JANET T. MILLS
GOVERNOR

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

TRACEY L. JOWETT, RDH, BSDH, IPDH
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KATHRYN WALKER NORRIS, RDH, EFDA, MSEd
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PETER R. SHUMWAY, D.M.D.
PENNY VAILLANCOURT
EXECUTIVE DIRECTOR

January 30, 2024

Senator Donna Bailey, Senate Chair
Representative Anne Perry, House Chair
Joint Standing Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333-0100

RE: Legislative report regarding changes to Dental Board membership

Dear Senator Bailey, Representative Perry and Members of the Committee:

On behalf of the Board of Dental Practice ("the Board"), please accept this report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services ("the Committee") as requested in a letter dated June 7, 2023. Specifically, the Committee requested a report back no later than January 31, 2024, its review of changes to existing board member composition "…to enhance representation for dental hygienists and dental therapists."

In an effort to engage stakeholders, the Board utilized a public hearing process to solicit comments from its licensees and interested parties such as professional associations, national trade organizations, and educational institutions to the questions posed below[1]:

Question 1. Would the public be better served if the current composition of the Board of Dental Practice was changed or expanded to enhance representation of dental hygienists and dental therapists? Below is the current composition of board seats:

Current composition: 5 dentists, 2 hygienists, 1 denturist, 1 public member (9 seats)

Question 2. Would the public be better served if the composition of the Board of Dental Practice was changed or expanded to represent a broader representation of licensed dental professionals? Below is a list of the major licensure and practice categories not identified above:

Dental licensure and practice categories: dentists with sedation permits, independent practice dental hygienists, public health dental hygienist, expanded functions dental assistants, dental radiographers, and faculty licensees.

A public hearing was held on November 17, 2023, with a written public comment deadline of December 1, 2023. A total of thirteen public comments were received, six comments received at hearing and the remaining comments received in writing. Enclosed are copies of all written comments, including a summary of all comments received prepared by board staff.

[1] See Board's Request for Public Comment dated October 23, 2023

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FAX: (207) 287-8140
WEBSITE ADDRESS: www.maine.gov/dental
E-MAIL ADDRESS: dental.board@maine.gov

At the Board's December 15, 2023 and January 19, 2024 meetings, it reviewed considered the following information which is enclosed for your review:

1. June 7, 2023 letter from the Committee.
2. October 23, 2003 letter from the Board requesting public comment.
3. December 8, 2023 board staff memo summarizing public comments.
4. Copies of all written public comments received.
5. Resource materials for the Board:
    a. LD 1581 sponsor amendment ;
    b. LD 1581 board staff testimony;
    c. LD 1581 Maine Dental Association/Maine Dental Hygienists' Association testimony
    d. February 2022 – Board strategic plan;
    e. September 2022 – Talking points for elimination of subcommittees; and
    f. February 2002 – Legislative report; "Sunrise Review of Oral Health are Issues".

In conclusion and after thorough discussions of the issues involved, the Board voted to submit the following recommendation Committee:

Recommendation. – No change to the composition of board membership. This recommendation is based on the lack of support for such a change in the public comments received and based on the Board's current opinion that the existing composition is necessary to meet its statutory mandate. The most significant statutory mandates of the Board is to conduct investigations, hold adjudicatory hearings, impose sanctions when deemed appropriate, and make determinations of educational equivalency when evaluating foreign trained professionals seeking licensure. To date, the majority of those efforts involve licensed dentists and having a majority membership of dentists who either participate as a voting member or who participate as a complaint officer is critical to the Board's mission to protect the public.

It is important to note that the Board also received specific comments to reinstate the Subcommittee on Dental Hygienists with expanded statutory authority to achieve greater professional autonomy. While the Board respects the opinions of those making this recommendation, it must respectfully defer to the Committee on this subject. As noted in the resource materials, the Board's recommendation to eliminate the Denturist and Dental Hygienist Subcommittees was not intended to diminish the professional roles of denturists or dental hygienists. Rather, it was part of a series of recommendations based on a strategic planning session designed to reallocate resources including transitioning from an affiliated board to a member board within the Office of Professional and Occupational Regulation.

Thank you for your time and please contact me at either penny.vaillancourt@maine.gov or by phone at (207)287-3333 should you have any questions regarding this report.

Sincerely,

Penny Vaillancourt

Penny Vaillancourt
Executive Director

Encs.

STATE OF MAINE
ONE HUNDRED AND THIRTY-FIRST LEGISLATURE
COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

June 7, 2023

Penny Vaillancourt
Executive Director
Maine Board of Dental Practice
143 State House Station
221 State Street
Augusta, Maine 04333-0143

Dear Ms. Vaillancourt:

As you know, the Joint Standing Committee on Health Coverage, Insurance and Financial Services recently considered **LD 1581, An Act Regarding Dental Hygienists and Dental Therapists**. As amended by the committee, the bill makes changes to the laws related to the licensing, scope of practice and type of supervision required by a dentist of certain activities performed by dental hygienists and dental therapists.

During the committee's consideration of LD 1581, the committee considered a proposed change to the membership of the Board of Dental Practice that would add 2 additional members who are dental hygienists. In response to those concerns, the committee decided to defer action on this proposal to allow additional time for consideration. We are writing to request that the Board of Dental Practice consult with stakeholders, including representatives of dental hygienists and other dental professionals, to review the current membership of the board and consider changes in board membership to enhance representation for dental hygienists and dental therapists. We ask that the board report on it review, and any recommendations for changes, to the committee no later than January 31, 2024.

If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid. Thank you for your consideration.

Sincerely,

Sen. Donna A. Bailey
Senate Chair

Rep. Anne C. Perry
House Chair

JANET T. MILLS
GOVERNOR

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PENNY VAILLANCOURT
EXECUTIVE DIRECTOR

October 23, 2023

REQUEST FOR PUBLIC COMMENT

On Friday, November 17, 2023 at 8:30 a.m. the Board of Dental Practice ("the Board") will conduct a public hearing to gather information from stakeholders and interested parties to consider changes in Board membership and report back to the Joint Standing Committee on Health Coverage, Insurance and Financial Services ("the Committee") no later than January 31, 2024.

The Committee's letter to the Board dated June 7, 2023, reads in part:

> During the committee's consideration of LD 1581, the committee considered a proposed change to the membership of the Board of Dental Practice that would add 2 additional members who are dental hygienists. In response to those concerns, the committee decided to defer action on this proposal to allow additional time for consideration. We are writing to request that the Board of Dental Practice consult with stakeholders, including representatives of dental hygienists and other dental professionals, to review the current membership of the board and consider changes in board membership to enhance representation for dental hygienists and dental therapists. We ask that the board report on it review, and any recommendations for changes, to the committee no later than January 31, 2024.

During this hearing, the Board will accept oral testimony and comments to the following questions posed below:

Question 1. Would the public be better served if the current composition of the Board of Dental Practice was changed or expanded to enhance representation of dental hygienists and dental therapists? Below is the current composition of board seats:

Current composition: 5 dentists, 2 hygienists, 1 denturist, 1 public member (9 seats)

Question 2. Would the public be better served if the composition of the Board of Dental Practice was changed or expanded to represent a broader representation of licensed dental professionals? Below is a list of the major licensure and practice categories not identified above:

Dental licensure and practice categories: dentists with sedation permits, independent practice dental hygienists, public health dental hygienist, expanded functions dental assistants, dental radiographers, and faculty licensees.

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E-MAIL ADDRESS: dental.board@maine.gov

Details for those wishing to provide comments: Stakeholders and interested parties may submit comments to the question orally on November 17th or in writing no later than December 1, 2023.

- **Oral comments:**
    - Manner of presentation: Oral comments may be provided either in person at Room #118 at the Marquardt Conference Room, Department of Marine Resources, East Campus, 32 Blossom Lane, Augusta, Maine or remotely over the Zoom platform.
    - Length of presentation: The Board anticipates limiting each comment to approximately 5 minutes, depending on the number of representatives who sign up to speak during the meeting.
    - How to sign up: If you wish to present your comments orally to the Board during the meeting, please send an email to Penny Vaillancourt (penny.vaillancourt@maine.gov) with the subject line "request to speak at November 17, 2023 meeting." Please provide (1) the name and title of the person presenting; (2) the name of the organization they represent, if applicable; (3) an indication whether the presenter will attend the meeting in person or remotely over the Zoom platform and (4) if the presenter will appear remotely, the email address to which the Zoom invitation should be sent.
    - **Deadline: You must sign up by email to speak by 5:00 p.m. on Monday, November 6th.** This deadline is necessary to help properly plan for the meeting and to ensure that all speakers receive their link for the Zoom meeting.
    - Accompanying written comments: Organizations providing oral comments may also submit written comments by the deadline listed below.
- **Written comments:**
    - How to submit: Written comments should be emailed to Penny Vaillancourt at (penny.vaillancourt@maine.gov) with the subject line "comments for November 17, 2023 meeting." Please be sure that the document you submit includes (1) the name and title of the person who prepared the comments; and (2) the name of the organization they represent, if applicable.
    - **Deadline: You must submit your written comments by 5:00 p.m. on Friday, December 1, 2023.** Comments received after that date will not be accepted.

Please contact Penny Vaillancourt at either penny.vaillancourt@maine.gov or by phone at (207)287-3333 should you have any questions.

STATE OF MAINE
BOARD OF DENTAL PRACTICE
INTER-OFFICE MEMORANDUM

****

TO: Members of the Board of Dental Practice

FROM: Board Staff

DATE: December 8, 2023

RE: Legislative Report on LD 1581 – Outline of Resource Materials

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Below are resource materials and a summary of the public comments received for the Board's review as part of its report back to the Joint Standing Committee on Health Care, Insurance and Financial Services (HCIFS):

LD 1581 – Various legislative documents:

1. Draft Amendment to LD 1581 proposing to add two dental hygiene members (one of which may hold a dental therapy authority and one with an EFDA authority) to the Board's composition.
2. Board Testimony dated May 4, 2023 on LD 1581 and proposed amendment to board composition.
3. Joint MDA and MDHA statement at HCIFS work session held on May 17, 2023 regarding the dental hygiene subcommittee.
4. HCIFS letter dated June 7, 2023 requesting the Board to convene a stakeholder process.
5. Board letter requesting public comments dated October 23, 2023 which was sent to interested parties and all current licensees.

Subcommittee reference documents:

6. Sunrise Review report submitted by Commissioner Head to the Joint Standing Committee on Business, Research and Economic Development dated February 15, 2008.
7. Final MBDP Strategic Planning Workshop Notes dated February 2, 2022.
8. Talking Points on Proposed Elimination of Subcommittees dated September 27, 2022.

Public comment summary:

9. Written public comment: Seven written comments were received which are enclosed for your review and below are highlights of each comment:
    a. Dr. Richard Huot: No change in membership is necessary. Each group is proportionally represented and notes current chair is a dental hygienist. Dr. Huot also states that "Oral care is best administered when all team members re on the same age at the point of care, and not necessarily at the dental board member level.
    b. Pauline A. Bernardy, RDH: Does not feel that the public is better served by changing board composition. Ms. Bernardy also states that a dentist/owner "…bears the burden of operations and oversight of the practice. Also the one held liable in any public complaint. Therefore it just makes sense for dentists to have a bigger representation."
    c. Dr. Scott Bernardy: Opposed to expanding the current members noting the level of education/expertise needed to guide future dental regulations noting a "…lack of experience and expertise could bring forth a flawed dental health structure." Dr. Bernardy also noted that the dentists "…bear the greatest burden" and "…should have more than a simple majority on the Dental Board."

d. Dr. Thomas Bauer: Comments received expressed his strong opinion that adding dental hygiene members to the Board does not better serve the public. Additional comments included references to a profession being "… defined by the establishment and maintenance of a hierarchy of competence that governs the rules and norms of that profession." Dr. Bauer also highlighted concerns regarding undermining the standard of care, vulnerability to external interests, damaging the morale of the profession, and diminishing the power and credibility of the Maine Board of Dental Practice. Dr. Bauer also provided comment that dental hygienists serve a vital role in the dental community and understands their desire to want more control over their own profession, but that the Dental Board is not the place. He further states that "A clear dentist majority must always be preserved for the Board to render credible, qualified judgements that serve and protect the public."
e. Dan Walker, Esq. (Preti, Flaherty) on behalf of the Maine Dental Hygiene Association: Comments received referenced a joint statement between the MDHA and the MDA that was provided to the HCIFS committee recommending reinstating the Dental Hygiene Subcommittee. The commenter also provided a legislative history demonstrating support for the dental hygiene community and the noted support for the subcommittee over the years.
f. Dr. Brad Rand: Noted the Board's recent disciplinary actions and asks the Board to consider whether adding members who do not have sedation experience would impact decisions on those cases. Dr. Rand also noted that while adding other license types to the Board's membership "…could dilute the board's ability to act on highly sensitive and highly specialized cases, and may ring your representation out of harmony with frequency of each licensee brought before you."
g. Gray McGinnis, VP of Government Relations, Association of Dental Support Organizations: Requested the board add a dedicated spot for a DSO-supported dentist noting the change in landscape of dentistry which includes an increase of the dental support organization practice model.

10. Oral public comment: Six individuals provided oral testimony at the Board's November 17, 2023 meeting a recording of which is included for your reference:
    a. Therese Cahill, Executive Director, Maine Dental Association: Offered virtual comments consistent with the joint statement provided at the legislative work session that no change should be made or is necessary to further protect the public. Ms. Cahill further recommends that either reinstatement of the dental hygiene subcommittee with more autonomy to the practice of dental hygiene or convene a task force to increase self regulation in its current composition might be considered. Also, does not support adding additional board members or changing the composition of the Board as it does not align with other state dental boards.
    b. Traci Dempsey, President, Maine Dental Hygienist Association: Offered virtual comments reflective of joint statement referenced above supporting the reinstatement of the dental hygiene subcommittee and does not support changing the composition of the Board.

c. Dr. Michael Dowling, Chair of Council of Government Relations, Maine Dental Association: Attended the hearing in person and echoed responses provided by the Ms. Cahill and Ms. Dempsey and provided specific responses to the Board's two questions as to whether the public would be better served by increasing the number of dental hygienists to the Board and by expanding the Board's membership to other licensed dental professional types. Dr. Dowling's answer was "no" to both questions noting the Board's primary charge is to protect the public and that is done by rule promulgation and disciplinary action. The Board in its current construction has the capacity to consider all aspects of dentistry with a variety of viewpoints and expertise. Expansion does not protect the public – a larger board is not more efficient board and an expansion would bog down board actions. Expansion of the Board would be a detriment to the protection of the public as it would make Maine an outlier from other state boards and may serve as a disincentive to attracting providers to the state at a time when services are desperately needed. Recommendation is to reinstate the dental hygiene subcommittee with increased autonomy.

d. Dr. Nick Roy, Secretary of the Maine Academy of General Dentistry: Offered virtual comment that included a summary of questions posed from 30+ members to better understand the nature and purpose of LD 1581. The summary questions included: What initiated this proposal such as an event or was the public negatively affected by the Board's current representation? How will increasing hygiene members increase the Board's effectiveness in protecting the public? Who proposed this bill and is there any bias in the goals set forth by increased representation of hygienists? Has the Board considered a subcommittee as was explored in the past? The Maine AGD would support further exploration in giving dental hygienist members achieve autonomy. Has the Board evaluated the negative impacts of discrepancies of education and training? It is possible that a dentist will be judged by a majority that is not a peer and may be counterproductive in protecting the public. The Maine AGD supports the comments provided by Ms. Cahill and Ms. Dempsey to reinstate the subcommittee and further explore the matter via a task force.

e. Dr. Joseph Dumont, President of the Maine Academy of General Dentistry: Attended the meeting in person and provided comment that he spoke with Dr. Roy and the Maine AGD's desire is to maintain the existing board composition and explore the reinstatement of the dental hygiene subcommittee.

f. Lorrain Klug, IPDH: Offered virtual comment including her experience in attending board meetings since 1995 and appointed by the Governor as one of the first dental hygiene members appointed to the subcommittee. Supports reinstating the dental hygiene subcommittee and provided historical changes to the subcommittee including streamline licensing changes requiring less meetings. To be more efficient, increase the subcommittee's authority when reinstating the subcommittee so that final decisions are made at the subcommittee level increasing efficiencies.

From: Richard Huot
To: Vaillancourt, Penny
Cc: Therese Cahill
Subject: Comments for November 17, 2023 meeting.
Date: Monday, October 23, 2023 12:36:32 PM

Ms. Vaillancourt

I am providing written testimony for your Nov 17th board meeting, since I will be unavailable to come to Augusta for the actual meeting. I am speaking as a licensed dentist in Maine, and sole owner of the consulting company below.

As a member of the Bucksport Regional Health Center staff on a per diem basis, I see no need to include the suggested groups in the notice for better representation on the current board.

Each group is proportionally represented, and I believe the current chair of the board is a hygienist, so all opinions can be fairly heard.

Recently HRSA stated that there is an increase in Health Profession Shortage Areas (HPSA) nationwide, and ME is certainly part of that trend.

The oral care of Maine residents will only be best served by making sure that all geographic areas of the state have a dentist in their community, and hire the appropriate allied personnel to serve the needs of that community. Oral care is best administered when all team members are on the same page at the point of care, and not necessarily at the dental board member level.

The charter of UNE College of Dental Medicine was supposed to have alleviated the dentist shortage problem, but there remains insufficient financial incentives to have dental school graduates to practice in these HPSA areas, and the high cost of tuition is one of a large number of issues why there is a maldistribution of dentists statewide.

Having a different makeup of the board will not necessarily address these issues, and the current board is balanced according to the current number of dental workforce members that are represented in the mix.

Thank you. Ms. Therese Cahill, Executive Director of the Maine Dental Association is copied on this email.

Richard A Huot DDS
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"He who dares not offend cannot be honest"

-----Thomas Paine-----

From: Pauline Bernardy
To: Vaillancourt, Penny
Subject: comment for Nov.17th meeting
Date: Monday, October 23, 2023 2:02:22 PM

In response to the question of changing the board composition, I do NOT feel the public would be better served especially if they dilute it to include EFDA's and radiographers. They do not have the level of expertise or education of Dentists. Furthermore it is the dentist/ owner that bears the burden of operations and oversight of the practice. Also the one held liable in any public complaint. Therefore it just makes sense for dentists to have a bigger representation on the board.

Pauline A Bernardy, RDH

From: Scott Bernardy
To: Vaillancourt, Penny
Subject: Comments for November 17th meeting
Date: Monday, October 23, 2023 2:20:42 PM

To the Dental Board of Maine Examiners,

I am opposed to expanding the current number of Boards Members for several reasons. First is the educational requirements required for licensed dentists versus other dental professionals is significantly more comprehensive delving deeper into subjects such as pathology, pharmacology, human anatomy, neurology, etc.. This level of expertise will be vital to guide any future changes to dental regulations. Having a Board with 6 non dentist members to 5 dentists could present risks to the public where the lack of experience and expertise could bring forth a flawed dental health structure.
Secondly, the burden of expensive dental office ownership and the one dental professional held liable for most any infractions is the dentist and not the dental hygienist or EFDA or radiographer. Thus the ones who bear the greatest burden should have more than a simple majority on the Dental Board.

Sincerely,
J Scott Bernardy, DDS

From: Thomas Bauer
To: Vaillancourt, Penny
Subject: Fwd: Hi Greg, here is draft 2, please comment
Date: Friday, November 3, 2023 9:25:40 AM

Dear Penny,

I have attached my comments for the November 17, 2023 meeting. Please let me know if you need any clarification.

Thank you!
~TJ Bauer
Androscoggin Orthodontics

I am writing to express my strong opinion that the proposed addition of two hygienists to the existing structure of the Maine Board of Dental Practice does not better serve the public.

A profession, whether it be medicine, dentistry, science, or law, is defined by the establishment and maintenance of a hierarchy of competence that governs the rules and norms of that profession. Such a hierarchy safeguards the public welfare by defining the boundaries of good practice. Matters concerning the definition of "good practice" within a profession must always be adjudicated by those individuals exhibiting the highest level of competence in their discipline, whether by training, experience, or accreditation. If this is not permitted to be the case with dentistry in particular, then even efforts made in good faith made by non-dentist providers will have adverse, unintended consequences:

Undermining the standard of care. Modern dentistry is an increasingly challenging and complex discipline that has been carefully constructed over the past hundred years with clinical best practices derived from rigorous, peer-reviewed knowledge. These best practices, which we call the "standard of care", could not have been created without competent peer review. How then can violations of the standard of care be adjudicated without the same highly qualified review process? Quite simply, they cannot. The actions of a dentist must be judged by a governing body that has attained the knowledge and experience needed to understand the challenges, and best practices, for each unique clinical situation. Non-dentist providers do not meet that standard, and are unable to better safeguard the public welfare.

Vulnerability to external interests. A majority opinion consisting entirely of non-dentists, capable of rendering an adverse opinion against a dentist, must never occur. Licensing, credentialing, and adjudicating the standard of care are responsibilities that must reside with dentists alone. This assertion is particularly relevant, in fact, because external influences continually seek to disrupt these responsibilities. Product vendors would have us believe their recommendations are not only preferred but essential for the practice of good dentistry. Pseudoscientific courses and publications present information under the guise of legitimate continuing education. The public itself sometimes demands dental services that are unsound or not in their own best interests. The Board must remain a dentist-controlled entity where evidence-based and experience-based judgements alone uphold the standard of care.

Damaging the morale of the profession. The COVID-19 pandemic affected the morale of the Maine dental community in negative ways that persist to this day. Maine dentists readily accepted the additional burden of physically difficult infection control precautions that COVID-19 required. They complied with the state requirement to shut down clinical operations for nine weeks, in spite of ongoing educational loan payments, business loan payments, and operational expenses. They watched helplessly as the profession was hollowed out by departing staff who did not want to comply with the vaccine mandate, and then watched with equally profound frustration as the vaccine mandate was later reversed. To this day, operations in many practices remain more difficult because staffing in dentistry has not fully recovered. Now, some would ask them to accept a lack of ownership over existential questions governing their own profession! Rural Maine is already critically underserved in dental services. Should not every effort should be made to make Maine an attractive destination for young professionals?

Diminishing the power and credibility of the Maine Board of Dental Practice. In the event that an adverse judgement against a constituent dentist is made, the decision of the governing body adjudicating the matter can be credible only if the decision is well informed, thoughtfully reasoned, and absolute. A judgement rendered by unqualified, or lesser qualified, individuals will undoubtedly be vulnerable to rebuttal, appeal, and even litigation. It would not be difficult to imagine that countersuits against the Board as an entity could be extrapolated to the Board members individually, and service on the Board would then become a calling that no dentist would want. The Board would become a sterile exercise in bureaucracy, unable to protect the public at all.

There is no doubt that hygienists serve a vital role in the Maine dental community. They are the front line of primary preventive dental care. They outnumber dentists, and are critically understaffed three years after the pandemic. It is understandable that they want more control over their own profession, however the Maine Board of Dental Practice is not the place for them to accomplish this goal. A clear dentist majority must always be preserved for the Board to render credible, qualified judgements that serve and protect the public.

Thank you for your time and consideration.

Received 11-28-2023

PretiFlaherty

Portland, ME
Augusta, ME
Concord, NH
Boston, MA
Washington, DC

TESTIMONY ON BEHALF OF THE
MAINE DENTAL HYGIENISTS' ASSOCIATION
November 17, 2023

Chair Jowett and Vice Chair Norris and Members of the Board of Dental Practice, my name is Dan Walker. I am an attorney at Preti Flaherty, and I am submitting written comments today on behalf of the Maine Dental Hygienists' Association (MDHA).

MDHA represents over 1,300 dental hygienists across the state of Maine providing safe, effective, quality care for patients. MDHA is aligned with the American Dental Hygienists' Association whose vision is to have "dental hygienists are integrated into the health care delivery system as essential primary care providers to expand access to oral health care" and they work to

- Ensure access to quality oral health care.
- Increase awareness of the cost-effective benefits of prevention.
- Promote the highest standards of dental hygiene education, licensure, practice and research.
- Represent and promote the interests of dental hygienists.

We wanted to provide written comments to supplement the joint statement made at the public hearing made by MDHA and the Maine Dental Association (MDA) that seeks to reestablish the subcommittee for dental hygienists. We believe that it is necessary to provide the Board historical context for this request to explain why this representation matters.

First, we wanted to provide a brief legislative history of the past twenty years that demonstrates that the Legislature has consistently supported the dental hygienists having their own subcommittee on the Board.

In 2004, in the 121st Legislature, LD 1958 proposed recommendations from the Joint Standing Committee on Business, Research and Economic Development review of the Board of Dental Examiners which included creating the subcommittee on dental hygienist and gave it "authority to issue recommendations on matters within its scope and would be binding unless overturned by a 2/3 supermajority of the board." *See* Analyst Summary. This created 32 M.R.S. §1079 (2003) (PL 2003, c. 669, §3).

I was working in the Legislature at that time with the denturists, who were also being given their own subcommittee, and it was a highly contentious proposal and debate. The eventual decision to give these two groups, the dental hygienist and denturist, a voice that was independent of the Dentist was the right one. But not only was it the right one, it was an important step to building peace between the various practice groups in the dental field.

In 2005, in the 122nd Legislature, LD 1385 gave additional authority to the subcommittee by granting them the authority to be a part of the dental hygienist for licensure by endorsement by giving them the authority to interview the candidate. *See* Analyst Summary. This amended 32 M.R.S. §1079 (2005) (PL 2005, c. 289, §1).

In 2008, in the 123rd Legislature, LD 2277 created the new license category of independent practice dental hygienist (IDPH) and gave additional authority to the subcommittee by granting them the ability to review the applications for licensure, submissions relating to continuing education and initial review of the complaints. The original version of the bill proposed to give the two subcommittees rulemaking authority but that was later removed in an amendment. *See* Analyst Summary. This amended 32 M.R.S. §1079 (2007) (PL 2007, c. 620, Pt. A, §2).

The subcommittee was not touched again until, in 2016, in the 127th Legislature, LD 1596 was proposed as a concept draft to "recodify the Maine Revised Statutes, Title 32, chapter 16" and included "restructuring of the board [and] increasing statutory authority for the subcommittees of the board." Executive Director Vaillancourt indicated in her testimony at the public hearing that this bill was brought forward after the Board asked the Legislature for its own opportunity to review its practices instead of the multiple bills that were proposed the previous session. This restructuring retained the subcommittee and created the 32 M.R.S. §18327 (2017) (PL 2015, c. 429, §21).

Second, we wanted to note a few other attempts that were ultimately unsuccessful but provide additional information about the landscape of the important mission of providing equitable representation.

The most relevant is that in 2014, in the 126th Legislature, LD 933 attempted to create the State Board of Dental Hygiene. The bill was slightly amended by the Committee and was engrossed by the House and Senate. However, it was ultimately vetoed by Governor LePage who "vetoed more bills approved by the Legislature than the combined total of all governors… since 1917." The House was able to overrule the veto, but it was sustained in the Senate.

Other relevant legislative history includes:

1. There was a failed attempt, in 2019, to establish the State Board of Dental Hygiene that was withdrawn by the sponsor. *See* LD 1309, An Act To Establish the State Board of Dental Hygiene.
2. There was a failed attempt in 2015 to allow the Dental Hygienist Subcommittee to have rulemaking authority. *See* LD 1211, An Act To Provide Rule-making Powers and Increased Authority over Dental Hygienists to the Subcommittee on Dental Hygienists.
3. There was another failed attempt in 2015 to rename the Dental Board to allow for equitable membership of the dental profession (2 dentist, 2 dental hygienists, 2 denturists and 3 members of the public). *See* LD 540, An Act To Improve Access to Dental Care through the Establishment of the Maine Board of Oral Health.

All of these examples that we have provided clearly show that the Legislature and even the Board has chosen to support the dental hygienist having a voice and that the subcommittee has been supported and worked over the years. This is why we were alarmed when we learned that Commissioner Head dissolved the subcommittee last year in an apparent attempt to save money.

We do not have a comment on the decision to move the Board to the jurisdiction of the Department of Professional & Financial Regulations; however, we do have a strong comment about the decision to do it through the budget process without consulting any stakeholders and disbanding the subcommittees in that move. We hope that the Board recognizes the imbalances that this unilateral move has created and listens to the joint ask of the MDHA and MDA to restore the balance.

Received 11.29.2023

Ms. Penny Vaillancourt, Board Chair Tracey Jowett, and board members

My name is Brad Rand. I am a general dentist licensed to practice in the state of Maine and a past president of the Maine Dental Association. I appreciate the opportunity to make comment on LD 1581 regarding composition of the Maine Board of Dental Practice and I represent myself in what I share with you today.

As I tallied the most recent 3 years worth of "disciplinary actions taken" into groupings, some patterns appeared. The 3 most common acts during that time period that resulted in disciplinary considerations were: failure to complete license renewal appropriately, substance misuse, and sedation (in that order).

One could assume that any member of your board would feel comfortable weighing decisions about licensure administration or substance concerns. However, I personally would have to rely heavily on the experience and opinion of a board member who provides sedation were I to weigh nuanced situations regarding sedation. An adverse event alone may or may not signal that there was inappropriate action on the part of a licensee (although investigation of such adverse events certainly should be one way that the public is protected). My comment here is simply to consider whether addition of members without sedation experience would result in reliance on the opinion of only a select few board members, especially given how frequently you consider those decisions.

If you group "disciplinary actions taken" by type of licensee, dentists are the most common licensee brought before the board. Viewed through this lens, it would be most practical to have representation in some form from each type of licensee, without diluting things so that licensees with more common disciplinary actions against them are underrepresented.

Certainly, having consistent involvement of an independent practice dental hygienist/dental therapist and an EFDA would add depth to your already highly-capable board. However, addition of too many supplemental board members could dilute the board's ability to act on highly sensitive and highly specialized cases, and may bring your representation out of harmony with frequency of each licensee brought before you.

With gratitude to each of you for your service on the board,

C. Bradford Rand, DDS

Received 12.01.2023

STATE OF MAINE
BOARD OF DENTAL PRACTICE
143 STATE HOUSE STATION
AUGUSTA, MAINE

My name is Gray McGinnis, and I am the Vice-President of Government Relations for the Association of Dental Support Organizations (ADSO). I appreciate the opportunity to submit written testimony relating to the composition of the Maine Board of Dental Practice.

The ADSO is a non-profit organization committed to supporting its members, allowing affiliated dentists to focus on patients, expanding access to quality dental care, and improving the oral health of their communities. The ADSO currently has three member companies operating in Maine.

I am writing today in response to the request for comments regarding changes to board membership. The ADSO is specifically interested in question 2:

Would the public be better served if the composition of the Board of Dental Practice was changed or expanded to represent a broader representation of licensed dental professionals?

The ADSO would like to formally request that the Board of Dental Practice consider adding a dedicated spot on the board for a DSO-supported dentist. The landscape of dentistry is dramatically changing, much in part due to the continued evolution of the oral healthcare marketplace and the increasing prevalence of the dental support organization (DSO) practice model.

Our members represent a shift from the traditional model of solo dental practices to a more collaborative, network-based approach. DSOs provide non-clinical administrative and management services to dental practices, including marketing, staffing, billing, and purchasing. This support allows dentists to focus more on patient care than the business aspects of running a practice.

The data from the American Dental Association's Health Policy Institute could not be more straightforward; dentistry is changing drastically, and the growth trajectory of DSOs continues to accelerate. Private practice ownership continues to decline, from 84.7% in 2005 to 73% in 2021. 10.4% of U.S. dentists were affiliated with dental service organizations in 2019, up from 8.8% in 2017. Meanwhile, dental school seniors planning to join a DSO increased from 12% in 2015 to 30% in 2020.

Given these significant contributions and the evolving role of DSOs in dentistry, it is increasingly crucial for DSO-supported dentists to serve on state dental boards. Their presence on these boards ensures that a wide range of perspectives are heard, especially those that align with modern, evolving practices in dental health care. DSO-supported dentists can provide valuable insights into clinical efficiencies, technology integration, and innovative patient care models.

Furthermore, their inclusion can aid in developing well-informed regulations and policies that reflect the current state of dental practice and address critical access issues – such as improving utilization among rural and underserved populations. This is particularly relevant in discussions around licensing, practice standards, and patient care protocols, where the unique perspective of DSO-affiliated professionals can lead to more comprehensive and practical outcomes. Including these professionals on dental boards promotes diversity in expertise and perspective, crucial for advancing and adapting the dental profession in an ever-changing healthcare landscape.

Thank you for your time and consideration of this critical issue. Please let me know if you have any questions or if there is any additional information that ADSO can provide.

Sincerely,

Gray McGinnis
Vice-President Government Relations
Association of Dental Support Organizations

LD 1581
Proposed Sponsor's Amendment for Public Hearing
Proposed by Sponsor, Rep. Mastraccio
FOR HCIFS REVIEW

SPONSOR'S DRAFT COMMITTEE AMENDMENT:

LD 1581, An Act Regarding Dental Hygienists and Dental Therapists

[changes from original bill shown in bold italics and strikethrough]

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

Sec. 1. 32 MRSA 32 MRSA § 18302, subsection 38 is enacted to read:

38. Dental hygiene diagnosis. "Dental hygiene diagnosis" means the identification of an existing oral health problem that a dental hygienist is qualified and licensed to treat.

Sec. 2. 32 MRSA § 18322, subsection 1 is amended to read:

1. Membership; terms; removal. The board consists of ~~9~~ 11 members appointed by the Governor as follows:

A. Five dentists. Each dentist member must hold a valid dental license under this chapter and must have been in the actual practice of dentistry in this State for at least ~~10~~ 3 years immediately preceding appointment. A dentist is not eligible to serve as a member of the board while employing a dental hygienist or a denturist who is a member of the board;

B. ~~Two~~ Four dental hygienists. Each dental hygienist member must hold a valid dental hygiene license under this chapter and must have practiced in the State for at least ~~6~~ 3 years immediately preceding appointment. A dental hygienist is not eligible to serve as a member of the board while employed by a dentist who is a member of the board. One dental hygienist member may also hold a valid provisional or dental therapy practice authority and one dental hygienist member may also hold a valid expanded function dental assisting license;

C. One denturist. The denturist member must hold a valid denturist license under this chapter and must have practiced in the State for at least 6 years immediately preceding appointment. A denturist is not eligible to serve as a member of the board while employed by a dentist who is a member of the board; and

D. One public member. The public member must be a person who has no financial interest in the dental profession and has never been licensed, certified or given a permit in this or any other state for the dental profession.

Sec. 3. 32 MRSA § 18341, subsection 4 is enacted to read:

4. Basic Life Support. An applicant seeking an initial or a renewed license must include evidence of basic life support certification.

Sec. 4. 32 MRSA § 18350 is amended to read:

§18350. Continuing education

LD 1581
Proposed Sponsor's Amendment for Public Hearing
Proposed by Sponsor, Rep. Mastraccio
FOR HCIFS REVIEW

As a condition of renewal of a license to practice, an applicant must have a current ~~cardiopulmonary resuscitation~~ basic life support certification and complete continuing education during the licensing cycle prior to application for renewal. The board may prescribe by rule the content and types of continuing education activities that meet the requirements of this section.

Sec. *5* ~~1~~. 32 MRSA §18374, sub-§1, as amended by PL 2021, c. 223, §12, is further amended to read:

1. Scope of practice; direct supervision. A dental hygienist and faculty dental hygienist may perform the following under the direct supervision of a dentist:

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

Sec. 6. 32 MRSA §18374, sub-§1-A is enacted to read:

1-A. Scope of practice; general supervision. Under the general supervision of a dentist, a dental hygienist and faculty dental hygienist may administer local anesthesia, as long as the dental hygienist or faculty dental hygienist has authority to administer the medication pursuant to section 18345.

Sec. *7* ~~2~~. 32 MRSA §18374, sub-§2, as amended by PL 2021, c. 223, §12, is further amended to read:

2. Scope of practice~~; general supervision~~. A dental hygienist and faculty dental hygienist may perform ~~under the general supervision of a dentist~~ all of the activities that may be delegated to an unlicensed person pursuant to section 18371, subsection 3. A dental hygienist and faculty dental hygienist may also perform the following procedures ~~under the general supervision of a dentist~~:

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

A-1. Prescribe, dispense or administer fluoride, silver diamine fluoride, antimicrobial solutions for mouth rinsing, other nonsystemic antimicrobial agents, desensitizing agents and resorbable antimicrobial agents;

~~C. Apply desensitizing agents to teeth;~~

~~D. Apply fluoride to control caries;~~

F. Apply sealants;

J. Expose and process radiographs;

S. Perform all procedures necessary for a complete prophylaxis, including but not limited to scaling and root planing and periodontal maintenance;

~~U. Perform complete periodontal and dental restorative charting;~~

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

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

JJ. Place temporary restorations ~~as an emergency procedure, as long as the patient is informed of the temporary nature of the restoration~~ in compliance with the protocol adopted by the board; ~~and~~

TT. Smooth and polish ~~amalgam~~ restorations~~.~~;

~~ZZ. Administer local anesthesia, as long as the dental hygienist or faculty dental hygienist has authority to administer the medication pursuant to section 18345, subsection 2, paragraph D;~~

ZZ. ~~AAA~~. Perform dental hygiene assessment, dental hygiene diagnosis and dental hygiene treatment planning for dental hygiene services; and

AAA ~~BBB~~. Obtain impressions for and deliver athletic mouth guards and custom fluoride trays.

Sec. *8* ~~3~~. 32 MRSA §18375, sub-§1, as amended by PL 2017, c. 388, §§20 and 21, is further amended to read:

1. Scope of practice. An independent practice dental hygienist may perform only the following duties ~~without supervision by a dentist~~:

~~A. Interview patients and record complete medical and dental histories;~~

~~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 but not limited to scaling and root planing and periodontal maintenance;

~~F. Apply fluoride to control caries;~~

~~G. Apply desensitizing agents to teeth;~~

~~H. Apply topical anesthetics;~~

I. Apply sealants;

J. Smooth and polish ~~amalgam~~ restorations~~, limited to slow-speed application only~~;

L. Obtain impressions for and deliver 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;

~~O. Apply topical antimicrobials, including fluoride but excluding antibiotics, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The independent practice dental hygienist shall follow current manufacturer's instructions in the use of these medicaments;~~

P. Expose and process radiographs, including but not limited to vertical and horizontal bitewing films, periapical films, panoramic images and full-mouth series, ~~under protocols developed by the board as long as the independent practice dental hygienist has a written agreement with a licensed dentist that provides that the dentist is available to interpret all dental radiographs within 21 days from the date the radiograph is taken and that the dentist will sign a radiographic review and findings form~~ and provide the radiographs to a dentist as needed~~;~~ ~~and~~

Q. Prescribe, dispense or administer ~~anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse. For the purposes of this paragraph, "topical" includes superficial and intraoral application.~~ fluoride, silver diamine fluoride, antimicrobial solutions for mouth rinsing, other nonsystemic antimicrobial agents, desensitizing agents and resorbable antimicrobial agents;***and***

~~R. Administer local anesthesia, as long as the independent practice dental hygienist has authority to administer the medication pursuant to section 18345, subsection 2, paragraph D; and~~

R ~~S~~. Perform dental hygiene assessment, dental hygiene diagnosis and dental hygiene treatment planning for dental hygiene services.

Sec. *9* 4. 32 MRSA §18376, sub-§1, as amended by PL 2017, c. 388, §§22 and 23, is further amended to read:

1. Scope of practice. A public health dental hygienist may perform the following procedures in a public health setting ~~under a supervision agreement with a dentist that outlines the roles and responsibilities of the collaboration~~:

A. Prescribe, dispense or administer ~~anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse~~ fluoride, silver diamine fluoride, antimicrobial solutions for mouth rinsing, other nonsystemic antimicrobial agents, desensitizing agents and resorbable antimicrobial agents;

~~B. Apply cavity varnish;~~

~~C. Apply desensitizing agents to teeth;~~

~~D. Apply fluoride to control caries;~~

~~E. Apply liquids, pastes or gel topical anesthetics;~~

F. Apply sealants;

~~G. Apply topical antimicrobials, including fluoride but excluding antibiotics, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The public health dental hygienist shall follow current manufacturer's instructions in the use of these medicaments. For the purposes of this paragraph, "topical" includes superficial and intramuscular application;~~

I. Expose and process radiographs upon written standing prescription orders from a dentist who is available to interpret all dental radiographs ~~within 21 days~~ and who will complete and sign a radiographic review and findings form;

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

~~K. For the purposes of eliminating pain or discomfort, remove loose, broken or irritating orthodontic appliances;~~

~~L. Give oral health instruction;~~

~~M. Interview patients and record complete medical and dental histories;~~

~~N. Irrigate and aspirate the oral cavity;~~

~~O. Isolate operative fields;~~

P. Perform all procedures necessary for a complete prophylaxis, including but not limited to scaling and root planing and periodontal maintenance;

~~Q. Perform complete periodontal and dental restorative charting;~~

~~R. Perform dietary analyses for dental disease control;~~

~~S. Perform temporary filling procedures without a dentist present under protocols adopted by board rule;~~

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

~~U. Perform pulp vitality tests pursuant to the direction of a dentist;~~

~~V. Place and remove gingival retraction cord without vasoconstrictor;~~

~~W. Place and remove matrix bands for purposes of fabricating or placing temporary restorations;~~

~~X. Place and remove rubber dams;~~

~~Y. Place and remove wedges for purposes of fabricating or placing temporary restorations;~~

Z. Place temporary restorations in compliance with the protocol adopted by board rule;

~~AA. Remove excess cement from the supragingival surfaces of teeth;~~

~~BB. Retract lips, cheek, tongue and other tissue parts;~~

CC. Smooth and polish restorations~~, limited to slow-speed application only~~;

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

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

FF. Obtain impressions for and deliver athletic mouth guards and custom fluoride trays; and

~~GG. Take intraoral photographs.~~

HH. Perform dental hygiene assessment, dental hygiene diagnosis and dental hygiene treatment planning for dental hygiene services~~; and~~

~~II. Administer local anesthesia, as long as the public health dental hygienist has authority to administer the medication pursuant to section 18345, subsection 2, paragraph D.~~

Sec. *10* ~~5~~. 32 MRSA §18377, sub-§1, as amended by PL 2021, c. 223, §13, is further amended to read:

1. Scope of practice. A dental therapist may perform the following procedures in limited practice settings, if authorized by a written practice agreement ~~with~~ under the general supervision of a supervising dentist licensed in this State pursuant to subsection 3.

A. To the extent permitted in a written practice agreement, a dental therapist may provide the care and services listed in this paragraph only under the ~~direct~~ general supervision of the supervising dentist:

(1) Perform oral health assessments, pulpal disease assessments for primary and young teeth, simple cavity preparations and restorations and simple extractions;

(2) Prepare and place stainless steel crowns and aesthetic anterior crowns for primary incisors and prepare, place and remove space maintainers;

(4) Administer local anesthesia and nitrous oxide analgesia;

(6) Conduct urgent management of dental trauma, perform suturing, extract primary teeth and perform nonsurgical extractions of periodontally diseased permanent teeth if authorized in advance by the supervising dentist; and

(7) Provide, dispense and administer anti-inflammatories, nonprescription analgesics, antimicrobials, antibiotics and anticaries materials.

B. To the extent permitted in a written practice agreement, a dental therapist may provide the care and services identified in section 18371, subsection 3 and section 18374 under the general supervision of the supervising dentist.

Sec. *11* ~~6~~. 32 MRSA §18377, sub-§3, ¶B, as amended by PL 2019, c. 388, §10, is further amended to read:

B. A dental therapist may practice ~~only~~ under the ~~direct~~ general supervision of a dentist through a written practice agreement signed by both parties. A written practice agreement is a signed document that outlines the functions that the dental therapist is authorized to perform, which may not exceed the scopes of practice specified in subsections 1 and 2. A dental therapist may practice only under the standing order of the supervising dentist, may provide only care that follows written protocols and may provide only services that the dental therapist is authorized to provide by the written practice agreement.

Sec. 12. Review of membership. No later than January 31, 2028, the Board of Dental Practice shall review the membership of the board required in the Maine Revised Statutes, Title 32, section 18350, subsection 1 and make a recommendation for any changes in board membership to the joint standing committee of the Legislature having jurisdiction over licensing of dental professionals. The joint standing committee of the Legislature having jurisdiction over licensing of dental professionals may submit legislation based on the board's recommendation to the Second Regular Session of the 133rd Legislature.

Sec. 13. Staggered terms; Board of Dental Practice. Notwithstanding the Maine Revised Statutes, Title 32, section 18350, subsection 2, of the 2 additional dental hygienist members appointed to the Board of Practice as required by this Act, one member must be appointed to serve an initial term of 2 years and one member must be appointed to serve an initial term of 3 years.

SUMMARY

This amendment replaces the bill and makes the following changes to the laws related to the licensing and scope of practice of dental hygienists.

1. It adds a definition of dental hygiene diagnosis.
2. It removes general supervision from a dental hygienists' and faculty dental hygienists' scope of practice.
3. It changed the level of supervision from direct to general for dental hygienists who hold a local anesthesia practice authority.
4. It aligns the scope of practice procedures consistent with current practices of dental hygienists, including the practice authorities governing independent practice dental hygienists, public health dental hygienists, and dental therapists.
5. It removes a written practice agreement requirement for dental hygienists who hold a public health dental hygienist practice authority.
6. It changed the level of supervision from direct to general for the dental therapist practice authority.

7. It amends the life support certification for all individuals licensed by the Board to be basic life support instead of CPR certification.

The amendment also adds 2 additional members to the Board of Dental Practice who are dental hygienists and provides for staggered terms for their initial appointment. The amendment also requires the Board of Dental Practice to review the membership of the board and to make a recommendation for any changes in board membership to the Legislature no later than January 31, 2028. The Legislature is authorized to report out legislation based on the recommendation.

JANET T. MILLS
GOVERNOR

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

TRACEY L. JOWETT, RDH, ACTING CHAIR
KATHRYN WALKER NORRIS, RDH, EFDA, ACTING VICE CHAIR
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PENNY VAILLANCOURT
EXECUTIVE DIRECTOR

TESTIMONY OF

PENNY VAILLANCOURT, EXECUTIVE DIRECTOR
MAINE BOARD OF DENTAL PRACTICE

NEITHER FOR NOR AGAINST LD 1581

"An Act Regarding Dental Hygienists and Dental Therapists"

Sponsored by Representative Mastraccio

BEFORE THE JOINT STANDING COMMITTEE ON
HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

May 4, 2023 1:00 P.M.

Good afternoon Senator Bailey, Representative Perry, and Members of the Committee. My name is Penny Vaillancourt and I am the Executive Director of the Maine Board of Dental Practice. Thank you for the opportunity to provide testimony on LD 1581, as amended.

The Board of Dental Practice ("the Board") is a professional licensing board affiliated with the Department of Professional and Financial Regulation ("the DPFR"), and its sole purpose is to protect the public health and welfare of Maine citizens. The Board accomplishes this mission by ensuring that the public is served by competent and honest practitioners through its licensure process, conducting investigations into allegations of unprofessional conduct and imposing sanctions when deemed appropriate.

The Board is providing the following information to the Committee as it considers the intent and implications of this proposal which aims to align the various dental hygiene scopes of practice to reflect competencies required for dental hygienists who successfully complete the academic standards as well as the national and regional examination standards to ensure competent dental hygiene practice.

Legislative history:

Since 2016, the Board has worked closely with stakeholders in identifying statutory changes to the Dental Practice Act to increase licensure program efficiencies, stabilize funding, streamline licensure, align scopes of practice to reflect current delivery of care models, and to reduce barriers to otherwise qualified individuals to practice in their respective professions. That work has been largely successful, and the last remaining task was to bring forward a legislative proposal to align the dental hygiene scope of practice to reflect national academic and examination competencies required for licensure.

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Discussion of LD 1581 – April 14, 2023 Board Meeting:

At its April 14th meeting, the Board discussed LD 1581 including a potential amendment that would make further changes to dental hygiene supervision and would add two new dental hygiene seats to the Board's membership increasing the number of seats from nine members to eleven members.[1] The discussion reflected general support but with some members wanting more time to consider all of the changes and some members not supportive of adding two dental hygiene seats to the Board. Below are highlights of that discussion of the four board members in attendance:

- Consistent scopes of practice: Support to make consistent the various scopes of practice for dental hygiene practice, including the advanced practice categories of independent practice dental hygiene ("IPDH"), public health dental hygiene ("PHS") and dental therapy.

- Clarifies scope of practice to include periodontal maintenance: Support so long as there is a dental diagnosis of periodontal disease documented in the patient's file who receives periodontal maintenance treatment by a dental hygienist.

- Change in local anesthesia supervision: Supports the change in supervision from direct to general so long as the baseline life support certification is increased for all licensees to be Basic Life Support Certification for Healthcare Providers.

- Changes in supervision; repeal of practice agreements; repeal of 21 day agreements: Notwithstanding a request for more time to consider the implications of the change, the Board did not object to removing general supervision of dental hygienists, changing supervision of dental therapists from direct to general, repealing the 21-day agreement requirement for both IPDH and PHS practice when taking dental radiographs, or repealing the practice agreement requirement for PHS practice.

  There was discussion of three common scenarios in which the current Dental Practice Act prohibits a dental hygienist from either working or providing dental hygiene services without obtaining general supervision of a dentist to which LD 1581 as amended would allow:

  - A dental hygienist wishing to volunteer services at charitable events such as the Maine Summer Special Olympics;
  - A dental hygienist wishing to work in a school setting as part of a school oral health program; and
  - A dental hygienist continuing to provide hygiene services to patients in a dental clinic that temporarily lost a dentist staff member.

- Changes to Board Membership: Notwithstanding objections and/or concerns raised with adding two new dental hygiene members to the Board as noted earlier, there was recognition by one board member to have board membership reflect more broadly those dental professionals regulated by the Board.

[1]. Current Board membership is five dentists, two dental hygienists, one denturist, and one public member ref: 32 M.R.S. § 18322(1).

Technical changes to the amendment:

1. Further amend Section 2 – 32 MRSA § 18322, sub-§1(C) of the amendment to make consistent the eligibility requirements for board members:

> ***C. One denturist. The denturist member must hold a valid denturist license under this chapter and must have practiced in the State for at least ~~6~~ 3 years immediately preceding appointment. A denturist is not eligible to serve as a member of the board while employed by a dentist who is a member of the board; and***

2. Correct citation on Section 6 – 32 MRSA § 18374, sub-§1-A should read:

> ***1-A. Scope of practice; general supervision. Under the general supervision of a dentist, a dental hygienist and faculty dental hygienist may administer local anesthesia, as long as the dental hygienist or faculty dental hygienist has authority to administer the medication pursuant to section 18345, subsection 2, paragraph D.***

3. Further amend Section 7 – 32 MRSA § 18374, sub-§2(ZZ), Section 8 – 32 MRSA § 18375, sub-§1(R), and Section 9 – 32 MRSA § 18376, sub-§1(HH) to reflect the full range of dental hygiene competencies as noted by the American Dental Education Association and the American Dental Hygiene Association as follows:

> ***Perform dental hygiene assessment, dental hygiene diagnosis and dental hygiene treatment planning, and implementation in the identification, prevention and management for oral disease ~~for dental hygiene services~~***

4. Amend Section 7 – 32 MRSA § 18374, sub-§2(A-1), Section 8 – 32 MRSA § 18375, sub-§1(Q), and Section 9 – 32 MRSA § 18376, sub-§1(A) to include the following:

> ***Prescribe, dispense or administer ~~anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse. For the purposes of this paragraph, "topical" includes superficial and intraoral application.~~ fluoride, silver diamine fluoride, antimicrobial solutions for mouth rinsing, other nonsystemic antimicrobial agents, desensitizing agents, topical anesthetics and resorbable antimicrobial agents;***

Again, thank you for the opportunity to comment. I would be happy to answer any questions now or at work session.

Joint Statement from the Maine Dental Association and the Maine Dental Hygienists' Association Regarding

LD 1581: An Act Regarding Dental Hygienists and Dental Therapists

Senator Bailey, Representative Perry and members of the Committee on Health Coverage, Insurance and Financial Services, on behalf of both the Maine Dental Association and the Maine Dental Hygienists' Association, we would like to offer the following joint statement regarding LD 1581. We thank you for reading this statement and for providing the catalyst for our two organizations to come together in a way we are not used to. Anyone who has worked in Augusta for any period of time, or watched legislation related to dental practice in Maine should find it notable that our two organizations are offering joint testimony. We are optimistic that this has provided the opportunity for our groups to work together more closely.

Following the public hearing regarding LD 1581 a lot of information has become available and we convened a meeting of leadership representing the MDA and the MDHA. This meeting was fruitful and provided us, as both representatives of, and experts on oral health for the State of Maine, the chance to discuss this legislation to better understand each other's positions and work together to find a compromise. As this bill pertains to the way in which our professions practice, and we are the stakeholders who hold expertise in this field, we believe a great deal of deference should be given to the positions outlined below.

First, as this bill addresses the scope of practice of dental hygienists, we believe these changes are in keeping with the education that dental hygienists receive. These changes would allow dental hygienists in Maine to practice to the full extent of their education and provide care to Mainers that are in need of dental care. Given workforce shortages, especially in dental care, allowing dental hygienists to practice to their level of education frees up other staff resources. We support this section of the legislation together.

Second, in regard to the scope of practice and supervision of dental therapists, likewise, we believe these changes are acceptable. When Maine established its model for dental therapists, much was unknown as to the education of this new practitioner type. As accreditation standards have been adopted and the model has become more widespread, we believe that Maine should follow the pattern adopted by many other states and make the changes to the supervision requirements LD 1581 provides.

The collaborative practice agreement and the requirement of 2000 hours of experience before general supervision is permissible provide for the standard of care we believe is necessary. Removal of the original practice requirements will expand access to care. Again, we support this section of the legislation together.

Lastly, both our organizations oppose the changes to the Board of Dental Practice composition as the amendment to this bill proposes. It is our understanding that the changes to the board of Dental Practice were made in response to the elimination of the Subcommittee on Dental Hygienists. It is our position that the Subcommittee should be reinstated as soon as possible and should be given more autonomy when it comes to the practice of dental hygiene. If it is not legislatively possible to reinstate the Subcommittee at this time, we believe a task force should be convened to work towards the end goal of an increase in self-regulation while still remaining part of the Board of Dental Practice as it is currently constituted. We do not believe that there should be any addition of board members. We do not believe that adding members, be they dentists, hygienists or other members furthers the boards mandate of protection of the public. We see changing the composition of the Board of Dental Practice as being unaligned with dental boards around the country and other professional boards in the State of Maine.

Our organizations have reached the positions above after much thought and deliberation. As we have stated, we represent the stakeholders to this legislation and while we respect that the disposition of this legislation is up to this committee, we hope that you will take into consideration the expressed joint opinions we have shared here.

Thank you for your consideration and thank you for bringing our organizations together.

Traci Dempsey, RDH, IPDH, MDHA President
Norma Desjardins, DMD, MDA President
Lorraine Klug, RDH, IPDH, MDHA Immediate Past President
Michael Dowling, DMD, MDA Government Relations Chair
Therese Cahill, Executive Director, MDA

Maine Board of Dental Practice Strategic Planning Workshop

Highlight Notes

February 11, 2022, The Ice Vault, Hallowell, Maine

These notes were taken mostly on the spot by facilitator Craig Freshley. They are not a complete record of what was discussed and they have not been checked for accuracy or approved by the Board.

About the Retreat

Attendance

1. Dr. Zajkowski
2. Tracey Jowett, RDH
3. Dr. Scholl
4. Dr. Davis
5. Dr. Walawender
6. Dr. Ray
7. Lourdes Wellington, Public Member
8. Mike Adkins, Denturist Subcommittee Member
9. Commissioner Anne Head
10. Penny Vaillancourt, Board staff
11. Kerrie Ingram, Board staff
12. Craig Freshley, Facilitator
13. Members of the public

Focus of the Retreat

This workshop presented an excellent opportunity for the Board to discuss big picture systemic issues that we don't normally have a chance to discuss. In planning the retreat we identified several topics that would of great value for the board to discuss and/or resolve. In fact, we figured to have about twice as much to talk about as we actually have time to talk about. As a result we designed a retreat to focus on the four most important things at this time:

- Emergency Preparedness in the Future
- Consumer Complaints
- Emerging Regulation and Practice Issues
- Organizational Development

It was expectation to come to conclusions on each of these topics and that our conclusions would provide guidance to the Executive Director as she prepares the Draft Strategic Plan, and will also provide guidance to the Commissioner as she makes larger and longer term plans.

So that the workshop was inclusive, collaborative, and efficient, it was professionally facilitated by Craig Freshley of Good Group Decisions based in Brunswick. Craig has facilitated previous workshops of the Board and worked with Dr. Mark Zajkowski, Tracey Jowett, and Penny Vaillancourt to develop this agenda. In addition to planning and facilitating the workshop, Craig also prepared these notes.

Agenda

8:50 **Arrival and Refreshments**

9:00 **Opening**
Dr. Mark Zajkowski will welcome the group and offer some opening remarks. Penny Vaillancourt will say a few words and introduce facilitator Craig Freshley who will explain the workshop format. We will do some quick introductions and give everyone a chance to say hello.

9:20 **Emergency Preparedness for the Future**
- Let's imagine we receive word that a brand new pandemic is going to hit us in 2027, five years from now. We know it's coming. Weird, but just pretend.
    - Here's the question: ***What should the Maine Board of Dental Practice do to prepare for such an emergency?***
- We will answer this question first by writing our individual ideas and then we will put them all up on the wall. We will discuss and organize all the ideas.
- We will come to conclusions about the top steps to be taken.
- Even though a hypothetical exercise, this will help us be better prepared for any type of future crisis.

9:50 **Emerging Regulatory and Practice Issues**
- What are the leading emerging and regulatory practice issues that the Board should make plans for?
- We expect to start with this open-ended question and we anticipate discussing things such as our relationship with the legislature, scope of jurisdiction, and related.

10:40 **Break**

11:00 **Consumer Complaints**
- We will ask ourselves: **Does the complaint process protect the public and is it fair for licensees?**
- We will explore various aspects of this question and explore other questions related to how the Board handles complaints.
- We expect to come to conclusions about how to improve investigations, enforcement, anesthesia, specialties, and related.

12:30 **Lunch**

1:20 **Organizational Development**

To meet current and future demands, it's clear that the Maine Board of Dental Practice needs to ramp up capacity along the following lines:

- Staff Capacity
  - Add new positions
    - Dental Director
    - Complaint Coordinator
  - Improve investigations and other functions
- Financial Resources
  - Adequate resources required to implement the plans we are making
- Board Development
  - Board member onboarding
  - Role of the subcommittees
- We will also ask if there are any other organizational development issues to be discussed by the Board.

2:30 **Vision, Emerging Issues, Other**

- We expect to review the 2017 Vision Statement and discus if it should be revised.
- As time allows we might also discuss Emerging Issues, Special Projects, and/or other topics to be addressed in our Draft Strategic Plan.

3:00 **Break**

3:20 **Reflections from the Commissioner**

Commissioner Anne Head plans to offer some reflections and encouragement.

3:50 **Closing Comments**

This is a chance for each person to say a brief last word; perhaps a reflection about the workshop or a particular hope going forward.

4:00 **Adjourn**

Ground Rules

- The answers are among us
- Hands to speak
- Minimize distractions
- Seek common ground

- Name tensions
- Flexible agenda
- Discussion among board and staff
- Themes and conclusions now and later
- Neutral facilitation and reporting

Emergency Preparedness for the Future

Set up

Let's imagine we receive word that a brand new pandemic is going to hit us in 2027, five years from now. We know it's coming. Weird, but just pretend.

What should the Maine Board of Dental Practice do to prepare for such an emergency?

Craig asked participants to write answers to these questions which we then discussed and organized on the wall as follows. See photo below.

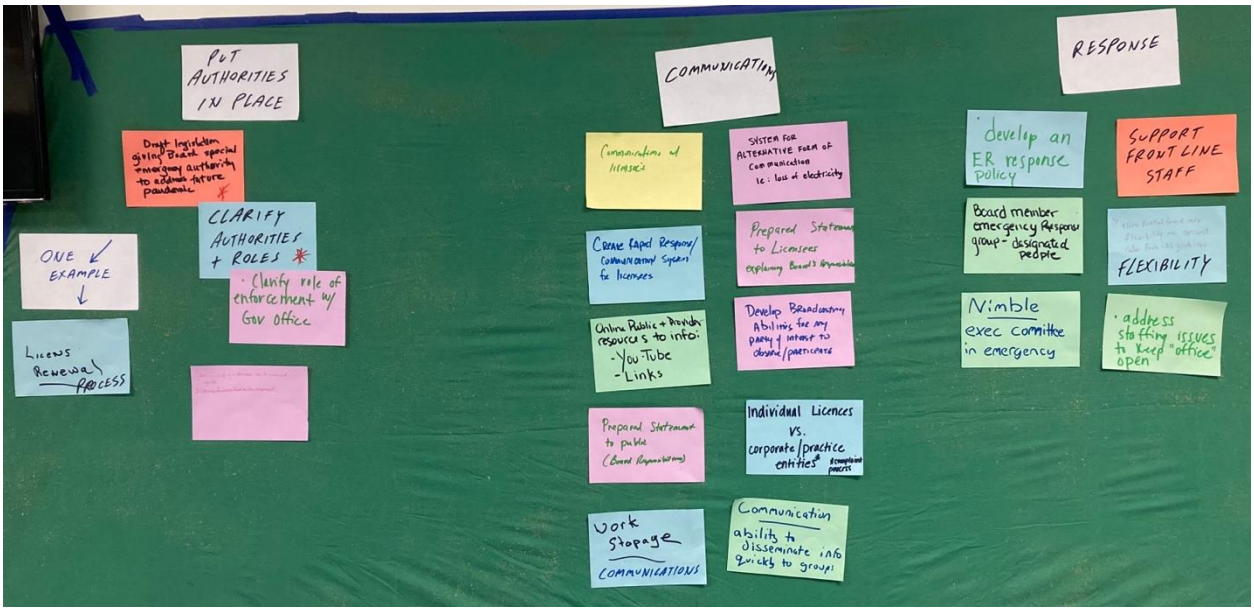
Answers

- Get authorities in place in advance
    - Draft legislation giving board special emergency authority to address future pandemic
        - Clarify authorities and roles [starred]
            - Clarify role of enforcement with government office
        - One Example
            - License renewal process
    - Use COVID guidelines as a current guide

- Communications
    - Communications with licensees
    - System for alternative form of communications ie. Loss of electricity
    - Create rapid response communication system for licensees
    - Prepared statement to licensees explain board's responsibilities
    - Online public and provider resources to info
        - YouTube
        - Links
    - Develop broadcasting abilities for any party or interest to observe/participate
    - Prepared statement to public (Board responsibilities)
    - Individual licenses VS. Corporate/practice entities (if complaint process)
    - Work stoppages affect communications

- Communication – ability to disseminate information quickly to groups

- Response
  - Develop an ER response policy
  - Support front line staff
  - Board member emergency response group – designated people
  - Allow dental board more flexibility on current rules from CDC Guidelines.
  - Nimble executive committee in emergency
  - Address staffing issues to keep "office" open



Emerging Regulatory and Practice Issues

Craig asked the following question and facilitated a discussion of answers: **What are the leading emerging and regulatory practice issues that the Board should make plans for?**

Initial Ideas

- Tele-dentistry
  - Lots of issues to be worked out
- The role of corporate dentistry
  - Regulating entities (companies, dental school) not just the licensee
- Mail-in Dentistry
- Access to care
  - Need to be careful that restricting trade does not restrict access to care

- Expanding scope of all license categories and advertising
- Changing delivery of care models
- Licensure mobility and pathways to licensure
    - The Board needs to be prepared for this
- Anesthesia
    - Regulating the permitting and delivery
        - An adverse event would not work well in our current process

How to regulate corporate entities

- Ideas
    - Regulate all "practice," rather than just licensees
    - Provide more authority to regulate entities
    - Refer corporate cases to another entity that regulates entities
    - License facilities in addition to individuals
    - What we want to address
        - Some authority to handle ethical and business-related issues
    - Licensing/regulating more entities could generate income
    - Inspections for health and safety is the biggest lift
    - Other states require a facilities license and a license for each practitioner/administrator
    - It would be good if we had a model that doesn't limit access to care, such as another practitioner taking responsibility for health and safety when "the dentist is out"
    - Need to consider that all entities are not the same
        - Different sizes
        - Serving different populations
    - Need to protect the public AND provide access
    - Need to be careful not to "scare away" practitioners
- Conclusion

  There was general agreement on the following:
    - We need to put things in place so that dental practice entities are more fully regulated
- Next steps
    - Penny will collect and bring best practices for the Board to consider
    - The legislative timing is now
        - We need prepare legislation quickly

Ideas about licensure mobility and pathways to licensure

- The Board needs to be prepared for upcoming changes
- We need to be able to recognize licenses in other states without delay
- We need to have continuing and growing influence in the Legislature
    - This requires collecting and presenting data
- How the board can help

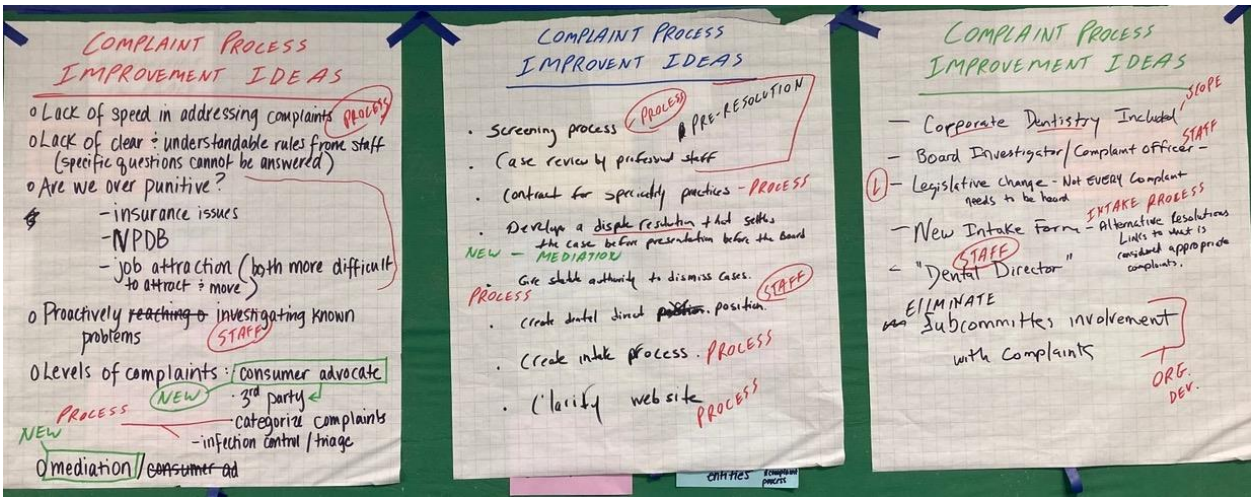
- Spend time at Board meetings getting briefed on what's happening and what's coming
- Universal license process or compact license process

Consumer Complaints

Craig asked the following question: **Does the complaint process protect the public and is it fair for licensees? How could it be improved?**

First Ideas

Participants considered answers to the above questions as individuals, then in pairs, then in small groups. Answers were jotted by three small groups. See photo.



Organized Ideas

As a group we discussed the comments and Craig labeled some in red on the spot and later organized them as follows:

- Process Improvement Ideas
  - Address lack of speed in addressing complaints
  - Address lack of clear and understandable rules from staff (specific questions cannot be answered)
  - Improve screening process
    - Pre-Resolution
    - Case review by professional staff
    - Develop a dispute resolution that settles the case before presentation before the board

        - Give staff authority to dismiss cases
            - Legislative change – not every complaint needs to be heard
    - Categorize complaints
        - Infection control / triage
    - Clarify website
    - Establish a new intake process
        - New intake form
            - Alternative resolutions links to what is considered appropriate complaints.

- New Creation Ideas
    - Third party consumer advocate
    - Mediation

- Staff Capacity Ideas
    - Dental Director
        - Create dental director position
    - Board investigator/Complaint officer
        - Proactively investigate known problems
    - Contract for specialty practices

- Organizational Development Ideas
    - Eliminate subcommittees involvement with complaints

- Other Ideas
    - Include Corporate Dentistry
    - Are we over punitive?
        - Insurance issues
        - NPDB
        - Job attraction (both more difficult to attract and move)

Discussion

- It's important that staff don't answer questions that staff are not qualified to answer
    - Unfortunately, people are unsatisfied that staff can't answer but rather are deferred to their dental leaders

- Top Topics
    - Staffing
    - Intake process
    - Pre-screening with multiple pathways to resolution
    - Consider providing some sort of a consumer advocate
    - Reconsider how punitive we are
    - Scope of jurisdiction to include entities
    - Re-organize to eliminate sub-committees

Pre-screening with Multiple Pathways to Resolution

Potential Categories of Complaints

1. Patient Care
2. Fee disputes
3. Communication disputes between patients and dentists
4. Infection control
5. Substance use
6. Patient abandonment/ practice closure
7. Financial
8. Criminal conduct
9. Providing patient records
10. Unlicensed practices
11. Unrelated

Potential Paths

- One Idea – Five Paths
  - Letter of Guidance
  - Send it mediation (might require statutory change)
  - To the Full Board
  - Dismissal by staff (would require statutory change)
  - Consent agreement

- Another Idea – Two Paths
  - Has merit
    - Go to the Board
  - No Merit
    - Staff decide

How

- A staff team reviews cases and decides whether it gets dismissed
  - Someone needs to be on the team with dental expertise
  - There would need to be some guidance from board

- Provide more clarity and guidance at the website
  - Require more steps so the complaints are more on target and better defined
    - It's an indirect way to categories

To Initiate New ways

- Delegation Orders from the Board could allow staff to have more authority

- For some issues, change the law

Conclusions

Next steps

- Ask staff for a recommendation
- Ask the different types of licensees for input on how it should work

General agreement

There was general agreement with the following:

- We want to streamline the complaint resolution process as follows:
    - Filter the intake
    - Insulate the board
    - Hire an investigator
    - Maintain public confidence and public health

Organizational Development

To Discuss

- Add new positions
    - Dental Director
    - Complaint Coordinator
    - Improve investigations and other functions

- Financial Resources
    - Adequate resources required to implement the plans we are making

- Board Development
    - Board member onboarding
    - Role of the subcommittees

- Other Issues
    - Anything else?

Current situation

- We are doing fine on the Licensing side
- We are struggling and losing ground on the Complaint side
- Board Investigator position is vacant and hopefully will be funded in the next budget
    - This person needs to be a nurse and out in the field
- Full time compliance review is needed

- The current staffing situation is unmanageable
    - The shoulders of the staff are heavy
- Relocating physical space is a big deal
- Other boards have larger professional staff

Proposals for Improvements

- Add staff capacity
    - Board Investigator (currently established but unfunded)
    - Dental Director (not full time)
    - Reclassify current three positions to be more competitive

- Streamline administrative burden
    - Eliminate the subcommittees

- Increase Revenue
    - Increase fees

- Reclassify ourselves from an Affiliated Board to an Umbrella Board
    - Umbrella boards share admin and overhead
        - More financial security if in financial difficulties
    - Affiliated boards have total independent regulatory authority

Discussion about Elimination of the Subcommittees

- Would save administrative burden
- Would free up $10k or so
- Eliminating the dental hygiene subcommittee would
    - decrease hygienist representation on the board
    - impact access to health care – which is often championed by hygienists
- Idea – add another seat on the board for a dental hygienist
    - Could be added
    - Could change a dentist seat to a hygienist seat when it becomes vacant
- Denturist committee will meet whether or not formally constituted by the Dental Board
- Don't see how adding a tenth board member adds to efficiency or helps access to care
- The number of complaints handled by subcommittees are small, and so eliminating them makes sense
- There's an optics issue if we were to eliminate the hygienist subcommittee without adding a hygienist seat on the board. It looks like decreasing representation.
- This board should not be restricting any trade in any way, and shouldn't appear so

Discussion about Board Development

- Recent experiences
  - Staff reached out to help me – it was good
  - It was horrifying – didn't work well
  - I like knowing the history
    - I like knowing the precedents

- Ideas for improvements
  - Make as level a playing field as possible
  - Assign mentors
    - Former board members mentor current board members?
  - Basic training about the board role
  - Develop a board manual
    - Show all the organizations that this organization works with
  - Develop video training modules
  - Have a program of ongoing training for board members, not just when they join

Discussion of Financial Needs (in addition to staffing)

Needs

- Training for staff
- Technology
  - Complaint dashboard
  - Enhancing our existing system
- Website
- Professional development for board members
- Capital improvements
  - Our current space is becoming inadequate

Discussion

- Consideration of pros and cons of getting revenues from fees vs. getting fees from the general fund
- Idea: Charge fees to entities once we put in place a framework to regulate entities
- Idea: sliding fees

Conclusion

- General agreement that we should raise fees in order to pay for the above improvements, including increasing staff capacity
  - Fee increases should be equitable to all licensing types
    - Look at potentially increasing the cap on hygienist fees

- Look especially at the fees for Dental Residencies
- Use BLS Salary data as the basis

Vision Statement

Current

In 2021, the Maine Board of Dental Practice has an extremely positive and trustworthy reputation, statewide and nationally, for ensuring public safety through the fair and consistent application of Maine laws and rules. The Board is the go-to resource for accurate information and clear expectations about the practices it regulates. Its work is highly efficient and user-friendly. Members of the Board are trusted and respected for their integrity and commitment to public service. Staff are highly competent and well-regarded. Funding is adequate to support continuous development and ongoing work required to achieve this vision.

Comments

- We have achieved this vision, except maybe that last line about funding.
- We could ask for feedback at the website: how are we doing on this vision?
- We could ask when licensees renew their licenses
- How about a newsletter from the board to licensees?
    - It would help people understand our role
    - What we do and don't do
    - We could explain how we are funded

Conclusion

- General agreement on the Vision Statement for the next five years.
- Same language. Change the date to 2027.

Commissioner's Remarks

Presentation

- Compliments and Thank Yous
    - I compliment every person in this room for the work you are doing
    - You have come here today to discuss these really important topics
    - You should be very proud of the transformation of this board
    - I have a unique role with this board. Thank you Penny.

- Financial Planning
    - Price out what each function costs you today and what it will cost in your preferred future
    - If you do not ask for new positions in the next budget cycle, you will not get them. Ask for what you need
    - It is important to do it now
    - Look five years into the future

- Relations with the Legislature
    - The Legislature may have the perception that licensing boards "protect their own" rather than " protecting the public
    - The Legislature is in charge
        - the Board must make its needs and opinions known to legislators
    - Universal licensing is a big topic now
        - The Commissioner introduced an alternative bill
    - Boards like this one and others are funded by fees so their operating funds are not under direct control of the Legislature

- Last Words
    - Be open minded
    - Consider worse case scenarios
    - On-boarding of new board members is really critical
    - Thank you

Discussion

- The best defense is a good offense
- The legislature wants to allow providers to come here and work immediately, and that's good, yet it needs to be balanced with protecting the public.

Closing Comments

- Really excited about topics we discussed, such as transparency and education
- Happy to be part of this
- Great appreciation for board staff
- Always a pleasure working with this group
- Lots of respect for everyone here
- Pleased with the progress we've made
- This exceeded expectations
- Thanks for the agenda planning
- Everyone here is very welcoming
- Excited for the next steps
- Relieved and excited
- Thanks to Penny for this opportunity

- This type of gathering helps us excel
- Very hopeful
- Thanks to everyone
- We don't want anyone to lose the trust of this place
- Love to be part of this group
- Hopefully this has been good for new members
- "It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat."
    - Theodore Roosevelt

Board of Dental Practice – Talking Points on Proposed Legislation
Elimination of Subcommittees on Dental Hygiene and Denturist
September 27, 2022

"An Act to An Act to Include the Board of Dental Practice as a Licensure Program within the Office of Professional and Occupational Regulation"

Background to the Proposal: At its strategic planning session held on February 11, 2022, the subcommittees and full board met to discuss a variety of topics in preparation for the next Government Evaluation Act report, including organizational development/restructuring. There was discussion to increase staff capacity, streamline the administrative burdens, increase revenue, and reclassify the Board as an affiliated board to an umbrella board under OPOR.

Talking Points Specific to the Elimination of the Subcommittees:

- Statutory authority: subcommittees have authority to perform initial reviews of applications, initial reviews of complaints and continuing education submissions and vote out those recommendations to the full Board for adoption. The Board has adopted all recommendations and has not rejected a subcommittee's recommendation since at least 2014.

- Legislative and rulemaking involvement: subcommittees are represented on the Board's rulemaking committee, which was created to bring forward recommended rules changes to the Board for consideration. Most recently, the Board has been utilizing a more robust stakeholder process involving not only subcommittee members, but members of the professional associations for dentists, dental hygienist and denturists.

- Membership: subcommittees are comprised of five members each – three of which are current board members appointed by the Chair, and two are members of the respective professions appointed by the Governor. The Dental Hygiene Subcommittee has not had two additional dental hygiene members since 2018(?). The Denturist Subcommittee has one additional denturist member.

- Meetings; agendas: subcommittees rarely meet – the denturist met twice during the last fiscal year and the dental hygienists met four times. The agenda items are usually minutes, an application review and an occasional complaint review. Most of the complaint cases are filed against a dentist – there is only one active case filed against a dental hygiene member out of a caseload of 161 active cases.

- Fiscal/Process efficiencies: subcommittee per diem costs is approximately $10,000 biennially. There are additional staffing and legal resources expended on the subcommittees to support the organizational structure beyond scheduling monthly meetings. The licensure process is inefficient and overly cumbersome for applicants to have to go through two review processes and for consumers and licensees to have their complaint cases heard by two separate tribunals.

- Other: the establishment of the subcommittees was a result of legislative compromise to address concerns raised by the dental hygiene and denturist professions that the Board was restricting their trade by proposing and adopting rules that were beneficial to the dentist profession. Since that time, the Board has undergone significant and substantial organizational changes, including the hiring of professional staff (executive director and board investigator) and removed all scopes of practice provisions out of board rulemaking and into its governing practice act. Consequently, the Board's role today is very focused on its rulemaking authority, investigating complaint, conducting adjudicatory hearings and imposing discipline when deemed appropriate.

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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G	*Public Health Supervision Data (Maine Board of Dental Examiners)*
H	*Draft Legislation—Independent Practice Dental Hygienist (Prepared by DPFR Staff)*

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.

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.

Prepared by Department of Professional and Financial Regulation

Sunrise Report on Oral Health Issues

February 15, 2008