STATE OF MAINE
BOARD OF DENTAL PRACTICE
143 STATE HOUSE STATION
AUGUSTA, MAINE
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Program Evaluation Report

As Required by the Government Evaluation Act
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Submitted to the

Joint Standing Committee on
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BOARD OF DENTAL PRACTICE

Program Evaluation Report

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Board of Dental Practice Overview

The Board of Dental Practice ("the Board") is a licensing program affiliated with the Department of Professional and Financial Regulation. The Board is a nine-member regulatory body comprised of 5 dentists, 2 dental hygienists, 1 denturist, and 1 public member. The Board's regulatory structure includes two subcommittees, a Dental Hygienist Subcommittee, and a Denturist Subcommittee. Each subcommittee is a five-member panel comprised of three Board members and two members from each of the profession regulated by the subcommittee. All members are appointed by the Governor.

Board's Mission

The Board's sole purpose as established by Title 5, section 12004-A, subsection 10, is to protect the public health and welfare. The Board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the profession regulated by the Board by testing, licensing, regulating, and disciplining practitioners of those regulated professions.

The Maine State Legislature has given the Board statutory authority to hold hearings, take evidence, and issue subpoenas as part of its proceedings. The statute mandates that the Board investigate complaints; adopt fees that are reasonable and necessary; submit a budget to the Commissioner; appoint an executive director; delegate to staff authority review and approve applications; establish protocols for the operation of a professional review committee; order a licensee to submit to an examination when a determination that a physical illness, a mental illness or the use of intoxicants or drugs prevents the licensee from practicing competently or safely to patients; and adopt rules that are necessary for the implementation of the Maine Dental Practice Act. The subcommittees are authorized by statute to perform initial reviews of complaints, perform initial reviews of applications for licensure, and report recommendations to the Board for final action.

Dental professions regulated by the Board include dentistry, dental hygiene, denturism, expanded function dental assisting, and dental radiography. The Board also issues practice authorities to qualified dental hygienists in the following areas: dental therapy, independent practice dental hygiene, public health dental hygiene, use of nitrous oxide analgesia, and the administration of local anesthesia. Lastly, the Board issues permits to qualified dentists who provide sedation and general anesthesia services to patients when performing dental procedures.

The Board is a dedicated revenue agency, which means that it relies solely on fees collected from the regulated community of dental professionals to meet its statutory mandates. The Board does not receive funding from any other source, nor does it receive an allotment from the general fund.

A. Enabling or Authorizing Law

The Board of Dental Practice is authorized through the following sections of Maine law:

Title 1, Chapter 13 "Freedom of Access Act"

Title 5, Chapter 149 "Budgets":
§ 1665 "Budget estimates"

Title 5, Chapter 375 "Maine Administrative Procedure Act"

Title 5, Chapter 379 "Boards, Commissions, Committees and Similar Organizations":
§ 12004-A(10) "Board of Dental Practice"

Title 10, Chapter 901 "Department of Professional and Financial Regulation":
§ 8001-A: "Department; affiliation"
§ 8003(5): "Authority of bureaus, offices, boards or commissions"
§ 8003-A: "Complaint investigation"
§ 8003-B: "Confidentiality of investigative records"
§ 8003-D: "Investigations; enforcement duties; assessments"
§ 8003-E: "Citations and fines"
§ 8005: "Compliance with support orders, license qualifications and conditions"
§ 8005-A: "Licensees not in compliance with court ordered fine, fee or restitution; license qualifications and conditions"
§ 8006: "Licensees not in compliance with court of support and other court orders; enforcement of parental support obligations and suspensions"
§ 8011: "Veterans and military spouses"

Title 24, Chapter 21 "Maine Health Security Act"
§ 2502(4-A): "Professional review committee"

Title 32, Chapter 143 "Dental Professions"

Title 36, Chapter 7 "Uniform Administrative Provisions"

45 C.F.R. Part 60 "National Practitioner Data Bank"

B. Description of Program

The Board was established in 1891 to protect the public health and welfare by seeking to ensure that the public is served by competent and honest practitioners. This is done by establishing minimum standards of proficiency, and by examining, licensing, regulating and disciplining those who practice in the profession. The primary responsibilities of the Board are to license qualified applicants; promulgate rules; investigate allegations of unprofessional conduct and incompetent practice; and impose disciplinary sanctions when deemed appropriate.

The Dental Practice Act has evolved through a series of legislative changes and below are highlights of those statutory changes:

1891: "Board of Examiners" was created consisting of "five dentists of good standing" to regulate dentistry in this State such that an individual must be licensed by the Board to practice dentistry.

1917: The licensure category of "dental hygienist" was created to regulate individuals working under the supervision of a dentist. The statute was amended again in 1975 to add a dental hygiene member and a public member to the Board.

1983: The licensure category of "dental radiographer" was created to regulate individuals who use ionizing radiation on patients while under the supervision of a dentist.

1993: Additional licensure categories to practice dentistry with varying limitation on scopes of practice were created to regulate individuals practicing as a resident dentist, dental student extern, charitable dentist, and clinical educator. The statute was further amended in 2011 to include the regulation of individuals practicing as a limited dentist and a faculty dentist.

1997: The licensure category of "denturist" was created to regulate individuals practicing denturism. The statute was amended again in 2002 to add a denturist member to the Board.

2005: The licensure category of expanded function dental assistant and public health hygiene were created.

2007: The licensure category of independent practice dental hygiene was created to regulate individuals practicing dental hygiene without requiring the supervision of a dentist. In 2013, an additional dental hygiene licensure category was created to regulate individuals practicing dental hygiene therapy. In 2019, the practice category was further amended and identified as the practice of dental therapy.

2016: Title 32, Chapter 16 "Dentists and Dental Hygienists" was repealed and replaced with Title 32, Chapter 143 "Dental Professions." The new chapter clarified the Board's regulatory authority, removed duplicative statutory language, streamlined the licensing provisions, and streamlined existing scopes of practice. Subsequent amendments have occurred in 2017, 2018 and 2019 to further clarify licensure categories and scopes of practice.

The Board is staffed by an executive director, an executive secretary, a board assistant and an investigator who are responsible for administering all regulatory functions associated with the Board including the issuing of licenses to qualified applicants, investigating consumer complaints, conducting inspections and serving as a resource to its regulated professionals, consumers, employers, educational institutions, professional associations, and the general public. The Board's powers and duties are enumerated in 32 M.R.S. § 18323 and the duties of the Board's executive director are found at 32 M.R.S. § 18323(6).

In 2014, the Board began a comprehensive review of its organizational structure, staffing needs and processes involving board meetings, rulemaking, licensing, rulemaking, and consumer complaints. To coordinate that review, the Board convened its "first-ever" workshop in the summer and fall of 2016, with the assistance of a facilitator to analyze its strengths, weaknesses opportunities and threats. This analysis produced the Board's vision statement and set into motion a phased approach to accomplishing it goals by 2021. The Board's Final Report dated October 7, 2016, is found in Attachment A.

Vision Statement

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 the work required to achieve this vision.

The Board has since identified a strategic plan to achieve its vision by setting goals, prioritizing its work and mapping out phases of implementation. The phases of implementation include: develop legislative initiatives; adopt rulemaking proposals as necessary; increase efficiencies to the licensure and consumer complaint case processes; educate consumers and the regulated community with effective communication strategies; and identify funding and staffing levels necessary to maintain current level of services in the most efficient manner possible. To date, the Board has accomplished many of its goals and continues to identify areas of growth and improvement, which are described in more detail below.

Program Goal: Continue effective regulation of dental professionals to ensure safe and competent practice.

Program Objective: Clarify the Board's statutory authority over individuals practicing in the dental profession, identify minimum standards for licensure, streamline the licensure process, clarify scopes of practice and set practice requirements to ensure safe and ethical practice.

Legislative Initiatives and Implementation

The Board's executive director develops legislative proposals on behalf of the Board. During the summer of 2015, the executive director undertook a comprehensive review of the Board's governing statutes and rules. An analysis of that review revealed in part, inconsistencies regarding requirements for licensure among the various licensure categories, ambiguity regarding the Board's statutory authority to regulate unlicensed individuals and/or entities, and lacked clear scopes of practice of regulated dental professionals. Consequently, at its October 15, 2015 meeting, the Board voted unanimously to propose legislation to repeal and replace its governing statute. That effort was successful and resulted in the "new" Dental Practice Act, which became effective July 29, 2016. Since that time, the Board has reported back to the Legislature a second phase of legislative changes now known as the "Phase II Report." The Board's legislative report dated April 27, 2017, is found in Attachment B.

Additional legislative changes beginning in 2015 to the present include:

- Restoring the Board's adjudicatory hearing authority.
- Expanding the dental hygiene scope of practice to include the prescribing of certain medications and expanding the denturism scope of practice to include additional procedures.
- Transitioning the licensure category of independent practice dental hygiene from a pilot project to a permanent practice category to avoid any gaps in dental hygiene services.
- Creating a denturist externship permit as a licensure category to allow individuals enrolled in a denturist program to gain supervised, clinical experience in Maine.
- Repealing and replacing the Board's authorizing statute creating the "new" Dental Practice Act.
- Setting limitations on prescribing opioid medication and mandating continuing education requirements as a condition to prescribe opioid medication.
- Amending the requirements of clinical supervised experience to qualify for independent practice dental hygiene.
- Clarifying scopes of practice to eliminate redundancy and eliminating certain categories of licensure as identified in the Board's 2017 Phase II Report.
- Adjusting fee caps for dentists and dental hygienists.
- Clarifying requirements for qualifications to practice dental therapy and refining the practice requirement for dental therapy.

Efforts to fully implement the above-mentioned statutory changes included the following:

- Licensure improvements:
    - Adopting a delegation policy to allow staff to approve licenses, issue preliminary denials and offer consent agreements in coordination with legal counsel (Assistant Attorney General) to avoid delays in the licensure process. The Board's current delegation policy and delegation chart dated July 1, 2019 is appended as Attachment C.
    - Eliminating the issuance of paper licenses and mailing licenses to individuals. Increasing utilization of technology and the Board's licensing system, Agency License Management System (ALMS), to issue licenses electronically.
    - Offering online services, including the renewal of licenses for licensees, which increased from an average of 50% online renewals in 2014 to 96% online renewals in 2018.
    - Eliminating unnecessary application steps such as personal interviews with the Board and revising the applications to clearly identify the qualifications and the documents required for licensure, including the development of checklists for applicants.
    - Identifying resources for newly-licensed dental professionals such as child mandated reporting laws, resources for substance abuse and/or behavioral issues, and laws specific to opioid prescription requirements, including enrollment with Maine's Prescription Monitoring Program (PMP).

- Transition of the inspection process for Board-issued sedation and general anesthesia permits:
    - Due to a growing backlog of inspections and lack of clear regulations governing the inspection process, the Board shifted to a self-inspection process by adopting rulemaking changes, and requiring licensees to submit documentation attesting to meeting the requirements to transition existing permit holders.
    - Board staff completed the transition of 136 permits (90 dentists) into the new rule and adjusted the renewal cycle of permits from a paper renewal process to an online renewal process.
    - Board staff transitioned existing permits from a five-year permit to a two-year permit to align with the dentist renewal cycle, which fully utilizes the online renewal service.

- Transition of certain dental hygiene licenses and permits into practice authorities:
    - Statutory changes eliminated separate licensure categories for dental hygienists and identified the expanded scopes as "authorities" to streamline the issuing and renewing of licenses. This effort eliminates the need for a dental hygienist to file separate renewal applications and fees for the practice categories of independent dental hygiene, public health hygiene, dental therapy, administration of local anesthesia and nitrous oxide analgesia.
    - Board staff completed the transition of over 1,100 dental hygiene permits and separate licensure categories to align with the new statute.
    - The final phase to this implementation is final adoption of the Board's proposed rulemaking efforts, which is scheduled for a public comment hearing on November 8, 2019.

- Transition of dental radiographers and expanded function dental assistants from a five-year staggered renewal to a biennial fixed renewal date:
    - Board experienced an increase in unlicensed practice violations and confusion in the licensure process for five-year licensure categories and has since streamlined all licenses and permits into a fixed, biennial renewal date.
    - Board staff completed the transition of over 1,700 five-year licenses into a two-year fixed biennial term.
    - The final phase to this implementation is final adoption of the Board's proposed rulemaking efforts, which is scheduled for a public comment hearing on November 8, 2019.

Board staff manages the application review process, including the collection and verification of education and examination information. Licenses are issued by Board staff in accordance with the Board's delegation policy. Currently, the Board maintains a total of 5,452 licenses, including active and inactive status, permits, and authorities, as detailed in the following chart:

License / Permit Category	Active Status	Inactive Status
Dentists (all categories)	972	24
Moderate Level I Permit (Enteral)	20	
Moderate Level II Permit (Parenteral)	34	
Deep Sedation/General Anesthesia Permit	52	
Itinerant Sedation Dentist/Other Permit	12	
Dental Hygienists	1,355	62
IPDH authority	127	
Nitrous oxide authority	304	
Local anesthesia authority	685	
Public Health status/authority	34	
Denturists	40	4
Expanded Function Dental Assistants	111	
Dental Radiographers	1,606	10
Totals	**5,352**	**100**

Rulemaking Initiatives and Implementation

In 2015, the Board created a separate rulemaking committee comprised of two Board members, a member of the Subcommittee of Dental Hygienists and a member of the Subcommittee on Denturists. The purpose of the committee is to review, draft and report recommended rulemaking changes to the Board. The Board's executive director serves as the rulemaking coordinator for the Board to ensure compliance with the rulemaking requirements set forth in the Maine Administrative Procedure Act. The rulemaking activities adopted by the Board since 2015 are described in more detail below:

- June 2015: Board Rules, Chapter 17 "Requirements for Establishing a Board Approved Dental Hygiene Therapy Program"
- December 2015: Board Rules, Chapter 16 "Rules for Independent Practice Dental Hygienists to Process Dental Radiographs
- December 2015: Board Rules, Chapter 5 "Requirements for Licensure as a Denturist"
- August 2017: Board Rules, Chapter 14 "Rules for the Use of Sedation and General Anesthesia:
- November 2018: Board Rules, Chapter 13 "Continuing Education"
- July 3, 2019: Board Rules, Chapter 7 "Establishment of Fees"
- November 8, 2019: Public hearing - Board Rules, Chapters 1 through 6, and 8 through 12*

*On November 8, 2019 at 2:00 p.m. the Board will conduct a hearing for the purpose of receiving public comment regarding its rulemaking proposal to repeal and replace Board Rules Chapters 1 through 6 and 8 through 12. This rulemaking effort repeals exiting chapters and identifies new chapters to fully implement the statutory changes and clarify expectations regarding safe and competent practices. The proposal clarifies qualifications for licensure and registration, identifies the requirements to renew and reinstate a license and practice authority, and identifies practice requirements of dental professionals to ensure public protection in areas such as infection control, radiation protection, safety and sanitary requirements, emergency protocols, dental adverse occurrence reporting, inventory control for controlled substances, patient records and recordkeeping requirements, informed consent provisions, practice and sale notification requirements, use of certain materials, lasers and digital equipment, after-hours patient care, and placement of temporary restorations without the use of dental radiographs.

Program Goal: To ensure that dental professionals who require a license provide safe services to the public and conduct themselves in a competent and ethical manner.

Program Objective: To regulate licensee conduct through examination and enforcement of standards of practice and conduct, and impose discipline, when warranted.

Enforcement

The Board enforces its regulations utilizing an administrative complaint process that is designed to balance the due process rights of licensees against the public's right to know about unprofessional or incompetent practice of licensees. Complaints filed with the Board are docketed into its case management system which is managed by board staff. The Board's administrative complaint process is described in more detail below:

Complaint Process

A. Filing a Complaint

To file a complaint against a licensee, an individual must file the complaint in writing.

- Complaints may be filed online; or
- Complaints can be mailed to the Board by requesting either a copy of the forms or downloading the forms online.
- FMI: https://www.maine.gov/dental/consumer-information/file-complaint.html

B. Document Exchange

After the complaint is docketed, Board staff acknowledges receipt of the complaint and sends a copy of the complaint to the licensee. The licensee is asked to respond within 30 days. Upon receipt of the licensee's response, a copy is sent to the complainant. The complainant is asked to reply within 10 days, but a reply is not mandatory. The complainant's reply, like the original complaint, is shared with the licensee.

C. Investigation

Copies of the complaint, the licensee's response, and the complainant's reply are sent to the Board's complaint committee. Generally, the complaint committee consists of one Board member who serves as complaint officer, Board staff/investigator, and legal counsel (Assistant Attorney General). The complaint committee may investigate the complaint beyond the document exchange described above. The complainant, the licensee, or other persons with information pertinent to the complaint may be contacted by a member of the complaint committee as part of the investigation.

D. After Investigation

The complaint committee evaluates the information obtained during the investigation and makes a recommendation to the Board. The recommendation is an agenda item at a regularly-scheduled Board meeting. The Board's meeting schedule and meeting agendas are listed on the Board's website at: www.maine.gov/dental.

The recommendation to the Board may be one of the following:

1. Dismiss the complaint

If there is insufficient evidence to determine whether or not a violation of the Board's statute or rules occurred, if the licensee's conduct does not appear to constitute a violation of the Board's statute or rules, or if the complaint committee believes that no violation occurred, the complaint committee may recommend dismissal of the complaint. A dismissal cannot be appealed by the complainant, but a dismissed complaint may be reopened if new evidence is received.

2. Proceed with a consent agreement

A consent agreement is a voluntary mechanism for resolving enforcement matters without a hearing or further proceeding. A consent agreement is a negotiated settlement between the Board, the licensee and the Attorney General in which the licensee admits to one or more violations of the statute or rules and agrees to the sanctions to be imposed. The complainant is not a party to the consent agreement. Consent agreements are a matter of public record.

3. Schedule the matter for an adjudicatory hearing

Adjudicatory hearings are held before the Board and are conducted in accordance with the Maine Administrative Procedure Act. The Board utilizes a state contract to obtain legal services of a presiding officer in cases involving adjudicatory proceedings. The Assistant Attorney General assigned to the Board presents the case on behalf of Board staff by calling witnesses to testify, presenting documentary evidence, and making opening statements and closing arguments, among other things. The licensee also has the right to testify, to call other witnesses to testify on his/her behalf, and to present documentary evidence. The complainant may be called as a witness as well. The licensee has the right to be represented by a lawyer at his or her own expense and to request the issuance of subpoenas to compel the attendance of witnesses and the production of documents. Each side may cross-examine witnesses called by the other side. All testimony is taken under oath.

At the close of the hearing the Board deliberates and votes on whether or not a violation of the Board's statute or rules occurred. If the Board determines that one or more violations occurred, then the Board will decide on levels of sanctions to impose. Once the Board's decision has been drafted in written form and ratified by the Board by vote, then the Decision and Order constitutes the final action of the Board.

E. Penalties

The Board may impose any of the following sanctions:

- Issue a warning, censure or reprimand to a licensee
- Suspend a license for up to 90 days per violation or occurrence
- Revoke a license
- Impose a civil penalty of up to $1,500 per violation or occurrence
- Impose conditions of probation on a licensee
- Assess the actual costs of the investigation and/or hearing

Confidentiality

With limited exceptions, complaints and investigative records are confidential during the pendency of an investigation. Complaints are only identified by complaint number on Board meeting agendas, and board members avoid referring to the complainant or licensee by name when evaluating the recommendation of the complaint committee. The complaint and the complaint file become public upon the conclusion of an investigation, unless confidentiality is required by some other provision of law. Patient/client treatment records obtained during investigation remain confidential indefinitely.

Reporting of Disciplinary Action

All disciplinary action imposed on licensees by way of consent agreement, decision and order or final licensing actions on applications are entered into the Board's licensing system and posted on the Board's website. The Board is required to report adverse action taken against a licensee to the National Practitioner Database (NPDB) maintained by the U.S. Department of Health and Human Services.

Recovery of Money Damages

The Board cannot order a licensee to pay money damages to a complainant, although a licensee may agree to restitution or reimbursement in a voluntary consent agreement. The primary purpose of the complaint process is to protect the public against dishonest or incompetent practitioners by disciplining violators. The penalties listed above protect the public by disciplining the licensee, discouraging future violations by the licensee, rehabilitating the licensee, and promoting compliance by other licensees. The complaint process is not designed to redress violations by the recovery of money damages to compensate persons harmed by the licensee's conduct. There are other venues by which a consumer and/or complainant may file action against the licensee to seek such compensation/award of damages.

Compliance Monitoring:

Board staff monitors and tracks compliance with Board orders and voluntary consent agreements to ensure that licensees who are the subject of Board discipline comply with limitations and conditions on their practices. Failure of licensees to comply can result in additional discipline. The Board has a contractual agreement with the Maine Medical Professionals Health Program (MPHP) to monitor licensees mandated to participate in either a substance use program or a behavioral health program. The Board has adopted a protocol for the operation of a professional review committee that identifies roles, responsibilities and reporting requirements when licensees are participating either voluntarily or by mandate of the Board in a medical professionals' health program. The Board's current protocols dated October 11, 2019, are found in Attachment D.

Complaint Case Information:

During Fiscal Year 2019 (July 1, 2018 – June 30, 2019) 74 new complaint cases were opened, and 117 cases were closed. Of the cases closed during the fiscal year, 27 were resolved through voluntary consent agreements; 52 were dismissed for lack of jurisdiction or lack of evidence of a violation; 7 were resolved by board decision and order; and 30 were dismissed with a letter of guidance.

The types of violations found in cases resulting in disciplinary sanctions in FY 19 included:

- Unlicensed practice
- Failure to disclose; misrepresentation
- Failure to comply with a consent agreement
- Criminal conduct
- Substance abuse
- Violating standard(s) of care
- Practice closure violation
- Patient abandonment

Sanctions imposed during FY19 include but are not limited to: warnings, censures, reprimands, probation (which may include terms such as practice/substance abuse monitoring, continuing education, compliance with dental regulations, patient case reviews), civil penalties and actual costs of the Board's investigation and/or hearing. During FY19, the civil penalties collected and placed in the state's General Fund total $20,400; and an additional $4,539.00 in costs were collected by the Board.

Case information specific to the number of cases opened and cases closed for Fiscal Years 2015 through 2019 is summarized below:

Complaint Case Fiscal Year		**Cases Opened**	**Cases Closed**
FY 15	(July 1, 2014 – June 30, 2015)	29	39
FY 16	(July 1, 2015 – June 30, 2016)	94	36
FY 17	(July 1, 2016 – June 30, 2017)	84	34
FY 18	(July 1, 2017 – June 30, 2018)	79	68
FY 19	(July 1, 2017 – June 30, 2019)	74	117

Case information specific to the disposition of closed cases for Fiscal Years 2015 through 2019 is summarized below:

Closed Cases by Fiscal Year	Cases Dismissed	Cases Dismissed w/Letter of Guidance	Cases Resolved by Consent Agreement	Cases Resolved by Final Order
FY 15 (39 cases)	18	11	9	1
FY 16 (36 cases)	8	4	16	8
FY 17 (34 cases)	7	3	20	4
FY 18 (68 cases)	33	13	16	6
FY 19 (117 cases)	52	30	27	7

Case information specific to the number of cases filed by licensure category for Fiscal Years 2015 through 2019 is summarized below:

Complaints Filed by Fiscal Year	Dentists	Dental Hygienists	Denturists	Dental Radiographers
FY 15	33	2	1	2
FY16	17	5	n/a	11
FY17	13	13	1	6
FY18	31	7	5	11
FY19	57	8	4	13

Case information specific to disciplinary violations and sanctions imposed by licensure type for Fiscal Years 2015 through 2019 is summarized below:

Disciplinary Actions by Fiscal Year	Dentists	Dental Hygienists	Denturists	Dental Radiographers
FY 15	7	2	n/a	2
FY16	7	5	n/a	10
FY17	8	13	1	5
FY18	7	1	1	8
FY19	12	6	1	13

Program Goal: Increase accessibility regarding regulations governing dental professions to educate consumers and the regulated community and increase transparency regarding Board processes and actions.

Program Objective: Enhance the use of the Board's website and its online licensing system to increase accessibility to the Board's processes and functions. Develop a communication plan to conduct outreach efforts to clarify the Board's role and responsibilities.

Website / Public Accessibility

On June 26, 2016, the Board launched its new website, which was designed and developed in partnership with InforME, the state's e-government portal provider. The site serves as a tool to inform both the public and individuals practicing in the dental profession of the current regulations governing safe, ethical and competent practice, provides 24-hour online services and increases accessibility to the Board's proceedings. The redesigned site brought the Board's official web presence into the Maine.gov network with a new address, www.maine.gov/dental. It also modernized the look of the site, reorganized data for better usability, and provided additional services, including many online services.

The Board has increased the use of its ALMS database to further streamline its licensing process by implementing an online/email notification system that allows an applicant and/or a licensee to receive electronic notifications to print licenses avoiding delays associated with the traditional printing and mailing of licenses by the Board. Individuals can also check the status of an application online or the status of a license online by utilizing the Board's online licensing portal at: https://www.pfr.maine.gov/almsonline/almsquery/SearchIndividual.aspx

As part of the website project, board staff developed updated applications and forms, and included descriptions of the various licensure and permitting categories. The applications and forms can be found at the Board's website at: https://www.maine.gov/dental/licensure/forms.html

Communication / Outreach Efforts

The Board utilizes its website and its electronic notification platform in its ALMS licensing database to communicate with licensees regarding legislative changes and rulemaking activities. Since 2015, the Board has been sending out legislative updates including implementation efforts to better engage and inform the regulated community. Twice a year, the Board's Chair sends a personalized message to licensees providing critical updates and encourages participation with various Board proceedings and processes.

Individual Board members and the Board's executive director have participated in events, seminars, conferences and continuing education activities to educate participants regarding the Board's priorities, its role and responsibility as a regulatory agency, and to bring clarity regarding its existing regulations. Examples of venues include educational institutions, oral health coalition meetings, professional association meetings, national state board association meetings, national examination meetings, regulatory board association trainings, and accreditation visits.

Members of the Board are active in representing the Board at the national level engaging in national dialogue regarding regulatory practice issues facing the dental professions. Recently, the American Board of Dental Examiners, Inc. (ADEX) appointed Dr. Stephen Morse to serve as the district director for dentists of Maine, Vermont and Massachusetts, and Tracy Jowett, RDH, to serve as the district director for dental hygienists of Maine, Vermont and Massachusetts. Similarly, Nancy Foster, RDH, EFDA, EdM serves as the Board's appointee to the American Association of Dental Boards, which is a compilation of state dental boards.

Board staff fields phone calls and responds to email and in-person inquiries regarding requirements for licensure, scopes of practice, and consumer-related issues from a variety of customers such as the general public, applicants, licensees, employers, attorneys, legislators, educational programs, other state agencies, and other state dental licensing boards. Although the Board's role is limited in its ability to provide practice or legal advice to dental professionals, Board staff attempts to highlight and clarify existing statutes and rules when appropriate.

Public Accountability: The Board's meetings are open to the public and its discussions and votes are a matter of public record in accordance with the Freedom of Access Act (1 M.R.S. §§ 401-410). However, 10 M.R.S. § 8003-B establishes the rule of confidentiality for all complaints and investigative records of the agency during the pendency of an investigation. Request from members of the public and media are handled by Board staff in coordination with the Board's legal counsel (Assistant Attorney General).

Program Goal: Maintain current level of services to ensure public protection.

Program Objective: Identify appropriate levels of administrative support, legal support and funding to maintain existing services.

Staffing Levels

The Board assessed its operational and organizational needs and hired an executive director in 2014. The responsibilities of the executive director include managing the Board's resources and finances to maintain the current level of service to meet its statutory mandates, while at the same time identify cost-savings to increase efficiencies and utilization of limited resources. This brought the total number of staffing resources from three, full-time positions to four, full-time positions.

At its October 2016 workshop, the Board identified the need to hire an investigator to conduct the necessary inspections and investigations given the increase in the number of complaint cases filed and additional legislative mandates. It also identified the need to have one Assistant Attorney General assigned to the Board as it was experiencing an increased need in legal services as a result of increased licensure applications requiring action, consumer complaints, administrative hearings, legislative mandates, rulemaking proceedings, and Freedom of Access Act requests.

The Board restructured its staffing structure, which resulted in the reclassification of a vacant administrative support position into a staff investigator position. In July 2019, the Board hired an investigator (acting capacity), who works in coordination with the assistant attorney general and is assigned to manage the complaint caseloads, investigate cases, and work in coordination with the complaint committee. In addition, the Board was recently assigned one assistant attorney general to

provide services to the Board. The combined addition of the investigator position and the assignment of one legal counsel to the Board has resulted in significant efficiencies including a reduction in aging caseloads and improvements to the Board's complaint process.

Financial Management

The Board is a dedicated revenue agency, which means that it relies solely on fees collected from the regulated community of dental professionals to meet its statutory mandates. The Board does not receive funding from any other source, nor does it receive an allotment from the general fund. 32 M.R.S. § 18323(3) authorizes the Board to establish by rule fees in amounts that are reasonable and necessary to sustain the operations of the Board on an ongoing basis.

The Board's executive director is responsible for financial management including preparation of biennial budget information based on historical data specific to each program; monitoring incoming dedicated revenue from license fees; analyzing trends in revenue streams; and recommending fee adjustments to the Board when necessary to ensure financial stability of each program. Fee adjustments are made through the APA rulemaking process.

A new fee schedule was adopted by the Board effective July 3, 2019, to stabilize the Board's finances. Since 2007, the Board experienced fluctuations in its collection of revenue through decreases in fee structure, increases in fee structures, and transfers of cash balances to the general fund in the amount of $230,000 since 2012. These factors combined with increasing expenses projected a cash deficit for the Board's 2020-2021 budget.

The Board will continue to work closely with the Commissioner's office and the Governor's office over the next few biennium cycles to identify a financial plan, including revisions to its fee structure necessary to maintain the current level of services necessary for the Board to meet its statutory mandate.

C. Organizational Structure

The Board of Dental Practice is a state regulatory board established by the Maine State Legislature in 1891 to identify the regulatory oversight needed to protect the public from incompetent and unprofessional dental professionals. The Board's executive director is responsible for ensuring that the program meets the public protection mandates set by the Legislature. The Board's staff includes four (4) full-time employees consisting of an executive director, an executive secretary, a board assistant, and an investigator.

The Board's organizational chart is found in Attachment E.

D. Repealed, P.L. 2013 c. 307

E. Financial Summary

The Board's financial summary is found in Attachment F.

F. Repealed, P.L. 2013 c. 307

G. Areas of Coordination with Other State and Federal Agencies

The Board establishes and maintains close working relationships with many state and federal agencies that share regulatory oversight.

Office of the Governor/Department of Professional and Financial Regulation

The Board submits its budgetary requirements, legislative proposals, and rulemaking proposals to the Commissioner of the Department of Professional and Financial Regulation for review and approval. The Board has streamlined many of its financial policies by utilizing the professional services provided by the Commissioner's office to reduce duplication of effort and to ensure compliance with applicable federal and state laws.

The efforts by the Governor's Office to appoint and maintain active membership to the Board and its subcommittees has made a remarkable contribution to the Board's ability to maintain quorum, achieve its statutory mandates, and accomplish many of its goals. Additionally, the Board benefits from its working relationship with the Commissioner's office to ensure it has the resources it needs to accomplish its vision. The Commissioner's office provides insight and guidance on a number of regulatory issues, communicates goals and expectations of the administration, and provides board membership training to further clarify roles and responsibilities of a regulatory agency.

The Office of the Attorney General

The Attorney General's Office provides legal counsel to the Board through an agreement with the Department of Professional and Financial Regulation. The Board's assigned legal counsel provides legal services to the Board and Board staff specific to its monthly agenda items and its processes related to legislation, rulemaking, licensure and complaints. Matters involving unlicensed practice are referred to the Office of the Attorney General once brought to the Board's attention.

Maine Department of Public Safety and United States Department of Justice

The Board coordinates with the State Bureau of Identification (SBI) within the Department of Public Safety relates to the identification and background checks of license applicants and licensees. The Board also coordinates with the staff of the New England Field Division of the U.S. Department of Justice, Drug Enforcement Administration on federal regulations specific to the prescribing, dispensing, and administration of controlled substances.

Maine Department of Health and Human Services

The Board shares information with the Maine Department of Health and Human Services with regard to dental radiation practices and allegations involving MaineCare services and reimbursement. The Board also coordinates with the Office of Substance Abuse compliance with the prescription drug monitoring program. Finally, the Board collaborates with the department to educate licensees who are required to obtain mandated child abuse training by law.

Maine Department of Education

The Board shares information with the Maine Department of Education regarding the accreditation of educational institutions and private for-profit organizations providing training for certificate programs in the professions of denturism, dental assisting and dental radiography.

Affiliated Board and Boards within the Office of Professional and Occupational Regulation

The Board coordinates and shares information with other health boards affiliated with the Department of Professional and Financial Regulation such as the Board of Licensure in Medicine, Board of Nursing, Board of Osteopathic Licensure, Board of Optometry and other health related boards within the Office of Professional and Occupational Regulation.

H. Constituencies

The Board serves the general public, including more than 4,000 licensees as well as applicants seeking licensure, permits, registrations and/or practice authorities. The Board also serves various local, state and national professional associations, educational institutions, national accrediting organizations, national and regional examination organizations and national state board associations.

I. Alternative Delivery Systems

The Board through its affiliation with the Department of Professional and Financial Regulation now provides many online services to its licensees and consumers through its website services provided pursuant to an agreement with InforME. Details regarding its online renewal services is described in greater detail in Section B. The Board will soon be launching an initiative to utilize online services for initial licensure to accomplish its goal of a paperless licensing process.

J. Emerging Issues

Legislation

In 2017, the Board reported out a comprehensive list of emerging issues requiring further policy discussion (legislative review). A partial listing of the issues is noted below with the comprehensive list identified in the report included as Attachment B.

- Sunrise review of regulating dental assistants and dental practices.
- Clarify regulation of teeth whitening.
- Refine list of "delegated duties" as they do not reflect current practice.
- Amend dental hygiene scope of practice to reflect principles of practice without enumerating procedures.
- Allow denturists and dental hygienists to delegate to unlicensed individuals.
- Clarify dentists' scope of practice to include dermal fillers and Botox for non-dental related procedures.
- Eliminate certain requirements for faculty dentist licensure.
- Identify a pathway for foreign-trained dentists without a doctoral degree from a CODA-accredited dental program.
- Exempt supervision requirements when volunteering services.

Resident Dentist Licensure - Legislation

There has been an increase in the number of resident dentist applicants seeking to obtain advanced clinical experiences in Maine by enrolling in accredited training programs with educational institutions. These programs provide not only a valuable educational experience, but also provide dental care to the most vulnerable populations and those without access to care.

The existing licensure requirements are overly burdensome and may deter future programs due to costs and an extensive application process. The Board supports reexamining this category of licensure and is prepared to recommend a legislative proposal to simplify the licensure category into a registration category.

Opioid Prescribing / Pain Management - Rulemaking

The Board will be redrafting Board Rules Chapter 14 "Rules for the Use of Sedation and General Anesthesia" and Board Rules Chapter 21 "Use of Controlled Substances for Treatment of Pain" to fully implement state laws regarding the prescribing of opioid medication and guidance from the Centers for Disease Control and Prevention.

Budget/Collection of Fees - Rulemaking

As noted in Section B, the Board will continue to monitor its financial stability in close coordination with the Commissioner's office. It is anticipated that the Board's fee structure will likely need to be revised via the rulemaking process to identify additional revenue for the upcoming fiscal year biennium.

Board Member Training

As noted in Section G, the Board has identified board membership training as a priority and will continue to identify training opportunities in coordination with the Commissioner's office. The Board will continue to conduct its own training as new members are appointed to the Board.

K. Information Specifically Requested by the Committee

None requested.

L. Comparison of Related Federal Laws and Regulations

There are no federal laws that specifically provide for the regulation of dental professions. However, there are both state and federal laws that pertain to the privacy of medical/dental information as noted in Section A.

M. Collecting, Managing and Using Personal Information

The Board collects information from applicants, licensees, consumers and other entities. Some of the information collected in personal information such as home address, telephone number, social security numbers, financial information and healthcare information. The Board complies with state and federal laws with regard to the confidentiality of certain information such as social security numbers and healthcare information.

The Board adheres to policies consistent with the Department of Professional and Financial Regulation to train employees about the proper use of personal information. In addition, the Board complies with state law requiring the freedom of access to public records, not otherwise confidential by law. Information shared on its website does not contain personal information.

Personal information is redacted as protected by statute when processing a public or FOAA request. Board staff consults with its legal counsel when determining whether the request can be responded to without supplying other personal information.

N. List of Reports, Applications and Other Paperwork

The Board's statutory authority to require individuals to file applications and relevant data is located at 32 M.R.S. §§ 18341–18352 and 18379. The Board receives more than 337 applications for initial licensure annually and processes approximately 2,500 applications for renewal of licensure annually. All applications can be found online at: https://www.maine.gov/dental/licensure/forms.html

Applicants and licensees are encouraged to utilize the Board's online services to update their license application information and to renew their licenses. Licenses may be renewed electronically 24 hours a day, 7 days a week, up to 60 days prior to the license expiration date. A list of the licensure, permit and registration types can be found in Attachment G.

O. List of Reports Required by the Legislature

Public Law 2016, chapter 429 "An Act to Revise the Laws Regarding Dental Practices" required the Board to submit a report to the Joint Standing Committee on Labor, Commerce, Research and Economic Development and recommended further statutory changes to the scopes of practice relevant to the

changing delivery models of dental services and any other dental practice issue. The report was submitted on April 28, 2017, and can be found as Attachment B.

Public Law 2018, chapter 388 "An Act to Align the Laws Governing Dental Therapy with Standards Established by the American Dental Association Commission on Dental Accreditation" requires the Board to submit a report no later than February 1, 2020, to the Joint Standing Committee on Health Coverage, Insurance and Financial Services, recommending changes to the statutory definitions of supervision and recommending a definition of teledentistry. The Board is convening the ad hoc committee's first meeting on November 1, 2019, at 9:00 a.m. Public Law 2018, chapter 388 can be found as Attachment H.

P. List of Organizational Units and Programs

None.

Q. Statutory Provisions Requiring Legislative Review

None.

Attachment A

Maine Board of Dental Practice

Final Report

Friday, October 7, 2016

Augusta, Maine

Good Group Decisions

98 Maine Street, Brunswick, Maine, 04011 207-729-5607 www.GoodGroupDecisions.com

Contents

This report is organized by topic, not necessarily the order in which things were discussed.

About the Workshop

Attendance

- Paul P. Dunbar, DDS
- Catherine J. Kasprak, IPDH
- Geraldine A. Schneider, DMD
- Lisa P. Howard, DDS
- Stephen G. Morse, DMD
- Rowan Morse
- Tricia Spearin, RDH
- Glen S. Davis, DMD
- Ann-Marie Grenier, IPDH
- Nancy Foster, RDH, EFDA
- Kathryn A. Young, LD

Board Staff

- Kerrie Ingram
- Penny Vaillancourt

Facilitators

- Craig Freshley
- Kerri Sands

Objectives

- Build on the good work of our June 17 workshop at which we achieved consensus on a vision for our organization and how to achieve it.
- Establish specific performance measures for evaluating progress towards achieving our vision.
- Identify ways to improve meetings and overall board functioning.

Opening Remarks

Board Chair Dr. Geraldine Schneider welcomed the group with the following remarks:

- Good morning; I am looking forward to this
- We are building on our discussion about building a better board
- Today we will put our ideas together and make an action plan to move forward

Agenda and Ground Rules

Facilitator Craig Freshley explained the planned agenda (See Appendix A) and the following ground rules, things to keep in mind for an effective meeting:

- **The answers are among us**
- **Hands to speak**
- **Minimize distractions**
- **Seek common ground** - Always looking for what we have in common

- **Name tensions** - If we have disagreements, name them and recognize that there are several ways to look at an issue
- **Discussion among board and staff** - Although anyone is welcome to attend and observe
- **Flexible agenda**
- **Themes and conclusions now and later**
- **Neutral facilitation and reporting**

The group decided to be on a first name basis for the day.

What We Do Well

Everyone was invited to name "one thing that we (members and staff of the Board of Dental Practice) are doing really well now." The following comments and themes were captured.

Themes

- **General improvement / Shift**
  - Trust
  - Culture
  - Attentiveness
- **Organization**
  - Consistency
  - Roles and responsibilities
  - Teamwork
  - Adjudicatory hearings
  - Use of information technology
  - How board meetings are run
- **Communications**
  - External
    - Communications to licensed practitioners
    - Website
    - Informational updates by e-mail
  - Internal
    - Website
    - Staff is so approachable

All Comments

- Pleased to receive email about the expiration date of my license

- Organization of new statute into a binder - I like that we are moving more towards tech and the binder
- Communication
- Fine tuning the website
- Communication - Penny's outreach to dental societies, being more visible, website improvements
- The board book, the website
- Getting the hang of adjudicatory hearings - we are better at the process
- We are more consistent in how we handle questions and issues we deal with - licensure and discipline
- There's been a dramatic shift in trust since we were able to air out roles and responsibilities of staff and board. We have made great progress.
- We work together well as a team
- We are lucky to have Penny
- Things are going in a better direction. Coming back to board meetings it feels totally different than in the past - more organized and efficient.
- We are improving every day in every aspect. You only have three choices - getting worse, staying the same, or getting better. I see attempts by everyone on the board to get better.
- There has been a change in culture, commitment, and attentiveness. People are clearly reading the material in advance. Everyone treats this like a priority.
- It is obvious that the intentions of everyone are to improve. The meetings are well organized. Gerry runs them well - it's hard but you do a great job.
- Organized, streamlined, efficient
- Excellent, approachable, problem-solving leadership
- Less "fluff" in board books
- Communications
    - Board is getting the message out to licensed practitioners
        - Example - reminder cards
    - Website - lots more info available
    - Email summaries of changes in statute - simple, straightforward, effective
    - We do not talk with each other between board meetings - that is not allowed - but if there is a simple question that we need answered, Penny and Kerrie are very approachable and provide immediate answers

June 17 Workshop Review

Craig reviewed the key conclusions from the June 17 Board Workshop and explained a handout with the Vision Statement that was developed and the list of ideas to achieve it (see Appendix B). Participants had a chance to share perspectives on how the board has been functioning since the June workshop.

Craig summarized the following highlights from June 17:

- Anne Head, Commissioner of the Department of Professional and Financial Regulation, talked about board characteristics
    - Board members as leaders and the board as a group
    - Knowing the rules, being good communicators, being committed, respecting the process
    - When acting as a board - be on best behavior
- SWOT Analysis - strengths, weaknesses, opportunities, threats
    - This is a board that is on its way up
    - Strengths and Opportunities
        - Staff
        - Board
        - Increasing efficiencies
        - Improving reputation
        - Partnerships
    - Most Significant Threats
        - Reputation damage via media and misinformation
        - Legislative process
        - Fiscal climate
        - Corporate dentistry
        - Different dedication level of younger professionals
        - Scope of practices evolution
    - Weaknesses Most Needing to Be Addressed
        - Alignment between workload and resources
        - Trust and reputation / History
        - Board composition
            - Oral surgeon on the board
            - Proportional representation of hygienists
        - Understanding
            - Statutes
            - Board's role vs. staff role
            - Role of the Executive Committee
        - Communications

Craig referred to the list of ideas for "how to achieve awesome", how to achieve the vision (see Appendix B), and noted that as the board develops performance measures, these are the things to measure.

Participants reflected on board functioning since the workshop:

- Has the workshop has had an impact? Yes.
- What Maine is doing today is unheard of. We are ahead of other states already. At a recent national conference, national leaders said that boards need to have training and come together as organizations.
    - We want to do performance measures and collect data and report it out - that's going above and beyond.
- We are overwhelmed with work. That is the context for coming to today's meeting.
- The legislature is not even in session yet and the staff are overwhelmed
- There are some cases that take up so much time - these are out of our hands
- It is incredible what our staff do
- It is justification for increasing our investigator staff

Revised Vision Statement

Participants reviewed the Vision Statement that was developed at the June 17 workshop, and suggested a few changes. As a result, Craig revised the statement on screen. The group generally approved the revised statement although there was not a formal adoption.

Vision Statement Developed on June 17

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. Members of the Board are trusted and respected for their high integrity and commitment to public service. Supported by highly competent staff and funding, the Board's work is highly efficient and user-friendly.

Changes Made on October 7

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 the work required to achieve this vision.

~~Supported by highly competent staff and funding, the Board's work is highly efficient and user-friendly.~~

Resulting Revised Statement

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 the work required to achieve this vision.

Discussion

- Fantastic - it nicely reflects the work we did
- "Highly competent staff and funding" is clunky wording - how can you have highly competent funding?
- "Funding" needs an adjective
    - Appropriate
    - Robust
    - Adequate
- "Supported by highly competent staff that are properly funded"
- "Adequately staffed"
- We'd love to have more staff and an increase in pay but "funding" is really about contracting for expertise
- Concept is good but too many "high" or "highly"
- The part about funding - is it really true?
    - It's an aspirational vision
    - It says what we need

How to Measure Performance Going Forward

Introduction: About Performance Measures

Craig provided a basic explanation of what performance measures are and how they are used. (See Appendix C for handout.)

Explanation

- Quantitative measures
  - Can be numbers on a graph over time
  - They are better because they are irrefutable - you can measure an increase or decrease in percentages
  - For example, the number of cases settled or a rating on a scale of 1 to 10 regarding some issue
- Qualitative measures
  - Reflected in a discussion about an issue or responses to an open-ended survey question
  - Have the same discussion year after year and capture the notes; it takes some discipline
  - Or ask the same survey question the same way year after year, and tease out themes
- Outcome based measures
  - Such as the number of cases resolved
  - The world cares more about outcomes
- Activity based measures
  - Measures input rather than output
  - Such as the number of hours spent adjudicating cases, or how much money was spent
- Performance measures need a reference
  - This could be a either a peer group or your own history
    - If we want to measure number of cases settled this year, we also need to know how many cases we settled last year, or how many cases other states settled
  - Sometimes we fall into the trap of reacting to numbers without real reference
  - Be careful not to make a judgment about a data point until we build a history
  - Don't even set a goal until you have a reference point
    - Sometimes groups choose an arbitrary goal, and then when they don't meet it they find themselves having to make excuses - it is a waste of time
- Why measure performance
  - It works like magic, for example in employee evaluation, measuring performance is very effective
    - "What gets measured gets managed"

- It is a statement of priority, internally - we learn where adjustments should be made
- Convey performance to others and build credibility
- Measuring performance can have a huge return on investment, can demonstrate that you are achieving valuable things with the money you spend and make the case for additional investment

Comments

- If we compared ourselves with other states, we would have to qualify the data
  - Every state regulates so differently
  - In Massachusetts, the average dentist goes before the board 3 times in his or her career, but in Maine it's way under 1
- Pick states with similar numbers of licensed professionals and see how many cases were filed - even if the processes were different
  - You'd have to compare to see if cases are going up
- I'd like to know how many board hours are invested to prepare for cases
  - The cases cost us too - beyond staff time and resources
- This takes time to track. We can have good intentions, but it takes staff time and is costly to track hours.
- This is good feedback. We have systems in place that can pull some data now, but once we hear what the board wants we can assess whether we can get that data from our system.

Ideas for Performance Measures

Together we brainstormed answers to this question: "What are the three most important things to measure in order to assess progress towards our vision?" Everyone wrote his or her ideas on paper. We organized ideas into categories on the wall, discussed, and then made an ordered list on the screen.

Conclusions

The group generally approved the following ordered list of Performance Measures as shown on the screen during the meeting.

Now

1. Number of cases
   a. Dismissed
   b. Dismissed with letter of guidance
   c. Consent agreement
      i. Level of sanction

    d. Adjudicatory hearing - decision and order
        i. Level of sanction
        ii. Cost of adjudicatory hearings
    e. Other tools
2. Revenues and expenditures
    a. Biennial revenues by source
    b. Biennial expenses by source

Next

1. Education of Licensees
    a. Understanding of the rules and the statute
    b. Understanding CE requirements
2. Time spent on cases
    a. Average time between opening and closing
        i. All cases
        ii. Low risk
        iii. Medium risk
        iv. High risk

Later

1. Increased efficiency
    - Number of complaints filed online
    - Number of renewals online
2. Perception of licensees
    - Annual survey of licensees
3. Public perception
    - Annual board discussion
4. Perception of complaint process
    - Survey participants about the process

To Do

Note: This list emerged as we discussed performance measures. These items are "things we should do," not necessarily performance measures.

- Establish new rules in line with the new statute
- Establish a streamlined protocol for making new rules
- Report appropriately to the Board
- Clarify rules regarding CE so that staff time auditing them declines
- Public education about how we process complaints
- Board education on the budgeting process

All Ideas

These are the written ideas submitted by participants.

- Time Per Case
  - Decrease in time per case complaint within reason
  - Board performance complaint resolutions - number and time frame
  - Hours/time spent - staff, board
  - Break down of time /issue preparing for meetings
- Number of Cases
  - Decrease in number of cases annually!??
  - Number of cases
  - Length of time to resolve - 0-3 months, 6-9 months, 9-12 months, and 1 year?
  - Prevention efforts - reduction in unlicensed practice
  - Number of cases received, reviewed, and disposed of per year and number of months "taken"
- Outcome of Cases
  - Outcome
    - Cases
    - Issues
  - Outcomes of complaint cases
  - Number of complaints resolved
  - Average time to resolve complaints
- Rules
  - Consistency of rules and enforcement
  - Number of rules reviewed, revised, and changes adopted
  - Number of rules needing to go through process of comm/rule hearing
    - Should decline over next 3 years
  - Rules subcommittee report back to board - as does DHSC & DSC
- CE Auditing
  - Number of licensees who fail CE audit (hopefully reduced due to better communication)
- Website Activity
  - Number of visitors to website
  - Number of inquiries of website, board, and staff, and for what
  - Monitor number of hits on website - create an increase in high-information licensees
- License Renewals
  - Number of prof. renewing online vs. previous year(s)
  - Number of licensees who fail to renew on time (reflection of new statute)
  - On time licensing
- Resources
  - Assessment of board resources (staff, $)
  - Review funding levels from prior years and compare to desired funding levels
- Perceptions

    - Licensee perceptions - "How are we doing?"
    - Survey the licensed professionals to determine effectiveness of improved communication
    - Public /complaint perception - "How are we doing?"
    - Trust from the public
    - Year-end survey to board - perception
        - Was year organized?
        - Adequate communication
        - Meetings efficient
        - Qualitative yearly review
- Education effort
- Performance compared to similar states

Discussion

- Caveat: Some of us very new to the board. I am not sure if we are ahead of or behind schedule, but I'd like to see a decrease in time spent per complaint - within reason.
    - The measure would be average for the year - maybe "case complaint time"
- A decrease in cases annually. We are not supposed to be an educating board, but it would be good to see the message getting around about what's right and wrong
- Data on our cases
    - How many cases filed per year
    - Out of those, how many were dismissed, dismissed with a letter of guidance, had a consent agreement, had decision and order, adjudicated, etc.
    - Then there is data within those categories
        - Sanctions levels
        - Level of discipline imposed
        - What were the practice issues identified within
            - Such as, the need to keep better records
    - What was the nature of the allegation
        - Sometimes there has been a violation but we can't go forward because there is not enough info - but we don't want to lose the data about the complaint
- Number of rules revised or changes adopted
    - The number of rules needing to go through hearings should decline
- Number of inquires on the website and what they are
    - Also phone calls
- Number of hits on the website
- High-information licensees
    - More info to licensees might reduce the number of cases
- How many renewing on line
- Level of on-time licensing
    - Hope that the number of failures to renew on time goes down
- Licensee perception - how are we doing?

- Public perception - are we doing our job adequately, efficiently? Are we communicating well to the public?
    - Survey about effectiveness of improved communication
    - Trust from the public
- Do a board survey about perception
- Measure perception of licensees, the public, and the board
    - Have we ever done a survey on this?
        - Only informally through the website and phone calls
    - The majority of people renew on time and don't get in trouble - if perceptions are otherwise, the survey might be misleading
- Number of licensees that fail an CE audit
    - Kerrie spends many hours per day arguing with dentists about what qualifies for CE. Why are we spending so many resources on documentation? We forgo getting to patient care cases.
    - What we need is more clear and concise CE rules. There is a lack of clarity about the rules.
    - The measure is the amount of time staff has to spend on this. The fix is improved rules and improved clarity.
    - Do we need to collect data to justify why the rules need to be changed?
        - Kerrie would need to make checkmarks about types of phone calls, or something like that
    - We have developed an FAQ sheet on our website; it is based on the number of calls we get on the same issue. But people don't go to website - they want to call Kerrie and argue over a word in a rule.
    - Are we required to audit a certain percentage?
        - Yes. 10%. The board came up with this number in past years; not sure how.
        - Also anyone who has a consent agreement is audited.
        - Would 3% be just as accurate as 10%?
        - Maybe that number could be adjusted, peeled back
    - I am astounded that nurses are not required to have CEUs
    - If we want to have a discussion about this it has to go back to the Legislature
    - We don't need to study how much time Kerrie spends. The heart of it is that the rules are misinterpreted by everyone. Let's just clear it up.
    - We have so much info available now - it's amazing that anyone should lack understanding
- Measure if there is correlation between a decrease in violations and increase in website use
- Measure whether the board's efforts to refine rules and do more education and outreach is reflected in the number of violations
- Just a note that the website is out of our control. We may not be able to track independent hits.
- Why do we want to track website use?
    - It has to do with communication. It is a major platform for our information dissemination.

- An indicator of interest
- Number of hits in response to emails informing of statute change
- If number went up what would be your conclusion?
  - The number of hits might indicate that the website is too confusing
- Measure how the section where patients file complaints is being used. Is the public aware and are they using it, or are they writing letters?
  - We can collect this from case management side
  - The goal would be to streamline processes and reduce burden on staff; the increase in website use would be an indicator
- There are hard numbers about license renewals online - this is related to the website
- If the board decides to go paperless, the performance measure is how many will use online renewal vs. use the paper forms
  - It would be great to see how many people use online forms
- The goal is efficiency
  - People using website to do things that the staff doesn't have to do
  - We have retroactive data on this

- What about rules do we want to change and what should we measure to see if it changes?
  - We just changed the statute, with a complete repeal and replacement of all the rules. That all needs to be done now.
  - Measure the rate at which we are finalizing new rules?
    - What is value in determining the rate?
    - Doing the rules is just part of the job
  - The number of rules that need to be changed?
    - That's a political issue and out of our control
    - Writing rules is an art form - there is a way to write your rules so they stand the test of time
    - When Penny started, the rules were very difficult to interpret and use
    - It's been a big effort to make a new better foundation (the statute) and now it's time to create new better rules - without micromanaging
  - How effective are rules? Do people understand them? Do people understand what the board is putting into practice?
  - Our three jobs as a board are 1) dealing with complaints (discipline), 2) writing and revising rules, and 3) licensing. So we need some indicator about rules, but maybe it's about prioritizing.
  - There is a way of monitoring rules to prevent a gap between the rules and the statute like there was before
  - The rules subcommittee should report to the board on what happens at its meetings. If they don't maybe that contributes to the gap.
    - It's a measure of the effectiveness of internal communication
    - Caution: In the rules subcommittee we are "making the sausage" and I'm not sure it's effective to provide updates while it's being made
    - The subcommittee on rules has no statutory authority. It's the workhorse that puts together something for the board to review. In the past the board's rulemaking efforts were not organized and had gotten

backlogged. So we are figuring out a better way to do this. The subcommittee now includes a hygienist and public representatives.
    - We have increased the rate at which we are adopting new rules - that's real work. So that is a quantitative measure.
        - That measures success at doing our fundamental job
    - We need to write rules for 18 chapters. If we did it in 3 years that's 6 per year.
    - The pace at which rules are done is somewhat arbitrary
        - The CE rules should not take that long, but anesthesia rules are taking a long time
        - Ideally we would get all the rules done now and then in a couple years we are reviewing rather than feeling constantly behind
    - The problem with rules is that they are always changing
- What do we want to track about <u>cases</u>?
    - Time per case
    - We already track the date of opening and date it's dispose
        - The goal is to reduce time it takes for resolution
    - We have a current backlog and sometimes it feels like the cases are just sitting there. Sometimes it looks on the surface like we are not doing things, when there is actually momentum on a case. For cases that are assigned to complaint officer, until it's ready to present we don't have updates or a sense of progress.
    - Sometimes the exchange of documents or extent of investigation differs from cases to case
    - A goal would be to classify high, medium, and low risk case
        - For the low ones, get them up and out the door
    - Set a goal of average times to close cases of different types
    - This would help set expectations for licensees and consumers
        - The Arizona Board of Nursing has a policy statement that explains how they process complaints and what people can expect. We do a good job explaining the process but not the expected time.
    - Is the number of case backlogs a measure? A measure of the extent to which you are processing cases? When we see at our meetings that there are 70 cases, I don't know how serious they are.
    - Caution: We do need to keep the case information confidential
    - The priority ranking - high, medium, low - would be a tool for the complaints committee
        - We could adopt this principle for any new case going forward, but let's not get bogged down in ranking current and past cases

      Craig summarized: "The level of risk will be assigned for all cases going forward, not retroactively; and the risk level assigned to each case will not be available to the public."

    - Caution: This concept of assigning high, medium, low risk to cases was just raised today. It has not been vetted by the board and is not representative of any board conclusions.

- Sometimes a case seems like not a big deal but then more comes to light, and a case has bigger implications
- We have a societal expectation that things happen right away
- When a complaint is received, how fast does a letter go out to consumer acknowledging receipt?
  - Depends on the workload. In some case it takes months. We are trying to get out of the backlog.
  - We could get 30 or 50 complaints in one day. That is a tremendous amount of lifting that has to happen - there is quite a process even to log the case in.
- How much time is spent by the AG in preparing for these cases?
  - Would like to reduce the amount of cost. We only have limited resources; all of our money comes from fees.
  - We can sometimes charge the licensee for the cost of the hearing
  - If we have to raise our fees, we would need to justify that we had X amount of cases, each costing X. It would be good to have the data.
- What can be done about cost is out of the board's hands. Processing cases is part of the board's mission and part of doing our business as a group.
- This has to do with licensee perception and with rulemaking
- All it takes is one very serious case to have a big impact on the budget
- There is some value in measuring the cost of adjudicating the cases
  - Not just the cost of the AG, but also our staff
- Before I joined the board I didn't realize that we pay for this service from our fees. It's a budget item. How do you plan for it? The number would be helpful.

- Is there something we want to measure about <u>resources</u>?
  - We see information about fees, etc. every month in the board book
  - We could have one-pager with metrics that we could glance at
  - Renewals will fluctuate - certain years you will have more
  - We need education about the budgeting process
    - The budget is biennial with a built-in 2 year work program
      - These are fixed and can't be changed
    - Our proposed anticipated revenues and expenses are based on history
    - Once the budget is made, when changes are needed it's a legislative process
    - You have hired Penny to manage the budget. If you want to see it every month and have a discussion about it…
  - What the board wants to discuss is how to manage unexpected expenses
  - Now that the board has adjudicatory power, I think we will see more cases result in a consent agreement - they don't need to go to hearing. But all it takes is one or two cases to make us ask whether we need to increase the fees. For example, an expert witness or an examination that we did not anticipate.
- How should we measure <u>perception</u>?
  - Survey of licensees
  - Licensees are a known universe of people - we have names and address

    - We could establish a survey instrument and ask the same question year after year
- How to assess public perception?
    - This is almost impossible to do
    - The board gets immediate feedback from the legislative committee - constituents, schools, etc. We often know who those folks are. But the number of complaints to the legislative committee not tracked.
    - Craig suggested the following ideas:
        - Add a question on to quarterly statewide survey done by Critical Insights - they survey a random sample of the public
        - Commission a media study
            - How many times you are mentioned in the press every year
                - Number of negative mentions
                - Number of positive mentions
            - Research backs up that this is a good indicator of public opinion
        - Both of these are expensive to do well
        - A third option is to have a qualitative discussion about public opinion at a board meeting, annually. Take notes and keep a record year after year.
- Do we collect data on satisfaction with the way consumers' complaints are resolved?
    - We might get skewed results, if people think we can get a fee reduced or intervene monetarily. We don't have the power to do some things.
    - The nature of the business is that it's about conflict - there's a winner and a loser
    - Someone could be dissatisfied with the eventual result, but appreciate the process. You could learn meaningful things depending on how you ask the questions.
        - For example: Was the process clear? Fair? Did you receive good customer service?
- Should we measure education efforts?
    - We are not an education board but our mission is to protect the public
    - We do outreach and relationship building
    - How effective is the board in terms of educating licensees and the public
    - This is related to people's use of the website
    - This is captured in other ways. If our efforts are successful we will see changes in outcomes.
- The board might be interested in hearing perception of the process from both sides - not just the consumer but also the licensee
- Caution: We are not budgeted for any of these costs. The first opportunity to increase our budget is FY 2020. That is the reality of anything with a cost associated.
- Could a volunteer subgroup work on this later?
    - Hope that everyone has an equal voice in identifying measures
        - Hesitant to do this work in a subcommittee
- Would like to have a few solid working plans when we leave today
- Suggest that we focus on the number of cases. We can come back as a group 6 months from now and pick off another performance measure.
- We need to figure out the CE issue so we can free up staff time to handle cases

    - We are working on Chapter 13 right now and hope to report to the board soon. This will help with CE
    - A reminder that even if you change a rule there's a 2-year transition, and that's okay
- We could have these performance measures visible as we have board discussions, so for example, as we talk about ideas for educating licensees we could remind ourselves what direction we are heading in
    - When these are finalized, yes, they will be available to the whole board
- On an annual basis, we should report our efforts and tracking. This format is a framework and we can start to put data in it.
- The time spent on cases should be done now. I am not able to draw any good conclusions by looking at how the backlog changes.
    - It would be very time consuming to get that number
- A reminder that we don't have any unexpected expenses - it's all budgeted
- We can't do it all right away, but some of these things we can do, and we are on a good path for improving
- The idea of an annual survey of the perception of licensees - is there a way to tack this on to license renewals? Just ask a few questions?
    - We would have to ask the licensing agency and the Department
    - Staff could develop a survey that could be sent electronically
    - Or the board could develop a Survey Monkey tool

How To Improve Our Meetings And Overall Board Functioning

In small groups we brainstormed ideas for things that would most improve meetings and functioning as a board. Each small group shared their ideas with the full group and we discussed together.

Summary of Ideas

- Reference sheets about hygiene and practice
    - For members and the public
- Reduce redundancy
    - Penny should only have to give the Executive Director's report once
        - But retain aspects of attention to different subgroups
    - Subcommittees attend beginning of board meeting to hear Penny's report and give their reports
    - Clear and concise statements
    - Note: It's getting better
- Board member tutorials
    - On a schedule known in advance
        - So public can attend
        - So board can prepare
    - Topics
        - Statutes
        - Rules
        - Licensing scheme
    - Manual that explains basic dentistry – "Dental 101"
- Full time investigator/inspector
- Anticipate securing contracts for expert case reviewers

Discussion

- Reduce redundancy
    - Sometimes board members arrive later and ask questions that have already been answered earlier in the meeting
    - Subcommittees could meet at the start of the meeting to hear reports and present their own reports
    - Penny's report doesn't take very much time
    - Penny needs to maintain a dialogue and relationships that are specific to the subcommittees
        - Penny does not want to lose the opportunity to speak with each subcommittee

    - At first this felt like a redundancy but now I realize that there is value in having a report tailored to each subcommittee and to the whole board
    - Seems redundant and inefficient to hear the reports multiple times
    - There are about 8 people who hear a report more than once
    - It feels redundant for the staff too
        - The structure is inherently redundant. Things have to go to the committee and then to the board. This means lots of copying, picking an item up and putting it down multiple times.
    - Is there a creative solution?
    - Is the hygiene subcommittee info in the board book every month?
        - Board members receive all the info but the staff has to load it up in three different ways
        - Could we do a subcommittee board book and then a board book?
        - If we have to upload things three ways for the books, could they be public documents? Could we whittle down the info so that it's suitable for the public?
            - Good ideas, but would not actually save time
        - We can revisit this concept if we have a new breakthrough idea
    - This is a needle in a haystack. We are talking about the needle, but the haystack is the cases, no matter what. How we deal with cases is a number one management issue.
    - How much time could we save it we all showed up at the same time? We could be ready to vote if we heard the questions at the subcommittee levels.
- Full time investigator
    - Staff has put in a request to the governor for a waiver to hire for this
    - Staff appreciates the board's recognition that we are limited in resources and that we want to utilize positions in best way possible.
    - The legislature increases our responsibility without increasing resources
    - Can the board members advocate on behalf of the staff?
        - Penny reported that the Commissioner serves the board well and is able to advocate for what is needed. Penny feels supported by the Commissioner.
- Contracting
    - Earlier the board had decided to put parameters around identifying and approving people to serve as experts, so Penny could vet them and bring suggestions to the board for consideration and approval.
- Things have improved so much - the board book is condensed, we are staying on schedule, meetings are running well and are well organized.

Closing Comments

Each person had a chance to make a last comment, such as a reflection about the retreat or a specific hope or concern for the future.

- Everything we talked about today can be solved if we get another investigator and help reduce our cases
- So far it's all good - even if we are opposed to each other's ideas we work well together
- We are heading in great directions
- We are coming together. For board members to take another day in addition to regular board days, we really appreciate it. It means a lot.
- If you miss a meeting, you miss a lot. If you missed this meeting you'd miss this growth and development among the group and this discussion about how we communicate.
- The biggest issue is the overwhelming workload. You have helped identify some skills to triage and manage it - this is the right direction.
- The board is moving toward being more efficient and effective.
- Agree with what's been said already. This is a good group. We work well together. We are fair-minded. We have the people's interests and safety first and foremost.
- As was said earlier, "What gets measured gets managed". I am glad we talked about performance. We can manage those things!
- Great momentum, good trajectory. We have come a lone way since June.
- Thanks to the staff for this extra work on top of your day-to-day work.
- Thanks Dr. Schneider for your leadership.
- Compliments to those who took this extra day to work on these issues. We have high quality people and we are pointed in the right direction.
- Echo what everyone's said
- It is important to take time away from our giant list of things to do, to look at the process of how we do it

Dr. Schneider closed the workshop with the following comments:

- Appreciative of all our participation
- Everyone put in lots of effort
- We bring enthusiasm to this work
- The facilitation helped make this happen
- Thank you to everyone

The meeting adjourned at 12:30 pm.

Appendix A: Agenda

Maine Board of Dental Practice

Workshop Agenda

Friday, October 7, 2016

Maine Hospital Association, 33 Fuller Rd, Augusta

Objectives

- Build on the good work of our June 17 Workshop at which we achieved consensus on a vision for our organization and how to achieve it.
- Establish specific performance measures for evaluating progress towards achieving our vision.
- Identify way to improve meetings and overall board functioning.

Agenda

8:15 **Arrival and Light Refreshments**

8:30 **Opening**
- President Geraldine A. Schneider, DMD will offer a brief welcome
- Facilitator Craig Freshley will explain the agenda and ground rules
- We will do some quick introductions, perhaps with a twist

8:45 **June 17 Workshop Review**
- We will remind ourselves of key conclusions from June 17 Board Workshop, especially the Vision Statement we develop and the List of Ideas we developed to achieve it.
- We will also share perspectives on how the Board has been functioning since the Workshop

9:05 **How to Measure Performance Going Forward**
- What is a performance measure?
  Before beginning to suggest and discuss performance measures, let's first make sure we have a shared understanding of what a "performance measure" is and how we expect them to be used.
- Ideas for Performance Measures
  We will begin by brainstorming. Then organize our ideas into categories. Then we will prioritize them in each category. We

might find that some are best suited for either short term of long term.

10:20 **Break**

10:40 **Continue Discussion of Performance Measures**

- Conclusions

  Lets try to decide what actual performance measures we intend to use.

11:30 **How to improve our meetings and overall board functioning**

- We will begin with brainstorming and try to conclude with a concise list of specific practices that will improve our meetings and board functioning.

12:15 **Closing Comments**

- This is a chance for each person to make a last comment, perhaps a reflection about the retreat or perhaps a specific hope or concern for the future.

12:30 **Adjourn**

Appendix B: June 17 Workshop Highlights

Maine Board of Dental Practice

Highlights from the June 17 Board Workshop

This summary was prepared by Craig Freshley and distributed as a handout on October 7.

Vision

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. Members of the Board are trusted and respected for their high integrity and commitment to public service. Supported by highly competent staff and funding, the Board's work is highly efficient and user-friendly.

What Needs to Happen to Achieve our Vision

- Goal setting
  - Set goals to be met and review on a regular basis
  - Have at least one meeting per year like today to review our programs
- Board training
  - Topics
    - Segmented statute/rules review
    - Training in conflict resolution, law matters, etc.
  - Methods
    - More workshops
    - Host board member in-services/training seminars
    - Tutorials for public members
- Better organized meetings
  - Structure the meeting day to tackle the most important issues first
  - Have the statute/rule in front of us for reference
- Make the most of what we have, such as "staff awesomeness"
  - Streamline information sharing
  - Increase efficiency
  - Workload/resource alignment
- Better outreach and engagement
  - Engage with increased outreach efforts
  - Communicate with professions and public more
  - Provide greater info
  - Positive image - work on perception
  - Engage licensed community on practice issues - try to stay current
  - Invite public comments at board meetings (time limited)

    - Provide case studies to reduce complaints
- More money / Increased Budget
    - Raise all licensing/permit fees (so we can be fully staffed)
    - Obtain funding to provide adequate staffing levels for the board
    - Advocate for board's need for resources
    - Grant writing to help secure more money
- Clarify roles and transparency expectations
    - Address trust issues
    - Understand role of staff

Appendix C: About Performance Measures

Maine Board of Dental Practice

About Performance Measures

This overview was prepared by Craig Freshley and distributed as a handout on October 7.

A performance measure is a particular thing you can look at over time to assess performance; to answer "how are we doing?"

- Quantitative are best
  - Qualitative are second best
- Outcome-based is best
  - Measures of activity are second best

A performance measure needs a reference

- Reference group
- History

A performance measure needs a goal or objective

- Based upon reference group performance or historical performance

Performance measures are used to

- Establish top priorities
  - What gets measured gets managed
- Internal review and assessment
  - So we know where adjustments have to be made
- Convey performance to others
  - Tell other people "how we are doing" with credibility

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

Report of the Board of Dental Practice

Submitted to the

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

Pursuant to Public Law 2016, c. 429

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

April 28, 2017

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

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

"An Act To Revise the Laws Regarding Dental Practices"

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

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Public Law Background

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

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

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

dental assistant/certified dental assistant, and two licensed denturists. Two members of the Board served as co-chairs, and the Board's Executive Director provided staffing resources to the committee. **(Appendix 1)** (Not attached but on file with the Board.)

Board Objective - Role of the Ad Hoc Committee

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ad Hoc Committee Process and Discussions

The ad hoc committee convened in public session on December 2, 2016, January 20, 2017, and March 3, 2017 from 9:00 a.m. to 12:00 p.m. Meeting materials were distributed to participants in advance to the extent practicable, and meeting notes were recorded for each meeting. **(Appendices 2, 3, and 4)** (Not attached but on file with the Board.)

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

Ground rules were provided at the beginning of each meeting. Each participant was given an opportunity to express their interests and/or concerns regarding the work of the ad hoc committee. Complete comments and meetings notes are available in the "Draft Report of the Ad Hoc Committee" document dated March 6, 2017. (**Appendix 5)** Highlights of the ad hoc committee discussions are noted below: (Appendix not included but on file with the Board.)

1) **RDH practice issues**:

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

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

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

3) **Denturist practice issues**:

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

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

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

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

1) **Recommended Statutory Changes**

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

b) Dental Hygiene scope of practice

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

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

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

2) Issues Identified for Rulemaking Changes

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

b) Dentist training responsibilities when delegating to unlicensed persons

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

3) Issues Identified for Further Legislative Consideration

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

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

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

Regulatory Context in Consideration of Ad Hoc Committee Work

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

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

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

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

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

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

Board's Recommendations

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

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

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

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

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

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

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

List of Appendices

PROPOSED CHANGES TO DENTAL PRACTICE ACT
APRIL 28, 2017

Title 32: PROFESSIONS AND OCCUPATIONS

Chapter 143: DENTAL PROFESSIONS

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Subchapter 1: GENERAL PROVISIONS

§18301. SHORT TITLE

This chapter may be known and cited as "the Dental Practice Act." [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18302. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2015, c. 429, §21 (NEW).]

1. Board. "Board" means the Board of Dental Practice established in Title 5, section 12004-A, subsection 10.

[2015, c. 429, §21 (NEW) .]

2. Charitable dentist license. "Charitable dentist license" means the authority granted to an individual to provide free dental care as requested by a charitable or social organization within the State when resident dental services are not available.

[2015, c. 429, §21 (NEW) .]

3. Clinical dentist educator license. "Clinical dentist educator license" means the authority granted to an individual who is licensed as a dentist in another state or jurisdiction to participate in clinical education for individuals licensed under this chapter.

[2015, c. 429, §21 (NEW) .]

4. Commissioner. "Commissioner" means the Commissioner of Professional and Financial Regulation.

[2015, c. 429, §21 (NEW) .]

5. Dental auxiliary. "Dental auxiliary" means a dental radiographer, expanded function dental assistant, dental hygienist, independent practice dental hygienist, public health dental hygienist, dental hygiene therapist or denturist.

[2015, c. 429, §21 (NEW) .]

6. Dental hygiene. "Dental hygiene" means the delivery of preventative, educational and clinical services supporting total health for the control of oral disease and the promotion of oral health provided by a dental hygienist in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

7. Dental hygiene therapist. "Dental hygiene therapist" means a person who holds a valid license as a dental hygienist issued by the board and is authorized to practice dental hygiene therapy under this chapter.

[2015, c. 429, §21 (NEW) .]

8. Dental hygiene therapy. "Dental hygiene therapy" means the delivery of dental hygiene services, including performance of certain dental procedures in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

9. Dental hygienist. "Dental hygienist" means a person who holds a valid license as a dental hygienist issued by the board.

[2015, c. 429, §21 (NEW) .]

10. Dental radiographer. "Dental radiographer" means a person who holds a valid license as a dental radiographer issued by the board.

[2015, c. 429, §21 (NEW) .]

11. Dental radiography. "Dental radiography" means the use of ionizing radiation on the maxilla, mandible and adjacent structures of human beings for diagnostic purposes while under the general supervision of a dentist in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

12. Dentist. "Dentist" means a person who holds a valid dentist license issued by the board.

[2015, c. 429, §21 (NEW) .]

13. Dentistry. "Dentistry" means the scope of practice for a dentist as described in section 18371.

[2015, c. 429, §21 (NEW) .]

14. Denture. "Denture" means any removable full or partial upper or lower prosthetic dental appliance to be worn in the human mouth to replace any missing natural teeth.

[2015, c. 429, §21 (NEW) .]

15. Denturism. "Denturism" means the process of ~~taking~~ obtaining denture impressions and bite registrations for the purpose of making, producing, reproducing, constructing, finishing, supplying, altering or repairing of a denture to be fitted to an edentulous or partially edentulous arch or arches and the fitting of a denture to an edentulous or partially edentulous arch or arches, including the making, producing, reproducing, constructing, finishing, supplying, altering and repairing of dentures, without performing alteration to natural or reconstructed tooth structure, in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

16. Denturist. "Denturist" means a person who holds a valid denturist license issued by the board.

[2015, c. 429, §21 (NEW) .]

17. Department. "Department" means the Department of Professional and Financial Regulation.

[2015, c. 429, §21 (NEW) .]

18. Direct supervision. "Direct supervision" means the supervision required by the board by rule of those tasks and procedures requiring the physical presence of the supervisor in the practice setting at the time such tasks or procedures are being performed. In order to provide direct supervision of patient treatment, the supervisor must at least diagnose the condition to be treated, authorize the treatment procedure prior to implementation and examine the condition after treatment and prior to the patient's discharge.

[2015, c. 429, §21 (NEW) .]

19. Expanded function dental assistant. "Expanded function dental assistant" means a person who holds a valid expanded function dental assistant license issued by the board.

[2015, c. 429, §21 (NEW) .]

20. Expanded function dental assisting. "Expanded function dental assisting" means performing certain dental procedures under the supervision of a dentist in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

21. Faculty. "Faculty" means, when used in conjunction with a license issued under this chapter, the authority granted to an individual who is authorized to practice only within the school setting, including any satellite locations approved by the board, and who teaches dentistry, dental hygiene or denturism as part of a clinical and didactic program.

[2015, c. 429, §21 (NEW) .]

22. General supervision. "General supervision" means the supervision required by the board by rule of those tasks and procedures when the physical presence of the supervisor is not required in the practice setting while procedures are being performed.

[2015, c. 429, §21 (NEW) .]

23. Independent practice dental hygienist. "Independent practice dental hygienist" means a person who holds a valid license as a dental hygienist issued by the board and who is authorized to practice independent dental hygiene.

[2015, c. 429, §21 (NEW) .]

24. License. "License" means a license or permit issued by the board granting authority to an individual authorized under this chapter to perform certain services.

[2015, c. 429, §21 (NEW) .]

25. Limited dentist. "Limited dentist" means a dentist who has retired from the regular practice of dentistry and who holds a valid license issued by the board to practice only in a nonprofit clinic without compensation for work performed at the clinic. Services provided by a limited dentist must be in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

26. Local anesthesia. "Local anesthesia" means a drug, element or other material that results in a state of insensibility of a circumscribed area or the loss of sensation in some definite, localized area without inhibition of conscious processes.

[2015, c. 429, §21 (NEW) .]

27. Nitrous oxide analgesia. "Nitrous oxide analgesia" means a gas containing nitrous oxide used to induce a controlled state of relative analgesia with the goal of controlling anxiety.

[2015, c. 429, §21 (NEW) .]

28. Practice setting. "Practice setting" means the physical location where services authorized under this chapter are provided to the public.

[2015, c. 429, §21 (NEW) .]

29. Provisional dental hygiene therapist. "Provisional dental hygiene therapist" means a person who holds a valid license as a dental hygienist issued by the board and who is authorized to practice dental hygiene therapy under the supervision of a dentist in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

30. Public health dental hygiene. "Public health dental hygiene" means the delivery of certain dental hygiene services under a written supervision agreement with a dentist for the purpose of providing services in a public health setting in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

31. Public health dental hygienist. "Public health dental hygienist" means a person who holds a valid license as a dental hygienist issued by the board and who is authorized to practice public health dental hygiene in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

32. Public health setting. "Public health setting" means a place where the practice of public health dental hygiene occurs, and includes, but is not limited to, public and private schools, medical facilities, nursing homes, residential care facilities, mobile units, nonprofit organizations and community health centers.

[2015, c. 429, §21 (NEW) .]

33. Resident dentist license. "Resident dentist license" means the authority granted to an individual who is a graduate of an approved dental school or college, who is not licensed to practice dentistry in this State and is authorized to practice under the direct or general supervision and direction of a dentist in a board-approved setting in accordance with this chapter.

[2015, c. 429, §21 (NEW) .]

34. Reversible intraoral procedures. "Reversible intraoral procedures" means placing and removing rubber dams and matrices; placing and contouring amalgam, composite and other restorative materials; applying sealants; supragingival polishing; and other reversible procedures.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18303. INDIVIDUAL LICENSE

Only an individual may be licensed under this chapter and only a licensed individual may provide services for which a license is required under this chapter. [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18304. LICENSE REQUIRED

1. Unlicensed practice. Except as provided in section 18305 and section 18371, subsections 3 and 6, a person may not practice or profess to be authorized to practice the activities described in this chapter without a license or during any period when that person's license has expired or has been suspended or revoked.

[2015, c. 429, §21 (NEW) .]

2. Unlawful practice. A person may not:

A. Practice dentistry under a false or assumed name; [2015, c. 429, §21 (NEW).]

B. Practice dentistry under the name of a corporation, company, association, parlor or trade name; [2015, c. 429, §21 (NEW).]

C. While manager, proprietor, operator or conductor of a place for performing dental operations, employ a person who is not a lawful practitioner of dentistry in this State to perform dental practices as described in section 18371; [2015, c. 429, §21 (NEW).]

D. While manager, proprietor, operator or conductor of a place for performing dental operations, permit a person to practice dentistry under a false name; [2015, c. 429, §21 (NEW).]

E. Assume a title or append a prefix or letters following that person's name that falsely represent the person as having a degree from a dental college; [2015, c. 429, §21 (NEW).]

F. Impersonate another at an examination held by the board; [2015, c. 429, §21 (NEW).]

G. Knowingly make a false application or false representation in connection with an examination held by the board; or [2015, c. 429, §21 (NEW).]

H. Employ a person as a dental hygienist, independent practice dental hygienist, denturist or dental radiographer who is not licensed to practice. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

3. Penalties. A person who violates this section commits a Class E crime. Violation of this section is a strict liability crime as defined in Title 17-A, section 34, subsection 4-A.

[2015, c. 429, §21 (NEW) .]

4. Injunction. The Attorney General may bring an action in Superior Court pursuant to Title 10, section 8003-C, subsection 5 to enjoin a person from violating this chapter.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18305. PERSONS AND PRACTICES NOT AFFECTED; EXEMPTIONS

1. Persons and practices not affected. Nothing in this chapter may be construed to limit, enlarge or affect the practice of persons licensed to practice medicine, osteopathy or dentistry in this State. Nothing in this chapter may be construed to prohibit a duly qualified dental surgeon or dental hygienist from performing work or services performed by a denturist licensed under this chapter to the extent those persons are authorized to perform the same services under other state law.

[2015, c. 429, §21 (NEW) .]

2. Exemptions. The requirement of a license under this chapter does not apply to:

A. A resident physician or a student enrolled in and attending a school or college of medicine or osteopathy; [2015, c. 429, §21 (NEW).]

B. A licensed physician or surgeon who practices under the laws of this State, unless that person practices dentistry as a specialty; [2015, c. 429, §21 (NEW).]

C. A qualified anesthetist or nurse anesthetist who provides an anesthetic for a dental operation; a certified registered nurse under the direct supervision of either a licensed dentist who holds a valid sedation or general anesthesia permit or a licensed physician who provides an anesthetic for a dental operation; a certified registered nurse under the direct supervision of a licensed dentist or physician who removes sutures, dresses wounds or applies dressings and bandages; and a certified registered nurse under the direct supervision of a licensed dentist or physician who injects drugs subcutaneously or intravenously; [2015, c. 429, §21 (NEW).]

D. A person serving in the United States Armed Forces or the United States Department of Health and Human Services, Public Health Service or employed by the United States Department of Veterans Affairs or other federal agency while performing official duties, if the duties are limited to that service or employment; [2015, c. 429, §21 (NEW).]

E. A graduate dentist or dental surgeon in the United States Army, Navy or Air Force; the United States Department of Health and Human Services, Public Health Service; the United States Coast Guard; or United States Department of Veterans Affairs who practices dentistry in the discharge of official duties; [2015, c. 429, §21 (NEW).]

F. A person having a current license to perform radiologic technology pursuant to section 9854 and who is practicing dental radiography under the general supervision of a dentist or physician; [2015, c. 429, §21 (NEW).]

G. A dentist licensed in another state or country at meetings of the Maine Dental Association or its affiliates or other like dental organizations approved by the board, while appearing as a clinician; [2015, c. 429, §21 (NEW).]

H. Any person, association, corporation or other entity who fills a prescription from a dentist for the construction, reproduction or repair of prosthetic dentures, bridges, plates or appliances to be used or worn as substitutes for natural teeth; [2015, c. 429, §21 (NEW).]

I. A dental laboratory technician constructing, altering, repairing or duplicating a denture, plate, partial plate, bridge, splint, orthodontic or prosthetic appliance with a prescription as set forth in section 18371, subsection 6; [2015, c. 429, §21 (NEW).]

J. A student enrolled in a board-approved dental program, dental hygiene program, dental therapy program, expanded function dental assisting program, dental radiography program or a denturism program practicing under the direct or general supervision of that student's instructors; [2015, c. 429, §21 (NEW).]

~~K. A student participating in a board-approved externship program who is registered and practicing under direct or general supervision as set forth in section 18348, subsection 1; and [2015, c. 429, §21 (NEW).]~~

L. An individual licensed under this chapter who is registered and practicing under the direct supervision of a dentist as set forth in section 18348, subsection 2 or 3 for the purpose of obtaining clinical experience needed for meeting the requirements to administer sedation, local anesthesia or general anesthesia. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18306. FRAUDULENT SALE OR ALTERATION OF DIPLOMAS OR LICENSES

1. Fraudulent or altered diploma or license; bribery. A person may not:

A. Sell or offer to sell a diploma conferring a dental degree or license granted pursuant to the laws of this State; [2015, c. 429, §21 (NEW).]

B. Procure a license or diploma with intent that it be used as evidence of the right to practice dentistry by a person other than the one upon whom the diploma or license was conferred; [2015, c. 429, §21 (NEW).]

C. With fraudulent intent alter a diploma or license to practice dentistry; [2015, c. 429, §21 (NEW).]

D. Use or attempt to use an altered diploma or license; or [2015, c. 429, §21 (NEW).]

E. Attempt to bribe a member of the board by the offer or use of money or other pecuniary reward or by other undue influence. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Penalty. A person who violates this section commits a Class E crime. Except as otherwise specifically provided, violation of this section is a strict liability crime as defined in Title 17-A, section 34, subsection 4-A.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18307. REVIEW COMMITTEE IMMUNITY

A dentist who is a member of a peer review committee of a state or local association or society composed of doctors of dentistry, a staff member of such an association or society assisting a peer review committee and a witness or consultant appearing before or presenting information to the peer review committee are immune from civil liability for, without malice, undertaking or failing to undertake any act within the scope of the function of the committee. [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18308. REQUIREMENTS REGARDING PRESCRIPTION OF OPIOID MEDICATION

1. Limits on opioid medication prescribing. Except as provided in subsection 2, an individual licensed under this chapter whose scope of practice includes prescribing opioid medication may not prescribe:

A. To a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day; [2015, c. 488, §32 (NEW).]

B. To a patient who, on the effective date of this section, has an active prescription for opioid medication in excess of 100 morphine milligram equivalents of an opioid medication per day, an opioid medication in an amount that would cause that patient's total amount of opioid medication to exceed 300 morphine milligram equivalents of opioid medication per day; except that, on or after July 1, 2017, the aggregate amount of opioid medication prescribed may not be in excess of 100 morphine milligram equivalents of opioid medication per day; [2015, c. 488, §32 (NEW).]

C. On or after January 1, 2017, within a 30-day period, more than a 30-day supply of an opioid medication to a patient under treatment for chronic pain. For purposes of this paragraph, "chronic pain" has the same meaning as in Title 22, section 7246, subsection 1-C; or [2015, c. 488, §32 (NEW).]

D. On or after January 1, 2017, within a 7-day period, more than a 7-day supply of an opioid medication to a patient under treatment for acute pain. For purposes of this paragraph, "acute pain" has the same meaning as in Title 22, section 7246, subsection 1-A. [2015, c. 488, §32 (NEW).]

[2015, c. 488, §32 (NEW) .]

2. Exceptions. An individual licensed under this chapter whose scope of practice includes prescribing opioid medication is exempt from the limits on opioid medication prescribing established in subsection 1 only:

A. When prescribing opioid medication to a patient for:

(1) Pain associated with active and aftercare cancer treatment;

(2) Palliative care, as defined in Title 22, section 1726, subsection 1, paragraph A, in conjunction with a serious illness, as defined in Title 22, section 1726, subsection 1, paragraph B;

(3) End-of-life and hospice care;

(4) Medication-assisted treatment for substance use disorder; or

(5) Other circumstances determined in rule by the Department of Health and Human Services pursuant to Title 22, section 7254, subsection 2; and [2015, c. 488, §32 (NEW).]

B. When directly ordering or administering a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility.

As used in this paragraph, "administer" has the same meaning as in Title 22, section 7246, subsection 1-B. [2015, c. 488, §32 (NEW).]

[2015, c. 488, §32 (NEW) .]

3. Electronic prescribing. An individual licensed under this chapter whose scope of practice includes prescribing opioid medication and who has the capability to electronically prescribe shall prescribe all opioid medication electronically by July 1, 2017. An individual who does not have the capability to electronically prescribe must request a waiver from this requirement from the Commissioner of Health and Human Services stating the reasons for the lack of capability, the availability of broadband infrastructure and a plan for developing the ability to electronically prescribe opioid medication. The commissioner may grant a waiver for circumstances in which exceptions are appropriate, including prescribing outside of the individual's usual place of business and technological failures.

[2015, c. 488, §32 (NEW) .]

4. Continuing education. By December 31, 2017, an individual licensed under this chapter must successfully complete 3 hours of continuing education every 2 years on the prescription of opioid medication as a condition of prescribing opioid medication. The board shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2015, c. 488, §32 (NEW) .]

5. Penalties. An individual who violates this section commits a civil violation for which a fine of $250 per violation, not to exceed $5,000 per calendar year, may be adjudged. The Department of Health and Human Services is responsible for the enforcement of this section.

[2015, c. 488, §32 (NEW) .]

SECTION HISTORY
2015, c. 488, §32 (NEW).

Subchapter 2: BOARD OF DENTAL PRACTICE

§18321. BOARD CREATION; DECLARATION OF POLICY; COMPENSATION

1. Board creation; declaration of policy. The Board of Dental Practice, as established in Title 5, section 12004-A, subsection 10, is created within this subchapter, its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions.

[2015, c. 429, §21 (NEW) .]

2. Compensation. Members of the board, the Subcommittee on Denturists under section 18326 and the Subcommittee on Dental Hygienists under section 18327 are entitled to compensation according to the provisions of Title 5, chapter 379.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18322. BOARD MEMBERSHIP

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

A. Five dentists. Each dentist member must hold a valid dental license under this chapter and must have been in the actual practice of dentistry in this State for at least 10 years immediately preceding appointment. A dentist is not eligible to serve as a member of the board while employing a dental hygienist or a denturist who is a member of the board; [2015, c. 429, §21 (NEW).]

B. Two dental hygienists. Each dental hygienist member must hold a valid dental hygiene license under this chapter and must have practiced in the State for at least 6 years immediately preceding appointment. A dental hygienist is not eligible to serve as a member of the board while employed by a dentist who is a member of the board; [2015, c. 429, §21 (NEW).]

C. One denturist. The denturist member must hold a valid denturist license under this chapter and must have practiced in the State for at least 6 years immediately preceding appointment. A denturist is not eligible to serve as a member of the board while employed by a dentist who is a member of the board; and [2015, c. 429, §21 (NEW).]

D. One public member. The public member must be a person who has no financial interest in the dental profession and has never been licensed, certified or given a permit in this or any other state for the dental profession. [2015, c. 429, §21 (NEW).]

The Governor may accept nominations from professional associations and from other organizations and individuals. A member of the board must be a legal resident of the State. A person who has been convicted of a violation of the provisions of this Act or any prior dental practice act, or who has been convicted of a crime punishable by more than one year's imprisonment, is not eligible for appointment to the board. Appointments of members must comply with Title 10, section 8009.

[2015, c. 429, §21 (NEW) .]

2. Terms. Terms of the members of the board are for 5 years. A person who has served 10 years or more on a dental examining board in this State is not eligible for appointment to the board. A member may be removed by the Governor for cause.

[2015, c. 429, §21 (NEW) .]

3. Quorum; chair; vice-chair. Notwithstanding any provision of law to the contrary, a majority of the members serving on the board constitutes a quorum. The board shall elect its chair and vice-chair annually.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18323. POWERS AND DUTIES OF THE BOARD

The board has the following powers and duties in addition to all other powers and duties imposed by this chapter: [2015, c. 429, §21 (NEW).]

1. Hearings and procedures. The power to hold hearings and take evidence in all matters relating to the exercise and performance of the powers and duties vested in the board and the authority to subpoena witnesses, books, records and documents in hearings before the board;

[2015, c. 429, §21 (NEW) .]

2. Complaints. The duty to investigate complaints in a timely fashion on its own motion and those lodged with the board or its representatives regarding the violation of a provision of this chapter or of rules adopted by the board;

[2015, c. 429, §21 (NEW) .]

3. Fees. The authority to adopt by rule fees for purposes authorized under this chapter in amounts that are reasonable and necessary for their respective purposes, except that the fee for any one purpose may not exceed $550;

[2015, c. 429, §21 (NEW) .]

4. Budget. The duty to submit to the commissioner its budgetary requirements in the same manner as is provided in Title 5, section 1665. The commissioner shall in turn transmit these requirements to the Department of Administrative and Financial Services, Bureau of the Budget without revision, alteration or change, unless alterations are mutually agreed upon by the department and the board or the board's designee. The budget submitted by the board to the commissioner must be sufficient to enable the board to comply with this chapter;

[2015, c. 429, §21 (NEW) .]

5. Adequacy of budget, fees and staffing. The duty to ensure that the budget submitted by the board to the commissioner pursuant to subsection 4 is sufficient, if approved, to provide for adequate legal and investigative personnel on the board's staff and that of the Attorney General to ensure that complaints pursuant to this chapter can be resolved in a timely fashion;

[2015, c. 429, §21 (NEW) .]

6. Executive director; duties. The power to appoint an executive director who serves at the pleasure of the board and who shall assist the board in carrying out its duties and responsibilities under this chapter. The executive director is responsible for the management of the board's affairs, including the authority to employ and prescribe the duties of personnel within the guidelines, policies and rules established by the board;

[2015, c. 429, §21 (NEW) .]

7. Authority to delegate. The power to delegate to staff the authority to review and approve applications for licensure pursuant to procedures and criteria established by rule;

[2015, c. 429, §21 (NEW) .]

8. Protocols for professional review committee. The authority to establish protocols for the operation of a professional review committee as defined in Title 24, section 2502, subsection 4-A. The protocols must include the committee reporting information the board considers appropriate regarding reports received, contracts or investigations made and the disposition of each report, as long as the committee is not required to disclose any personally identifiable information. The protocols may not prohibit an impaired licensee under this chapter from seeking alternative forms of treatment; and

[2015, c. 429, §21 (NEW) .]

9. Authority to order a mental or physical examination. The authority to direct a licensee, who by virtue of an application for and acceptance of a license to practice under this chapter is considered to have given consent, to submit to an examination whenever the board determines the licensee may be suffering from a mental illness or physical illness that may be interfering with competent practice under this chapter or from the use of intoxicants or drugs to an extent that prevents the licensee from practicing competently and with safety to patients. A licensee examined pursuant to an order of the board may not prevent the testimony of the examining individual or prevent the acceptance into evidence of the report of an examining individual. The board may petition the District Court for immediate suspension of a license if the licensee fails to comply with an order of the board to submit to a mental or physical examination pursuant to this subsection.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18324. RULES

The board shall adopt rules that are necessary for the implementation of this chapter. The rules may include, but need not be limited to, requirements for licensure, license renewal and license reinstatement as well as practice setting standards that apply to individuals licensed under this chapter relating to recordkeeping, infection control, supervision and administering sedation and anesthesia. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18325. DISCIPLINARY ACTION; JUDICIAL REVIEW

1. Disciplinary action. The board may suspend, revoke, refuse to issue or renew a license pursuant to Title 5, section 10004. The following are grounds for an action to refuse to issue, modify, suspend, revoke or refuse to renew the license of a person licensed under this chapter:

A. The practice of fraud, deceit or misrepresentation in obtaining a license or authority from the board or in connection with services within the scope of the license or authority; [2015, c. 429, §21 (NEW).]

B. Misuse of alcohol, drugs or other substances that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients; [2015, c. 429, §21 (NEW).]

C. A professional diagnosis of a mental or physical condition that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients; [2015, c. 429, §21 (NEW).]

D. Incompetence in the practice for which the licensee is licensed or authorized by the board. A licensee is considered incompetent in the practice if the licensee has:

(1) Engaged in conduct that evidences a lack of ability or fitness to perform the duties owed by the licensee to a client or patient or the general public; or

(2) Engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed; [2015, c. 429, §21 (NEW).]

E. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed or authorized by the board; [2015, c. 429, §21 (NEW).]

F. Subject to the limitations of Title 5, chapter 341, conviction of a crime that involves dishonesty or false statement or that relates directly to the practice for which the licensee is licensed or authorized by the board, or conviction of a crime for which incarceration for one year or more may be imposed; [2015, c. 429, §21 (NEW).]

G. Engaging in false, misleading or deceptive advertising; [2015, c. 429, §21 (NEW).]

H. Aiding or abetting unlicensed practice by a person who is not licensed or authorized as required under this chapter; [2015, c. 429, §21 (NEW).]

I. Failure to provide supervision as required under this chapter or a rule adopted by the board; [2015, c. 429, §21 (NEW).]

J. Engaging in any activity requiring a license or authority under this chapter or rule adopted by the board that is beyond the scope of acts authorized by the license or authority held; [2015, c. 429, §21 (NEW).]

K. Continuing to act in a capacity requiring a license or authority under this chapter or a rule adopted by the board after expiration, suspension or revocation of that license or authority; [2015, c. 429, §21 (NEW).]

L. Noncompliance with an order of or consent agreement executed by the board; [2015, c. 429, §21 (NEW).]

M. Failure to produce any requested documents in the licensee's possession or under the licensee's control relevant to a pending complaint, proceeding or matter under investigation by the board; [2015, c. 429, §21 (NEW).]

N. Any violation of a requirement imposed pursuant to section 18352; [2015, c. 488, §33 (AMD).]

O. A violation of this chapter or a rule adopted by the board; and [2015, c. 488, §33 (AMD).]

P. Failure to comply with the requirements of Title 22, section 7253. [2015, c. 488, §34 (NEW).]

[2015, c. 488, §§33, 34 (AMD) .]

2. Judicial review. Notwithstanding Title 10, section 8003, subsection 5, any nonconsensual revocation pursuant to Title 10, section 8003, subsection 5 of a license or authority issued by the board may be imposed

only after a hearing conforming to the requirements of Title 5, chapter 375, subchapter 4 and is subject to judicial review exclusively in the Superior Court in accordance with Title 5, chapter 375, subchapter 7.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW). 2015, c. 488, §§33, 34 (AMD).

§18326. SUBCOMMITTEE ON DENTURISTS

The Subcommittee on Denturists, referred to in this section as "the subcommittee," is established as follows. [2015, c. 429, §21 (NEW).]

1. Membership. The subcommittee consists of 5 members as follows:

A. The denturist who is a member of the board; [2015, c. 429, §21 (NEW).]

B. Two denturists, appointed by the Governor, who are legal residents of the State and have practiced in the State for at least 6 years immediately preceding appointment; and [2015, c. 429, §21 (NEW).]

C. Two dentists who are members of the board, appointed by the chair of the board. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Terms. Each of the 3 members of the subcommittee who also are members of the board shall serve on the subcommittee for the duration of that member's term on the board. The term of a member of the subcommittee who is not a member of the board is 5 years.

[2015, c. 429, §21 (NEW) .]

3. Duties. The subcommittee shall:

A. Perform an initial review of all complaints involving denturists. Upon completion of its review of a complaint, the secretary of the subcommittee shall report to the board the subcommittee's recommended disposition of the complaint. The board shall adopt the subcommittee's recommended disposition of a complaint unless no fewer than 2/3 of the board members who are present and voting vote to reject that recommended disposition; and [2015, c. 429, §21 (NEW).]

B. Perform an initial review of all applications for licensure as a denturist and all submissions relating to continuing education of denturists. Upon completion of its review of an application or submission, the secretary of the subcommittee shall report to the board the subcommittee's recommended disposition of the application or submission, including issuance, renewal, denial or nonrenewal of a denturist license. The board shall adopt the subcommittee's recommended disposition of an application or submission unless no fewer than 2/3 of the board members who are present and voting vote to reject that recommended disposition. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

4. Quorum; chair; secretary. Notwithstanding any provision of law to the contrary, a majority of the members serving on the subcommittee constitutes a quorum. The subcommittee shall annually elect its chair and secretary.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18327. SUBCOMMITTEE ON DENTAL HYGIENISTS

The Subcommittee on Dental Hygienists, referred to in this section as "the subcommittee," is established. [2015, c. 429, §21 (NEW).]

1. Membership. The subcommittee consists of 5 members as follows:

A. A dental hygienist who is a member of the board; [2015, c. 429, §21 (NEW).]

B. Two dental hygienists, appointed by the Governor, who are legal residents of the State and have practiced in the State for at least 6 years immediately preceding appointment; and [2015, c. 429, §21 (NEW).]

C. Two dentists who are members of the board, appointed by the chair of the board. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Terms. Each of the 3 members of the subcommittee who also are members of the board shall serve on the subcommittee for the duration of that member's term on the board. The term of a member of the subcommittee who is not a member of the board is 5 years.

[2015, c. 429, §21 (NEW) .]

3. Duties. The subcommittee shall:

A. Perform an initial review of all complaints involving dental hygienists and dental hygienists with additional authority pursuant to section 18345, subsection 2. Upon completion of its review of a complaint, the secretary of the subcommittee shall report to the board the subcommittee's recommended disposition of the complaint. The board shall adopt the subcommittee's recommended disposition of a complaint unless no fewer than 2/3 of the board members who are present and voting vote to reject that recommended disposition; and [2015, c. 429, §21 (NEW).]

B. Perform an initial review of all applications for licensure as a dental hygienist or a dental hygienist with additional authority pursuant to section 18345, subsection 2 and all submissions relating to continuing education of dental hygienists. Upon completion of its review of an application or submission, the secretary of the subcommittee shall report to the board the subcommittee's recommended disposition of the application or submission, including issuance, renewal, denial or nonrenewal of a dental hygienist license. The board shall adopt the subcommittee's recommended disposition of an application or submission unless no fewer than 2/3 of the board members who are present and voting vote to reject that recommended disposition. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

4. Quorum; chair; secretary. Notwithstanding any provision of law to the contrary, a majority of the members serving on the subcommittee constitutes a quorum. The subcommittee shall annually elect its chair and secretary.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

Subchapter 3: LICENSING QUALIFICATIONS

§18341. APPLICATION; FEES; GENERAL QUALIFICATIONS

1. Application. An applicant seeking an initial or a renewed license must submit an application with the fee established under section 18323 and any other materials required by the board.

[2015, c. 429, §21 (NEW) .]

2. Age. An applicant must be 18 years of age or older.

[2015, c. 429, §21 (NEW) .]

3. Time limit. An applicant has 90 days after being notified of the materials needed to complete the application to submit those materials to the board. Failure to complete the application within that 90-day period may result in a denial of the application.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18342. DENTIST

1. Dentist license. Except as provided in section 18347, an applicant for licensure as a dentist must comply with the provisions of section 18341 and must provide:

A. Verification of a doctoral degree in dentistry from a dental school accredited as required by board rule; and [2015, c. 429, §21 (NEW).]

B. Verification of passing all examinations required by the board. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Faculty dentist license. An applicant for a faculty dentist license must comply with section 18341 and must provide:

A. Verification of an active dental license in good standing issued under the laws of another state or a Canadian province; and [2015, c. 429, §21 (NEW).]

B. Credentials, satisfactory to the board, including a letter from the employing school of dentistry, dental hygiene or denturism indicating that the applicant satisfies the credentialing standards of the school and that the applicant will teach:

(1) Dentistry, dental hygiene or denturism in this State as part of a clinical and didactic program for professional education for dental students and dental residents accredited by the American Dental Association Commission on Dental Accreditation or a successor organization approved by the board;

(2) Dental hygiene in this State as part of a clinical and didactic program for professional education for dental hygiene students and dental hygiene residents accredited by the American Dental Association Commission on Dental Accreditation or a successor organization approved by the board; or

(3) Denturism in this State as part of a board-approved clinical and didactic program for professional education for denturism students. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

3. Limited dentist license. An applicant for a limited dentist license must comply with section 18341 and must provide:

A. Verification of a doctoral degree in dentistry from a dental school accredited as required by board rule; [2015, c. 429, §21 (NEW).]

B. Verification that the applicant has been licensed as a dentist in good standing issued under the laws of this State or has an active dental license in good standing issued under the laws of another state or a Canadian province; [2015, c. 429, §21 (NEW).]

C. Verification of passing all examinations required by board rule; and [2015, c. 429, §21 (NEW).]

D. Verification that the applicant will be practicing dentistry in a nonprofit dental clinic without compensation for work performed at the clinic. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

~~**4. Clinical dentist educator license.** An applicant for a clinical dentist educator license must comply with section 18341 and must provide:~~

~~A. Verification of an active dental license in good standing issued under the laws of another state or a Canadian province; and [2015, c. 429, §21 (NEW).]~~

~~B. An outline of the clinical education program to be offered to practitioners in this State. [2015, c. 429, §21 (NEW).]~~

~~[2015, c. 429, §21 (NEW) .]~~

~~**5. Charitable dentist license.** An applicant for a charitable dentist license must comply with section 18341 and must provide:~~

~~A. Verification of a doctoral degree in dentistry from a dental school accredited as required by board rule; [2015, c. 429, §21 (NEW).]~~

~~B. Verification that the applicant has been licensed as a dentist in good standing under the laws of this State or has an active dental license in good standing issued under the laws of another state or a Canadian province; [2015, c. 429, §21 (NEW).]~~

~~C. Verification of passing all examinations required by board rule; and [2015, c. 429, §21 (NEW).]~~

~~D. Verification that the purpose of the license is to offer free dental care in conjunction with a charitable or social organization. [2015, c. 429, §21 (NEW).]~~

[2015, c. 429, §21 (NEW) .]

4. Visiting Dentist License. An applicant for a visiting dentist license must comply with section 18341 and must provide:

A. Verification that the applicant is licensed as a dentist in good standing issued under the laws of this State or has an active dental license in good standing issued under the laws of another state or a Canadian province; [2015, c. 429, §21 (NEW).]

C. Verification of passing all examinations required by board rule; and [2015, c. 429, §21 (NEW).]

6. Resident dentist license. An applicant for a resident dentist license must comply with section 18341 and must provide:

A. Verification of a doctoral degree in dentistry from a dental school accredited as required by board rule; [2015, c. 429, §21 (NEW).]

B. Verification of passing all examinations required by board rule; [2015, c. 429, §21 (NEW).]

C. Verification that the applicant will be practicing dentistry in a board-approved practice setting within the State; and [2015, c. 429, §21 (NEW).]

D. A statement from the sponsoring dentist that demonstrates that the level of supervision and control of the services to be performed by the applicant are adequate and that the performance of these services are within the applicant's dental knowledge and skill. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18343. DENTAL RADIOGRAPHER

1. Dental radiographer license. Except as provided in section 18347, an applicant for a dental radiographer license must comply with section 18341 and must provide:

A. Verification of a high school diploma or its equivalent as determined by the board; and [2015, c. 429, §21 (NEW).]

B. Verification of passing an examination in dental radiologic technique and safety required by board rule. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18344. EXPANDED FUNCTION DENTAL ASSISTANT

1. Expanded function dental assistant license. Except as provided in section 18347, an applicant for an expanded function dental assistant license must comply with section 18341 and must provide:

A. Verification of a high school diploma or its equivalent as determined by the board; [2015, c. 429, §21 (NEW).]

B. Verification of one of the following:

(1) A current certificate as a certified dental assistant from a board-approved certificate program;

(2) An active dental hygiene license in good standing issued under the laws of this State; or

(3) An active dental hygiene license in good standing issued under the laws of another state or a Canadian province; [2015, c. 2, §22 (COR).]

C. Verification of having successfully completed training in a school or program required by board rule; and [2015, c. 429, §21 (NEW).]

D. Verification of passing all examinations required by board rule. [2015, c. 429, §21 (NEW).]

[2015, c. 2, §22 (COR) .]

SECTION HISTORY
RR 2015, c. 2, §22 (COR). 2015, c. 429, §21 (NEW).

§18345. DENTAL HYGIENIST

1. Dental hygienist license. Except as provided in section 18347, an applicant for a dental hygienist license must comply with section 18341 and must provide:

A. Verification of having successfully passed all examinations required by board rule and one of the following:

(1) Verification of an associate degree or higher in dental hygiene from a ~~school~~ program accredited by the American Dental Association Commission on Dental Accreditation, or its successor organization; or

(2) Verification of having completed at least 1/2 of the prescribed course of study in an accredited dental college as a dental student. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Additional authority. A dental hygienist licensed under this section or section 18347 who applies for additional authority must comply with section 18341 and must provide:

A. For independent practice dental hygienist authority:

(1~~) If the applicant has a bachelor's degree or higher in dental hygiene from a dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation or its successor organization, v~~Verification of 2,000 work hours of clinical practice ~~during the 4 years preceding the application; or~~

~~(2) If the applicant has an associate degree in dental hygiene from a dental hygiene program accredited by the American Dental Association Commission on Dental Accreditation or its successor organization, verification of 5,000 work hours of clinical practice during the 6 years preceding the application.~~

For purposes of meeting the clinical practice requirements of this paragraph, the applicant's hours in a private dental practice or nonprofit setting under the supervision of a dentist may be included as well as the applicant's hours as a public health dental hygienist or, prior to the effective date of this Act, as a dental hygienist with public health supervision status; [2015, c. 429, §21 (NEW).]

B. For public health dental hygienist authority:

(1) A copy of the written agreement between the applicant and a supervising dentist that outlines the roles and responsibilities of the parties, which must include, but is not limited to, the level of supervision provided by the dentist, the practice settings, the standing orders and the coordination and collaboration that each party must undertake if additional patient care is needed; and

(2) Verification that the services will be offered in a public health setting; [2015, c. 429, §21 (NEW).]

C. For dental hygiene therapist authority:

(1) Verification of having successfully completed a dental hygiene therapy program that:

(a) Is accredited by the American Dental Association Commission on Dental Accreditation or a successor organization;

(b) Is a minimum of 4 semesters;

(c) Is consistent with the model curriculum for educating dental hygiene therapists adopted by the American Association of Public Health Dentistry or a successor organization;

(d) Is consistent with existing dental hygiene therapy programs in other states approved by the board; and

(e) Meets the requirements for dental hygiene therapy education programs adopted by board rule;

(2) Verification of a bachelor's degree or higher in dental hygiene, dental hygiene therapy or dental therapy from a school accredited by the American Dental Association Commission on Dental Accreditation or a successor organization;

(3) Verification of passing a clinical examination and all other examinations required by board rule. The clinical examination must be a comprehensive, competency-based clinical examination approved by the board and administered independently of an institution providing dental hygiene therapy education;

(4) Verification of having engaged in 2,000 hours of supervised clinical practice under the supervision of a dentist and in conformity with rules adopted by the board, during which supervised clinical practice the applicant is authorized to practice pursuant to paragraph F.

For purposes of meeting the clinical requirements of this subparagraph, an applicant's hours of supervised clinical experience while enrolled in the dental hygiene therapy program under subparagraph (1) may be included as well as hours completed under the supervision of a dentist licensed in another state or a Canadian province, provided that the applicant was operating lawfully under the laws and rules of that state or province; and

(5) A copy of the written practice agreement and standing orders required by section 18377, subsection 3; [2015, c. 429, §21 (NEW).]

D. For local anesthesia authority:

(1) Verification of having successfully completed a course of study required by board rule; and

(2) Verification of passing all examinations required by board rule; [2015, c. 429, §21 (NEW).]

E. For nitrous oxide analgesia authority:

(1) Verification of having successfully completed a course of study required by board rule; and

(2) Verification of passing all examinations required by board rule; and [2015, c. 429, §21 (NEW).]

F. For provisional dental hygiene therapist authority:

(1) Verification of meeting the requirements of paragraph C, subparagraphs (1) to (3); and

(2) A copy of the written agreement between the applicant and a dentist who will provide levels of supervision consistent with the scope of practice outlined in section 18377 and in conformity with rules adopted by the board.

During the period of provisional authority the applicant may be compensated for services performed as a dental hygiene therapist. The period of provisional authority may not exceed 3 years. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

3. Faculty dental hygiene license. An applicant for a faculty dental hygienist license must comply with section 18341 and must provide:

A. Verification of an active dental hygiene license in good standing issued under the laws of another state or a Canadian province; and [2015, c. 429, §21 (NEW).]

B. Credentials, satisfactory to the board, including a letter from the employing school of dentistry, dental hygiene or denturism indicating that the applicant satisfies the credentialing standards of the school and that the applicant will teach:

(1) Dental hygiene or denturism in this State as part of a clinical and didactic program for professional education for dental students and dental residents accredited by the American Dental Association Commission on Dental Accreditation or a successor organization approved by the board;

(2) Dental hygiene in this State as part of a clinical and didactic program for professional education for dental hygiene students and dental hygiene residents accredited by the American Dental Association Commission on Dental Accreditation or a successor organization approved by the board; or

(3) Denturism in this State as part of a board-approved clinical and didactic program for professional education for denturism students. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18346. DENTURIST

1. Denturist license. Except as provided in section 18347, an applicant for a denturist license must comply with section 18341 and must provide:

A. Verification of a high school diploma or its equivalent as determined by the board; [2015, c. 429, §21 (NEW).]

B. Verification of a diploma from a board-approved denturism postsecondary institution; and [2015, c. 429, §21 (NEW).]

C. Verification of passing all examinations required by board rule. The content of one examination must have a clinical component and a written component concerning, but not limited to, dental materials, denture technology, United States Department of Health and Human Services, Centers for Disease Control and Prevention guidelines, basic anatomy and basic pathology. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Faculty denturist license. An applicant for a faculty denturist license must comply with section 18341 and must provide:

A. Verification of an active denturist license in good standing issued under the laws of another state or a Canadian province; and [2015, c. 429, §21 (NEW).]

B. Credentials, satisfactory to the board, including a letter from the employing school of dentistry, dental hygiene or denturism indicating that the applicant satisfies the credentialing standards of the school. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18347. ENDORSEMENT; APPLICANTS AUTHORIZED TO PRACTICE IN ANOTHER JURISDICTION

The board is authorized, at its discretion, to waive the examination requirements and issue a license or grant an authority to an applicant who is licensed under the laws of another state or a Canadian province who furnishes proof, satisfactory to the board, that the requirements for licensure under this chapter have been met. Applicants must comply with the provisions set forth in section 18341. [2015, c. 429, §21 (NEW).]

1. Applicants licensed in another jurisdiction. An applicant for licensure or seeking authority under this chapter who is licensed under the laws of another jurisdiction is governed by this subsection.

A. An applicant who is licensed in good standing at the time of application to the board under the laws of another state or a Canadian province may qualify for licensure by submitting evidence to the board that the applicant has held a substantially equivalent, valid license for at least 3 consecutive years immediately preceding the application to the board at the level of licensure applied for in this State. [2015, c. 429, §21 (NEW).]

B. An applicant who does not meet the requirements of paragraph A but is licensed in good standing at the time of application to the board under the laws of another state or a Canadian province may qualify for licensure by submitting evidence satisfactory to the board that the applicant's qualifications for licensure are substantially similar to the requirements in this chapter for the relevant license. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18348. REGISTRATION REQUIREMENTS

~~**1. Dentist externship registration.** A dentist may register under that dentist's license a student for the purpose of providing clinical supervision outside of the academic setting. A registration under this section expires one year from the date the registration is granted. An applicant must comply with section 18341 and must provide:~~

~~A. Verification that the student has an academic affiliation and good academic standing as a dental student in a school approved by the board; [2015, c. 429, §21 (NEW).]~~

~~B. Verification from the dental school that the student has completed satisfactory training and is ready to perform limited dental services outside of the school setting under the supervision of a dentist; and [2015, c. 429, §21 (NEW).]~~

~~C. A statement from the supervising dentist that outlines the level of supervision that the dentist will provide and that attests that the performance of these services by the student will add to the student's knowledge and skill in dentistry. [2015, c. 429, §21 (NEW).]~~

[2015, c. 429, §21 (NEW) .]

2. Sedation and general anesthesia registration. A dentist who holds a permit to administer sedation pursuant to section 18379 may register another dentist under that dentist's license for the purpose of providing clinical supervision in administering sedation or general anesthesia under direct supervision. A registration under this subsection expires one year from the date the registration is granted. Applicants must comply with section 18341 and must submit a letter from the supervising dentist describing the practice settings in which supervision will occur as well as attesting that these arrangements are commensurate with the registrant's education, training and competency.

[2015, c. 429, §21 (NEW) .]

3. Local anesthesia/nitrous oxide analgesia registration. A dentist may register a dentist or dental hygienist under that dentist's license for the purpose of providing clinical supervision in administering local anesthesia or nitrous oxide analgesia under direct supervision. A registration under this section expires one year from the date the registration is granted. Applicants must comply with section 18341 and must submit a letter from the supervising dentist describing the practice settings in which supervision will occur as well as attesting that these arrangements are commensurate with the registrant's education, training and competency.

[2015, c. 429, §21 (NEW) .]

4. Denturist ~~externship~~ trainee registration. A denturist or dentist may register under that dentist's or denturist's license an individual who has completed the educational requirements ~~student~~ for the purpose of providing additional clinical supervision outside of the academic setting. A registration under this section expires one year from the date the registration is granted, but may be renewed for an additional year. An applicant must comply with section 18341 and must provide:

A. Verification that the ~~student~~ trainee ~~has an academic affiliation and good academic standing as a~~ successfully completed ~~denturist student in a~~ a denturist program approved by the board; [2015, c. 429, §21 (NEW).]

~~B. Verification from the denturist program that the student has completed satisfactory training and is ready to perform limited denturist services outside of the school setting under the supervision of a denturist or a dentist; and~~ [2015, c. 429, §21 (NEW).]

C. A letter from the supervising denturist ~~or dentist~~ that describes the level of supervision that the dentist will provide and that attests that the performance of these services by the ~~student~~ trainee will add to the ~~student's~~ their knowledge and skill in denturism to prepare them for full licensure. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18349. LICENSE RENEWAL; REINSTATEMENT

1. Renewal. Licenses under this chapter expire at such times as the commissioner may designate. In the absence of any reason or condition that might warrant the refusal of granting a license, the board shall issue a renewal license to each applicant who meets the requirements of sections 18341 and 18350.

[2015, c. 429, §21 (NEW) .]

2. Late renewals. Licenses may be renewed up to 90 days after the date of expiration if the applicant meets the requirements of subsection 1 and pays a late fee established by the board pursuant to section 18323, subsection 3.

[2015, c. 429, §21 (NEW) .]

3. Reinstatement. A person who submits an application for reinstatement more than 90 days after the license expiration date is subject to all requirements governing new applicants under this chapter, except that the board may, giving due consideration to the protection of the public, waive examination if that renewal application is received, together with the penalty fee established by the board pursuant to section 18323, subsection 3, within 2 years from the date of the license expiration.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18350. CONTINUING EDUCATION

As a condition of renewal of a license to practice, an applicant must have a current cardiopulmonary resuscitation certification and complete continuing education during the licensing cycle prior to application for renewal. The board may prescribe by rule the content and types of continuing education activities that meet the requirements of this section. [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18351. INACTIVE STATUS

A licensee who wants to retain licensure while not practicing may apply for an inactive status license. The fee for inactive status licensure is set under section 18323, subsection 3. During inactive status, the licensee must renew the license and pay the renewal fee set under section 18323, subsection 3, but is not required to meet the continuing education requirements under section 18350. The board shall adopt rules by which an inactive status license may be reinstated. [2015, c. 429, §21 (NEW).]

An individual who practices under a clinical dentist educator license, a charitable dentist license or a resident dentist license or as a provisional dental hygiene therapist may not apply for inactive status. [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18352. DUTY TO REQUIRE CERTAIN INFORMATION FROM APPLICANTS AND LICENSEES

1. Report in writing. A licensee and an applicant for licensure shall report in writing to the board no later than 10 days after any of the following changes or events:

A. Change of name or address; [2015, c. 429, §21 (NEW).]

B. Criminal conviction; [2015, c. 429, §21 (NEW).]

C. Revocation, suspension or other disciplinary action taken in this State or any other jurisdiction against any occupational or professional license held by the licensee or applicant; or [2015, c. 429, §21 (NEW).]

D. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the board. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

Subchapter 4: SCOPE OF PRACTICE; SUPERVISION; PRACTICE REQUIREMENTS

§18371. DENTIST

1. Scope of practice. A dentist, ~~charitable dentist, clinical dentist educator~~, faculty dentist, limited dentist or resident dentist may:

A. Perform a dental operation or oral surgery or dental service of any kind, gratuitously or for a salary, fee, money or other compensation paid, or to be paid, directly or indirectly to the person or to any other person or agency who is a proprietor of a place where dental operations, oral surgery or dental services are performed; [2015, c. 429, §21 (NEW).]

B. ~~Take~~ Obtain impressions of a human tooth, teeth or jaws and perform a phase of an operation incident to the replacement of a part of a tooth; [2015, c. 429, §21 (NEW).]

C. Supply artificial substitutes for the natural teeth and furnish, supply, construct, reproduce or repair a prosthetic denture, bridge, appliance or any other structure to be worn in the human mouth; [2015, c. 429, §21 (NEW).]

D. Place dental appliances or structures in the human mouth and adjust or attempt or profess to adjust the same; [2015, c. 429, §21 (NEW).]

E. Furnish, supply, construct, reproduce or repair or profess to the public to furnish, supply, construct, reproduce or repair a prosthetic denture, bridge, appliance or other structure to be worn in the human mouth; [2015, c. 429, §21 (NEW).]

F. Diagnose or profess to diagnose, prescribe for and treat or profess to prescribe for and treat disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws or adjacent structure; [2015, c. 429, §21 (NEW).]

G. Extract or attempt to extract human teeth; [2015, c. 429, §21 (NEW).]

H. Correct or attempt to correct malformations of teeth and jaws; [2015, c. 429, §21 (NEW).]

I. Repair or fill cavities in the human teeth; [2015, c. 429, §21 (NEW).]

J. Diagnose malposed teeth and make and adjust appliances or artificial casts for treatment of the malposed teeth in the human mouth with or without instruction; [2015, c. 429, §21 (NEW).]

K. Use an x-ray machine for the purpose of taking dental x-rays and interpret or read or profess to interpret or read dental x-rays; [2015, c. 429, §21 (NEW).]

L. Use the words dentist, dental surgeon or oral surgeon and the letters D.D.S. or D.M.D. and any other words, letters, title or descriptive matter that represents that person as being able to diagnose, treat, prescribe or operate for a disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws or adjacent structures and state, profess or permit to be stated or professed by any means or method whatsoever that the person can perform or will attempt to perform dental operations or render a diagnosis connected with dental operations; [2015, c. 429, §21 (NEW).]

M. Prescribe drugs or medicine and administer local anesthesia, analgesia including nitrous oxide and oxygen inhalation and, with the appropriate permit issued by the board, administer sedation and general anesthesia necessary for proper dental treatment; and [2015, c. 429, §21 (NEW).]

N. Take case histories and perform physical examinations to the extent the activities are necessary in the exercise of due care in conjunction with the provision of dental treatment or the administration of anesthesia. A dentist is not permitted to perform physical examinations within a hospital licensed by the Department of Health and Human Services unless this activity is permitted by the hospital. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Limitations. Individuals practicing dentistry as described in this section who possess one of the following licenses shall adhere to the restrictions in this subsection.

~~A. An individual with a charitable dentist license may provide dental services only in conjunction with the charitable or social organization for which the license was issued by the board and may not accept remuneration for those services. Authority to practice as a charitable dentist may not exceed one year. [2015, c. 429, §21 (NEW).]~~

~~B. An individual with a clinical dentist educator license may provide dental services only as part of the clinical education program under which the license was issued by the board. Authority to practice as a clinical dentist educator may not exceed 7 days in any calendar year. [2015, c. 429, §21 (NEW).]~~

~~C~~A. An individual with a faculty dentist license may provide dental services only as part of the education program for which the license was issued by the board. [2015, c. 429, §21 (NEW).]

~~D~~B. An individual with a limited dentist license may provide dental services only in the nonprofit dental clinic for which the license was issued by the board and may not accept remuneration for those services. [2015, c. 429, §21 (NEW).]

C. An individual with a visiting dentist license may provide dental services. Authority to practice may not exceed one year.

~~E~~D. An individual with a resident dentist license may provide dental services only under the supervision of the sponsoring dentist and in accordance with the level of supervision and control for which the license was issued by the board. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

3. Delegation authorized. A dentist may delegate to an unlicensed person the activities listed in this subsection. A dentist who delegates activities as described is legally liable for the activities of that unlicensed person and the unlicensed person in this relationship is considered the dentist's agent.

A. A dentist may delegate the following activities to an unlicensed person as long as these activities are conducted under the general supervision of the delegating dentist:

(1) Changing or replacing dry socket packets after diagnosis and treatment planned by a dentist;

(2) For instruction purposes, demonstrating to a patient how the patient should place and remove removable prostheses, appliances or retainers;

(3) For the purpose of eliminating pain or discomfort, removing loose, broken or irritating orthodontic appliances;

(4) Giving oral health instructions;

(5) Irrigating and aspirating the oral cavity;

(6) Performing dietary analyses for dental disease control;

(7) Placing and recementing with temporary cement an existing crown that has fallen out as long as the dental assistant promptly notifies the dentist this procedure was performed so that appropriate follow-up can occur;

(8) Placing and removing periodontal dressing;

(9) Pouring and trimming dental models;

(10) Removing sutures and scheduling a follow-up appointment with the dentist within 7 to 10 days of suture removal;

(11) Retracting lips, cheek, tongue and other tissue parts;

(12) ~~Taking and pouring~~Obtaining impressions for study casts;

(13) Taking and recording the vital signs of blood pressure, pulse and temperature;

(14) Taking dental plaque smears for microscopic inspection and patient education; and

(15) Taking intraoral photographs. [2015, c. 429, §21 (NEW).]

B. If the unlicensed person has successfully passed a certification examination administered by a national dental assisting board, the dentist may delegate to that unlicensed person the following additional activities, as long as these activities are conducted under the general supervision of the dentist:

(1) Placing temporary fillings on an emergency basis as long as the patient is informed of the temporary nature of the fillings; and

(2) Removing excess cement from the supragingival surfaces of teeth. [2015, c. 429, §21 (NEW).]

C. A dentist may delegate to an unlicensed person the following intraoral activities, which must be conducted under the direct supervision of the delegating dentist:

(1) Applying cavity varnish;

(2) Applying liquids, pastes and gel topical anesthetics;

(3) Assisting a dentist who provides orthodontic services in preparation of teeth for attaching, bonding and cementing fixed appliances in a manner appropriate and according to manufacturer's directions;

(4) Delivering, but not condensing or packing, amalgam or composite restoration material;

(5) Fabricating temporary crowns and bridges, limiting handpiece rotary instrumentation used in the fabrication to extraoral use only, as long as the dentist checks the occlusion and fit prior to releasing the patient;

(6) Irrigating and drying root canals;

(7) Isolating the operative field;

(8) Performing ~~cold~~ pulp vitality testing with confirmation by the dentist;

(9) Performing electronic vitality scanning with confirmation by the dentist;

(10) Performing preliminary selection and fitting of orthodontic bands, with final placement and cementing in the patient's mouth by the dentist;

(11) Placing and cementing temporary crowns with temporary cement;

(12) Placing and removing matrix bands, rubber dams and wedges;

(13) Placing elastics and instructing in their use;

(14) Placing, holding or removing celluloid and other plastic strips prior to or subsequent to the placement of a filling by the dentist;

(15) Placing or removing temporary separating devices;

(16) Placing wires, pins and elastic ligatures to tie in orthodontic arch wires that have been fitted and approved by the dentist at the time of insertion;

(17) Preparing tooth sites and surfaces with a rubber cup and pumice for banding or bonding of orthodontic brackets. This procedure may not be intended or interpreted as an oral prophylaxis, which is a procedure specifically reserved to be performed by dental hygienists or dentists. This procedure also may not be intended or interpreted as a preparation for restorative material. A dentist or dental hygienist shall check and approve the procedure;

(18) Reapplying, on an emergency basis only, orthodontic brackets;

(19) Recording readings with a digital caries detector and reporting them to the dentist for interpretation and evaluation;

(20) Removing composite material using slow-speed instrumentation for debonding brackets, as long as the dentist conducts a final check prior to release of the patient;

(21) Removing excess cement from the supragingival surfaces of teeth;

(22) Removing gingival retraction cord;

(23) Removing orthodontic arch wires and tension devices and any loose bands or bonds, but only as directed by the dentist;

(24) Selecting and trying in stainless steel or other preformed crowns for insertion by the dentist;

(25) ~~Taking~~ Obtaining impressions for opposing models and retainers;

(26) ~~Taking~~ Obtaining impressions for single-arch athletic mouth guards, bleaching trays, custom trays and fluoride trays; and

(27) Taking intraoral measurements and making preliminary selection of arch wires and intraoral and extraoral appliances, including head gear. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

4. Delegation not authorized. A dentist may not delegate any dental activity not listed in subsections 3 or 6 to an unlicensed person.

[2015, c. 429, §21 (NEW) .]

5. Supervision of dental hygiene therapists. A dentist, referred to in this section as the "supervising dentist," who employs a dental hygiene therapist shall comply with this subsection.

A. A supervising dentist shall arrange for another dentist or specialist to provide any services needed by a patient of a dental hygiene therapist supervised by that dentist that are beyond the scope of practice of the dental hygiene therapist and that the supervising dentist is unable to provide. [2015, c. 429, §21 (NEW).]

B. The supervising dentist is responsible for all authorized services and procedures performed by the dental hygiene therapist pursuant to a written practice agreement executed by the dentist pursuant to section 18377. [2015, c. 429, §21 (NEW).]

C. Revisions to a written practice agreement must be documented in a new written practice agreement signed by the supervising dentist and the dental hygiene therapist. [2015, c. 429, §21 (NEW).]

D. A supervising dentist who signs a written practice agreement shall file a copy of the agreement with the board, keep a copy for the dentist's own records and make a copy available to patients of the dental hygiene therapist upon request. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

6. Prescription for laboratory services. A dentist who uses the services of a person not licensed to practice dentistry in this State to construct, alter, repair or duplicate a denture, plate, partial plate, bridge, splint, orthodontic or prosthetic appliance shall first furnish the unlicensed person with a written prescription, which must contain:

A. The name and address of the unlicensed person; [2015, c. 429, §21 (NEW).]

B. The patient's name or number. In the event the number is used, the name of the patient must be written upon the duplicate copy of the prescription retained by the dentist; [2015, c. 429, §21 (NEW).]

C. The date on which the prescription was written; [2015, c. 429, §21 (NEW).]

D. A description of the work to be done, with diagrams if necessary; [2015, c. 429, §21 (NEW).]

E. A specification of the type and quality of materials to be used; and [2015, c. 429, §21 (NEW).]

F. The signature of the dentist and the number of the dentist's state license. [2015, c. 429, §21 (NEW).]

The dentist shall retain for 2 years a duplicate copy of all prescriptions issued pursuant to this subsection for inspection by the board.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18372. DENTAL RADIOGRAPHER

1. Scope of practice. A licensed dental radiographer may practice dental radiography under the general supervision of a dentist or an independent practice dental hygienist.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18373. EXPANDED FUNCTION DENTAL ASSISTANT

1. Scope of practice; direct supervision. An expanded function dental assistant may perform the following reversible intraoral procedures authorized under the direct supervision of a dentist:

A. Apply cavity liners and bases as long as the dentist:

(1) Has ordered the cavity liner or base;

(2) Has checked the cavity liner or base prior to the placement of the restoration; and

(3) Has checked the final restoration prior to patient dismissal; [2015, c. 429, §21 (NEW).]

B. Apply pit and fissure sealants after an evaluation of the teeth by the dentist at the time of sealant placement; [2015, c. 429, §21 (NEW).]

C. Apply supragingival desensitizing agents to an exposed root surface or dentinal surface of teeth; [2015, c. 429, §21 (NEW).]

D. Apply topical fluorides recognized for the prevention of dental caries; [2015, c. 429, §21 (NEW).]

E. Cement provisional or temporary crowns and bridges and remove excess cement; [2015, c. 429, §21 (NEW).]

F. Perform ~~tooth~~ pulp vitality tests; [2015, c. 429, §21 (NEW).]

G. Place and contour amalgam, composite and other restorative materials prior to the final setting or curing of the material; [2015, c. 429, §21 (NEW).]

~~H. Place and remove periodontal dressing; [2015, c. 429, §21 (NEW).]~~

~~I.~~H Place and remove retraction cord; [2015, c. 429, §21 (NEW).]

~~J. Record readings with a digital caries detector and report them to the dentist for interpretation and evaluation; [2015, c. 429, §21 (NEW).]~~

~~K~~I. Size, place and cement or bond orthodontic bands and brackets with final inspection by the dentist; [2015, c. 429, §21 (NEW).]

~~L~~J. Supragingival polishing. A dentist or a dental hygienist must first determine that the teeth to be polished are free of calculus or other extraneous material prior to polishing. Dentists may permit an expanded function dental assistant to use only a slow-speed rotary instrument and rubber cup. Dentists may allow an expanded function dental assistant to use high-speed, power-driven handpieces or instruments to contour or finish newly placed composite materials; [2015, c. 429, §21 (NEW).]

~~M~~K. ~~Take and pour~~Obtain impressions for bleaching trays, athletic mouth guards, provisional or temporary crowns, bridges, custom trays and fluoride trays;and [2015, c. 429, §21 (NEW).]

L. Perform delegated duties as listed in Section 18371(3).

~~N. Apply cavity varnish; [2015, c. 429, §21 (NEW).]~~

~~O. Apply liquids, pastes and gel topical anesthetics; [2015, c. 429, §21 (NEW).]~~

~~P. Assist a dentist who provides orthodontic services in preparation of teeth for attaching, bonding and cementing fixed appliances in a manner appropriate and according to the manufacturer's directions; [2015, c. 429, §21 (NEW).]~~

~~Q. Fabricate temporary crowns and bridges, limiting handpiece rotary instrumentation used in the fabrication to extraoral use only, as long as the dentist checks the occlusion and fit prior to releasing the patient; [2015, c. 429, §21 (NEW).]~~

~~R. Irrigate and dry root canals; [2015, c. 429, §21 (NEW).]~~

~~S. Isolate the operative field; [2015, c. 429, §21 (NEW).]~~

~~T. Perform cold vitality testing with confirmation by the dentist; [2015, c. 429, §21 (NEW).]~~

~~U. Perform electronic vitality scanning with confirmation by the dentist; [2015, c. 429, §21 (NEW).]~~

~~V. Place and remove matrix bands, rubber dams and wedges; [2015, c. 429, §21 (NEW).]~~

~~W. Place elastics and instruct in their use; [2015, c. 429, §21 (NEW).]~~

~~X. Place, hold or remove celluloid and other plastic strips prior to or subsequent to the placement of a filling by the dentist; [2015, c. 429, §21 (NEW).]~~

~~Y. Place or remove temporary separating devices; [2015, c. 429, §21 (NEW).]~~

~~Z. Place wires, pins and elastic ligatures to tie in orthodontic arch wires that have been fitted and approved by the dentist at the time of insertion; [2015, c. 429, §21 (NEW).]~~

~~AA. Prepare tooth sites and surfaces with a rubber cup and pumice for banding or bonding of orthodontic brackets. This procedure may not be intended or interpreted as an oral prophylaxis, which is a procedure specifically reserved to be performed by dental hygienists or dentists. This procedure also may not be intended or interpreted as a preparation for restorative material. A dentist or dental hygienist shall check and approve the procedure; [2015, c. 429, §21 (NEW).]~~

~~BB. Reapply, on an emergency basis only, orthodontic brackets; [2015, c. 429, §21 (NEW).]~~

~~CC. Remove composite material using slow-speed instrumentation for debonding brackets, as long as the dentist conducts a final check prior to release of the patient; [2015, c. 429, §21 (NEW).]~~

~~DD. Remove orthodontic arch wires and tension devices and any loose bands or bonds, but only as directed by the dentist; [2015, c. 429, §21 (NEW).]~~

~~EE. Select and try in stainless steel or other preformed crowns for insertion by the dentist; [2015, c. 429, §21 (NEW).]~~

~~FF. Take impressions for opposing models and retainers; and [2015, c. 429, §21 (NEW).]~~

~~GG. Take intraoral measurements and make preliminary selection of arch wires and intraoral and extraoral appliances, including head gear. [2015, c. 429, §21 (NEW).]~~

~~[2015, c. 429, §21 (NEW) .]~~

2. Scope of practice; general supervision. An expanded function dental assistant may perform the following procedures under the general supervision of a dentist:

~~A. Place temporary fillings on an emergency basis as long as the patient is informed of the temporary nature of the fillings; [2015, c. 429, §21 (NEW).]~~

~~B. Remove excess cement from the supragingival surfaces of teeth; [2015, c. 429, §21 (NEW).]~~

~~C. Change or replace dry socket packets after diagnosis and treatment planned by a dentist; [2015, c. 429, §21 (NEW).]~~

A. Perform delegated duties as listed in Section 18371(3).

~~D. For instruction purposes, demonstrate to a patient how the patient should place and remove removable prostheses, appliances or retainers; [2015, c. 429, §21 (NEW).]~~

~~E. For the purpose of eliminating pain or discomfort, remove loose, broken or irritating orthodontic appliances; [2015, c. 429, §21 (NEW).]~~

~~F. Give oral health instructions; [2015, c. 429, §21 (NEW).]~~

~~G. Irrigate and aspirate the oral cavity; [2015, c. 429, §21 (NEW).]~~

~~H. Perform dietary analyses for dental disease control; [2015, c. 429, §21 (NEW).]~~

~~I. Place and recement with temporary cement an existing crown that has fallen out as long the dental assistant promptly notifies the dentist this procedure was performed so that appropriate follow-up can occur; [2015, c. 429, §21 (NEW).]~~

~~J. Place and remove periodontal dressing; [2015, c. 429, §21 (NEW).]~~

~~K. Pour and trim dental models; [2015, c. 429, §21 (NEW).]~~

~~L. Remove sutures and schedule a follow-up appointment with the dentist within 7 to 10 days of suture removal; [2015, c. 429, §21 (NEW).]~~

~~M. Retract lips, cheek, tongue and other tissue parts; [2015, c. 429, §21 (NEW).]~~

~~N. Take and pour impressions for study casts; [2015, c. 429, §21 (NEW).]~~

~~O. Take and record the vital signs of blood pressure, pulse and temperature; [2015, c. 429, §21 (NEW).]~~

~~P. Take dental plaque smears for microscopic inspection and patient education; and [2015, c. 429, §21 (NEW).]~~

~~Q. Take intraoral photographs. [2015, c. 429, §21 (NEW).]~~

~~[2015, c. 429, §21 (NEW) .]~~

3. Procedures not authorized. An expanded function dental assistant may not engage in the following activities:

A. Complete or limited examination, diagnosis or treatment planning; [2015, c. 429, §21 (NEW).]

B. Surgical or cutting procedures of hard or soft tissue; [2015, c. 429, §21 (NEW).]

C. Prescribing drugs, medicaments or work authorizations; [2015, c. 429, §21 (NEW).]

D. Pulp capping, pulpotomy or other endodontic procedures; [2015, c. 429, §21 (NEW).]

E. Placement and intraoral adjustments of fixed or removable prosthetic appliances; or [2015, c. 429, §21 (NEW).]

F. Administration of local anesthesia, parenteral or inhalation sedation or general anesthesia. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18374. DENTAL HYGIENIST

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

A. Administer local anesthesia or nitrous oxide analgesia, as long as the dental hygienist or faculty dental hygienist has authority to administer the relevant medication pursuant to section 18345, subsection 2, paragraph D or E; [2015, c. 429, §21 (NEW).]

~~B. Irrigate and dry root canals; [2015, c. 429, §21 (NEW).]~~

~~C. Record readings with a digital caries detector and report them to the dentist for interpretation and evaluation; [2015, c. 429, §21 (NEW).]~~

~~D. Remove socket dressings; [2015, c. 429, §21 (NEW).]~~

~~E. Take cytological smears as requested by the dentist; and [2015, c. 429, §21 (NEW).]~~

~~F~~B. ~~Take~~ Obtain impressions for nightguards and occlusal splints ~~as long as the dentist takes all measurements and bite registrations~~. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Scope of practice; general supervision. A dental hygienist and faculty dental hygienist may perform the following procedures under the general supervision of a dentist:

A. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse; [2015, c. 429, §21 (NEW).]

~~B. Apply cavity varnish; [2015, c. 429, §21 (NEW).]~~

~~C~~B. Apply desensitizing agents to teeth; [2015, c. 429, §21 (NEW).]

~~D.~~C. Apply fluoride to control caries; [2015, c. 429, §21 (NEW).]

~~E. Apply liquids, pastes or gel topical anesthetics; [2015, c. 429, §21 (NEW).]~~

~~F~~D. Apply sealants ~~, as long as a licensed dentist first makes the determination and diagnosis as to the surfaces on which the sealants are applied; [2015, c. 429, §21 (NEW).]~~

~~G. Cement pontics and facings outside the mouth;~~ [2015, c. 429, §21 (NEW).]

~~H. Change or replace dry socket packets after diagnosis and treatment planned by a dentist; [2015, c. 429, §21 (NEW).]~~

~~I. Deliver, but not condense or pack, amalgam or composite restoration material; [2015, c. 429, §21 (NEW).]~~

~~J~~E. Expose and process radiographs; [2015, c. 429, §21 (NEW).]

~~K. Fabricate temporary crowns and bridges, limiting handpiece rotary instrumentation used in the fabrication to extraoral use only, as long as the dentist checks the occlusion and fit prior to releasing the patient; [2015, c. 429, §21 (NEW).]~~

~~L. For instruction purposes, demonstrate to a patient how the patient should place and remove removable prostheses, appliances or retainers; [2015, c. 429, §21 (NEW).]~~

~~M. For the purpose of eliminating pain or discomfort, remove loose, broken or irritating orthodontic appliances; [2015, c. 429, §21 (NEW).]~~

~~N. Give oral health instruction; [2015, c. 429, §21 (NEW).]~~

~~O~~F. Interview patients and record complete medical and dental histories; [2015, c. 429, §21 (NEW).]

~~P. Irrigate and aspirate the oral cavity; [2015, c. 429, §21 (NEW).]~~

~~Q. Isolate operative fields; [2015, c. 429, §21 (NEW).]~~

~~R~~G. Obtain bacterial sampling when treatment is planned by the dentist; [2015, c. 429, §21 (NEW).]

~~S~~H. Perform all procedures necessary for a complete prophylaxis, including root planing; [2015, c. 429, §21 (NEW).]

~~T. Perform cold vitality testing with confirmation by the dentist; [2015, c. 429, §21 (NEW).]~~

~~U~~I. Perform complete periodontal and dental restorative charting; [2015, c. 429, §21 (NEW).]

~~V. Perform dietary analyses for dental disease control; [2015, c. 429, §21 (NEW).]~~

~~W. Perform electronic vitality scanning with confirmation by the dentist; [2015, c. 429, §21 (NEW).]~~

~~X~~J. Perform oral inspections, recording all conditions that should be called to the attention of the dentist; [2015, c. 429, §21 (NEW).]

~~Y~~K. Perform postoperative irrigation of surgical sites; [2015, c. 429, §21 (NEW).]

~~Z. Perform preliminary selection and fitting of orthodontic bands, as long as final placement and cementing in the patient's mouth are done by the dentist; [2015, c. 429, §21 (NEW).]~~

~~AA. Place and recement temporary crowns with temporary cement; [2015, c. 429, §21 (NEW).]~~

~~BB. Place and recement with temporary cement an existing crown that has fallen out; [2015, c. 429, §21 (NEW).]~~

~~CC~~L. Place and remove gingival retraction cord without vasoconstrictor; [2015, c. 429, §21 (NEW).]

~~DD. Place and remove matrix bands, periodontal dressing, rubber dams and wedges; [2015, c. 429, §21 (NEW).]~~

~~EE. Place elastics or instruct in their use; [2015, c. 429, §21 (NEW).]~~

~~FF. Place, hold or remove celluloid and other plastic strips prior to or subsequent to the placement of a filling by the dentist; [2015, c. 429, §21 (NEW).]~~

~~GG~~M. Place localized delivery of chemotherapeutic agents when treatment is planned by the dentist; [2015, c. 429, §21 (NEW).]

~~HH. Place or remove temporary separating devices; [2015, c. 429, §21 (NEW).]~~

~~II. Place wires, pins and elastic ligatures to tie in orthodontic arch wires that have been fitted and approved by the dentist at the time of insertion; [2015, c. 429, §21 (NEW).]~~

~~JJ. Place temporary restorations as an emergency procedure, as long as the patient is informed of the temporary nature of the restoration; [2015, c. 429, §21 (NEW).]~~

~~KK. Pour and trim dental models; [2015, c. 429, §21 (NEW).]~~

~~LL~~N. Prepare tooth sites and surfaces with a rubber cup and pumice for banding or bonding of orthodontic brackets. This procedure may not be interpreted as a preparation for restorative material; [2015, c. 429, §21 (NEW).]

~~MM. Reapply, on an emergency basis only, orthodontic brackets; [2015, c. 429, §21 (NEW).]~~

~~NN. Remove composite material using slow-speed instrumentation for debonding brackets, as long as the dentist conducts a final check prior to release of the patient; [2015, c. 429, §21 (NEW).]~~

~~OO. Remove excess cement from the supragingival surfaces of teeth; [2015, c. 429, §21 (NEW).]~~

~~PP. Remove orthodontic arch wires and tension devices and any loose bands or bonds, but only as directed by the dentist; [2015, c. 429, §21 (NEW).]~~

~~QQ. Remove sutures; [2015, c. 429, §21 (NEW).]~~

~~RR. Retract lips, cheek, tongue and other tissue parts; [2015, c. 429, §21 (NEW).]~~

~~SS. Select and try in stainless steel or other preformed crowns for insertion by the dentist; [2015, c. 429, §21 (NEW).]~~

~~TT.~~O. Smooth and polish amalgam restorations; [2015, c. 429, §21 (NEW).]

~~UU. Take and record the vital signs of blood pressure, pulse and temperature; [2015, c. 429, §21 (NEW).]~~

~~VV~~P. ~~Take and pour~~Obtain impressions for study casts, athletic mouth guards, custom trays, bleaching trays, fluoride trays, opposing models, retainers and stents; [2015, c. 429, §21 (NEW).]

Q. Perform delegated duties as listed in Section 18371(3).

~~WW. Take dental plaque smears for microscopic inspection and patient education; [2015, c. 429, §21 (NEW).]~~

~~XX. Take intraoral measurements and make preliminary selection of arch wires and intraoral and extraoral appliances, including head gear; and [2015, c. 429, §21 (NEW).]~~

~~YY. Take intraoral photographs. [2015, c. 429, §21 (NEW).]~~

~~[2015, c. 429, §21 (NEW) .]~~

3. Limitation. An individual with a faculty dental hygienist license may provide the services described in this section only as part of the education program for which the license was issued by the board.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18375. INDEPENDENT PRACTICE DENTAL HYGIENIST

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

A. Interview patients and record complete medical and dental histories; [2015, c. 429, §21 (NEW).]

B. Take and record the vital signs of blood pressure, pulse and temperature; [2015, c. 429, §21 (NEW).]

C. Perform oral inspections, recording all conditions that should be called to the attention of a dentist; [2015, c. 429, §21 (NEW).]

D. Perform complete periodontal and dental restorative charting; [2015, c. 429, §21 (NEW).]

E. Perform all procedures necessary for a complete prophylaxis, including root planing; [2015, c. 429, §21 (NEW).]

F. Apply fluoride to control caries; [2015, c. 429, §21 (NEW).]

G. Apply desensitizing agents to teeth; [2015, c. 429, §21 (NEW).]

H. Apply topical anesthetics; [2015, c. 429, §21 (NEW).]

I. Apply sealants; [2015, c. 429, §21 (NEW).]

J. Smooth and polish amalgam restorations, limited to slow-speed application only; [2015, c. 429, §21 (NEW).]

~~K. Cement pontics and facings outside of the mouth; [2015, c. 429, §21 (NEW).]~~

~~L~~K. ~~Take~~ Obtain impressions for athletic mouth guards and custom fluoride trays; [2015, c. 429, §21 (NEW).]

~~M~~L. Place and remove rubber dams; [2015, c. 429, §21 (NEW).]

~~N~~M. Place temporary restorations in compliance with the protocol adopted by the board; [2015, c. 429, §21 (NEW).]

~~O~~N. Apply topical antimicrobials, including fluoride but excluding antibiotics, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The independent practice dental hygienist shall follow current manufacturer's instructions in the use of these medicaments; [2015, c. 429, §21 (NEW).]

~~P~~O. Expose and process radiographs, including but not limited to vertical and horizontal bitewing films, periapical films, panoramic images and full-mouth series, under protocols developed by the board as long as the independent practice dental hygienist has a written agreement with a licensed dentist that provides that the dentist is available to interpret all dental radiographs within 21 days from the date the radiograph is taken and that the dentist will sign a radiographic review and findings form; and [2015, c. 429, §21 (NEW).]

~~Q~~P. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse. For the purposes of this paragraph, "topical" includes superficial and intraoral application. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Practice standards. An independent practice dental hygienist has the duties and responsibilities set out in this subsection with respect to each patient seen in an independent capacity.

A. Prior to an initial patient visit, an independent practice dental hygienist shall obtain from the patient or the parent or guardian of a minor patient written acknowledgment of the patient's or parent's or guardian's understanding that the independent practice dental hygienist is not a dentist and that the service to be rendered does not constitute restorative care or treatment. [2015, c. 429, §21 (NEW).]

B. An independent practice dental hygienist shall provide to a patient or the parent or guardian of a minor patient a written plan for referral to a dentist for any necessary dental care. The referral plan must identify all conditions that should be called to the attention of the dentist. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18376. PUBLIC HEALTH DENTAL HYGIENIST

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

A. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse; [2015, c. 429, §21 (NEW).]

B. Apply cavity varnish; [2015, c. 429, §21 (NEW).]

C. Apply desensitizing agents to teeth; [2015, c. 429, §21 (NEW).]

D. Apply fluoride to control caries; [2015, c. 429, §21 (NEW).]

E. Apply liquids, pastes or gel topical anesthetics; [2015, c. 429, §21 (NEW).]

F. Apply sealants; [2015, c. 429, §21 (NEW).]

G. Apply topical antimicrobials, including fluoride but excluding antibiotics, for the purposes of bacterial reduction, caries control and desensitization in the oral cavity. The public health dental hygienist shall follow current manufacturer's instructions in the use of these medicaments. For the purposes of this paragraph, "topical" includes superficial and intramuscular application; [2015, c. 429, §21 (NEW).]

~~H. Cement ponties and facings outside the mouth; [2015, c. 429, §21 (NEW).]~~

~~I~~H. Expose and process radiographs upon written standing prescription orders from a dentist who is available to interpret all dental radiographs within 21 days and who will complete and sign a radiographic review and findings form; [2015, c. 429, §21 (NEW).]

~~J~~I. For instruction purposes, demonstrate to a patient how the patient should place and remove removable prostheses, appliances or retainers; [2015, c. 429, §21 (NEW).]

~~K~~J. For the purposes of eliminating pain or discomfort, remove loose, broken or irritating orthodontic appliances; [2015, c. 429, §21 (NEW).]

~~L.~~K. Give oral health instruction; [2015, c. 429, §21 (NEW).]

~~M~~L. Interview patients and record complete medical and dental histories; [2015, c. 429, §21 (NEW).]

~~N~~M. Irrigate and aspirate the oral cavity; [2015, c. 429, §21 (NEW).]

~~O~~N. Isolate operative fields; [2015, c. 429, §21 (NEW).]

~~P~~O. Perform all procedures necessary for a complete prophylaxis, including root planing; [2015, c. 429, §21 (NEW).]

~~Q~~P. Perform complete periodontal and dental restorative charting; [2015, c. 429, §21 (NEW).]

~~R~~Q. Perform dietary analyses for dental disease control; [2015, c. 429, §21 (NEW).]

~~S~~R. Perform temporary filling procedures without a dentist present under protocols adopted by board rule; [2015, c. 429, §21 (NEW).]

~~T~~S. Perform oral inspections, recording all conditions that should be called to the attention of the dentist; [2015, c. 429, §21 (NEW).]

~~U~~T. Perform pulp tests pursuant to the direction of a dentist; [2015, c. 429, §21 (NEW).]

~~V~~U. Place and remove gingival retraction cord without vasoconstrictor; [2015, c. 429, §21 (NEW).]

~~W~~V. Place and remove matrix bands for purposes of fabricating or placing temporary restorations; [2015, c. 429, §21 (NEW).]

~~X~~W. Place and remove rubber dams; [2015, c. 429, §21 (NEW).]

~~Y~~X. Place and remove wedges for purposes of fabricating or placing temporary restorations; [2015, c. 429, §21 (NEW).]

~~Z~~Y. Place temporary restorations in compliance with the protocol adopted by board rule; [2015, c. 429, §21 (NEW).]

~~AA~~Z. Remove excess cement from the supragingival surfaces of teeth; [2015, c. 429, §21 (NEW).]

~~BB~~AA. Retract lips, cheek, tongue and other tissue parts; [2015, c. 429, §21 (NEW).]

~~CC~~BB. Smooth and polish restorations, limited to slow-speed application only; [2015, c. 429, §21 (NEW).]

~~DD~~CC. Take and record the vital signs of blood pressure, pulse and temperature; [2015, c. 429, §21 (NEW).]

~~EE~~DD. Take dental plaque smears for microscopic inspection and patient education; [2015, c. 429, §21 (NEW).]

~~FF~~EE. ~~Take~~ Obtain impressions for and deliver athletic mouth guards and custom fluoride trays; and [2015, c. 429, §21 (NEW).]

~~GG~~FF. Take intraoral photographs. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18377. DENTAL HYGIENE THERAPIST

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

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

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

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

(3) Provide referrals;

(4) Administer local anesthesia and nitrous oxide analgesia;

(5) Perform preventive services;

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

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

(8) Administer radiographs; and

(9) Perform other related services and functions authorized by the supervising dentist and for which the dental hygiene therapist is trained. [2015, c. 429, §21 (NEW).]

B. To the extent permitted in a written practice agreement, a dental hygiene therapist may provide the care and services listed in section 18374, subsections 1 and 2 under the general supervision of the supervising dentist. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Supervision responsibilities. A dental hygiene therapist may be delegated a dentist's responsibility to supervise up to 2 dental hygienists and 3 unlicensed persons in any one practice setting through a written practice agreement pursuant to subsection 3.

[2015, c. 429, §21 (NEW) .]

3. Practice requirements. A dental hygiene therapist must comply with the following practice limitations.

A. A dental hygiene therapist may provide services only in a hospital; a public school, as defined in Title 20-A, section 1, subsection 24; a nursing facility licensed under Title 22, chapter 405; a residential care facility licensed under Title 22, chapter 1663; a clinic; a health center reimbursed as a federally qualified health center as defined in 42 United States Code, Section 1395x(aa)(4) (1993) or that has been determined by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services to meet the requirements for funding under Section 330 of the Public Health Service Act, 42 United States Code, Section 254(b); a federally qualified health center licensed in this State; a public health setting that serves underserved populations as recognized by the federal Department of Health and Human Services; or a private dental practice in which at least 50% of the patients who are provided services by that dental hygiene therapist are covered by the MaineCare program under Title 22 or are underserved adults. [2015, c. 429, §21 (NEW).]

B. A dental hygiene therapist may practice only under the direct supervision of a dentist through a written practice agreement signed by both parties. A written practice agreement is a signed document that outlines the functions that the dental hygiene therapist is authorized to perform, which may not exceed the scopes of practice specified in subsections 1 and 2. A dental hygiene therapist may practice only under the standing order of the supervising dentist, may provide only care that follows written protocols and may provide only services that the dental hygiene therapist is authorized to provide by the written practice agreement. [2015, c. 429, §21 (NEW).]

C. A written practice agreement between a supervising dentist and a dental hygiene therapist must include the following elements:

(1) The services and procedures and the practice settings for those services and procedures that the dental hygiene therapist may provide, together with any limitations on those services and procedures;

(2) Any age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;

(3) Procedures to be used with patients treated by the dental hygiene therapist for obtaining informed consent and for creating and maintaining dental records;

(4) A plan for review of patient records by the supervising dentist and the dental hygiene therapist;

(5) A plan for managing medical emergencies in each practice setting in which the dental hygiene therapist provides care;

(6) A quality assurance plan for monitoring care, including patient care review, referral follow-up and a quality assurance chart review;

(7) Protocols for administering and dispensing medications, including the specific circumstances under which medications may be administered and dispensed;

(8) Criteria for providing care to patients with specific medical conditions or complex medical histories, including requirements for consultation prior to initiating care; and

(9) Specific written protocols, including a plan for providing clinical resources and referrals, governing situations in which the patient requires treatment that exceeds the scope of practice or capabilities of the dental hygiene therapist. [2015, c. 429, §21 (NEW).]

D. Revisions to a written practice agreement must be documented in a new written practice agreement signed by the supervising dentist and the dental hygiene therapist. [2015, c. 429, §21 (NEW).]

E. A dental hygiene therapist shall file a copy of a written practice agreement with the board, keep a copy for the dental hygiene therapist's own records and make a copy available to patients of the dental hygiene therapist upon request. [2015, c. 429, §21 (NEW).]

F. A dental hygiene therapist shall refer patients in accordance with a written practice agreement to another qualified dental or health care professional to receive needed services that exceed the scope of practice of the dental hygiene therapist. [2015, c. 429, §21 (NEW).]

G. A dental hygiene therapist who provides services or procedures beyond those authorized in a written agreement engages in unprofessional conduct and is subject to discipline pursuant to section 18325. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

4. Dental coverage and reimbursement. Notwithstanding Title 24-A, section 2752, any service performed by a dentist, dental assistant or dental hygienist licensed in this State that is reimbursed by private insurance, a dental service corporation, the MaineCare program under Title 22 or the Cub Care program under Title 22, section 3174-T must also be covered and reimbursed when performed by a dental hygiene therapist authorized to practice under this chapter.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18378. DENTURIST

1. Scope of practice. A denturist and faculty denturist may:

A. ~~Take~~ Obtain denture impressions and bite registrations for the purpose of or with a view to the making, producing, reproducing, construction, finishing, supplying, altering or repairing a denture to be fitted to an edentulous or partially edentulous arch or arches; [2015, c. 429, §21 (NEW).]

B. Fit a denture to an edentulous or partially edentulous arch or arches, including by making, producing, reproducing, constructing, finishing, supplying, altering or repairing dentures without performing alteration to natural or reconstructed tooth structure. A denturist may perform clinical procedures related to the fabrication of a removable tooth-borne partial denture, including cast frameworks; [2015, c. 429, §21 (NEW).]

C. Perform procedures incidental to the procedures specified in paragraphs A and B, as specified by board rule; and [2015, c. 429, §21 (NEW).]

D. Make, place, construct, alter, reproduce or repair nonorthodontic removable sports mouth guards and provide teeth whitening services, including by fabricating whitening trays, providing whitening solutions determined to be safe for public use and providing any required follow-up care and instructions for use of the trays and solutions at home. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Limitation. An individual with a faculty denturist license may provide the services described in this section only as part of the education program for which the license was issued by the board.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18379. SEDATION AND GENERAL ANESTHESIA PERMITS

The board shall adopt by rule the qualifications a dentist must have to obtain a permit from the board authorizing the administration of sedation and general anesthesia. The board shall also adopt the guidelines

for such administration, including but not limited to practice setting requirements. [2015, c. 429, §21 (NEW).]

SECTION HISTORY
2015, c. 429, §21 (NEW).

Subchapter 5: PRACTICE STANDARDS

§18391. AMALGAM BROCHURES; POSTERS

1. Brochure; poster. The Director of the Bureau of Health within the Department of Health and Human Services shall develop a brochure that explains the potential advantages and disadvantages to oral health, overall human health and the environment of using mercury or mercury amalgam in dental procedures. The brochure must describe what alternatives are available to mercury amalgam in various dental procedures and what potential advantages and disadvantages are posed by the use of those alternatives. The brochure may also include other information that contributes to the patient's ability to make an informed decision when choosing between the use of mercury amalgam or an alternative material in a dental procedure, including, but not limited to, information on the durability, cost, aesthetic quality or other characteristics of the mercury amalgam and alternative materials. The director shall also develop a poster that informs patients of the availability of the brochure.

The Director of the Bureau of Health shall, in consultation with the Department of Environmental Protection, adopt the brochure and the poster described in this subsection through major substantive rules pursuant to Title 5, chapter 375, subchapter 2-A.

[2015, c. 429, §21 (NEW) .]

2. Display. A dentist who uses mercury or a mercury amalgam in any dental procedure shall display the poster adopted by the Department of Health and Human Services, Bureau of Health under this section in the public waiting area of the practice setting and shall provide each patient a copy of the brochure adopted by the bureau under this section. The Department of Health and Human Services shall also post on its publicly accessible website a copy of the brochure that is suitable for downloading and printing by dentists, patients and other interested parties.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18392. REMOVABLE DENTAL PROSTHESIS; OWNER IDENTIFICATION

1. Identification required. Every complete upper and lower denture and removable dental prosthesis fabricated by a dentist or denturist, or fabricated pursuant to the dentist's or denturist's work order or under the dentist's or denturist's direction or supervision, must be marked with the name and social security number of the patient for whom the prosthesis is intended. The markings must be made during fabrication and must be permanent, legible and cosmetically acceptable. The exact location of the markings and the methods used to apply or implant the markings must be determined by the dentist or dental laboratory fabricating the prosthesis. If, in the professional judgment of the dentist or dental laboratory, this identification is not practical, identification must be provided as follows:

A. The social security number of the patient may be omitted if the name of the patient is shown; [2015, c. 429, §21 (NEW).]

B. The initials of the patient may be shown alone, if use of the name of the patient is impracticable; or [2015, c. 429, §21 (NEW).]

C. The identification marks may be omitted in their entirety if none of the forms of identification specified in paragraphs A and B are practicable or clinically safe. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. Applicability. A removable dental prosthesis in existence prior to September 23, 1983 that was not marked in accordance with subsection 1 at the time of its fabrication must be marked in accordance with subsection 1 at the time of a subsequent rebasing.

[2015, c. 429, §21 (NEW) .]

3. Violation. Failure of a dentist or denturist to comply with this section constitutes grounds for discipline pursuant to section 18325, as long as the dentist or denturist is charged with the violation within 2 years of initial insertion of the dental prosthetic device.

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

§18393. CONFIDENTIALITY

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Confidential communication" means a communication not intended to be disclosed to 3rd persons other than those present to further the interest of the patient in the consultation, examination or interview or persons who are participating in the diagnosis and treatment under the direction of the dentist, including members of the patient's family. [2015, c. 429, §21 (NEW).]

B. "Patient" means a person who consults or is examined or interviewed by a dentist or dental auxiliary. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

2. General rule of privilege. A patient has a privilege to refuse to disclose and to prevent another person from disclosing confidential communications made for the purpose of diagnosis or treatment of the patient's physical, mental or emotional conditions, including alcohol or drug addiction, among the patient, the patient's dentist and persons who are participating in the diagnosis or treatment under the direction of the dentist, including members of the patient's family.

[2015, c. 429, §21 (NEW) .]

3. Who may claim the privilege. The privilege under subsection 2 may be claimed by the patient, by the patient's guardian or conservator or by the personal representative of a deceased patient. The dentist or dental auxiliary at the time of the communication is presumed to have authority to claim the privilege, but only on behalf of the patient.

[2015, c. 429, §21 (NEW) .]

4. Exceptions. Notwithstanding any other provision of law, the following are exceptions to the privilege under subsection 2.

A. If the court orders an examination of the physical, mental or emotional condition of a patient, whether a party or a witness, communications made in the course of the examination are not privileged under this

section with respect to the particular purpose for which the examination is ordered unless the court orders otherwise. [2015, c. 429, §21 (NEW).]

B. There is not any privilege under this section as to communications relevant to an issue of the physical, mental or emotional condition of a patient in a proceeding in which the condition of the patient is an element of the claim or defense of the patient or of a party claiming through or under the patient or because of the patient's condition or claiming as a beneficiary of the patient through a contract to which the patient is or was a party or, after the patient's death, in a proceeding in which a party puts the condition in issue. [2015, c. 429, §21 (NEW).]

C. There is not any privilege under this section as to information regarding a patient that is sought by the Chief Medical Examiner or the Chief Medical Examiner's designee in a medical examiner case, as defined by Title 22, section 3025, in which the Chief Medical Examiner or the Chief Medical Examiner's designee has reason to believe that information relating to dental treatment may assist in determining the identity of a deceased person. [2015, c. 429, §21 (NEW).]

D. There is not any privilege under this section as to disclosure of information concerning a patient when that disclosure is required by law, and nothing in this section may modify or affect the provisions of Title 22, sections 4011-A to 4015 and Title 29-A, section 2405. [2015, c. 429, §21 (NEW).]

[2015, c. 429, §21 (NEW) .]

SECTION HISTORY
2015, c. 429, §21 (NEW).

PROPOSED CHANGES TO RDH SCOPE OF PRACTICE 32 MRS § 18374

APRIL 28, 2017

This document references clinical standards as identified in the American Dental Hygienists' Association's "Standards for Clinical Dental Hygiene Practice" 2016.

A. Assessment:

Health history: obtain a health history assessment for the purpose of collecting data verifies key elements of health status. Such data may include, but is not limited to demographics, vital signs, physical characteristics, social history, medical history, and pharmacologic history.

Clinical assessment - conduct a thorough and systematic observation to include an inspection of the head and neck and oral cavity including an oral cancer screening, documentation of normal or abnormal findings, and assessment of the temporomandibular function. Assessments include but are not limited to a current, complete and diagnostic set of radiographs for a comprehensive dental and periodontal examination, complete a full-mouth periodontal charting, a comprehensive hard-tissue evaluation that includes the charting of existing conditions and oral habits, and radiographs that supplement the data. Conduct a risk assessment to identify risks to general and oral health and to help develop and design strategies for preventing or limiting disease and promoting health.

B. Interpretation of Assessment

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

The formulation of a care plan focuses on dental hygiene education, patient self-care practices, prevention strategies, and treatment and evaluation protocols to focus on patient or community oral health needs. Analyzing and interpreting all data, formulating dental hygiene plan, communicating the plan with patients, determining patient needs that can be improved through dental hygiene care, and identifying referrals are all necessary steps when interpreting patient assessments.

C. Planning:

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

D. Implementation:

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

2. General supervision. A dental hygienist shall practice under the general supervision of a dentist. Examples of dental hygiene practice requiring general supervision include, but are not limited to:

i. Performing a prophylaxis including complete removal of hard, soft deposits, , cement, and stains by scaling, polishing, and perform root planing and periodontal debridement procedures;
ii. Applies agents: locally delivered chemotherapeutic agents such as desensitizing agents, topical anesthetics, topical antimicrobials, irrigation, and fluorides;
iii. Places dental sealants;
iv. Prescribe, dispense or administer anticavity toothpastes or topical gels with 1.1% or less sodium fluoride and oral rinses with 0.05%, 0.2%, 0.44% or 0.5% sodium fluoride, as well as chlorhexidine gluconate oral rinse; and
v. Expose and process dental radiographs.

3. Direct supervision. A dental hygienist shall practice under the direct supervision of a dentist when administering local anesthesia or nitrous oxide analgesia, as long as the dental hygienist has obtained the authority to administer the relevant medication pursuant to section 18345, subsection 2, paragraph D or E.

E. Evaluation

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

Maine Board of Dental Practice – Board Policy

Limited Delegation of Authority to Board Chair and Board Staff to Review and Approve Applications and Offer Consent Agreements

Effective Date:	**Expiration Date**:
July 1, 2019	June 30, 2021, unless rescinded earlier

I. Background

Pursuant to 32 M.R.S. § 18323(7), the Maine Board of Dental Practice and its subcommittees on Denturists and Dental Hygienists adopted a formal policy on January 19, 2018, delegating to the Board Chair, Subcommittee Chairs, and Board staff the review and approval of certain applications. The 2018 policy memorialized the delegation that had been authorized historically by vote, but not had not been formally adopted as a policy.

This Limited Delegation of Authority is a revision of the 2018 policy, and allows Board staff to issue preliminary denials with offers of prescribed consent agreements, reinstate expired licenses with offers of prescribed consent agreements to resolve unlicensed practice, and to approve certain responses to disclosures made on applications, among other things. The attached chart depicts the specific limited delegations authorized pursuant to this policy. (See Attachment 1.)

The purpose of this policy is to establish clear guidelines by which the delegation to the Board Chair and Board staff is to be implemented. The practical effect of this Limited Delegation of Authority will be to shorten the application resolution time and reduce the number of matters that the Board must address at its regular meetings. In addition, the applicant's wait time to license approval will be significantly reduced.

This policy expires on June 30, 2021, but may be revisited by the Board at any time.

II. Relevant Law

Pursuant to 10 M.R.S. § 8003(5)(C)(5) and 32 M.R.S. § 18323(7), the Board may "[d]elegate to staff the authority to review and approve applications for licensure pursuant to procedures and criteria established by rule."

Pursuant to 32 M.R.S. § 18325, the Board may "refuse to issue, modify, suspend, revoke or refuse to renew" the license of a dentist, dental radiographer, expanded function dental assistant, dental hygienist, or denturist.

Pursuant to 32 M.R.S. § 18325(1)(A), the Board has the authority to impose discipline on or deny licensure or license renewal to an applicant or licensee who makes a misrepresentation in obtaining a license from the Board.

Pursuant to 32 M.R.S. § 18325(1)(E), the Board has the authority to impose discipline on or deny licensure or license renewal to an applicant or licensee who has been convicted of certain crimes to the extent permitted by 5 M.R.S. §§ 5301-5303.

Pursuant to 5 M.R.S. §§ 5301-5303, the Board may refuse to approve an application for licensure if the applicant was convicted of a crime described in 5 M.R.S. § 5301(2) and the application was submitted within 10 years of the applicant's discharge from the correctional system. For purposes of this Delegation Order, such crimes will be referred to as "Potentially Disqualifying Crimes."

Pursuant to 32 M.R.S. § 18325(1)(N), the Board has the authority to impose discipline against an applicant or licensee for any violation of the requirements imposed pursuant to 32 M.R.S. § 18352.

Pursuant to 32 M.R.S. § 18352(1)(B), all licensees and applicants for licensure must report in writing to the Board any criminal conviction no later than 10 days after the date of conviction.

Pursuant to 10 M.R.S. § 8003(5)(A-1), the forms of discipline that the Board may impose include: the denial or refusal to renew a license; a warning, censure, or reprimand; imposition of probation; suspension of a license; revocation of a license or registration; and civil penalties of up to $1,500 for each violation.

Pursuant to 10 M.R.S. § 8003(5)(B), the Board "may execute a consent agreement that resolves a complaint or investigation without further proceedings."

Pursuant to 32 M.R.S. § 18341(3), the Board may deny an application for licensure or license renewal to an applicant or licensee who fails to submit requested materials within 90 days after being notified of the needed materials.

III. Limited delegation of authority to Board Chair and Board staff

The Board delegates limited authority to the Board Chair and Board staff as outlined below and itemized on Attachment 1:

1. Application Reviews:
   - Except for applications involving programs or courses of study not previously approved by the Board or its Subcommittee(s), Board staff may conduct reviews of applications as identified on Attachment 1.

2. Criminal Conviction – Disclosure:
   - Board staff may issue a license to an otherwise qualified applicant who discloses a criminal conviction on an application for licensure that is neither a Potentially Disqualifying Crime nor a crime related to substance use or misuse.

3. Criminal Conviction – Non-disclosure:
   - If an initial applicant fails to disclose a criminal conviction on the application that is neither a Potentially Disqualifying Crime nor a crime related to substance use or misuse, Board staff may preliminarily deny the application for licensure and offer a consent agreement to the applicant on terms and conditions as outlined in Attachment 1.

4. Criminal Conviction – Failure to report:
   - If a licensee discloses on a renewal application a criminal conviction that is neither a Potentially Disqualifying Crime nor a crime related to substance use or misuse, but which the licensee failed to previously report within 10 days of the conviction, Board staff may offer a consent agreement

to the licensee on the terms and conditions outlined in Attachment 1 and approve the application and renew the license upon receipt of the signed consent agreement.

5. Disclosures:
   - Disclosures of criminal convictions that have been previously reviewed and approved by the Board and/or a Subcommittee can be reviewed and approved by Board staff in subsequent filings.

6. Unlicensed practice:
   - Reinstatement applications that include admissions of practicing after the expiration of a license or permit but otherwise meet all other application requirements may be processed by Board staff, who will generate a Board-initiated complaint and offer a consent agreement to the applicant on the terms and conditions outlined in Attachment 1.

7. Waiver of Regional Examination:
   - Board staff may waive the regional examination requirements in connection with reinstatement applications if the regional examination waiver was previously granted by the Board.

8. Interim Consent Agreement – Pending Criminal Charge:
   - If a licensee has a pending criminal charge, and consistent with the prior vote of the Board, the Board Chair may sign an Interim Consent Agreement to which the licensee agrees to stop practicing pending final disposition of the criminal charge(s). Board staff will coordinate with legal counsel in generating a Board-initiated complaint to further investigate the criminal conduct.

9. Student Loan Default Disclosures:
   - Board staff may review and approve applications that disclose a default on a student loan and submit a statement regarding a repayment plan if the applicant is otherwise qualified for licensure.

10. Incomplete Applications
    - Board staff may administratively close applications in which the applicants have failed to submit application materials within the time constraints set forth in 32 M.R.S. § 18341(3).

Adoption

Adopted by the Board on June 14, 2019

Date: _____

_____
Stephen G. Morse, DMD, Chair

Other members of the Board:
Glen S. Davis, DMD, Vice Chair
Paul P. Dunbar, DDS
Nancy Foster, RDH, EFDA
Tracy Jowett, RDH
Todd Ray, DMD
M. Lourdes Wellington
Kathryn A. Young, LD
Mark D. Zajkowski, DDS, MD

MAINE BOARD OF DENTAL PRACTICE
Delegation of Application Reviews and Other Matters to Chairs and Board Staff – June 14, 2019

LICENSE/AUTHORITY/PERMIT TYPE	INITIAL LICENSURE/PERMIT	RENEWAL/REINSTATEMENT
Dental Hygienist	• Staff review	• Renewals - staff review • Reinstatements – staff review
Dental Hygienists w/PHS status	• Staff review	• N/A
Dental Radiographer	• Staff review	• Renewals - staff review • Reinstatements – staff review
Dentists	• Staff review	• Renewals - staff review • Reinstatements – staff review
Denturists	• Subcommittee/Board review	• Renewals - staff review • Reinstatements – staff review
Expanded Function Dental Assistants	• Staff review	• Renewals - staff review • Reinstatements – staff review
Faculty	• Subcommittee/Board review	• Renewals - staff review • Reinstatements – staff review
Independent Practice Dental Hygienist	• Staff review	• Renewals - staff review • Reinstatements – staff review
Local Anesthesia / Nitrous Oxide Analgesia	• Staff review	• Renewals - staff review • Reinstatements – staff review

Delegation Authority to Chairs and Board Staff – June 14, 2019 (cont.)

Sedation / General Anesthesia Permits	• Board Chair and Staff review	• Renewals - staff review • Reinstatements – staff review
Special Permits (Residents, Limited, Temporary)	• Staff review	• Renewals - staff review • Reinstatements – staff review
Pending Criminal Charge(s) Board Chair authorized sign an Interim Consent Agreement to which the licensee agrees to stop practicing pending the outcome of the criminal charge(s). Board staff authorized to file complaint.	• N/A	• N/A
Waiver of Regional Examination(s) Subcommittees/Board delegated to staff the ability to waive the regional examination requirements in a reinstatement application if the waiver had been previously granted by the Board.	• Staff review	• Staff review
Previously Disclosed Response(s) Subcommittees/Board delegated to staff the ability to approve applications which include disclosures that were previously disclosed, reviewed, and approved by the Subcommittees/Board.	• Staff review	• Staff review

Delegation Authority to Chairs and Board Staff – June 14, 2019 (cont.)

Student Loan Default Disclosure(s) Subcommittees/Board delegated to staff the ability to approve applications which include student loan default disclosures that include a statement regarding efforts to repay/payment plan.	• Staff review	• Staff review
Inactive to Active Licensure status request(s) Subcommittees/Board delegated to staff the ability to approve requests in accordance with Board Rule, Chapter 13.	• N/A	• Staff review
Incomplete applications Subcommittees/Board delegated to staff the ability to administratively close applications that exceed the statutory time limit.	• N/A	• N/A
Reinstatement applications w/disclosures of unlicensed practice. All licensure categories of practice except for sedation permits. DH Subcommittee/Board delegated to staff the ability to relicense otherwise qualified individuals who have disclosed unlicensed practice. The delegation includes authorizing board staff, in coordination with the Office of the Attorney General, to initiate a complaint, and to offer the licensee a consent agreement to resolve the technical violation.	• N/A	• The terms of the consent agreement include: a) Admission; b) Warning; and c) Payment of $50.00 civil penalty to be paid within 90 days. (Note: $500.00 civil penalty for dentists.)

Delegation Authority to Chairs and Board Staff – June 14, 2019 (cont.)

Criminal conviction; disclosed DH Subcommittee/Board delegated to staff the ability to issue a license to an otherwise qualified applicant who has no conviction for either a potentially disqualifying crime, or a crime related to substance use or misuse. Board staff will consult with the Office of the Attorney General regarding the criminal conduct disclosure.	• Staff review	• Staff review
Criminal conviction; failure to disclose DH Subcommittee/Board delegated to staff the ability to issue a preliminary denial and offer the applicant a consent agreement in consultation with the Office of the Attorney General to resolve a violation of 32 M.R.S. § 18325(1)(A). This limited delegation applies only to convictions that are neither potentially non-qualifying crimes, nor crimes related to substance use or misuse.	• The terms of the consent agreement include: a) Admission; b) Warning; and c) Payment of $xx.00 civil penalty to be paid within 90 days. (Note: $xxx.00 civil penalty for dentists.)	• The terms of the consent agreement include: a) Admission; b) Warning; and c) Payment of $xx.00 civil penalty to be paid within 90 days. (Note: $xxx.00 civil penalty for dentists.)
Criminal conviction; failure to report within 10 days DH Subcommittee/Board delegated to staff the ability to issue a preliminary denial and offer the applicant a consent agreement in consultation with the Office of the Attorney General to resolve a violation of 32 M.R.S. § 18352(1)(B). This limited delegation applies only to convictions that are neither potentially non-qualifying crimes, nor crimes related to substance use or misuse.	• The terms of the consent agreement include: a) Admission; b) Warning; and c) Payment of $xx.00 civil penalty to be paid within 90 days. (Note: $xxx.00 civil penalty for dentists.)	• The terms of the consent agreement include: a) Admission; b) Warning; and c) Payment of $xx.00 civil penalty to be paid within 90 days. (Note: $xxx.00 civil penalty for dentists.)

PROTOCOLS
For the
Committee on Medical Professionals' Health

I. **Purpose**. The purpose of this document is to establish protocols for the operation of a professional review committee as defined in Title 24, section 2502, subsection 4-A of the Maine Revised Statutes. These protocols are hereby established by the following professional licensing boards (hereinafter referred to collectively as "the Licensing Boards"):

a. Board of Licensure in Medicine;
b. Board of Osteopathic Licensure;
c. Board of Dental Practice;
d. Maine Board of Pharmacy;
e. State Board of Nursing; and
f. State Board of Veterinary Medicine.

II. **Recognized Professional Review Committee**. This document recognizes and approves the Committee on Medical Professionals' Health as a professional review committee to work with licensees of the Licensing Boards who are disabled or impaired by the misuse of alcohol or drugs or may be experiencing mental health or behavioral issues. For purposes of these Protocols, the term "Licensee" shall mean the specified licensees and applicants for licensure of the Licensing Boards as indicated below.

a. Board of Licensure in Medicine:
    i. Physicians; and
    ii. Physician assistants.
b. Board of Osteopathic Licensure:
    i. Physicians; and
    ii. Physician assistants.
c. Board of Dental Practice:
    i. Dentists;
    ii. Dental hygienists;
    iii. Denturists;
    iv. Dental Radiographers; and
    v. Expanded Function Dental Assistants.
d. Maine Board of Pharmacy:
    i. Pharmacists;
    ii. Pharmacy interns; and
    iii. Pharmacy technicians.
e. State Board of Nursing:
    i. Advanced practice registered nurses;
    ii. Registered nurses; and
    iii. Licensed practical nurses.
f. State Board of Veterinary Medicine:
    i. Veterinarians.

III. **Committee on Medical Professionals' Health**. The Committee on Medical Professionals' Health (hereinafter "the Committee") is a committee of health care practitioners formed and sponsored by the Maine Medical Association.

a. **Composition**.

i. The Committee will be comprised of health care professionals only, each of whom must hold an active license in good standing issued by one or more of the Licensing Boards.

ii. The Committee will be comprised of not less than 7 and no more than **20** members.

iii. The Committee's members shall include at least one licensed professional from each of the Licensing Boards.

b. **Selection of Committee members**.

i. The Committee, in consultation with the Maine Medical Association, shall be responsible for nominating and appointing members to the Committee on an annual basis subject to the advice and consent of the Licensing Board under which the appointee is licensed.

ii. Appointees should be selected without respect to age, sex, race, religion, or sexual orientation.

iii. Appointees should have demonstrated an interest in and knowledge of substance misuse or dependence or mental health or behavioral issues related to health care professionals.

iv. It is desirable that some, but not more than half, of the members of the Committee be health care professionals recovering from substance misuse or dependence.

c. **Meetings of Committee**.

i. The Committee will meet in accordance with its needs, but no fewer than six (6) times each calendar year.
ii. Committee meetings where active case review is being conducted must include a minimum of six (6) Committee members.

d. **Licensing Board Point of Contact**. Each Licensing Board will designate an individual on its staff who will act as a point of contact to whom the Committee shall direct its communications.

IV. **Duties of the Committee.** The role of the Committee is to provide reviews, access to evaluation and treatment, and monitoring services. The Committee does not provide treatment. The duties of the Committee are to:

a. Accept referral of Licensees who need consultation, assessment and/or evaluation for substance misuse, mental health and/or behavioral health issues;

b. Require referred and self-referred Licensees to undergo independent evaluation as appropriate;

c. Contract with these identified Licensees to ensure they obtain necessary evaluation and treatment;

d. Monitor the evaluation, treatment and aftercare of contracted Licensees as well as their sobriety and progress in recovery;

e. Make reports to the Licensing Boards to keep the Licensing Boards fully apprised of the volume and nature of the Committee's work, the utilization of its services, and the performance of its participants; and

f. Report Licensees to the Licensing Boards as required in these Protocols.

V. **Medical Professionals Health Program.** The Committee may fulfill its duties through the use of a Medical Professionals Health Program (hereinafter referred to as "Program"), that operates under the control and oversight of the Committee. If the Committee elects to utilize a Program, the Committee shall:

a. In collaboration with the Maine Medical Association, supervise and support the Director of the Program and the Program Staff;

b. Provide support and consultation as needed to the Director and Program Staff;

c. Prepare or cause to be prepared an annual budget for the Program; and

d. Ensure that the Program operates within the parameters of and in conformity with these Protocols.

VI. **Procedures for Fulfilling Duties of the Committee**

a. **Identification.**

i. **Referrals and reports.** Anyone may report a Licensee to the Committee and all referrals, whether made by telephone, mail, in person, or electronically, will become an active case. The Committee shall ensure

that secure and dedicated communications systems (telephone and email) are available twenty-four (24) hours a day. Anonymous referrals will be accepted, but every effort will be made to have informants identify themselves.

ii. **Action on all referrals.**

1. The Committee shall consider any report or referral made to it, the Director, or Program Staff to be a case. The Committee will assign a case number to and open a file for every case.

2. The Committee will make a timely response to any referral or report.

3. The Committee will obtain and document a description of the behavior(s), dates, places, and witnesses.

4. The Committee shall ensure that all case files are securely stored and accessible only to the Committee, the Director, and Program Staff.

5. The Committee, Director, and Program Staff shall protect the identity of confidential informants whenever possible, however confidentiality cannot be guaranteed.

6. The Committee, Director, and Programs Staff are not obligated to follow up with informants, but may choose to involve the informant if necessary to ensure that the Licensee receives assistance and/or ensure public safety.

iii. **Action on self-referrals.** When a Licensee reports him or herself to the Committee, the Committee will perform an assessment of the Licensee to determine whether and what kind of evaluation the Licensee should undergo to determine an appropriate course of treatment.

iv. **Action on third-party referrals and reports.**

1. When sufficient information exists, the Committee shall initiate an investigation of third-party referrals and reports for the purpose of determining the validity of the allegations. When necessary to make this determination, the Committee shall contact individuals who may have knowledge or reasonably be expected to have knowledge of the alleged behavior and/or the Licensee who has been identified may be invited to undergo an assessment with the Program.

2. Upon completing the investigation, the Committee shall determine appropriate next steps, which may include continued discussions with the Licensee, assessment, evaluation, treatment, monitoring, or discharge (case closure). The Committee shall ensure public safety standards and compliance with these Protocols are maintained. Anonymous and unconfirmed reports will be closed after three (3) months of inactivity.

3. If the Committee determines that an assessment of the Licensee should be performed and the Licensee declines to participate in the assessment, the Committee shall notify the appropriate Licensing Board in accordance with section VI(e)(i)(2).

4. If during the course of the investigation, evidence emerges indicating that harm has occurred to a patient or there is imminent danger of injury to a patient, the Licensee, or another person, the Committee shall notify the appropriate Licensing Board in accordance with section VI(e)(i)(2).

b. **Evaluation.** If the Committee determines that an evaluation is appropriate for the Licensee, the Committee shall enter into an agreement ("Evaluation Agreement") with the Licensee that specifies the evaluator and scope of evaluation. The Committee shall determine the appropriate evaluator for each referred Licensee and that the evaluations are performed by individuals whose scope of practice is appropriate to the condition being evaluated. The Committee shall ensure that evaluations determine and provide recommendations for appropriate level of care for the Licensee. If a Licensee fails to enter into a recommended Evaluation Agreement, the Committee shall notify the appropriate Licensing Board in accordance with section VI(e)(i)(2)

c. **Treatment**. The evaluation determines the appropriate level of treatment, but the Committee may request higher levels of treatment if other information indicates the Licensee is at greater risk than the evaluation suggests. The Committee in collaboration with the Licensee's treatment team shall determine the appropriate level of monitoring for each evaluated Licensee.

    i. **Determination of Monitoring and Aftercare. After** assessment and evaluation of the identified Licensee, the Committee will propose to the Licensee the level of care that is appropriate, based on the results of the assessment and evaluation and enter into a Monitoring Agreement with the Licensee as described in paragraph VI(d). If the identified Licensee declines to undergo an assessment or evaluation or execute a Monitoring Agreement, the Committee shall notify the appropriate Licensing Board in accordance with section VI(d)(i)(2).

ii. **List of treatment programs**. The Committee shall maintain a list of acceptable treatment programs, providers (therapists, psychiatrists, etc.), and self-help groups and provide the list to Licensees upon request. The list shall include a spectrum of recovery philosophies so that participants can be matched with providers and resources that will best meet their health and recovery needs.

d. **Monitoring.**

i. **Agreement with Licensee**. The Committee shall enter into a contract ("Monitoring Agreement") with each Licensee for whom it has determined that some level of treatment, and/or monitoring is appropriate ("Participating Licensee"). The Monitoring Agreement is a statement of the Participating Licensee's minimum required performance in recovery activities in exchange for which the Committee will provide documentation of recovery to agencies and organizations as needed by the Participating Licensee.

ii. **Compliant Participating Licensees**. As long as the Participating Licensee remains abstinent from alcohol and all other psychoactive drugs (excluding caffeine, nicotine, and those medications prescribed by the Licensee's treatment team that are not in conflict with the Committee's Medication Policy) and remains compliant with all terms of the Monitoring Agreement, except as otherwise provided in this protocol, the Committee will not report the Participating Licensee to the applicable Licensing Board.

iii. **Agreement provisions.**

1. **General Provisions.** Every Monitoring Agreement must contain the following terms:

a. Notice that any breach of the Monitoring Agreement is reportable to the applicable Licensing Board;

b. A requirement that the Participating Licensee abstain from using alcohol and potentially addictive or mood altering chemicals, except as prescribed by another clinician, knowledgeable of the abuse/dependency problem, for a valid illness;

c. A requirement that while undergoing treatment that includes hospitalization or partial hospitalization the Participating Licensee shall not engage in the active practice of health care and upon the termination of such level of treatment shall not return to the practice of health

care without first obtaining written approval to do so from the Committee or Director; and

d. A requirement that while underdoing evaluation, treatment and/or monitoring, the Participating Licensee shall not engage in active practice when determined not to be fit to practice by treatment providers or the Committee.

2. **Treatment and Monitoring Provisions.** The Monitoring Agreement shall impose requirements on the Participating Licensee that may include but are not limited to:

a. Acute treatment;

b. Continuing treatment (psychological, medical, and mutual support groups);

c. Monitoring—peer and physiologic;

d. Toxicology testing; and

e. Required reports and frequency.

iv. **Agreement duration**. The duration of the Monitoring Agreement is determined based on the evaluation of the severity of the illness, the illness type and the number of risk factors. The Committee shall not release a Participating Licensee from the program unless the Participating Licensee has been completely compliant for a continuous period of at least 18 months immediately prior to the release.

e. **Reporting**.

i. **Incident Reports—Immediate Notification**.

1. **Bases for Notification.** The Committee shall ensure that the appropriate Licensing Board is notified immediately when any of the following events occurs:

a. A Licensee fails to undergo a recommended assessment when a credible report has been submitted to the Committee;

b. A Licensee fails to undergo a recommended evaluation or there is a breach of an Evaluation Agreement;

c. A Licensee declines to sign a recommended Monitoring Agreement;

d. A Participating Licensee unilaterally terminates a Monitoring Agreement prior to completion and release by the Committee;

e. A Participating Licensee leaves the State of Maine or announces an intention to leave the State of Maine without first engaging the services of a comparable program in the destination jurisdiction;

f. A person has been harmed or placed in jeopardy directly or indirectly by the actions or omissions of a Licensee in the practice of the licensed profession;

g. There is a reasonable likelihood of a person being harmed by the actions or omissions of a Licensee in the practice of the licensed profession;

h. The Committee has information that the Licensee has engaged in criminal conduct reasonably contemporaneous with the Licensee's participation with the Committee;

i. The Licensee has been involuntarily committed for mental illness;

j. There has been a material breach of the Monitoring Agreement. A material breach of a Monitoring Agreement includes but is not limited to the following:

    i. Being impaired in a health care setting in the course of the licensee's employment;
    ii. Any abnormal toxicology test result, including toxicology results indicating the presence of prohibited substances;
    iii. Violation of a restriction on the licensee's practice as agreed to in the Monitoring Agreement;
    iv. An admission or relapse by the licensee;
    v. Any failure to seek follow up or a second opinion as required by the Monitoring Agreement; or
    vi. Any failure to comply with any combination of three or more attendance or reporting requirements within a six (6) month period.

2. **Form of Immediate Notification.**

    a. Immediate notification consists of notifying the point of contact for the applicable Licensing Board, both by email and telephonically, within twenty-four (24) hours of the discovery of a basis for notification by the Committee, Director, or Program Staff. A formal follow-up letter will be sent within five (5) business days thereafter unless requested sooner by staff of the applicable Licensing Board.

    b. The immediate notification to the applicable Licensing Board shall contain the following information:

        i. The name of the Participating Licensee;

        ii. The reason the notification is being made;

        iii. A description of the evidence indicating that a basis for immediate notification has occurred; and

        iv. Steps to be undertaken to ensure that the Participating Licensee is safe and not in danger of causing patient harm.

    c. After immediate notification, the Committee shall make available to the applicable Licensing Board a compliance history report outlining all major and minor issues of noncompliance during the period of monitoring, along with a summary of status assessments provided by the treatment team and/or the worksite and the results of all toxicological testing for the entire monitoring period.

ii. **Periodic Reports.**

1. The Committee shall report at least annually to each Licensing Board, the following information:

    a. The number of cases received, by profession;

    b. The number of assessments conducted by the Committee by profession;

    c. The number of evaluations made by profession;

d. The number of cases reported to the Licensing Boards based on evidence of patient injury or the potential for patient injury, by profession;

e. The number of Participating Licensees, along with the number of years that remain on their Monitoring Agreements, by profession;

f. The number of Participating Licensees who have successfully completed monitoring;

g. The number of Participating Licensees who have breached a term of a Monitoring Agreement, by profession;

h. Updates on standards regarding participation time frames, recidivism, etc.; and

i. Other information important to the Program.

VII. **Termination of Protocols**. Any Licensing Board may rescind its approval of these Protocols at any time with or without cause. A Licensing Board's rescission of these Protocols will render the Committee to be no longer a professional review committee for purposes of Title 24 section 2505 of the Maine Revised Statutes for that particular Licensing Board. Such a rescission shall not affect the status of the Protocols with respect to other Licensing Boards.

For the BOARD OF LICENSURE IN MEDICINE

Louisa Barnhart, M.D., Chair

Date: 10/8/2019

For the BOARD OF OSTEOPATHIC LICENSURE

Scott A. Thomas, D.O., Chair

Date: 10/10/2019

For the MAINE BOARD OF PHARMACY

Joseph Bruno, R.Ph., President

Date: 9/25/2019

For the BOARD OF DENTAL PRACTICE

Stephen G. Morse, DMD, Chair

Date: 10-11-2019

For the STATE BOARD OF NURSING

Valerie Fuller, DNP, Chair

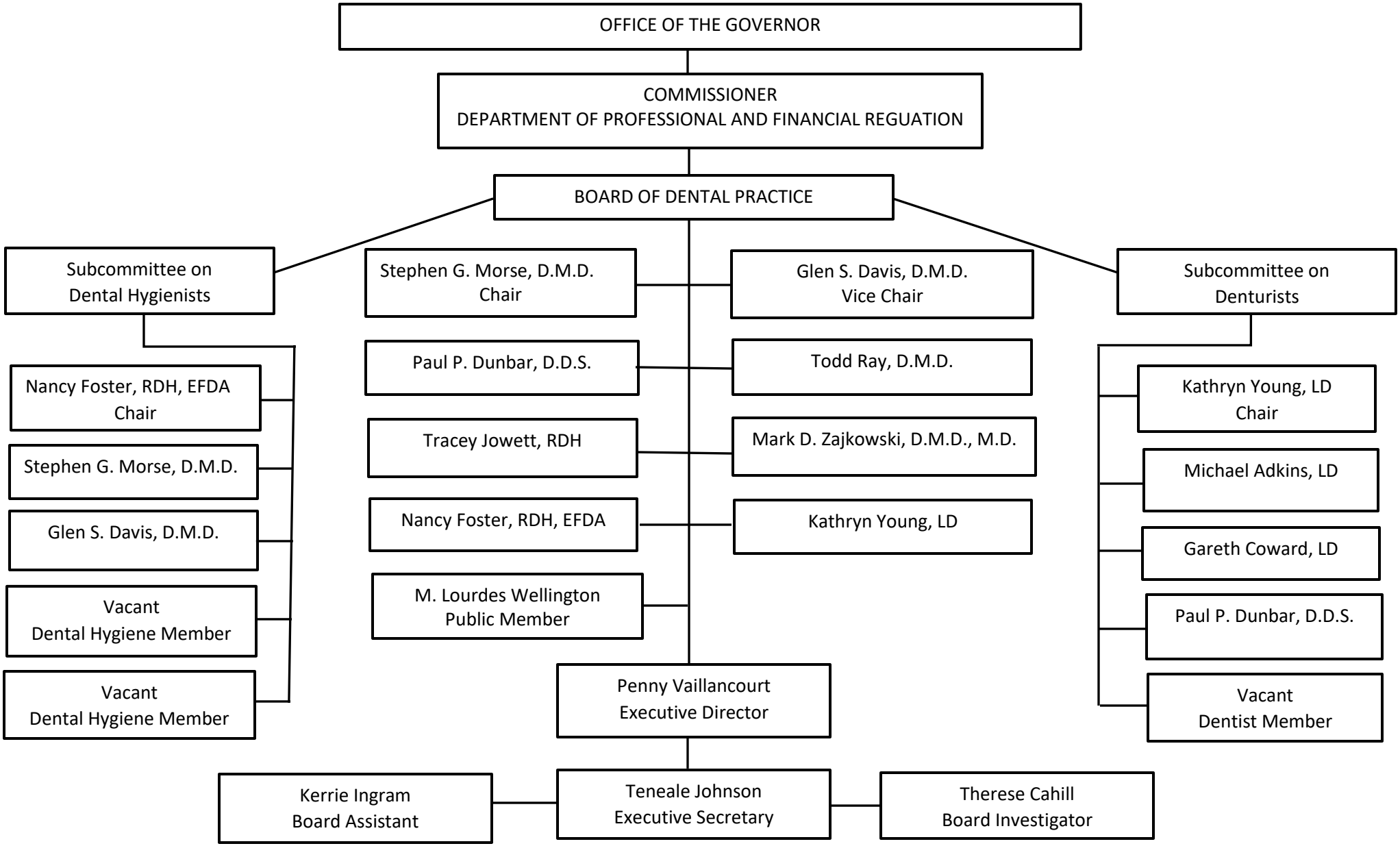
Date: 9/18/19

For the STATE BOARD OF VETERINARY MEDICINE

Donald Hoenig, ~~DVM~~, DVMS

Date: 25 Sept. 2019

Attachment B



October 2019

PROGRAM: **BOARD OF DENTAL PRACTICE (0384)**
FUNDING SOURCE: **Dedicated Revenue**

	FISCAL YEAR	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
ALLOCATED	PERSONAL SERVICES	$191,312	$201,855	$169,061	$175,388	$183,808	$308,261	$322,536	$321,976	$345,282	$353,664
	ALL OTHER	$205,156	$202,929	$213,940	$203,940	$202,822	$219,977	$210,079	$217,990	$270,627	$204,353
	TOTAL	**$396,468**	**$404,784**	**$383,001**	**$379,328**	**$386,630**	**$528,238**	**$532,615**	**$539,966**	**$615,909**	**$558,017**
EXPENDED											
	PERSONAL SERVICES	$144,928	$160,511	$162,117	$164,344	$182,301	$243,427	$264,116	$265,520	$293,472	$282,915
	ALL OTHER	$157,837	$133,392	$138,501	$144,332	$176,520	$179,886	$183,765	$189,552	$224,564	$144,326
	TOTAL	**$302,765**	**$293,903**	**$300,619**	**$308,676**	**$358,821**	**$423,313**	**$447,881**	**$455,072**	**$518,036**	**$427,241**

**Allocated includes funds allotted by Financial Order*

APPROVED | CHAPTER
JUNE 19, 2019 | 388
BY GOVERNOR | PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND NINETEEN

H.P. 1053 - L.D. 1441

An Act To Align the Laws Governing Dental Therapy with Standards Established by the American Dental Association Commission on Dental Accreditation

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §3174-XX, as amended by PL 2015, c. 429, §5, is further amended to read:

§3174-XX. Dental therapy reimbursement

1. Reimbursement. By October 1, 2015, the department shall provide for the reimbursement under the MaineCare program of dental ~~hygiene~~ therapists practicing as authorized under Title 32, section 18377 for the procedures identified in their scope of practice. Reimbursement must be provided to dental ~~hygiene~~ therapists directly or to a federally qualified health center pursuant to section 3174-V when a dental ~~hygiene~~ therapist is employed as a core provider at the center.

2. Rulemaking. The department shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.

Sec. 2. 24 MRSA §2317-B, sub-§21, as enacted by PL 2013, c. 575, §4 and affected by §10, is amended to read:

21. Title 24-A, sections 2765-A and 2847-U. The practice of dental ~~hygiene~~ therapy by a dental ~~hygiene~~ therapist, Title 24-A, sections 2765-A and 2847-U.

Sec. 3. 24-A MRSA §2765-A, as amended by PL 2015, c. 429, §12, is further amended to read:

§2765-A. Coverage for services provided by dental therapist

1. Services provided by dental therapist. An insurer that issues individual dental insurance or health insurance that includes coverage for dental services shall provide

coverage for dental services performed by a dental ~~hygiene~~ therapist licensed under Title 32, chapter 143 when those services are covered services under the contract and when they are within the lawful scope of practice of the dental ~~hygiene~~ therapist.

2. Limits; coinsurance; deductibles. A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

3. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing individual health insurance is the secondary payer.

4. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Sec. 4. 24-A MRSA §2847-U, as amended by PL 2015, c. 429, §14, is further amended to read:

§2847-U. Coverage for services provided by dental therapist

1. Services provided by dental therapist. An insurer that issues group dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by a dental ~~hygiene~~ therapist licensed under Title 32, chapter 143 when those services are covered services under the contract and when they are within the lawful scope of practice of the dental ~~hygiene~~ therapist.

2. Limits; coinsurance; deductibles. A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

3. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing group health insurance is the secondary payer.

Sec. 5. 32 MRSA §18302, sub-§§5, 7 and 8, as enacted by PL 2015, c. 429, §21, are further amended to read:

5. Dental auxiliary. "Dental auxiliary" means a dental radiographer, expanded function dental assistant, dental hygienist, independent practice dental hygienist, public health dental hygienist, dental ~~hygiene~~ therapist or denturist.

7. Dental therapist. "Dental ~~hygiene~~ therapist" means a person who holds a valid license as a dental hygienist issued by the board and is authorized to practice dental ~~hygiene~~ therapy under this chapter.

8. Dental therapy. "Dental ~~hygiene~~ therapy" means the delivery of dental hygiene services, including performance of certain dental procedures in accordance with this chapter.

Sec. 6. 32 MRSA §18302, sub-§29, as enacted by PL 2015, c. 429, §21, is amended to read:

29. Provisional dental therapist. "Provisional dental ~~hygiene~~ therapist" means a person who holds a valid license as a dental hygienist issued by the board and who is authorized to practice dental ~~hygiene~~ therapy under the supervision of a dentist in accordance with this chapter.

Sec. 7. 32 MRSA §18345, sub-§2, ¶¶C and F, as enacted by PL 2015, c. 429, §21, are amended to read:

C. For dental ~~hygiene~~ therapist authority:

~~(1) Verification of having successfully completed a dental hygiene therapy program that:~~

~~(a) Is accredited by the American Dental Association Commission on Dental Accreditation or a successor organization;~~

~~(b) Is a minimum of 4 semesters;~~

~~(c) Is consistent with the model curriculum for educating dental hygiene therapists adopted by the American Association of Public Health Dentistry or a successor organization;~~

~~(d) Is consistent with existing dental hygiene therapy programs in other states approved by the board; and~~

~~(e) Meets the requirements for dental hygiene therapy education programs adopted by board rule;~~

(2) Verification of a ~~bachelor's~~ master's degree ~~or higher in dental hygiene, dental hygiene therapy or~~ in dental therapy from a school accredited by the American Dental Association Commission on Dental Accreditation or ~~a~~ its successor organization or a master's degree in dental therapy from a program that meets the requirements adopted by board rule consistent with the accreditation standards identified by the American Dental Association Commission on Dental Accreditation or its successor organization;

(3) Verification of passing a clinical examination and all other examinations required by board rule. The clinical examination must be a comprehensive, competency-based clinical examination approved by the board and administered independently of an institution providing dental ~~hygiene~~ therapy education;

(4) Verification of having engaged in 2,000 hours of supervised clinical practice under the supervision of a dentist and in conformity with rules adopted by the board, during which supervised clinical practice the applicant is authorized to practice pursuant to paragraph F.

For purposes of meeting the clinical requirements of this subparagraph, an applicant's hours of supervised clinical experience ~~while enrolled in the dental hygiene therapy program under subparagraph (1) may be included as well as hours~~ completed under the supervision of a dentist licensed in another state or a Canadian province may be included, ~~provided that~~ as long as the applicant was operating lawfully under the laws and rules of that state or province; ~~and~~

(5) A copy of the written practice agreement and standing orders required by section 18377, subsection 3; and

(6) Verification of a current advanced cardiac life support certification;

F. For provisional dental ~~hygiene~~ therapist authority:

(1) Verification of meeting the requirements of paragraph C, subparagraphs ~~(1) to~~ (2), (3) and (6); and

(2) A copy of the written agreement between the applicant and a dentist who will provide levels of supervision consistent with the scope of practice outlined in section 18377 and in conformity with rules adopted by the board.

During the period of provisional authority the applicant may be compensated for services performed as a dental ~~hygiene~~ therapist. The period of provisional authority may not exceed 3 years.

Sec. 8. 32 MRSA §18351, last ¶, as amended by PL 2017, c. 388, §12, is further amended to read:

An individual who practices under a resident dentist license or as a provisional dental ~~hygiene~~ therapist may not apply for inactive status.

Sec. 9. 32 MRSA §18371, sub-§5, as enacted by PL 2015, c. 429, §21, is amended to read:

5. Supervision of dental therapists. A dentist, referred to in this section as the "supervising dentist," who employs a dental ~~hygiene~~ therapist shall comply with this subsection.

A. A supervising dentist shall arrange for another dentist or specialist to provide any services needed by a patient of a dental ~~hygiene~~ therapist supervised by that dentist that are beyond the scope of practice of the dental ~~hygiene~~ therapist and that the supervising dentist is unable to provide.

B. The supervising dentist is responsible for all authorized services and procedures performed by the dental ~~hygiene~~ therapist pursuant to a written practice agreement executed by the dentist pursuant to section 18377.

C. Revisions to a written practice agreement must be documented in a new written practice agreement signed by the supervising dentist and the dental ~~hygiene~~ therapist.

D. A supervising dentist who signs a written practice agreement shall file a copy of the agreement with the board, keep a copy for the dentist's own records and make a copy available to patients of the dental ~~hygiene~~ therapist upon request.

Sec. 10. 32 MRSA §18377, as enacted by PL 2015, c. 429, §21, is amended to read:

§18377. Dental therapist

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

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

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

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

(3) Provide referrals;

(4) Administer local anesthesia and nitrous oxide analgesia;

(5) Perform preventive services;

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

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

(8) Administer radiographs; and

(9) Perform other related services and functions authorized by the supervising dentist and for which the dental ~~hygiene~~ therapist is trained.

B. To the extent permitted in a written practice agreement, a dental ~~hygiene~~ therapist may provide the care and services listed in section 18374, subsections 1 and 2 under the general supervision of the supervising dentist.

2. Supervision responsibilities. A dental ~~hygiene~~ therapist may be delegated a dentist's responsibility to supervise up to 2 dental hygienists and 3 unlicensed persons in any one practice setting through a written practice agreement pursuant to subsection 3.

3. Practice requirements. A dental ~~hygiene~~ therapist must comply with the following practice limitations.

~~A. A dental hygiene therapist may provide services only in a hospital; a public school, as defined in Title 20-A, section 1, subsection 24; a nursing facility licensed under Title 22, chapter 405; a residential care facility licensed under Title 22, chapter 1663; a clinic; a health center reimbursed as a federally qualified health center as defined in 42 United States Code, Section 1395x(aa)(4) (1993) or that has been determined by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services to meet the requirements for funding under Section 330 of the Public Health Service Act, 42 United States Code, Section 254(b); a federally qualified health center licensed in this State; a public health setting that serves underserved populations as recognized by the federal Department of Health and Human Services; or a private dental practice in which at least 50% of the patients who are provided services by that dental hygiene therapist are covered by the MaineCare program under Title 22 or are underserved adults.~~

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

C. A written practice agreement between a supervising dentist and a dental ~~hygiene~~ therapist must include the following elements:

(1) The services and procedures and the practice settings for those services and procedures that the dental ~~hygiene~~ therapist may provide, together with any limitations on those services and procedures;

(2) Any age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;

(3) Procedures to be used with patients treated by the dental ~~hygiene~~ therapist for obtaining informed consent and for creating and maintaining dental records;

(4) A plan for review of patient records by the supervising dentist and the dental ~~hygiene~~ therapist;

(5) A plan for managing medical emergencies in each practice setting in which the dental ~~hygiene~~ therapist provides care;

(6) A quality assurance plan for monitoring care, including patient care review, referral follow-up and a quality assurance chart review;

(7) Protocols for administering and dispensing medications, including the specific circumstances under which medications may be administered and dispensed;

(8) Criteria for providing care to patients with specific medical conditions or complex medical histories, including requirements for consultation prior to initiating care; and

(9) Specific written protocols, including a plan for providing clinical resources and referrals, governing situations in which the patient requires treatment that exceeds the scope of practice or capabilities of the dental ~~hygiene~~ therapist.

D. Revisions to a written practice agreement must be documented in a new written practice agreement signed by the supervising dentist and the dental ~~hygiene~~ therapist.

E. A dental ~~hygiene~~ therapist shall file a copy of a written practice agreement with the board, keep a copy for the dental ~~hygiene~~ therapist's own records and make a copy available to patients of the dental ~~hygiene~~ therapist upon request.

F. A dental ~~hygiene~~ therapist shall refer patients in accordance with a written practice agreement to another qualified dental or health care professional to receive needed services that exceed the scope of practice of the dental ~~hygiene~~ therapist.

G. A dental ~~hygiene~~ therapist who provides services or procedures beyond those authorized in a written agreement engages in unprofessional conduct and is subject to discipline pursuant to section 18325.

4. Dental coverage and reimbursement. Notwithstanding Title 24-A, section 2752, any service performed by a dentist, dental assistant or dental hygienist licensed in this State that is reimbursed by private insurance, a dental service corporation, the MaineCare program under Title 22 or the Cub Care program under Title 22, section 3174-T must also be covered and reimbursed when performed by a dental ~~hygiene~~ therapist authorized to practice under this chapter.

Sec. 11. Board of Dental Practice to review dental practice laws and recommend changes. The Board of Dental Practice, in consultation with interested parties, shall review the Maine Revised Statutes, Title 32, chapter 143 and any rules adopted by the board and recommend changes to the statutory definitions of supervision and recommend a definition of "teledentistry" for the purpose of aligning current supervision practices and reflecting advancements in technology. The Board of Dental Practice shall submit its report and recommendations to the Joint Standing Committee on Health Coverage, Insurance and Financial Services no later than February 1, 2020. The Joint Standing Committee on Health Coverage, Insurance and Financial Services may report out a bill to the Second Regular Session of the 129th Legislature based on the board's recommendations.