthcare Delivery
Quality Assurance: 2-3

Domain V: Professionalism
Ethics and Professional Behavior: 1-1, 1-2, 1-4

Community Internship

2 credit hours

The focus of this course is on the accurate diagnosis and management of acute and chronic oral health problems within the primary care setting for the advanced dental hygiene practitioner. Students may elect to complete the internship in family, pediatric, women's, special needs or geriatric settings.

Competencies:
Domain I: Provision of Primary Oral Healthcare
Health Promotion and Disease Prevention: 1-1, 1-2, 1-3, 1-4
Provision of Primary Care 2-1, 2-2, 2-3, 2-4, 2-5, 2-6, 2-7, 2-8, 2-9, 2-10, 2-11, 2-12, 2-13, 2-14, 2-15:
Multidisciplinary Collaboration: 4-2
Domain III: Management of Oral Healthcare Delivery
Quality Assurance: 2-3
Domain V: Professionalism
Ethics and Professional Behavior: 1-1, 1-4

GLOSSARY

Access to Oral Health Services: assuring that conditions are in place for people to obtain the care that they need and want. (Isman R, Isman B: *Oral Health America White Paper: Access to Oral Health Services in the U.S. 1997 and Beyond,* Robert Wood Johnson Foundation, 1997.)

ADHP Diagnosis: identification of the patient's oral health condition or problem that an ADHP is educated to treat; diagnosis is part of the ADHP process of care that includes: assessment, diagnosis, planning, implementation, and evaluation within the ADHP scope of practice

Administration: providing direction or management for functions related to patient care or operation of a facility

Advanced Dental Hygiene Practitioner (ADHP): a dental hygienist who has graduated from an accredited dental hygiene program and has completed an advanced educational curriculum approved by the American Dental Hygienists' Association, which prepares the dental hygienist to provide diagnostic, preventive, restorative and therapeutic services directly to the public.

Advocacy: the act of speaking or of disseminating information intended to influence individual behavior or opinion, corporate conduct or public policy and law (www.voluntary-sector.ca/eng/about_us/glossary.cfm.)

Benchmarking: the process of improving performance by identifying baseline criteria and continuously identifying, understanding, and adapting outstanding practices and processes found inside and outside the profession (organization). (APQC White Paper for Senior Management based on the internationally acclaimed study Organizing and Managing Benchmarking. Benchmarking: Leveraging Best-Practice Strategies. www.apqc.org accessed 1/23/07).

Best Practices: refers to the clinical practices, treatments, and interventions that result in the best possible outcome for the patient and the healthcare facility providing those services. (Best Practices: Evidence-Based Nursing Procedures. 2nd Edition 2007, Lippincott Williams and Wilkins, Philadelphia.)

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 advanced dental hygiene practitioner and consists of services that the advanced dental hygiene practitioner is educated and licensed to provide (*Competencies for entry into the profession of dental hygiene* [As approved by the 2003 House of Delegates], *JDE* 2004; 68(7):745-749.)

Case Management: Process of coordinating an ongoing course of treatment to assure that it occurs in the most appropriate setting and that the best forms of services are selected and followed.
Adapted from: www.healthinsurecoverage.com/health_care_terms_glossary.html

Collaboration: the ongoing process of working together with other professionals and stakeholders using joint resources to achieve a shared goal.

Cultural Competence: set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross et al., 1989; Issacs & Benjamin, 1991).

Dental home: the ongoing relationship between oral health providers, and the patient inclusive of all aspects of oral health delivered in a comprehensive, continuously accessible, coordinated and family-centered way; establishment of a dental home begins within the first 12 months of age and includes referral to other healthcare providers when appropriate. (American Academy of Pediatrics, American Academy of Pediatric Dentistry)

Evidence-based Care: the integration of best research evidence with clinical expertise and patient values (*Evidence Based Medicine: How to Practice and Teach EMB*, David L. Sackett, Sharon E. Straus, W. Scott Richardson, *et al*, (Eds). 2nd Edition, 2000; Churchill Livingston: Edinburgh).

Palliative Therapy: Palliative care is any form of dental care or treatment that concentrates on reducing the severity of the symptoms of a disease or slows its progress rather than providing a cure. It aims at improving quality of life, and particularly at reducing or eliminating pain. (Oxford English Dictionary)

Patient: refers to the potential or actual recipients of ADHP care, and includes persons, families, groups and communities of all ages, genders, socio-cultural and economic states. (Adapted, American Dental Hygienists' Association: Policy 18-96 Glossary; 1996)

Primary Oral Healthcare: essential oral healthcare based on practical, scientifically sound, culturally appropriate, and socially acceptable methods; the first level of contact with the health system that should be universally accessible to people in their communities; involves community participation, is integral to, and a central function of, the country's health system.
www.cdhb.govt.nz/glossary.htm

Process of Care: The process of care includes assessment, diagnosis, planning, implementation and evaluation. (*American Dental Hygienists' Association: Policy 18-96 Glossary; 1996)*

Pulp cap (direct): procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair (Current Dental Terminology, 2007-2008, p. 17).

Pulp cap (indirect): procedure in which the nearly exposed pulp is covered with a protective dressing to protect the pulp from additional injury and to promote healing and repair via formation of secondary dentin (Current Dental Terminology, 2007-2008, p. 17).

Pulpotomy: the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing; to be performed on primary or permanent teeth; this is not to be construed as the first stage of root canal therapy (Current Dental Terminology, 2007-2008, p. 17)

Pulpal debridement (primary and permanent teeth): the relief of acute pain prior to conventional root canal therapy; not to be used when endodontic treatment is completed on the same day (Current Dental Terminology, 2007-2008, p. 17)

Quality Assurance: The formal and systematic monitoring and reviewing of healthcare delivery and outcomes; designing activities to improve healthcare and overcome identified deficiencies in providers, facilities, or support systems; and carrying out follow-up steps or procedures to ensure that actions have been effective and no new problems have been introduced.
www.tricare.osd.mil/mhsophsc/mhs_supportcenter/Glossary/Qg.htm

Telehealth: the use of advanced telecommunication technologies to exchange health information, consult and provide healthcare services across geographic, time, social, and cultural barriers (Adapted, Reid, 1996; Access April 2007)

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Appendix G

Public Health Supervision Statistics from 2004 through 2007

The information below was provided by the Maine Board of Dental Examiners at the Department's request.

Number of hygienists per year that held PHS status and the number of projects that were held for each year:

	Projects	Hygienists
2004	249	96
2005	232	80
2006	152	68
2007	116	68

Over time, hygienists working under PHS have combined multiple projects under one ID number, so the number of projects hasn't necessarily decreased.

Maine Board of Dental Examiners Statistics
January 30, 2008

Appendix H—Draft Legislation

Be it enacted by the people of the State of Maine as follows:

PART A

Sec. A-1. 32 MRSA c. 16, sub-c. 4-A is enacted to read:

Subchapter 4-A: Independent Practice Dental Hygienists

§1099-A. Independent Practice

An independent practice dental hygienist licensed by the board pursuant to this subchapter may practice without supervision by a dentist to the extent permitted by this subchapter. An independent practice dental hygienist, or a person employing one or more independent practice dental hygienists, may be the proprietor of a place where independent dental hygiene is performed and may purchase, own or lease equipment necessary for the performance of independent dental hygiene.

Every person practicing independent practice dental hygiene as an employee of another shall cause that person's name to be conspicuously displayed and kept in a conspicuous place at the entrance of the place where the practice is conducted.

§1099-B. Qualifications for licensure

To qualify for licensure as an independent practice dental hygienist, a person must be:

1. 18 years of age. 18 years of age or older;

2. Licensure as dental hygienist. Possess a valid license to practice dental hygiene issued by the Board of Dental Examiners pursuant to subchapter 4, or qualify for licensure as an independent practice dental hygienist by endorsement pursuant to section 1099-D; and

3. Education and experience. Meet the educational and experience requirements described in section 1099-C.

§1099-C. Education and Experience

An applicant for licensure as an independent practice dental hygienist must meet one of the following 2 sets of requirements:

1. Bachelor degree and 2,000 hours experience. Possess a bachelor degree from a dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation, or its successor organization, and document one year or 2,000 work hours of clinical practice in a traditional private dental practice during the 2 years preceding application; or

2. Associate degree and 6,000 hours experience. Possess an associate degree from a dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation, or its successor organization, and document 3 years or 6,000 work hours of clinical practice in a traditional private dental practice during the 6 years preceding application.

§1099-D Licensure by endorsement

A person eligible for licensure as a dental hygienist by endorsement pursuant to section 1098-D(2) or 1099 is also eligible for licensure as an independent practice dental hygienist by endorsement if the applicant meets the education and experience requirements set forth in section 1099-C.

§1099-E. Application

An applicant for licensure as an independent practice dental hygienist shall apply to the Board of Dental Examiners on forms provided by the board. The applicant shall include as part of the application such information and documentation as the board may require to act on the application. The application must be accompanied by the application fee set under section 1099-G.

§1099-F. License; biennial renewal; discontinuation of dental hygienist license

The Board of Dental Examiners shall issue a license to practice as an independent practice dental hygienist to a person who has met the requirements for licensure set forth in this subchapter and has paid the application fee. There is an initial license fee only for independent practice dental hygienists licensed by endorsement. The license must be exhibited publicly at the person's place of business or employment. The initial date of expiration of the license is the expiration date of the person's dental hygienist license issued by the board pursuant to subchapter 4 or, for independent practice dental hygienists licensed by endorsement, January 1st of the first odd-numbered year following initial licensure. On or before January 1st of each odd-numbered year, the independent practice dental hygienist must pay to the board a license renewal fee. Independent practice dental hygienists who have not paid the renewal fee on or before January 1st must be reinstated upon payment of a late fee if paid before February 1st of the year in which license renewal is due. Failure to be properly licensed by February 1st results in automatic suspension of a license to practice as a dental hygienist or an independent practice dental hygienist. Reinstatement of the independent practice dental hygienist license may be made, if approved by the board, by payment of a reinstatement fee to the board.

A dental hygienist license issued by the board pursuant to subchapter 4 of this chapter automatically expires upon issuance of an independent practice dental hygienist license to the same person.

§1099-G. Fees

The Board of Dental Examiners may establish by rule fees for purposes authorized under this subchapter in amounts that are reasonable and necessary for their respective purposes, except that the fee for any one purpose may not exceed $xxx. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

§1099-H. Continuing education

As a condition of renewal of a license to practice, an independent practice dental hygienist must submit evidence of successful completion of 30 hours of continuing education consisting of board-approved courses in the 2 years preceding the application for renewal. The Board of Dental Examiners and the independent practice dental hygienist shall follow and are bound by the provisions of section 1084-A in the implementation of this section.

Continuing education completed pursuant to section 1098-B may be recognized for purposes of this section in connection with the first renewal of an independent practice dental hygienist license.

The board may refuse to issue a license under this subchapter to a person who has not completed continuing education required by section 1098-B, or may issue the license only on terms and conditions set by the board.

§1099-I. Scope of practice

1. Independent 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;

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

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

D. Perform complete periodontal and dental restorative charting;

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

F. Apply fluoride to control caries;

G. Apply desensitizing agents to teeth;

H. Apply liquids, pastes or gel topical anesthetics;

I. Apply sealants;

J. Smooth and polish amalgam restorations, limited to slow speed application only;

K. Cement pontics and facings outside the mouth;

L. Take impressions for athletic mouth guards, and custom fluoride trays;

M. Place and remove rubber dams;

N. Place temporary restorations in compliance with the protocol adopted by the Board of Dental Examiners; and

O. Apply topical antimicrobials (excluding antibiotics), including fluoride 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. For the purposes of this section, "topical" includes superficial and intrasulcular application.

2. Practice under supervision. An independent practice dental hygienist may perform duties under the supervision of a dentist as defined and set forth in the rules of the Board of Dental Examiners pursuant to section 1095.

§1099-J. Responsibilities

An independent practice dental hygienist has the following duties and responsibilities with respect to each patient seen in an independent capacity pursuant to section 1099-I, subsection 1:

1. Acknowledgment. Prior to an initial patient visit, the independent practice dental hygienist shall obtain from the patient or the parent or guardian of a minor patient written acknowledgment of the patient'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.

2. Referral plan. The independent practice dental hygienist shall provide to the 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.

§1099-K. Mental or physical examination

For the purposes of this section, by application for and acceptance of a license to practice, an independent practice dental hygienist is considered to have given consent to a mental or physical examination when directed by the Board of Dental Examiners. The board may direct an independent practice dental hygienist to submit to an examination whenever the board determines the independent practice dental hygienist may be suffering from a mental illness that may be interfering with the competent independent practice of dental hygiene or from the use of intoxicants or drugs to an extent that they are preventing the independent practice dental hygienist from practicing dental hygiene competently and with safety to patients. An independent practice dental hygienist 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. Failure to comply with an order of the board to submit to a mental or physical examination results in the immediate suspension of the license to practice independent dental hygiene by order of the District Court until the independent practice dental hygienist submits to the examination.

§1099-L. Use of former employers' lists

An independent practice dental hygienist may not use or attempt to use in any manner whatsoever any prophylactic lists, call lists, records, reprints or copies of those lists, records or reprints, or information gathered from these materials, of the names of patients whom the independent practice dental hygienist might have served in the office of a prior employer, unless these names appear on the bona fide call or prophylactic list of the present employer and were caused to so appear through the independent practice of dentistry, denturism or independent practice dental hygiene as provided for in this chapter. A dentist, denturist or independent practice dental hygienist who employs an independent practice dental hygienist may not aid or abet or encourage an independent practice dental hygienist employed by such person to make use of a so-called prophylactic call list, or to call by telephone or to use written letters transmitted through the mails to solicit patronage from patients formerly served in the office of a dentist, denturist or independent practice dental hygienist that formerly employed the independent practice dental hygienist.

PART B

Sec. B-1. 32 MRSA §1062-A, sub-§1 is amended to read:

1. Penalties. A person who practices or falsely claims legal authority to practice dentistry, dental hygiene, independent practice dental hygiene, denturism or dental radiography in this State without first obtaining a license as required by this chapter, or after the license has expired, has been suspended or revoked or has been temporarily suspended or revoked, commits a Class E crime.

Sec. B-2. 32 MRSA §1081, sub-§2 is amended to read:

2. Exemptions. Nothing in this chapter applies to the following practices, acts and operations:

A. The practice of the profession by a licensed physician or surgeon under the laws of this State, unless that person practices dentistry as a specialty;

B. The giving by a qualified anesthetist or nurse anesthetist of an anesthetic for a dental operation; the giving by a certified registered nurse of an anesthetic for a dental operation under the direct supervision of either a licensed dentist who holds a valid anesthesia permit or a licensed physician; and the removing of sutures, the dressing of wounds, the application of dressings and bandages and the injection of drugs subcutaneously or intravenously by a certified registered nurse under the direct supervision of a licensed dentist or physician;

C. The practice of dentistry in the discharge of their official duties by graduate dentists or dental surgeons in the United States Army, Navy, Public Health Service, Coast Guard or Veterans Bureau;

D. The practice of dentistry by a licensed dentist of other states or countries at meetings of the Maine State Dental Association or its affiliates or other like dental organizations approved by the board, while appearing as clinicians;

E. The filling of prescriptions of a licensed dentist by any person, association, corporation or other entity for the construction, reproduction or repair of prosthetic dentures, bridges, plates or appliances to be used or worn as substitutes for natural teeth, provided that this person, association, corporation or other entity does not solicit nor advertise, directly or indirectly, by mail, card, newspaper, pamphlet, radio or otherwise, to the general public to construct, reproduce or repair prosthetic dentures, bridges, plates or other appliances to be used or worn as substitutes for natural teeth; ~~and~~

F. (rp).

G. The taking of impressions by dental hygienists, independent practice dental hygienists or dental assistants for study purposes only~~.~~, and

H. Practice by an independent practice dental hygienist pursuant to subchapter 4-A.

Sec. B-3. 32 MRSA §1081, sub-§3 is amended to read:

3. Proprietor. The term proprietor, as used in this chapter, includes a person who:

A. Employs dentists ~~or,~~ dental hygienists, independent practice dental hygienists, denturists or other dental auxiliaries in the operation of a dental office;

B. Places in possession of a dentist ~~or a,~~ dental hygienist, independent practice dental hygienist or other dental auxiliary or other agent dental material or equipment that may be necessary for the management of a dental office on the basis of a lease or any other agreement for compensation for the use of that material, equipment or office; or

C. Retains the ownership or control of dental equipment or material or a dental office and makes the same available in any manner for the use by dentists ~~or~~, dental hygienists, independent practice dental hygienists or other agents, except that nothing in this subsection applies to bona fide sales of dental equipment or material secured by a chattel mortgage or retain title agreement. A person licensed to practice dentistry may not enter into arrangements with a person who is not licensed to practice dentistry, with the exception of licensed denturists and independent practice dental hygienists, or the legal guardian or personal representative of a deceased or incapacitated dentist, pursuant to the provisions of Title 13, section 732.

Sec. B-4. 32 MRSA §1081, sub-§6 is enacted to read:

6. Dental hygienist. "Dental hygienist" or "independent practice dental hygienist" means a dental auxiliary licensed pursuant to subchapter 4 or 4-A, respectively, who delivers preventive and educational services for the control of oral disease and the promotion of oral health within the scope of practice authorized by the person's license.

Sec. B-5. 32 MRSA §1092, sub-§1 is amended to read:

1. Unlawful practice. A person may not:

A. Practice dentistry without obtaining a license;

B. Practice dentistry under a false or assumed name;

C. Practice dentistry under the license of another person of the same name;

D. Practice dentistry under the name of a corporation, company, association, parlor or trade name;

E. 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 1081;

F. While manager, proprietor, operator or conductor of a place for performing dental operations, permit a person to practice dentistry under a false name;

G. Assume a title or append or prefix to that person's name the letters that falsely represent the person as having a degree from a dental college;

H. Impersonate another at an examination held by the board;

I. Knowingly make a false application or false representation in connection with an examination held by the board;

J. Practice as a dental hygienist or independent practice dental hygienist without having a license to do so; or

K. Employ a person as a dental hygienist or independent practice dental hygienist who is not licensed to practice.

Sec. B-6. 32 MRSA §1094-D is amended to read:

§1094-D. Definitions

As used in this subchapter, unless the context otherwise indicates, "expanded function dental assistant" means an individual who holds a current valid certification under this subchapter to perform reversible intraoral procedures authorized by this subchapter under the direct supervision of a licensed dentist and under an assignment of duties by a dentist. As used in this subchapter, unless the context otherwise indicates, "reversible intraoral procedures" means placing and removing rubber dams and matrices; placing and contouring amalgam, composite and other restorative materials; applying sealants; supra gingival polishing; and other reversible procedures defined by the board not designated by this chapter to be performed only by licensed dentists ~~or~~, dental hygienists or independent practice dental hygienists.

Sec. B-7. 32 MRSA §1100-A is amended to read:

§1100-A. Definition

Duties of dental auxiliaries other than dental hygienists and expanded function dental assistants must be defined and governed by the rules of the Board of Dental Examiners, except that duties of independent practice dental hygienists set forth in section 1099-I, subsection 1 may not be restricted nor enlarged by the board. Dental auxiliaries include, but are not limited to, dental hygienists, independent practice dental hygienists, dental assistants, expanded function dental assistants, dental laboratory technicians and denturists.

PART C

Sec. C-1. 13 MRSA §732, sub-§4 is amended to read:

4. Dentists ~~and~~, denturists and independent practice dental hygienists. For the purposes of this chapter, a denturist or independent practice dental hygienist licensed under Title 32, chapter 16 may organize with a dentist who is licensed under Title 32, chapter 16 and may become a shareholder of a dental practice incorporated under the corporation laws. At no time may ~~a denturist~~ one or more denturists or independent practice dental hygienists in sum have an equal or greater ownership interest in a dental practice than the dentist or dentists have in that practice.

SUMMARY

This bill creates the new license category of independent practice dental hygienist (IPDH). An IPDH must meet the ordinary requirements for licensure as a dental hygienist and, in addition, must have an associate degree in dental hygiene with 3 years experience or a bachelor degree in dental hygiene with one year experience. The bill authorizes an IPDH to perform specified procedures without supervision by a dentist, but requires an IPDH to provide a patient with a referral plan to a dentist for any necessary dental care. Under this bill an IPDH could be the proprietor of a business, or could be an employee of a dentist, denturist, another IPDH or a business owned by persons who are not dental professionals.

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