JANET T. MILLS
GOVERNOR

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

January 27, 2022

Senator Heather Sanborn, Senate Chair
Representative Denise Tepler, House Chair
Joint Standing Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333-0100

RE: LD 1457 "An Act to Improve Access to Dental Hygiene by Authorizing Dental Hygienists to Perform Dental Hygiene Diagnosis"

Dear Senator Sanborn, Representative Tepler, and Members of the Committee:

At its January 14, 2022 meeting, the Board of Dental Practice held a thorough discussion regarding the committee's letter dated June 30, 2021. In that letter, the committee requested the Board to convene a stakeholder group to review changes proposed in LD 1457 and to report back the results of the collaborative effort no later than February 1, 2022.

As part of the Board's consideration of the request, it examined the proposals outlined in LD 1457 and is reporting back the following:

1) "Dental hygiene diagnosis" - LD 1457 sought to add the term "dental hygiene diagnosis" to the statutory scope of practice provisions specific to dental hygienists, independent practice dental hygienists and public health dental hygienists. While the proposed legislation did not include a definition of the term, references were made to the dental hygiene curriculum standards set by the Commission on Dental Accreditation ("CODA") *Accreditation Standards for Dental Hygiene Education Programs*, revised August 2019 (see link: CODA Standards - Dental Hygiene) , and a policy position of the professional dental hygiene association as outlined in the American Dental Hygienists' Associations' ("ADHA") *Standards for Clinical Hygiene Practice*, revised in 2016 (see link: ADHA - Dental Hygiene Practice).

   In reviewing the CODA curriculum standards, it has long been established that dental hygiene diagnosis is a core principal standard for educational programs seeking accreditation. CODA defines dental hygiene diagnosis as "Identification of an existing or potential oral health problem that a dental hygienist is qualified and licensed to treat." Specifically, Section 2-8c of the standards requires a dental hygiene curriculum to include dental sciences content in "tooth morphology, head, neck and oral anatomy, oral embryology and histology, oral pathology, radiography, periodontology, pain management, and dental materials." The intent is to provide "the student with knowledge or oral health and disease as a basis for assuming responsibility for assessing, planning and implementing preventative and therapeutic services."

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Similarly, the ADHA publication identifies standards of clinical care and incorporates a framework of six components in providing dental hygiene care to patients. The six components are assessment, dental hygiene diagnosis, planning, implementation and evaluation, and documentation. Standard 2 entitled "Dental Hygiene Diagnosis" reads:

> The ADHA defines dental hygiene diagnosis as the identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide. The dental hygiene diagnosis requires evidence-based critical analysis and interpretation of assessments in order to reach conclusions about the patient's dental hygiene treatment needs. The dental hygiene diagnosis provides the basis for the dental hygiene care plan. Multiple dental hygiene diagnoses may be made for each patient or client. Only after recognizing the dental hygiene diagnosis can the dental hygienist formulate a care plan that focuses on dental hygiene education, patient self-care practices, prevention strategies, and treatment and evaluation protocols to focus on patient or community oral health needs.
>
> I. Analyze and interpret all assessment data.
> II. Formulate the dental hygiene diagnosis or diagnoses.
> III. Communicate the dental hygiene diagnosis with patients or clients.
> IV. Determine patient needs that can be improved through the delivery of dental hygiene care.
> V. Identify referrals needed within dentistry and other health care disciplines based on dental hygiene diagnoses.

The principles identified in both the CODA standards and the ADHA clinical standards of practice already exist in regulations governing dental hygiene practice in Maine. A dental hygienist by virtue of education, training and examination is authorized to identify an existing or potential oral health problem that a dental hygienist is qualified and licensed to treat. The level and degree to which a dental hygienist's care plan is provided to a patient falls within the professional relationship established between the dental hygienist and the supervising dentist.

If the intent of the proposed change was to align statutory language to reflect the national standards, then please note that the Board had previously reported out such a recommendation in 2017. The report submitted to the committee on April 28, 2017 was the result of a stakeholder process that made recommendations for further discussion specific to dental hygiene scope of practice. The recommendation included adopting the ADHA standards as well as an alternative that was discussed among stakeholder members. The recommendation is attached, and the full report can be accessed online at: 2017 Legislative Report

2) Local anesthesia supervision" - LD 1457 also sought to change the level of dentist supervision from "direct" to "general" when a duly authorized dental hygienist administers local anesthesia to a patient. Respectfully submitted, it is not the Board's role to advance the policy positions of professional associations, rather it is the Board's role to protect the public. The Board has imposed discipline and is currently investigating patient care cases involving allegations of the unsafe use of local anesthesia and does not support minimizing the level of dentist supervision required to ensure safety for adult and/or pediatric dental patients.

If the intent of the proposed change was to increase the level of care when a dentist was out of the office, then perhaps the dentist and dental hygiene associations might consider offering the committee specific patient data or practice information that may be helpful in addressing the need for change. To date, the Board does not have that data and can only offer its case investigations that speak to the contrary for change.

The Board will make itself available to the committee should you have any questions. Again, thank you for giving the Board the opportunity to report back to you and we look forward to next steps as deemed appropriate.

Respectfully submitted,

Penny Vaillancourt

Penny Vaillancourt
Executive Director

Attach.

Cc w/attach.: Nichole Grohoski, Maine State Representative
Anne L. Head, Commissioner – Department of Professional and Financial Regulation

DRAFT PROPOSED CHANGES TO 32 MRS § 18374

DISCUSSION PURPOSES ONLY – APRIL 7, 2017

OPTION #1 -

Practice categories of dental hygiene practice:

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

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

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

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

OPTION #2 - ADHA Standards of Practice

Standard 1: Assessment

- Health History
- Clinical Assessment
- Risk Assessment

Standard 2: Dental Hygiene Diagnosis

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

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

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

Standard 3: Planning

Planning is the establishment of realistic goals and the selection of dental hygiene interventions that can move the client closer to optimal oral health.[24] The interventions

should support overall patient goals and oral health outcomes. Depending upon the work setting and state law, the dental hygiene care plan may be stand-alone or part of collaborative agreement. The plan lays the foundation for documentation and may serve as a guide for Medicaid reimbursement. Dental hygienists make clinical decisions within the context of legal and ethical principles.

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

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

Standard 4: Implementation

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

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

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

Standard 5: Evaluation

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

I. Use measurable assessment criteria to evaluate the tangible outcomes of dental hygiene care (e.g., probing, plaque control, bleeding points, retention of sealants, etc.).
II. Communicate to the patient, dentist, and other health/dental care providers the outcomes of dental hygiene care.
III. Evaluate patient satisfaction of the care provided through oral and written questionnaires.

IV. Collaborate to determine the need for additional diagnostics, treatment, referral, education, and continuing care based on treatment outcomes and self-care behaviors.

Self-assess the effectiveness of the process of providing care, identifying strengths and areas for improvement. Develop a plan to improve areas of weakness.

Standard 6: Documentation

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

I. Document all components of the dental hygiene process of care (assessment, dental hygiene diagnosis, planning, implementation, and evaluation) including the purpose of the patient's visit in the patient's own words. Documentation should be detailed and comprehensive; e.g., thoroughness of assessment (soft-tissue examination, oral cancer screening, periodontal probing, tooth mobility) and reasons for referrals (and to whom and follow-up). Treatment plans should be consistent with the dental hygiene diagnosis and include no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

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

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

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

V. Ensure compliance with the federal Health In- formation Portability and Accountability Act (HIPAA). Electronic communications must meet HIPAA

standards in order to protect confidentiality and prevent changing entries at a later date.

VI. Respect and protect the confidentiality of patient information.

OPTION #3 (Combination of Options #1 & #2)

STANDARDS OF PRACTICE

Standard 1: Assessment

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

I. HEALTH HISTORY

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

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

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

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

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

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

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

II. CLINICAL ASSESSMENT

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

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

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

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

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

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

III. RISK ASSESSMENT[20-21]

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

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

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VI. Respect and protect the confidentiality of patient information.

Summary

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

KEY TERMS